Banner Health Network

2025
Provider Resource Manual

VERSION 7.01, Updated January 10, 2025

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OVERVIEW

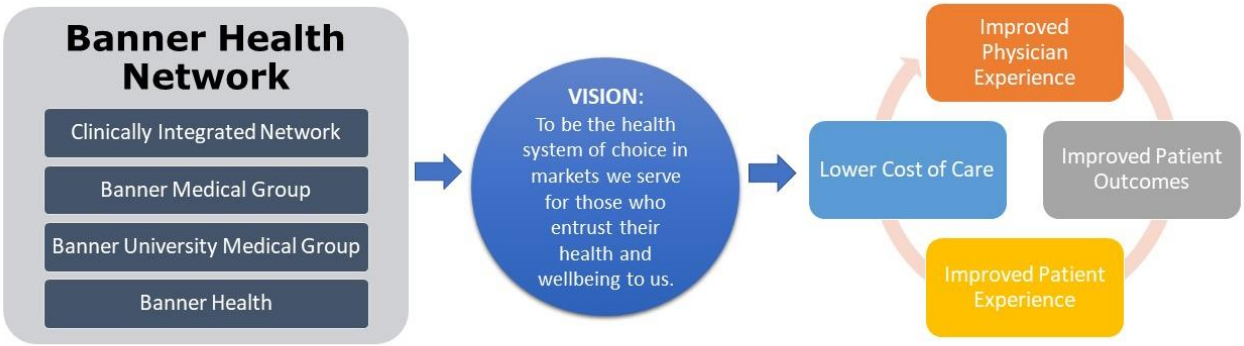
Banner Health Network (BHN) is an Accountable Care Organization that joins nonprofit Banner Health with Banner Medical Group (BMG), Banner University Medical Group (BUMG), and independent provider practices in Maricopa County, Pinal county and Payson.

BHN is comprised of more than 5,000 affiliated physicians and advanced practice providers, 20 Banner Health hospitals, in Arizona along with various other clinical services and facilities. Among other tools, the Network leverages sophisticated health information technology, highly engaged physician partners and community-based nurse case managers to maximize population health management potential and meet the goals of the Quadruple Aim.

BHN is overseen by an 18-member board of directors. Included among the members are 13 physicians representing independent providers and BMG, along with a Banner Health physician administrator. Two community representatives also serve on the board.

The Quadruple Aim is a framework designed by the Institute for Healthcare Improvement for optimizing the performance of health systems by simultaneously focusing on the experience of care, the health of the population, the per capita cost of care and the work life of health care providers.

Our Vision:



Participation Requirements:

All professional, ancillary and hospital services must be delivered by a network provider. Participation in BHN requires a contractual relationship with Banner Plan Administration (BPA), BHN or employment with Banner Medical Group (BMG) or Banner University Medical Group (BUMG).

BHN payer contracts offer participating providers access to Medicare Shared Savings Program (MSSP), Medicare Advantage, Medicaid and Commercial plans, including PPO and HMO.

This manual is an administrative tool for providers and staff, outlining expectations, policies and procedures for participation in BHN. It is not meant to be all-inclusive. Updates are made periodically.

Some sections of the manual provide brief benefit plan summaries and descriptions. If this information differs from the applicable benefit plan booklet, the terms of the member's plan will apply. Providers requiring specific member benefit details should contact the health plan directly. Information can also be found online at **www.BannerHealthNetwork.com**.

This BHN provider resource manual is compiled for providers to find answers to many questions about processes and procedures in doing business with BHN. In the event of a conflict between this manual and your provider agreement, the provider agreement shall govern.

BHN reserves the right to modify these operating guidelines at its discretion. Changes in administrative policy or operating guidelines may be communicated via written correspondence, the BHN website (**www.BannerHealthNetwork.com**), email notices or other formats, including fax.

We want to hear from you!
We value any feedback or comments you may wish to offer regarding this manual or suggestions about other information you would like to see included in future versions. Please share your ideas by emailing Provider Services at **ProviderExperienceCenter@BannerHealth.com**.

CONTACTS & QUICK REFERENCE

Provider Experience Center Team

To better serve our provider network, we've restructured our provider facing teams. Please find current contact information below:

Contact by Telephone:
Telephonic intake hub for all Provider Inquiries for the Health Plan(s) listed below: Refer to the back of the patient's ID card for the customer service phone number. Here are some phone numbers for Banner plans

- AARP Medicare Complete (United Healthcare) 480-684-7070 or 800-827-2464

Contact by Email
Providers can also email PEC at ProviderExperienceCenter@bannerhealth.com. You can also check AARP Medicare Complete (United Healthcare) claim status on https://www.bannerhealthnetwork.com/

Clinical Performance Team
Contact your assigned Care Transformation Specialist or Care Transformation Consultant via their contact number/email address. If you have questions about the assigned staff for your office, please contact ProviderExperienceCenter@bannerhealth.com.

ONLINE PROVIDER PORTAL

Providers have round-the-clock access to important network information through a secure provider portal on the BHN website. By visiting **www.BannerHealthNetwork.com**, you can find forms, claim information and more.

Your Personal Logon
Already have a password?
If you have a Log On, but have forgotten your password, go to **www.BannerHealthNetwork.com**. Choose **Log On** and select **Forgot Information**. The password will be immediately sent to the email address on the account.

Need to create a password?
If you do not have a provider Log On, simply go to **www.BannerHealthNetwork.com**. Choose **Sign Up** from the blue task bar at the top of the page**.** If you have two claims or two authorizations and the associated members' birthdays, you will receive your secure account immediately. If you do not have the claims or authorization information, your account will be created within 48 hours of indicating that you do not have claims or authorization information.

Information available on Provider Tools via the online provider portal includes, but is not limited to:

- Claims Status
- BHN Member Panel
- Prior Authorization requirements and forms
- Provider Interest form (add providers and products)
- Forms & Resources

Health Plan Information

Providers may or may not elect to participate in every plan. Contact your Care Transformation Consultant/Specialist representative to inquire about your current health plan participation.

Other important prior authorization phone numbers, web addresses and contact information can be found on the provider portal under **Provider Tools** and select **Prior Authorizations/Referrals**. Prior Authorization lists and forms, referral forms and links to plan sites can be found there.

Provider Experience Center (PEC)

480-684-7070 or 800-827-2464
ProviderExperienceCenter@BannerHealth.com

Providers can contact the PEC about the topics listed below:

- Claim Inquiries
- Prior Authorization Inquiries
- Reconsiderations/Reopens/Claim Dispute & Appeal Inquiries
- Check Tracer Inquiries
- Credentialing & Contracting Inquiries
- Provider Data Request (PDR) Status
- Refund Inquiries
- BHN Web Portal Inquiries/Assistance
- eServices Web Portal Inquiries/Assistance
- Member Rosters
- Escalated Issues & Provider Complaints

Banner Medicare Advantage Plans

For more information on all Banner Medicare Advantage plans, please visit the Banner Medicare Advantage website.

Banner|Aetna

Banner Health employees are insured by Banner|Aetna. Banner|Aetna is a jointly owned health plan company focusing on better patient outcomes at a lower cost, all while improving the overall member experience for employers and consumers in Arizona. The partnership combines Banner Health's high quality, local providers and delivery systems with Aetna's health plan experience, care management and health information technology.

- For plans of employees of Banner Health, call the Provider Concierge: **855-788-5803**
- Unique phone numbers are designated for different Banner|Aetna plans, so it is important to refer to the member ID card to find the correct number to call
- www.BannerAetna.com
- Navigate to the secure provider website:
  - https://navinet.navimedix.com/sign-in should be updated for Availity, https://apps.availity.com/availity/web/public.elegant.login.
  - Enter provider credentials
  - Select the Banner|Aetna plan view
- The Banner|Aetna Payer ID for EDI is **67895**
- If you have an issue that requires Network assistance, please contact our Provider Contact Center:
  - For health maintenance organization (HMO)-based and Medicare Advantage plans: **800-624-0756**
  - All other plans: **888-632-3862**
- For hospital-based physician additions, changes and terms, please send your request to **AZ-HospitalBasedProviders@aetna.com.**

Banner|Aetna Credentialing Information

- If you have questions related to credentialing including Provider and panel status, please call Aetna's Credentialing Customer Service at **1-800-353-1232**.
- For Physician or mid-level load request, please fax a letter of intent and provider information form to **859-455-8650**, ATTN: Provider Data Services.

BHN Contracts

- Contract questions: **BPAProviderContracting@BannerHealth.com**
- **New providers** joining an existing group practice must submit AzAHP forms and other required documents to **BUHPDataTeam@bannerhealth.com**
- **Address changes, additions or deletions, and name changes**. All provider demographic changes (address changes, additions or deletions, provider name changes, etc.) must be communicated immediately by emailing: **BUHPDataTeam@bannerhealth.com** and attaching the supporting documentation.
- **Provider and contract changes** (contract terminations, changes of ownership and tax identification number changes) must be communicated immediately by emailing: **ProviderLegalNotice@bannerhealth.com** and

attaching the supporting documentation. Please note that tax identification number changes will require a new agreement.

Other Important Contact Information

Banner Home Care

Banner Home Care is the exclusive provider of the following home care services:

- Home Health
- Home Infusion Therapy
- Durable Medical Equipment (DME) Specialty Medical Equipment for Respiratory and Wound Care
  - *Excluding: cardiac monitoring, chemotherapy infusion pumps, diabetic pumps and supplies, hearing aids and speech generating devices*
- Orthotics & Prosthetics (O&P)
  - *Excluding: eye prosthesis*

To obtain any of the services mentioned above from Banner Home Care, please contact the designated phone number listed in the chart below

Type of Service Needed	**Banner Home Health** *Physical & Occupational Therapy, Skilled Nursing for wound care or medication management, Speech Therapy and Dietician Support	**Banner Hospice and Palliative Care**	**Banner HME** Specialty Medical Equipment for Respiratory and Wound Care Cpap, Bi-pap, Non-invasive vents, Airway Clearance Vests, Oxygen and NPWT	**Banner Infusion Therapy** Home IV Therapy ABX, Steroids, TPN, Anti-Nausea's
During Regular hours	480-657-1500	480-657-1100	480-657-1600	602-747-8779
Weekends	480-657-1500	480-657-1100	480-657-1600	602-747-8779
After Hours	480-657-1500	480-657-1100	480-657-1600	602-747-8779
Email Referral	BHCIntake@BannerHealth.com	BHC-HospiceIntakeStaff@bannerhealth.com	bannerhmeleadership@bannerhealth.com	GilbertHITIntake@bannerhealth.com
Fax	480-657-1282	480-657-1786	888-403-4114	480-657-1782

Population Health Care Management

Population Health Management brings a team of people to support your members through the health care continuum. Each one is supported by a team of caring professionals, including a social worker, nurse case manager, registered dietitian, pharmacist, and health service navigator.

How we can help:

- Post-discharge assistance for continued care management support
- Disease/symptom education for newly diagnosed and uncontrolled complex medical conditions
- Managing referrals and communication with physician offices
- Overcoming barriers to self-management and social determinants of health
- Medications (education, therapeutic management, high risk meds, polypharmacy, cost barriers)
- Long term care planning/Advanced Directives and end-of life planning
- Crisis management
- Caregiver distress and family support resources
- Mental health needs (dementia, Alzheimer's, depression, substance abuse)
- Community resources (financial needs, ALTCS and LIS applications, transportation assistance, support groups, food banks, DME, VA benefits, private pay caregivers)
- Home safety concerns
- Additional resources like BHN Healthy Living Classes and Dial into Diabetes program

To make a referral, complete the Case Management Referral Form found on the provider portal and fax it to **480-655-2537**.

If you have any questions, please call **480-747-7799.**

Banner Nurse On Call

Banner Nurse On Call is a 24-hour hotline staffed by specially trained Banner nurses to answer questions about symptoms or medications or offer advice about other health and medical needs. The service is open to all members regardless of plan.

- 602-747-7990
- 888-747-7990

Clinical Connectivity

Clinical Connectivity is Banner Health's online link to clinical information. It is designed for physicians, clinical staff and health insurance staff to access clinical information quickly, easily and on their own schedules.

Applications available via Clinical Connectivity:

- Cerner Millennium: Clinical information for Banner Health facility (lab, imaging reports, dictation, clinical results)
- PACS Synapse: Radiology Imaging/Picture Archive Communication System (PACS)
- Report 2 Web: Free subscription agreement that allows you to receive communication regarding:
    - Notification of your patients coming to all Banner Health ERs/admitted or discharged
    - Labs ordered: Actual post discharge/outpatient labs
    - Cerner documents: ER Reports, H&P, Consults, Operative Notes, Imaging Reports and Discharge Summaries are available
- Direct Secure Messaging (DSM): Secure exchange of clinical health care data between Electronic Health Records (EHR) systems to improve patient coordination of care, enabling Banner Health and health care professionals outside of the organization to send and receive patient health information safely and securely
- Oventus: Perioperative solution to help automate and coordinate booking activities between our OR and surgery schedulers, making it easier for providers to access OR time

Learn more about Clinical Connectivity here: Banner Health: Clinical Connectivity

CARE TRANSFORMATION

Care Transformation representatives support BHN providers and serve as liaisons between contracted providers, their administrative staff and contracted health plans. Specifically, they offer support in understanding and navigating such areas as:

- Population Health Management

Section:A Provider Performance metrics such as Risk Adjustment and Stars Measures

- Practice Management workflows
- BHN policies and procedures
- Requests for participation in BHN
- General contracting and credentialing questions
- Coordinating network provider updates
- Provider specialty updates and changes
- Initial and ongoing provider education
- Interpreting health plan benefits
- Providing access to the provider resource manual, referral forms, formularies, etc.
- Developing and distributing provider communications

Network Provider Change Notification

Please visit the Update Practice Information page on the provider portal to make changes or updates to practice information. Contracted providers **must immediately** inform BHN of changes to the following:

- Name
- Addition or termination of a physician to practice
- Tax identification number (W-9 required)
- Address, phone number(s), billing service, etc.
- Loss of or change in hospital privilege status
- Loss of or change in professional liability insurance
- Loss of or change in licensure of a physician or other provider in the network
- Loss of or change in DEA status
- Practice closure to new patients
- Ability to perform the essential functions of the position, with or without accommodation
- Any other change that may affect status as a contracted provider, thus affecting BHN status

Please note: If a PCP leaves a contracted group, there is no guarantee that the Members will be reassigned within the same group and no guarantee that the Members will move to the PCP's new practice.

Changes must be submitted in writing at least 30 days prior to the effective date of the change. To update information about your practice, please visit the Practice Information Change page on the BHN Provider Portal.

Onboarding

All newly contracted practices and physicians/advanced practice providers are required to complete onboarding within 60 days of their BHN effective date. Onboarding for newly contracted practices will be provided to office staff. Onboarding for new physicians and advanced practice providers is offered directly to those providers. A Care Transformation representative will contact practice managers and/or new providers about onboarding options.

Engagement Meetings

Engagement meetings are held throughout the year and both providers and office staff are strongly encouraged to attend. A separate series for providers and office staff covers relevant topics for each audience. Meeting notices may be sent via fax and email.

RESPONSIBILITIES

Primary Care Physicians
PCPs are the principal health care managers responsible for identifying patients' needs and caring for those needs, including coordinating care with other providers when necessary.

PCP Responsibilities
PCPs caring for BHN contracted health plan members must:

- Support the goals of the Quadruple Aim, including balancing patient satisfaction, quality care and the cost of delivering care
- Support quality measures based on payer contracts by providing preventive services, wellness visits and documenting patient diagnoses
    - Utilize any supporting tools and resources supplied to help in the closure of clinical care gaps and appropriately document diagnosis
    - Support and collaborate on initiatives to increase access to care through alternative levels and settings (IHAs, wellness clinics, etc.)
    - Allow reasonable access for medical chart review and extraction to support risk adjustment and clinical gap closure
- Support the highest professional and ethical standards
- Maintain an office that is clean, accessible, safe and supportive of patient privacy and confidentiality
- Provide medically appropriate, proficient care to achieve the best possible outcomes and patient satisfaction
- Proactively identify and manage high-risk patients who have chronic illnesses
- Deliver high-quality, cost-effective health care, including making all reasonable efforts to provide diagnostic and treatment care within his/her scope of expertise, referring to specialists when necessary.
- **BHN network providers including specialists, hospitals, and ancillary providers should be used whenever services are available within the provider network**
- Demonstrate a commitment to the patient-physician relationship by taking complete patient history information, effectively communicating recommended medical treatments and/or lifestyle changes, and working with the patient and/or patient representative to develop appropriate care plans
- Utilize an Electronic Health Record (EHR) and comply with BHN and CMS Promoting Interoperability (PI) standards of EHR systems;
    - Providers are expected to use a PI EHR system
    - Providers are expected to use an EHR to electronically document and maintain patients' complete health records.
    - Providers are expected to use quality tools to actively manage its population – this may include tools that inform the practice on known care gaps and risk adjustment

  - In order to support quality measurement and to deliver next generation clinical support tools, providers are expected to share data from their EHR system with Banner Health – this may be accomplished through a data interface to the provider's EHR system or data extracts
- Abide by all BHN utilization and quality management policies and procedures
- Be receptive to feedback from BHN regarding practice/clinical behavior patterns
- Comply with all BHN contract terms, policies and procedures, including prior authorization and credentialing requirements
- Abide by service agreement terms that prohibit billing members for anything other than copayments, deductibles and/or coinsurance
- Obtain specific copayments at time of office visits
- Give members prior notice of service(s) not covered by plan and obtain written approval, including member signature, to proceed with non-covered service(s)
- Notify BHN in writing of any changes to his/her practice, including but not limited to changes in address, tax identification number, closure to new patients, and terminations; new providers joining practice, including advanced practice providers.
- Comply with all medical record documentation requirements and submit appropriate claim/encounter data
- During a PCP transition, forward all requested medical records in a timely manner
- Use appropriate health plan Prescription Drug Formulary
- Request non-formulary medications in accordance with individual health plan policies and procedures
- Submit claims electronically, including capitated encounters
- All primary care and office-based specialists contracted with BHN must provide accurate encounter information in a timely fashion
- Any provider offering concierge services within its practice must notify BHN immediately in writing with the names of the individual providers offering concierge services, the effective date for offering these services and the nature of the concierge services offered.

Covered Services (PCP)
PCPs will obtain prior authorization in accordance with authorization guidelines for each member's health insurance. Reimbursement will be paid according to the Provider Services Agreement.

RESPONSIBILITIES

Specialists

When specialty care is needed, PCPs shall coordinate referral to **in-network** contracted BHN specialists. **Referral to non-contracted specialists requires prior authorization.**

Self-Referrals

Before visiting a specialist, members should check with their health plan for additional details about possible copayments or coverage.

Specialist Responsibilities

Specialists caring for BHN contracted health plan members must:

- Support the highest professional and ethical standards
- Maintain an office that is clean, accessible, safe and supportive of patient privacy and confidentiality
- Demonstrate a commitment to the patient-physician relationship by taking complete patient history information, effectively communicating recommended medical treatments and/or lifestyle changes, and working with the patient and/or patient representative to develop care appropriate care plans
- Proactively identify and manage high-risk patients who have chronic illnesses
- Abide by all BHN utilization and quality management policies and procedures
- Specialists are strongly encouraged to implement Electronic Health Record (EHR) systems which fulfill Promoting Interoperability (PI) standards set by CMS
- Be receptive to feedback from BHN regarding practice/clinical behavior patterns
- Discuss treatment recommendations with PCP; obtain additional referral or authorization if services extend beyond those originally outlined by PCP
- Work with PCP to maximize continuity of care
- Send PCP written consult report that outlines findings and treatment recommendations
- **Use only contracted providers, including but not limited to, hospitals, outpatient surgical facilities, laboratories, radiology facilities and pharmacy providers**
- Comply with all contract terms, policies and procedures, including prior authorization and credentialing requirements
- Give members prior notice of service(s) not covered by plan and obtain written approval, including member signature prior to proceeding with non-covered service(s)

- Do not bill members for anything other than copayments, deductibles and/or coinsurance
- Obtain specified copayments at time of office visits
- During a specialist transition, forward all requested medical records in a timely manner
- Use appropriate Prescription Drug Formulary based on the member's health plan
- Request non-formulary medications in accordance with individual health plan policies and procedures
- Submit claims electronically, including capitated encounters
- All capitated providers must provide accurate encounter information in a timely fashion

Covered Services (Specialists)

Specialist physicians who receive a valid PCP referral and/or prior authorization will be paid according to their Provider Services Agreement for the covered services. Member eligibility is not guaranteed. If membership lapses during their treatment, the former member/participant is financially responsible for services rendered after the date of termination.

Access to Care/After-Hours Protocol

Contracted network physicians must provide appointment availability to plan members as follows:

- Emergency and Urgent Care – Within 24 hours or less
- Routine Follow-up Care – Within seven (7) Days
- Elective Care – Within 14 business days

All primary care physicians and office-based specialists contracted with BHN must provide or arrange for medical care for their patients 24 hours a day, seven days a week, including phone accessibility.

The provider or the designated covering physician or health care professional must be available to provide care personally or direct the member to the most appropriate treatment setting.

Authorization is not required for urgent or emergent care, whether in or out of the service area.

Members should call 911 or go to the nearest hospital in case of an emergency.

Physician Office Hours

Information about office hours and after-hours instructions must be clearly noted and easily accessible. Provider will generally be available and accessible by phone seven days per week and 24 hours per day, while maintaining reasonable office

hours of at least six hours per day, five days per week; provided, however, that when Provider is not available, Provider will: (a) secure coverage for Members by other Participating Providers, and such coverage for primary care Members will be by other primary care Participating Providers; and (b) arrange for urgent care and Emergency Services coverage if Provider is unavailable due to vacation, illness, or after hours; in each case assuring that the covering Participating Provider furnishes services on the same terms and conditions and in compliance with all standards required by this Agreement.

Physician Panels

To open or close a member panel, please reach out to your assigned Care Transformation Consultant or Specialist. If you are unsure of who that is, please contact our Provider Experience Center at 480-684-7070 or 800-827-2464 or ProviderExperienceCenter@bannerhealth.com.

Updates/Changes
Panel Change - Open or Close Panel
Submit AzAHP Practitioner/Practice Change Form
Submit to BUHPDataTeam@bannerhealth.com

Discharging a Member from Your Care (PCPs and Specialists)

In the event that a provider (PCP or specialist) encounters a patient who unreasonably refuses to follow the course of prescribed medical treatment or otherwise behaves in an unreasonably disruptive manner, the patient can be discharged upon physician request, given the physician has made good faith efforts to work with the patient.

Below are guidelines for appropriately discharging a patient:

- The physician must provide the patient with a 30-day written notice of discharge, sent via certified mail with return receipt requested.
- The letter should indicate that the patient is being discharged from your care along with instructions for the patient to contact his or her health plan for assistance selecting a new PCP or specialist.
- The physician must be available for urgent and emergency care during the 30-day notice period.
- Send a copy of the discharge letter to the appropriate health plan.

Affirmation of Ethical Decision Making

At BHN, utilization management decisions are based solely on medical necessity and appropriateness of care in accordance with the terms of plan coverage. Providers are not compensated for denying coverage, and there are no incentives for inappropriate under-utilization of services.

All BHN participants, including physicians, employees, consultants and management staff responsible for utilization management decisions, must sign an Affirmation of

Ethical Decision-Making statement as part of the contracting process and each year thereafter.

BHN's Affirmation of Ethical Decision-Making statement is available at **www.BannerHealthNetwork.com.**

Annual Compliance Attestation and Disclosure Statement

The Centers for Medicare & Medicaid Services (CMS) identifies certain contractors as First Tier, Downstream and Related Entities (FDRs). Those entities have particular obligations to minimize the inappropriate use of federal health care funds. BHN is contracted with several MA plans—under which BHN is considered a First-Tier entity—and therefore is subject to those obligations. According to regulatory guidance, your practice is considered a Downstream Entity to BHN, and therefore, CMS holds you subject to those obligations as well.

BHN Compliance performs an annual risk assessment and randomly selects a sample of providers in which we request that they complete a Compliance Attestation and Offshore Attestation, if indicated from Compliance Attestation response. These documents, when completed, memorialize the selected provider meets the obligations set forth by CMS regarding the use of federal health care funds. Providers are required to be compliant with applicable CMS regulations in order to participate in Banner networks.

Communication Options

An open line of communication is critical to the success of the Compliance Program and
multiple lines of communication are accessible to all Provider or Business Partners. Provider and Business Partners per their contracts, are expected and encouraged to report any actual or suspected violation of the laws or regulations relating to Medicare, AHCCCS, government program, or any other state or federal law.

Concerns can be reported to an employee's supervisor or to the Compliance Officers via phone
call, email, in-person report, mail, or fax (see below for contact information) or via the ComplyLine at **1-888-747-7989** / **https://bannerhealthcomplyline.ethicspoint.com**. Concerns can also be reported to BHN's President, the CEO of BMA, BMA-Dual, or B – UFC CEO, BNC or BNSA's Director, or BPA's VP ASO Administrator.

Provider Resources

Electronic Health Records (EHR)

All primary care providers are required to utilize an EHR. Specialist physicians are highly encouraged to adopt EHR systems.

The use of EHR technology among PCPs is a requirement of CMS standards as well as a mandate of the BHN Board of Directors. The Board wishes to ensure that our providers are offering the highest standard in patient care and to demonstrate measurable quality.

BHN has partnered with two leading EHR organizations:

- Cerner Ambulatory
- eClinicalWorks

To schedule a web-based product demonstration, please speak with your Care Transformation Consultant or Specialist.

Marketing Materials

Provider-created marketing materials that co-brand with BHN must be submitted to BHN for review and approval. In some cases, such materials may need to be forwarded to the applicable Medicare Advantage health plans for review and approval. BHN's contracted providers are bound by BHN policies and Medicare Marketing Guidelines. Marketing materials are defined as any materials developed and/or distributed by entities covered by the Medicare Marketing Guidelines and targeted to Medicare beneficiaries.

OVERVIEW OF BHN PLANS & PRODUCTS

A current summary of BHN plans is available on the Provider Portal. Contact your Care Transformation Consultant or Specialist for more information.

MEMBER IDENTIFICATION (ID) CARDS

Providers should verify member eligibility and collect the appropriate copayment at each visit. Members are informed that copayments are due at the time of service.

To check benefits for an AARP Medicare/United Healthcare member, logon to United Healthcare's portal.

Providers may confirm eligibility and benefits by calling the customer service number(s) on the back of the member's ID card. Possession of an ID card does not guarantee eligibility or current PCP assignment.

CONTRACTING

Providers must submit an online request through the **Become a Participating Provider** link on **www.BannerHealthNetwork.com** or use this link to the online form: Join the Network/Update Practice Information. Please allow approximately 120 days for a response. Please attach all requested forms.

Submission of a request does not guarantee participation. Participation is based on network need and is contingent upon successful completion of contracting and credentialing.

Requesting additional products should also be submitted by email to BPAProviderContracting@bannerhealth.com.

A request to add a practitioner to an existing contract should be submitted to BUHPDataTeam@bannerhealth.com with the required AzAHP form and attachments. Please note that based on a provider's specialty or geographic service area, we may not be able to add all requested providers or products to an existing contract.

Provider Agreement

Upon approval of a participation request, a provider agreement including relevant product and reimbursement exhibits will be generated, for review and electronic signature. The agreement outlines the relationship between the provider and the provider network.

Contract documents will be submitted to the provider via email through BHN's contract management system. Providers should electronically sign the contract documents and return them as instructed in the cover letter.

Failure to return the provider agreement, credentialing information and/or requested attachments in 90 days will result in cancellation of the contracting and credentialing processes.

Provider contracts are executed after we have received the signed contract and all required documents for credentialing. The contract will have an effective date of 45-60 days after both parties sign the contract. The executed contract will be submitted to the provider via DocuSign after loading into BHN systems has been completed. Each practitioner's effective date will be the latter of the contract effective date or the practitioner's credentialing effective date.

Most BHN products require that the practitioner also hold a direct contract with the health plan. A practitioner contracted and credentialed with BHN will not be effective for a product until after the health plan also contracts and credentials the practitioner.

If a request to participate in BHN is denied, the practitioner will receive a letter from Banner Plan Administration. The practitioner may reapply in six months.

Hospital Privileges

Practitioners must have clinical privileges in good standing at a hospital/facility that is designated by the practitioner as the primary admitting facility or a documented coverage arrangement through an affiliated practitioner or hospitalist.

- BHN members should be admitted to a Banner hospital or a BHN contracted hospital
- Practitioners exempt from the requirement of clinical privileges may include specialties for which hospital requirements are not needed, such as primary care, optometry, or endocrinology. Please refer to your provider contract for additional information on requirements.

Providers who are required, but do not have privileges at a Banner Health or in-network hospital must apply for and be granted privileges prior to seeing BHN patients or must request and be granted an exemption. Exemption requests must be made in writing at the time of application.

Providers are not authorized to treat BHN-contracted health plan members until they have completed the contracting and credentialing process and have received written participation notification from both BHN and the health plan.

CREDENTIALING

Before providing care to Banner Health Network members, practitioners are required to be credentialed per The National Committee for Quality Assurance (NCQA), State and Federal regulatory requirements. Practitioners that fall within the scope of credentialing will go through initial credentialing, re-credentialed at least every three years and ongoing monitoring conducted while participating within the network. The Credentialing program structure has established policies, procedures and criteria for network participation to ensure the credentialing department maintains compliance with required regulatory and accreditation standards.

A completed AzAHP form or roster should be completed in its entirety and emailed to BUHPDataTeam@bannerhealth.com.

Credentialing Program Resources

The CMO Senior Medical Director (Chairman) or designee and the Credentialing committee are responsible for the clinical aspects of the credentialing program. The Chairman has direct responsibility for the credentialing program.

1. The Chairman's responsibility includes but is not limited to:
   a) serving as a Chairman for the Credentialing Committee, Approves, reports, and distributes meeting minutes to members of the Credentialing Committee.
   b) Reviews and approves "clean files" (those meeting the clean file criteria).
   c) Reviews and approves credentialing policies and procedures.
   d) Performs peer review of practitioners who fail to meet the performance criteria and decides appropriate action(s).
   e) Provides primary oversight of all delegated credentialing activities.
   f) Reviews applicant's credentialing and approved or denies applications.

2. In addition to the role of the Chairman, resources in the credentialing program include:
   a) Credentialing Network Coordinator
   b) Credentialing Specialist
   c) Associate, Manager of Credentialing
   d) Associate, Director of Credentialing

Credentialing Committee Structure and Responsibilities

The Credentialing Committee is composed of a range of participating practitioners, including at least one primary care provider, specialty care and behavioral health practitioner and at least one participating practitioner who has no role in the management of the Banner Health Plan(s). The Credentialing Committee also includes practitioners with representation from these networks. Annually, each of the participants of the Credentialing Committee electronically sign a confidentiality agreement that addresses the confidential nature of the information reviewed, subsequent decision, conflict of interest, and nondiscrimination.

The Credentialing Committee does not make credentialing and re-credentialing decisions based on an applicant's race, ethic/national identity, gender, age, and sexual orientation or patient in which practitioner specializes and the Credentialing Specialists do not include this information when the file is presented to credentialing committee for review. This does not preclude the Provider Network from including practitioners in the network who meet certain demographic or specialty/cultural needs. Practitioner complaints received through the Network Management or Provider Relations Department are tracked to identify alleged discrimination occurrences. The results of these audits are presented to the Credentialing Committee annually.

Initial Credentialing and Recredentialing for Individual Practitioners:
Every practitioner required to go through the credentialing process must complete the credentialing application and attest to the accuracy of the information provided. BHN utilizes the Credentials Verification Organization (CVO) for the processing of the required primary source verified documentation. The CVO utilizes the Council for Affordable Quality Healthcare (CAQH) universal credentialing application. The application must have current information, be electronically signed, and dated and attested to include a review of:

a) Reason for inability to perform the essential function of the position
b) Lack of present illegal drug use
c) History of loss of licensure and felony convictions
d) History of loss of limitation of privileges or disciplinary action
e) Current malpractice insurance coverage.
f) Current and signed attestation confirming the correctness and completeness of the application.

All files completed through the CVO are processed according to State, Federal and NCQA standards. Once the file is received from the CVO the Credentialing Specialist reviews the file to ensure all necessary elements are included and if additional documentation is required. If it is identified the application is incomplete, a notification in writing or electronically is sent within seven calendar days after receipt of the of the application and include detailed list of missing information. After 30 calendar days and three outreaches are made for missing information the practitioner application is deemed withdrawn. Once the file review and additional required documents are received the file is prepared for credentialing committee review against the credentialing file criteria. If there are no issues or concerns identified within the practitioner file, it is included and becomes a part of the weekly clean file review performed by the credentialing committee chairperson for a decision. All files identified during the Credentialing Specialist review of the file as having concerns or issues identified against the credentialing criteria will be added to the monthly credentialing committee meeting for review and a decision.

All Practitioners are required to be recredentialed at least every 36 months for continued network participation. The credentialing department will prepare a roster of practitioners each month for processing by the CVO. The CVO will notify the

practitioners of the recredentialing process and required documentation promptly to meet the 36-month requirement. Failure to return the required documents by the deadline constitutes a decision by the practitioner to voluntarily discontinue participation in the B-UFC network. If a practitioner has a break in the participation of the BHN network that is more than 30 calendar days, the practitioner must go through the initial credentialing process.

Quality monitoring is conducted during the recredentialing process according to NCQA requirements. The credentialing department receives Quality of Care, Grievances and Appeal, Utilization, and Performance Data. The Credentialing Specialist completes the practitioner Quality Monitoring form and includes the document with each practitioner file.

Every practitioner going through the initial and recredentialing process has the right to review the information submitted to support the credentialing application. In the verification process, if any discrepancies are found in the information provided by a practitioner, the Credentialing Specialist contacts the practitioner by phone or in writing to validate the correct information. The Credentialing Specialist must notify the practitioner if there is a substantial variation in information regarding actions on licenses, malpractice claims history, or board certification. The practitioner may not review references or recommendations or other information that is peer review protected, and the credentialing department is not required to reveal the source of information if law prohibits disclosure.

Every practitioner also has the right to receive the status of his or her credentialing application and to correct any erroneous information in their credentialing application prior to the credentialing committee date, by email or by phone, and are provided with a deadline for submitting the corrections. The notifications include the following:

a) Erroneous information must be corrected within seven calendar days.
b) Submission of correction must be in the correct format.
c) Corrections must be submitted to the Credentialing Specialist.
d) Receipt of the correction is documented.

Upon request a practitioner will receive a copy of these rights.

All initial applicants will receive a written or electronic acknowledgement within seven calendar days, and all completed credentialing applications are processed within 60 calendar days as required by AHCCCS. Practitioners are notified of the credentialing and re-credentialing decisions within seven calendar days of the credentialing decision. Recredentialing applications where the decision was made to terminate the practitioner participation within the network will include instructions on appeal rights.

Ongoing Monitoring & Interventions

On a monthly basis, Practitioner and Facilities within the BHN network will be reviewed against reports received from various sources to determine any possible adverse events, disciplinary, non-disciplinary taken against a provider, which includes exclusions or ineligibility from any Federal or State programs and adverse license actions. Any action that terminates the provider from practicing independently and providing services as outlined within the contract(s) will be terminated from the BHN network. Any action that terminates the provider from temporarily providing services to members and is not related to quality reasons may be considered for reinstatement if the Credentialing department receives documentation that the issue was resolved within 30 calendar days of the termination. If the termination lasts more than 30 calendar days, the provider must complete the initial application process.

The Quality Management Department may refer potential quality of care concerns to the Credentialing committee. The referral will include:

a) Any corrective action plan(s) or action(s) to resolve the concern.
b) Any education/training that was completed.

The Peer Review Committee will refer any concerns regarding a provider's credentials to the Credentialing Committee. The Credentialing Committee may take appropriate action including termination from the BHN network.

Practitioner Site Quality

At least every six months, the credentialing staff will receive Grievance and Appeals data and will review for member complaints regarding office site quality. If two or more member complaints are received within a six-month timeframe, it may warrant a site visit. These results will be shared with the Credentialing Committee for review and any further possible action, if warranted. The site visit will be conducted within 60 calendar days. The following member complaints will be considered during review of the G&A data.

a) Physical accessibility
b) Physical appearance (handicapped accessible, well-lit waiting room, etc.)
c) Exam room space
d) Adequacy of equipment
e) Adequacy of medical/treatment record keeping.

A CAP (corrective action plan) is completed for any site visits where deficiencies are found with a plan to remedy within 15 calendar days. A follow-up visit is conducted within 30 calendar days once all deficiencies have been completed. These results will be shared with the Credentialing committee for review and any recommendations.

REFERRALS & PRIOR AUTHORIZATION

This section pertains to plans that have delegated the processing of prior authorization and utilization management to BHN. More information can be found in the Forms and Resources section of the secure website at **www.BannerHealthNetwork.com.**

The following guidelines establish minimum standards of evaluation and care that must be met prior to PCP referral to a BHN specialist. **Prior authorization is required for any services that are provided by an out-of-network provider/facility.** Prior authorization must be requested through the PCP. **For a complete list of services requiring prior authorization, visit www.BannerHealthNetwork.com**.

- For Banner|Aetna prior authorization information, visit www.banneraetna.com.
- For Banner Medicare Advantage prior authorization information, visit Banner Medicare Prior Authorization

Please note that each Plan managed by BHN has a separate prior authorization list, which is also available at BannerHealthNetwork.com.

Prior Authorization Guidelines

The PHSO Pre-Service Authorization Department is delegated to review requests for AARP United HealthCare Medicare Complete and delegated Banner|Aetna members. For Banner|Aetna members, requests can be submitted telephonically, by fax, mail or hand delivery.

The prior authorization submission processes outlined below apply to the following health plans:

- AARP Medicare Complete (United Healthcare)
- Banner|Aetna Commercial

Note: Prior authorization does not apply to the MSSP program.

Nurses, medical directors, pharmacists and board-certified specialists conduct medical reviews as needed to ensure services are:

- Included in an individual's benefit plan
- Provided at the most appropriate level of care and site
- Medically necessary

Prior authorization requests may be made via:

- Phone (PEC): **480-684-7070**; option 4
- Fax: 866-238-5564 or 520-874-3420 (inpatient/SNF/LTAC notifications)
- Mail:
  Banner Health Network
  Attn: Prior Authorizations Department
  PO Box 16423
  Mesa, AZ 85211-6423
- Hand delivery:
  Banner Health Network
  Attn: Prior Authorizations Department
  525 W. Brown Road
  Mesa, AZ 85201

Authorization requests should include:

- Name(s) of provider(s) already consulted
- Findings of provider(s) already consulted
- Rationale for service(s) needed
- Rationale for requiring non-network provider (if applicable)

The Authorization form is available at **www.BannerHealthNetwork.com**.

For questions about a prior authorization, please visit the secure provider portal on the BHN website, **www.BannerHealthNetwork.com**, or call **480-684-7070** or **800-827-2464**.

Upon receipt, authorization requests will be date stamped, and member eligibility verified. Failure to provide adequate documentation, including PCP and/or specialist's current notes, relevant labs, X-ray results and/or pre-op clearance, if required, may result in processing delays. The PCP and member will be notified of the request status.

All requests for service should be coordinated through and initiated by the PCP to maximize the continuity of care, unless the member is out of the service area. Authorization is not required for Emergency Department services. BHN prior authorization services are available 24 hours a day, 365 days per year.

Notice on Missing Prior Authorization Documentation

The Medical Management staff will contact the provider's office to request any missing information to document that the request is medically necessary. Two attempts to obtain records will be made.

If additional information is not received, the request will be reviewed with the information on file. If the request is denied, the member will need to follow the appeals process, which may result in a delay of service for your member.

Routine Referrals

An adequate medical evaluation should precede and be included with a referral. A BHN referral form is available, but you may use the practice's EHR generated referral for routine referral forms.
The evaluation should include the patients: Health history

- Physical exam
- Baseline testing as indicated
- Working assessment plan

The evaluation should anticipate the possible need for surgery. **If surgery is likely, medical clearance should be granted and documented prior to referral.**

Communication between the PCP and specialist is vital. Relevant X-rays, labs and clinical notes should be shared with the specialist at the time of referral.

Urgent/Emergent Care Needs

Treatment at an Emergency Department or Urgent Care does not require prior authorization.

Referrals to Non-Participating (Out-of-Network) Providers

Prior authorization is required for all services not available through a BHN-contracted provider, including:

- PCP and specialist procedures included in the current Prior Authorization list
- Out-of-Network (OON) services
- Out-of-Area (OOA) services

Please note: many AARP Medicare Complete (United Healthcare) members have access to a program called Passport. For members visiting outside of Maricopa and Pinal County and utilizing their Passport benefit, some services may not require prior authorization(s).

Post-Emergency Department and Urgent Care Follow-up

Patients are encouraged to follow up with their PCP after an emergency department or urgent care visit.

If the member was seen by a non-BHN specialist while in the emergency department or was referred to a non-BHN specialist by the emergency department, members will need approval to have one transition of care visit to complete care with the provider and to prepare for transition to an in-Network provider.

If ongoing health concerns necessitate continued care from the non-network specialist, prior authorization is required. The specialist must submit pertinent documentation explaining the need and requesting continuing care.

Post-Hospitalization Follow-up

Patients are encouraged to follow up with their PCP after discharge from the hospital. Prior authorization is required for any out-of-network specialists prior authorization is required, and can be submitted by the specialist for continuity of care, with appropriate documentation to support medical necessity.

After-Hours Prior Authorization

Authorization is not required for Emergency Department services. The answering service will direct members experiencing a medical emergency to hang up and dial 911.

Requests for after-hours prior authorization of non-emergent services will be processed by the answering service as follows:

- Answering service operator will record the caller's name, telephone number and affiliation (e.g., Banner Boswell Medical Center requesting member transfer to a skilled nursing facility)
- Information is promptly forwarded via email and electronic text message alert to the BHN After-hours registered nurse
- The BHN registered nurse will contact the caller to facilitate prior authorization, utilization management, or other member needs
- When appropriate, a BHN registered nurse will coordinate care through the established ancillary network (e.g., contact home health, arrange transportation, etc.)

Calls forwarded to the After-hours prior authorization nurse will be triaged for urgency.

Emergent or urgent requests will be processed immediately. Non-urgent requests will be deferred until the next business day.

Prior Authorizations for AARP Medicare Advantage (United Healthcare)

Submit request form by fax 866-238-5564

eviCore manages the following authorizations.

- Cardiology
- Cardiac CT, MR, PET
- Diagnostic Heart Cath

- Echo
- Interventional Pain Management
- Joint/Spine Surgery
- Medical Oncology
- Musculoskeletal
- Nuclear Stress
- Occupational Therapy
- Physical Therapy
- Radiation Therapy
- Stress Echo

eviCore Contact Info

- Fax: **888-693-3210**
- Phone: 888-444-9261
- Web: **www.evicore.com/pages/providerlogin.aspx**
- To review CPT Codes that will need prior auth see eviCore website
    - https://www.evicore.com/healthplan/bannerhealth

During the authorization process, approvals will either be automatic, or denials may be issued. Denials may require additional clarification or documentation and can be appealed.

When submitting information for approval on the eviCore.com portal, the membership that eviCore manages for BHN will be listed under **Banner Health Network** (e.g., AARP Medicare Complete United Healthcare). For the Banner Health employee membership under Aetna, select **Aetna Consumer Business.**

All other areas

All radiology, cardiopulmonary, therapy, ancillary and laboratory services should be provided at a contracted facility. Visit **www.BannerHealthNetwork.com** for a list of current contracted BHN providers and facilities.

Authorization Timelines

Urgent requests for infusion medications will be reviewed within 24 hours. Non-urgent requests for infusion medications on the PA list will be reviewed within 72 hours. All other urgent requests are reviewed as soon as possible, but no later than 72 hours of receipt of the request. Per CMS, the definition for Expedited/Urgent/STAT is: The Standard review timeframe may seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function.

Standard or Routine requests are reviewed within 14 calendar days.

The requesting provider will be notified of the request approval or denial via fax confirmation. The member will receive a written letter notifying him or her of the request determination. If the request is denied, the letter will outline the determination appeal process.

Please refer to Exhibit 1 for timelines associated with notification to commercial and Medicare Advantage plan members.

Questions?

Contact the PEC at **480-684-7070**; option 4 (metro Phoenix); toll-free **800-827-2464**.

Contact eviCore at www.evicore.com. They are available **24/7** and the quickest way to create prior authorizations and check existing case status. Or you can call them **at 888-444-9261** from 7 a.m. – 7 p.m. local time Monday – Friday.

CARE MANAGEMENT

The Population Health Management (PHM) model at Banner Health Network includes providing one-to-one care management for members. PHM is the support and empowerment of patients to make informed decisions while assisting them to navigate the health care system to access appropriate care. PHM also works to build strong partnerships with providers, while developing system improvements to support patient centered care. PHM encompasses a broad continuum of care services, from wellness and prevention through disease management and complex care management. This continuum of care represents the evolution of traditional disease management from one focused on managing single chronic conditions to one focused on managing multiple comorbidities. It recognizes that early intervention can keep healthy people well, help those who are at risk stave off the development of chronic conditions, and educate those with chronic illnesses about condition management techniques to mitigate complications and exacerbations.

Multidisciplinary Team Approach

PHM utilizes a multidisciplinary approach to member-centric health management goals and education, which may include primary prevention or behavior modification programs. The care management team supports BHN members within the MSSP, Banner|Aetna, Banner MA, B-UFC/ACC, Humana MA and UHC MA populations and works with their providers. This includes our NPA and BMG provider networks. (Note: we do work with members if their provider is not a BHN provider; this does occur with our MSSP members at times)

Team members include:

- Medical Director
- Providers
- RN Care Managers
- Health Partners (LMSW/LCSW)
- Health Service Navigators
- Pharmacists
- Dietitians

Services

Providers can access a wide range of care management services for their members to fit the specific needs for that member.

- Comprehensive needs assessment and initiation of interventions
- Care coordination across such service areas as:
    - Emergency care
    - Acute medical/surgical care
    - Skilled nursing
    - Custodial care

  - Physician office care
- Help accessing health plan services, community resources and financial assistance
- Develop individualized care plans, including goal setting, by working with the member, physician(s), family/caregiver
- Treatment plan education and reinforcement, including support services
- Assistance scheduling ongoing and/or follow-up care
- Support transitioning to new care environments (e.g., assisted living, group home setting)
- Referral for behavioral health services, including counseling and support groups
- Referral to Dial Into Diabetes for our members with Diabetes
- Referral to other appropriate disease management programs

Referrals to Care Management

Patients are identified as candidates for care management via:

- Initial BHN membership assessments
- Physician referrals (PCP or specialist)
- Care managers at:
  - Hospitals
  - Skilled nursing facilities
  - Emergency Departments
  - Home health agencies
- Service Center
- High risk/chronic disease diagnoses (e.g., CHF, COPD, CVD, diabetes)
- Medical Management department staff RNs (prior authorization or concurrent review)
- Frail Elderly System Algorithms

Care managers request assistance from other team members as needed.

BHN members must agree to enroll and participate in care management. They have the right to opt out of services and/or related education programs.

Enrollment in BHN care management is voluntary and there is no cost to members. Members may disenroll at any time.

FAST FACTS ABOUT BHN CARE MANAGEMENT

Q: ***Which patients in my office would benefit from referral to care management?***

A: Patients who have the following:

- Multiple related hospital admissions
- Diagnosis of a catastrophic or chronic illness resulting in major changes in lifestyle, living arrangements or caregiver roles
- Suspected emotional, social or financial problems complicating health status
- Suspected knowledge deficit about disease process
- Diabetes Management: New Diagnosis, Chronic or At Risk for Diabetes
- Non-adherence with medication, diet, medical treatment or appointments
- Cognitive/behavioral issues that contribute to poor self-care or impaired decision making
- Banner MA, B-UFC/ACC, Humana MA, and UHC MA for their primary health insurance

Q: ***What is the difference between referring to care management and home health?***

A: Home Health is utilized when a nurse is required to physically assess a member and report back on medical findings, or when skilled nursing care is required in the home for dressing changes, injections, infusion care, therapy, etc. Care management evaluates the social/clinical risk in the home/family and intervenes when appropriate to promote outpatient resources that may improve a member's health, safety and ability to continue safely living at home.

Q: ***Why would my patient benefit from this program?***

A: Care managers perform comprehensive member screenings and assessments to identify areas of potential need/support. They have facilitated member compliance with established medical treatment plans or initiation of new treatment plans in collaboration with physician(s). Care managers assist members in maximizing appropriate health plan benefits and accessing community services and resource programs.

Q: ***How can my patient receive services from this program?***

A: You or your staff can complete and return the Care Management Referral form available at **www.BannerHealthNetwork.com**. A care manager will contact your patient by telephone and arrange an appointment.

To meet confidentiality standards and abide by release of information rules, please inform the patient that a referral has been made and that they will be receiving a call from a BHN care manager.

Q: ***How will I know when my patient has been contacted by the care manager?***

A: Providers receive a summary from the care manager detailing the initial assessment, needs identification and recommended interventions. This communication initiates collaboration between the physician, member and care manager.

Referral to Care Management

- Care management referral forms available online: **www.BannerHealthNetwork.com**
- Fax: **480-655-2537**
- Phone: **602-747-7799**
- Email **BHNPopHealthSpec@BannerHealth.com**

Hearing Impaired Service

Members with hearing impairments may access Care Management staff and programs through the teletypewriter (TTY) line and Banner Health's contracted interpreter services.

TTY Line: (800) 367-8939

Interpreter Service:
Valley Center of the Deaf
3130 Roosevelt Street
Phoenix, AZ 85008
Phone: **602-267-1921**
Fax: **602-273-1872**

If an interpreter is unavailable, contact:
Freelance Interpreting Services
6420 E. Calle de las Estrella
Cave Creek, AZ 85331
Phone: **480-595-9515** (available 24/7)
Fax: **480-595-9516**

Advance Directives

Life Care Planning (Advance Directive) documents are created by the Office of the Arizona Attorney General.

Under federal law, all patients entering any hospital have the right to choose and refuse medical treatment. Sometimes patients become unable to make their own

decisions regarding medical treatment. Advance directives, written statements created by patients, can help health care providers and family members understand what the patient truly wants. Advance directives enable patients to document their health and end-of-life care decisions.

The Life Care Planning Packet and downloaded advance directive forms are available online at: https://www.bannerhealth.com/patients/patient-resources/advance-directives/forms**.** A list of additional advance directives resources can also be found on the BHN Provider Portal under **Forms & Resources**; scroll down to find it under **Resources.**

QUALITY MANAGEMENT

The BHN approach to clinical quality is based on the following principles:

- **Patient and Provider Satisfaction** – Meeting and exceeding the expectations of those we serve by actively engaging patients and families in the care process.
- **Teamwork** – Encouraging all parties to communicate and work collaboratively to meet the needs of those we serve.
- **Continuous Improvement** – Implementing process improvement strategies designed to improve clinical outcomes.
- **Evidence-based Practices** – Leveraging data from internal sources and credible external research to develop expected clinical practices.
- **Clinical Innovation** – Utilizing Banner Health's rapid identification and care deployment strategies to ensure an extraordinary patient experience that is safe, efficient and effective.
- **Culture of Safety** – Establishing a culture of safety that encourages, instills and inspires accountability and responsibility.
- **Learning** – Promoting organizational learning and knowledge sharing within Banner Health and other health care organizations to improve quality and patient safety.

Clinical Care Management Committee

The BHN Board of Directors delegates responsibility for oversight of clinical quality to the BHN Care Management Committee. The committee leads development of plans and activities designed to enhance care management and the delivery of high quality, cost-effective, coordinated care.

Functions of the Clinical Care Management Committee:

- Adopt a formalized process to review care delivery; evaluate results to ensure the plan is executed as intended/designed
- Identify emerging quality issues and recommend strategies to address such issues
- Assess quality measure data with a focus on patient safety, preventive services, chronic disease management and adherence to expected clinical practices
- Identify and analyze opportunities for improvement; implement improvement strategies and provide follow-up
- Conduct peer reviews via objective measurement, assessment and evaluation of providers' quality of care

BHN Clinical Quality Measures

BHN utilizes nationally recognized clinical quality measures established by CMS and the National Committee for Quality Assurance (NCQA) for Medicare Advantage Star Rating programs and the Medicare Shared Savings Program (MSSP). Quality measure data is used to continuously evaluate BHN performance in the areas of patient safety, preventive care and chronic disease management.

A list of the current measures can be found on the provider portal or check with your QIP for additional information.

2025 Calendar Year NCQA Medicare Advantage (MA) Stars Measures

PART C MEASURES

- **Breast Cancer Screening:** The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer during the past two years.
- **Colorectal Cancer Screening:** The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
- **Osteoporosis Management in Women who had a Fracture:** The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.
- **Diabetes Care – Eye Exam for Patients with Diabetes:** The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) who had an eye exam (retinal) performed during the measurement year.
- **Diabetes Care – Kidney Disease Monitoring:** The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator)
- **Diabetes Care – Glycemic Status Assessment for Patients With Diabetes: Controlling High Blood Pressure:** The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year.
- **Statin Therapy for Patients with Cardiovascular Disease:** The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year.
- **Transitions of Care:** For members ages 18 and older, percentage with an acute or non-acute inpatient discharge on or between Jan. 1–Dec. 1 of the measurement year with an Inpatient Admission Notification, Medication Reconciliation Post-Discharge, Patient Engagement After Inpatient Discharge, and Receipt of Discharge Information.

- **All Cause Readmission:** For members ages 18 and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- **Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions:** Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

PART D MEASURES

- **Medication Adherence for Diabetes Medications:** Percentage of patients with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
- **Medication Adherence for Hypertension (RAS antagonists):** Percentage of patients with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
- **Medication Adherence for Cholesterol (Statins):** Percentage of patients with a prescription for a cholesterol medication (a *statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.
- **Statin Use in Persons with Diabetes (SUPD):** The percent of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period.
- **Concurrent Use of Opioids and Benzodiazepines:** Percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines for 30 or more cumulative days.
- **Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults:** percentage of individuals with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.

2025 Calendar Year Medicare Shared Savings Program (MSSP) Clinical Quality Measures

- **CARE-2: Screening for Future Fall Risk –** Percentage of patients aged 65 years and older who were screened for future fall risk at least once during the measurement period.
- **PREV-7: Influenza Immunization –** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.

- **PREV-10: Tobacco Use: Screening and Cessation Intervention –** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user.
- **PREV-12: Screening for Depression and Follow-Up Plan** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
- **PREV-6: Colorectal Cancer Screening –** Percentage of adults 50 through 75 years who had the appropriate colorectal cancer screening.
- **PREV-5: Breast Cancer Screening –** Percentage of women aged 45 through 74 years who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.
- **DM-2: Diabetes - Hemoglobin A1c Poor Control –** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0% during the measurement period.
- **MH-1: Depression Remission at 12 Months -** Percentage of adult patients age 18 and older with major depression or dysthymia who reached remission 12 months after index event.
- **PREV-13: Statin Therapy for Prevention and Treatment of Cardiovascular Disease -** Percentage of patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period.
- **HTN-2: Controlling High Blood Pressure** – Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

For more information, including documentation requirements and technical specifications, or to arrange an in-office consultation with a BHN representative, please contact your Quality Improvement Specialist.

CLAIMS SUBMISSION & REIMBURSEMENT

Claims should be billed on industry standard CMS 1500 or UB forms and should include all specific ICD-10 codes and appropriate procedure codes and modifiers, if required.

Electronic Claims Submissions

In compliance with the Affordable Care Act, BHN offers payment via electronic funds transfer (EFT) through Automated Clearing House (ACH). Providers receiving payment via EFT are eligible to sign up for free access to the ePayment Center, an online resource offering the ability to search, view, print and download Electronic Remittance Advice specifically for Banner. For more information, contact your Banner representative.

To sign up for EFT, via the ePayment Center visit: https://bannerplan.epayment.center

1. Follow the instructions to obtain a registration code (a link will be sent to you)
2. Follow the link to complete your registration and set up your account
3. Log in to the portal and enter your bank account information to enroll
4. Review and accept the ACH Agreement and click **Submit**
5. Your bank account will be validated before electronic fund transfer (can take up to 6 business days)
6. If you need help call Zelis at 855-774-4392 or email help@epayment.center

The HIPAA-compliant ERA 835 file is available and can be imported into your practice management system. If you need assistance loading the file in your system, please contact your practice management vendor or your clearinghouse to retrieve the 835 file. Once enrolled in EFT, you automatically have access to the Zelis portal called Provider Portal. All of your EOPs, deposits and ERAs will be located here.

Fee-for-service payments will be reimbursed directly to the provider as claims are adjudicated. Payments are issued each business day.

Claims Payment Addresses

Refer to the back of the member's ID card for the appropriate claim submission address. ONLY claims for health plans listed below should be submitted to BHN for payment:

AARP United Medicare Complete
EDI Payer ID: 12X42 Institutional/Hospital and Professional submissions
Claims Address: PO Box 37459, Phoenix, AZ 85069

Claims for Medicare Shared Savings Plan ACO members follow the same claims submission process as traditional Medicare Fee-for-Service claims. Continue sending claims using your existing processes for paper or electronic claims submission. **Do not** send these claims to BHN.

Note the separate lines of business when submitting claims electronically. If claims are combined or submitted with incorrect identification, they may be directed to the wrong claims system and denied.

To ensure timely processing and payment, submit claims as follows:

NOTE: Box 32 on the CMS 1500 form must be filled in with the physical address of the site of service. Claims received with a PO Box or the word "SAME" in box 32 will be denied.

Institutional Providers

BHN encourages all institutional providers (hospitals, skilled nursing facilities, ambulatory surgery centers, etc.) to submit claims electronically.

Facility claims should be billed on the appropriate CMS UB form using the facility's National Provider Identifier (NPI). Physicians and facilities billing for ambulatory surgical services can use a CMS 1500 form for each service; however, the facility fee must be uniquely identified.

Professional Providers

If a physician or professional provider is unable to submit a claim electronically, the claim should be submitted via the CMS1500 (02/12) paper claim forms using OCR-Red ink (PMS 192) and the provider's National Provider Identifier (NPI). Enter the NPI in box J on the CMS 1500.

Timely Filing

BHN recommends that complete and accurate claims be submitted and received within 60 calendar days of the date of service in order to be considered for payment and to avoid filing denials. BHN may deny payment of claims received more than the original required submission time. Members are not liable for payment of a claim where payment was denied due to untimely filing.

Proof of Timely Filing

To dispute claims denied under the timely filing provision, proof of timely submission may include:

Electronic claims

- A copy of the electronic submission acceptance from the clearing house showing BHN's receipt of a clean claim within the original required submission time.

Hard copy claims

- A copy of a computer screen print showing the claim was submitted within the original required submission time, along with the following:

- Dates of timely follow-up conversations with BHN staff documenting date of call and representative name
- Any previous contact with BHN staff within the original required submission time regarding the claim (i.e., copies of letters, etc.)

Requesting Additional Information

Errors or omissions in claim submissions may result in a request for additional information to resolve claim discrepancies. Providers must promptly submit the requested information as noted in the request letter or Explanation of Payment (EOP) if the claim was denied to ensure timely processing. If the information is not received in a timely matter upon receipt of the request letter, the claim will be closed internally as an unclean, undeveloped claim. The closed claim will need to be resubmitted with the requested documentation.

BHN requires all providers to submit encounter data, regardless of payment means. Encounter data is defined by CMS as all data necessary to characterize the content and purpose of each encounter between a Medicare enrollee and a provider, supplier and/or physician. Billed charges should always be reflected on the claim form. Claims with "0" billed charges will be returned to the provider for correction.

Authorization

Claims with services requiring prior authorization will be denied if a prior authorization number was not obtained or the prior authorization was denied. The prior authorization number must be entered in box 23 of the 1500 form and box 63 of the facility claim form. Refer to **www.BannerHealthNetwork.com** for a complete list of services requiring such authorization.

Retrospective Review Requests for UHC MA

Retrospective Review is a post-service Utilization Management request for coverage of medical care or services that have already been received. Providers should adhere to all prior authorization requirements and prior to initiating a service. The health plan should be notified for all emergent inpatient admissions to allow for authorization and a medical necessity review.

A Retrospective Review request will be considered at the plan discretion when good cause can be shown why pre-service authorization did not occur prior to services being rendered and/or lack of notification or timely notification for an emergent inpatient admission. It may be possible to get a resolution without going through a formal appeal process and minimize the administrative burden for your claim submission.

Retrospective Review Request Guidelines

- Submit Retrospective Review Request within claim submission guidelines; the form can be found on BannerHealthNetwork.com.

- Complete the Retrospective Review Request Form with explanation why authorization was not obtained prior to services being rendered and/or lack of notification for emergency inpatient admission.

- Court-Ordered screening and evaluations are the responsibility of the county as specified in A.R.S. § 36-545 and cannot be reimbursed by Medicaid.

- Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26 and cannot be reimbursed.

- Submit Retrospective Review Request Form with a claim and appropriate attachments batched together; claim on top followed by the request form followed by remaining attachments.

Send to:
AARP United Medicare Complete
P.O. Box 37459
Phoenix, AZ 85069
Electronic Payer ID: 12x42

Upon receipt of a Retrospective Review Request with the required documentation, BPN will make a determination within 30 days of receipt. If it is determined that the request is not eligible for a Retrospective Review based on the above criteria, the provider will be notified and may submit an appeal.

Modifiers

If applicable, providers must use standard CPT and HCPCS modifiers to describe services rendered. Modifiers indicate that a service or procedure has been altered by some specific circumstance but has not changed definition or code.

Coding schemes

BHN providers are required to use appropriate coding schemes, as referenced by the coding resources below, in accordance with provider type and services rendered:

- CPT – Current Procedural Terminology
- CDT – Current Dental Terminology
- HCPCS – Health Care Procedure Coding System
- ICD-10-CM Codes – International Classification of Diseases, tenth revision, Clinical Modification.
- UB-04 Revenue Codes – National Uniform Billing Data Element Specifications

Resources

Providers are encouraged to reference the following resources:

- AMA's most current **CPT coding book**, which is published every October and contains new, revised and discontinued CPT codes for the coming year.
- The annual **alpha-numeric HCPCS update** on the CMS website at **http://cms.hhs.gov/hcpcsreleasecodesets/01_overview.asp**. At the end of every October, the CMS website lists new, revised and discontinued alpha-numeric codes for the coming year.
- The **ADA CDT coding book** or ADA website at **http://ada.org**
- The **ICD-10-CM code** set is available on the CDC website **https://www.cdc.gov/nchs/icd/icd10cm.htm.**

Resubmitting Requested Information

To avoid processing delays, BHN makes every effort to use information already available in our records and files before sending new records requests to providers. BHN will advise you if resubmission is required. Verbal and/or written confirmation of receipt will be provided upon resubmission.

Claim Status

To check the status of a claim processed by Banner Plan Administration, a Third-Party Administrator responsible for processing claims, log on to the secure provider portal at **www.BannerHealthNetwork.com**, then:

- Select "Claims Status"
- Enter the member ID and/or a date range
- Choose "Status"
- Search by claim type
- Claims are available for viewing for a period of 18 months.

After selecting a claim on the grid, you may send a secure message to the Provider Experience Center (PEC), including the ability to submit PHI documents related to a specific claim for review. If the member's claim information is not shown, call PEC at **(480) 684-7070**.

Payment Disputes

A provider may request review of an adjudicated claim. BHN may also adjust an adjudicated claim if it is determined that the claim was incorrectly paid or denied.

Both the provider and BHN must give written notice of a payment dispute within 120 days of the date of the claim being paid or denied in order to be eligible for reconsideration, except in the following situations:

- Claims involving subrogation and coordination of benefits for self-funded groups not governed by state law.

- Claims involving "fraud," which means, without limitation, a claim that includes or is based on a willful misstatement or omission of material fact by a member or provider, resulting in incorrect adjudication of a claim, and includes, without limitation, failure to disclose other applicable coverage, use of CPT codes that do not accurately reflect services provided, billing for services not rendered, billing for services under the name of a provider other than the provider who actually rendered the service.
- Claims where a longer period of time is required by applicable state or federal law, including, without limitation, adjustments required because of federally mandated changes in Medicare reimbursement rates, federal requirements that certain government payers be secondary payer or payer of last resort, and federal laws prohibiting providers from accepting more than the Medicare limiting charge.
- Claims where BHN is under a lawful order to adjust a claim because a member or provider prevailed on a health care appeal.
- Claims under a Worker's Compensation policy.

When disputing a claim payment for any reason (i.e., denial, underpayment, etc.), the provider must submit the request to BHN Reimbursement Services to:

Attn: BHN Reimbursement Services
Provider Payment Disputes
AARP United Medicare Complete
PO Box 16423
Mesa, AZ 85211
**Only list the appropriate plan name*

For all other plans, disputes must be submitted directly to the plan

- The request should include the Remittance Advice (RA), if applicable, and a brief written description of the reason for the request. Written requests are reviewed in the order received. Claim adjustments are made in accordance with BHN Claim Payment Policies and Procedures.
- If a claim adjustment is granted, the provider will receive an explanation of payment showing the adjusted claim information. Providers will receive written notification if a request for claim payment dispute is denied. BHN will respond within 30 days of receiving the request.
- A.R.S. 20-3102 prohibits claims adjustments more than one (1) year after the original processing date, except in cases of fraud. Medicare Advantage claims adjustments follow applicable Medicare regulations.

National Provider Identifier (NPI)

The NPI is a unique identification number for providers, regardless of health plan affiliation. The NPI is a lifetime number that follows an individual provider wherever he or she practices and an organizational health care provider for as long as the organization exists.

The NPI number must be included on all HIPAA transactions, including electronic claims. Detailed instructions on using the NPI in HIPAA transactions can be found in the HIPAA Transaction Implementation Guides, which are available on the Washington Publishing Company's website, www.wpc-edi.com.

The NPI is the provider identification number for paper claims submissions. Except for atypical providers, all providers must include the NPI on all paper claims. Failure to include an NPI may delay claim processing and could result in a returned claim.

Tax Identification Number (TIN) Edits

- TIN edits are in place to reject claims with one or more of the following errors:
  - Inconsistent rendering and billing provider tax ID
  - Billing tax ID not on file
  - Tax ID not valid for date of service
  - Tax ID/NPI combination not on file

Explanation of Payment through a Remittance Advice (RA)

BHN adheres to all relevant prompt payment requirements for all clean claims. Final reimbursement is determined using the contracted rate, less any copayment, coinsurance and/or deductible amounts. Contracted providers are issued a detailed RA for each claim, outlining how each service was processed for payment.

Electronic Remittance Advice (ERA)

ERA is the electronic equivalent of the provider remittance advice, containing information about claims payments, deductibles, copayments and cost shares. The ERA also provides details on how patients' claims were paid and, if applicable, why they were denied.

Electronic Funds Transfer (EFT)

In compliance with the Affordable Care Act, BHN offers payment via electronic funds transfer (EFT) through Automated Clearing House (ACH). Providers receiving payment via EFT are eligible to sign up for free access to Change Healthcare EFT (formerly Emdeon Payment Manager), an online resource offering the ability to search, view, print and download Electronic Remittance Advice from nearly 700 payers nationwide.

To sign up for EFT, select **Enroll Now** on the Change Healthcare website: **http://changehealthcare.com/resources/epayment-eft.**

Upon enrollment, choose your preferred payment method in the online Change Healthcare ePayment system or call **855-886-3863** to speak with a Change Healthcare representative. Have your NPI available.

The HIPAA-compliant ERA 835 file is available and can be imported into your practice management system. If you need assistance loading the file in your system, please contact your practice management vendor or Change Healthcare at (866) 506-2830. If you use a different clearinghouse, you will need to contact your clearinghouse to retrieve the 835 file from Change Healthcare. Once enrolled in EFT, you automatically have access to Change Healthcare's portal called Payment Manager. All of your EOPs, deposits and ERAs will be located here. If Change Healthcare is your clearinghouse, 835s are automatically available.

Fee-for-service payments will be reimbursed directly to the provider as claims are adjudicated. Payments are issued each business day.

Covered Services

Providers may obtain reimbursement only for services covered under a member's health benefit plan for medically appropriate treatments, tests, services, medications, supplies or equipment. Benefit structure, member contract limitations and other factors impact reimbursement. Reimbursements for telephonic and telemedicine consults are benefit plan specific.

Fee Schedule Updates

BHN reviews and updates Medicare fee schedules for most services at least quarterly, or per Medicare guidelines. Update notifications may be communicated via:

- Provider eNewsletter
- Email
- Fax
- Letters/written correspondence
- Other publications available to providers
- Claims will be placed on hold while fee schedule is updated
- BHN website - **www.BannerHealthNetwork.com**

Fee schedule changes that affect the provider agreement will be communicated by the provider network. See Contracting section for an overview of the contracting process.

Guarantee of Payment

Existence of a fee or rate, or information about benefits eligibility, does not guarantee service coverage and/or payment. Health benefit plan structure, member contract limitations and exclusions, and other factors impact reimbursement.

Payment Recoupment Policy

BHN may need to recoup a reimbursement paid to a provider. When recouping a reimbursement, BHN always attempts to recover the payment from the provider and practice that received the original payment. If the practice has changed or is no longer active, payment will be recovered from the individual contracted provider who was paid incorrectly, regardless of changes in location, affiliation or tax identification number.

- **Credit transactions:** Most provider contracts authorize BHN to recover overpayments or incorrect payments by credit transaction. Overpayments or incorrect payments are automatically deducted from the provider's payment and are identified on an EOB/RA. If a recovery results in a balance owed to BHN greater than the provider's payment, the balance will be carried forward and applied to future payment(s). BHN reserves the right to recover any amounts due through legal means.
- **Provider notification:** A letter with an explanation/reason for the recovery action will be sent to the provider. Offsets may be deducted from the provider's payment the same day the letter is mailed.

Billing the Patient

You may only bill members for copayments, coinsurance, and/or deductible amounts and any non-covered services previously agreed to by the member. Balance billing is not permitted.

Coordination of Benefits (COB) and Subrogation

Coordination of Benefits (COB) is the process of determining if more than one health plan is available to pay a member's medical bills. When benefits are coordinated, one plan normally pays benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. BHN will determine which insurance company bears the primary responsibility and which assumes secondary responsibility.

Subrogation procedures are used when a member has an illness or injury that is caused by a third party.

BHN has a legal right to recover any claims payment from the responsible party or their insurance company, including, but not limited to:

- Employer group health plans
- Worker's compensation

- No-fault or liability insurers
- Federal Black Lung program

Corrected Claims

Corrected claims must be submitted within a reasonable timeframe, but not more than the timely filing requirements as outlined in this manual. Corrected claims must include all charges, not just the corrected charges. The preferred method to submit corrected claims is through EDI using the "7" corrected bill segment. Corrected claims in a paper format may also be submitted using the claims address identified in this manual.

Assigning Payment of Benefits

ERISA regulations prohibit any benefit, payment right, right to sue other interest of any participant or beneficiary under the Plan from being subject to assignment, anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution or levy of any kind (either voluntary or involuntary) by anyone (including but not limited to providers of benefits), except as otherwise required by law, such as a qualified medical child support order. Any such attempt shall be void.

The Claims administrator does not pay benefits directly to non-network providers, although the Claims Administrator may elect to pay benefits directly to a non-network provider of benefits as a convenience of the Claims Administrator. Any payment by the Claims Administrator to a non-network provider of benefits shall not constitute an assignment of benefits or an assignment of any other rights under the plan.

RISK ADJUSTMENT

Risk Adjustment (RA) consists of a set of activities to appropriately document a patient's chronic conditions. The goal of our RA efforts is to enable a comprehensive and accurate account of the member and population's clinical profile. To that end, BHN has invested in tools to help BHN providers identify previously undocumented suspect medical conditions using data-based clinical algorithms. This robust clinical profile can then be used to develop care plans to manage the whole patient.

Additionally, risk adjustment helps drive appropriate reimbursement that accurately reflects population health status. All Risk Adjustment models, from Medicare CMS model, Medicaid CDPS-RX or 3M model, or ACA HHS model have a method of adjusting capitation payments to health plans for patients to account for the differences in expected health costs of individuals, calculated as a risk score. Each model considers demographic factors such as age and sex , some models have other special status's such as Dual, Institutional, TANF, etc. The models also calculate disease conditions categories sometimes referred to as Hierarchical Condition Categories (HCC), consisting of ICD-10-CM codes that make up disease categories used to calculate individual risk scores. The risk models may also be differentiated by specific cohorts such as ESRD for the CMS model. If the condition is not documented appropriately, it cannot be coded. If it cannot be coded, BHN will not be appropriately reimbursed for the chronic conditions it manages. Only conditions that follow regulatory guidelines will be considered for risk score calculations. An example from the CMS HCC model is that the ICD-10-CM requires a risk adjustable specialty type, risk adjustable eligible CPT code, and a risk adjustable place of service to be eligible for contribution to CMS risk scoring. Please refer to regulatory documentation to follow Risk Adjustment criteria.

Why does RA matter to me?

Risk Adjustment efforts give providers a more accurate understanding of a patient's underlying chronic conditions, improving their ability to deliver appropriate care. BHN is committed to providing the necessary tools and resources to facilitate best practice chronic diagnosis capture. Each primary care practice has been assigned a coder that has been trained specifically to capture chronic care diagnoses that impact risk adjustment. These coders, along with Care Transformation Consultants, can be contacted for any questions or RA-related issues.

RA also has important financial implications. Robust RA ensures that there are adequate resources available to care for our high-risk Medicare Advantage beneficiaries. Reimbursement is higher for members with significant illnesses and lower for healthier members. By providing appropriate reimbursement based on members' overall health status, **RA increases the resources available for those beneficiaries who require more costly and complex care.**

BHN contracts with several Medicare Advantage programs that use this model. As a result, we need our providers to supply consistent, accurate and thorough coding and documentation in support of their patients' ongoing care.

Risk Adjustment Resources

Several Risk Adjustment tools and resources are available on the secure BHN Provider Portal at **www.BannerHealthNetwork.com**. Resources include:

- Medicare Annual Assessment Benefit Guide
- Risk Adjustment Documentation Guide
- Annual Wellness Visit Toolkit

If you do not already have an account created on the BHN provider portal, you can request one at **www.BannerHealthNetwork.com/Account/RequestAccount**

How can I learn more?

In-office support, including chart reviews and a list of your patients in need of RA documentation, is available through BHN.

*Contact **ProviderExperienceCenter@BannerHealth.com** to learn more about these opportunities and resources.*

MEDICARE SHARED SAVINGS PROGRAM (MSSP) ACO

What is the Medicare Shared Savings Program?

The Medicare Shared Savings Program (MSSP) is a voluntary program that promotes accountability for a population of Medicare beneficiaries, improves the coordination of fee-for-service (FFS) items and services, encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery, and promotes higher value care.

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare beneficiaries. An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, the ACO may be eligible to share in the savings it achieves for the Medicare program (also known as performance payments). *https://data.cms.gov/medicare-shared-savings-program/> https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/about>*

Banner Health Network (BHN) began participating in CMS' Medicare Shared Savings Program in 2019. In 2024, BHN elected to re-apply with CMS for participation in MSSP for another five years. The new agreement period is January 2025 through December 2029. This shared savings program is ongoing and open each year to new ACO providers/participants.

Which MSSP track does Banner participate in?

MSSP offers two different participation options/tracks, which allows an ACO to select an option or track based on the level of risk the ACO wants to assume. The participation options are BASIC, which consists of track level's A through E, and ENHANCED, which offers the highest risk level and potential reward. BHN participates in the ENHANCED track.

- Upside Opportunity Downside Risk
  - Upside opportunity means the ACO shares in the savings if there are any. This is offered in all tracks.
  - Downside risk means the ACO pays back a portion of the loss if there is any. This is part of the methodology for all tracks with the exception of Level A and B which are one sided models.
  -

How will patients be affected by MSSP?

MSSP is designed to provide Medicare beneficiaries with higher quality, more seamless health care. By encouraging integration among health care providers on an accelerated risk track, the MSSP facilitates coordination between health care providers, resulting in better care for beneficiaries aligned with ACOs.

Are patients required to participate in MSSP?
Beneficiaries are aligned to the ACO based on the primary care physicians or providers they typically see that are contracted with the ACO. BHN is responsible for the cost and care of these beneficiaries throughout the performance year, unless the beneficiary moves to a Medicare Advantage health plan, loses their Medicare coverage or becomes enrolled in a health plan that is primary to Medicare. Being part of the ACO requires no action by the beneficiary.

What is "Opt Out?"
A Medicare beneficiary can contact CMS and ask to opt out of sharing their claims data with an MSSP ACO. Should the beneficiary elect to opt out of data sharing, the beneficiary is still aligned to the ACO and the ACO is financially responsible for the management of their care. Data sharing is used in care management and clinical outreach efforts and, ultimately, better clinical information for you, the provider. If asked about "opt out", please encourage the beneficiary to allow data sharing of their healthcare information with the ACO.
To opt out of data sharing, the beneficiary must call CMS at 1-800-MEDICARE (1-800-633-4227). Additional information on data sharing can be found in CMS' booklet, Medicare and You. https://www.medicare.gov/medicare-and-you.

Can I participate in more than one Medicare ACO?
- In MSSP, the provider practice that is submitted by the ACO must be exclusive to this program. This means that the practice and none of the individual providers billing under that TIN can participate in the following programs:

- Another ACO's MSSP
- Any other CMMI program with shared savings (such Realizing Equity, Access and Community Health (REACH).

CMS may change this list at any time. If BHN becomes aware of any other program exclusions, BHN will notify contracted MSSP providers.

How will I know if a Medicare beneficiary is a BHN MSSP ACO member?
During Q1 of each performance year, your Care Transformation Consultant will provide you with a list of Medicare beneficiaries aligned to your practice.

Can I refer outside of the BHN ACO network?
Medicare beneficiaries retain their freedom of choice and can receive services from any Medicare provider outside of the BHN ACO at any time. The advantage of

being a part of an ACO is the providers that collectively work together to provide better-coordinated healthcare across the continuum for the beneficiary. BHN's provider network is built on integration and care coordination processes focused on improving the patient experience, ensuring continuity of care and providing appropriate access to disease and case management programs.

How are physicians paid?

Providers that participate in the ACO will continue to receive Medicare FFS payments for claims submitted under Parts A & B. Claims are paid according to CMS' fee schedule.

How are providers rewarded for providing cost effective, quality care?

Provider practices participating in the BHN MSSP are eligible for an incentive payment –- a shared-savings based on cost-effective care and quality measures.

When the ACO earns shared savings, when would physicians receive their shared savings payments?

CMS will close out the performance year in late summer of the following performance year. BHN then includes the MSSP Shared Savings in the overall performance reconciliation, which includes all at-risk contracts. The savings from the MSSP program are distributed per the direction of the BHN Board of Directors. Please review the PCP Incentive program details for further detail and explanation.

What is MACRA and QPP?

The Medicare Access and CHIP Reauthorization Act (MACRA) is legislation signed into law, April 2015. MACRA created the Quality Payment Program (QPP) which repealed the Sustainable Growth Rate (SGR) formula and changed the way that Medicare rewards clinicians for value over volume. QPP aims to improve the quality and safety of care for all individuals and to reduce the administrative burden on clinicians, which allows time to focus on person-centered care and improving health outcomes.

QPP has two payment tracks in which eligible clinicians can choose to participate in:

- **Merit-based Incentive Payment System (MIPS)** is a quality reporting program, which streamlined and redefined legacy programs - Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (Value Modifier), and Meaningful Use (MU).
- This track rewards clinicians based on CMS' evaluation of the clinician's performance in quality of care, promoting interoperability, improvement activities and cost.
- To check your MIPS eligibility status, enter your NPI number in CMS' QPP Participation Tool and select the performance year.

- **Advanced Alternative Payment Model (APMs)** is a customized payment approach developed by CMS, which is designed to provide incentives to clinicians providing high-quality, and cost-efficient care.

- This track rewards clinicians that participate in value-based care models, such as Accountable Care Organizations (ACOs).

For more information on MACRA, visit CMS site: MACRA: MIPS & APMs
For more information on QPP: Quality Payment Program Overview

Why is Member Experience Important?

Most of us have high expectations for service and experience across industries, and health care consumers are no different. Our members' are the reason we exist and every interaction we have matters. Each of us is responsible for providing a great care experience, whether you provide direct member care or support those who do. Ultimately, ***you are*** the member experience. Everything you do impacts members' perceptions of the care they receive and whether they will choose BHN providers to care for them, or their family and friends, in the future.

CAPTURING THE MEMBER EXPERIENCE

A member's health care experience is obtained and tracked both internally and externally.

Internally, Banner Health contracts with a vendor to obtain near real-time member feedback for BMG, BUMG, and participating Affiliate providers. Members are asked a series of questions that align to CAHPS measures as well as being offered the ability to share comments about their experience.

- BMG and BUMG provider surveys will be emailed after a visit.
- Affiliate providers are provided with QR codes for the members to take the survey while in the office.

Externally, a Centers for Medicare & Medicaid Services (CMS) approved vendor will field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is a federally required, standardized, publicly reported survey. The CAHPS survey covers a range of topics that are important to healthcare consumers and are used to assess various aspects of healthcare quality such as a provider's communication skills and ease of accessing health care services.

CAHPS survey results are used by health care consumers, regulators and organizations that monitor quality of care, provider organizations, health plans, community collaboratives, and public and private health care purchasers. These individuals and organizations use the survey results to make informed decisions about their care and to improve the overall quality of care.

CAHPS surveys are specific to the type of insurance coverage a patient has. Each type of CAHPS survey is fielded once annually during a specific timeframe.

Type of Insurance	CAHPS Survey	Fielding Time
Medicare Advantage	CAHPS Medicare Advantage	March-May
Medicare Fee-for-service	CAHPS for MIPS	October-January
Medicaid	CAHPS Medicaid (Adult or Child)	December-March

Commercial	CAHPS Commercial (Adult or Child)	Various times of the year depending on plan

Below are some of the CAHPS questions specifically tied to a member's experience with their care provider:

Domain	**Question**
Annual Flu Vaccine	*Have you had a flu shot?*
Getting Appointments and Care Quickly	***In the last 6 months, how often have did you…*** • *…get care as soon as you needed.* • *…get an appointment at your check-up or routine care as soon as you needed*
Getting Needed Care	***In the last 6 months, how often…*** • *…did you get an appointment with a specialist as soon as you needed.* • *…was it easy to get the care, tests, or treatment needed?*
Care Coordination	***In the last 6 months,*** • *how often did you and your personal doctor talk about all the prescription medicines you were taking?* • *how often did your personal doctor seem informed and up to date about the care you got from specialist?* • *when you talked with your personal doctor during scheduled appointment, how often di he or she have your medical records and other information about your care?* • *when a doctor, nurse or other healthcare provider ordered blood test, x-ray. Or other test for you, how often did you get your test results?* • *did a doctor, nurse, or other health care provider explain the results of your blood test, x-ray. or other test?** • *did you get as much information as you needed about your tests results?** **Note*: proposed CMS question changes, **NOT** a final rule as of 12.1.2024, to replace *follow up to give you test results* and *communicate test results as soon as you needed them and manage your care among different providers and services.*

Overall Rating	***On a scale from 0 to 10, how would you rate your…*** • *…personal doctor?* • *…overall health care?* • *…specialist seen most often?*

Health Outcomes Survey

The Health Outcomes Survey (HOS) is specific to the Medicare Advantage population and captures patient-reported outcomes. The goal of the HOS is to gather valid and reliable clinically meaningful data that can be used to target quality improvement activities and help Medicare Advantage beneficiaries make informed health care choices. The HOS involves comparing the results from a baseline survey (occurs July to October) with a follow-up survey (occurs 2 years later from July-October) and focuses on the following areas:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

A copy of the HOS can be accessed ***here***

How Does Performance Impact Your Practice?

The value-based arrangements BHN has with various payors include performance on the member experience.

The Centers for Medicare & Medicaid Services (CMS) also uses a Star Rating System to measure how well Medicare Advantage plans perform in several categories, including the patient experience.

Ratings range from 1 to 5 stars, with five being the highest and one being the lowest. While plans receive an individual rating in each evaluation category, Medicare assigns one rating to summarize a plan's overall performance.

The Medicare Star Rating System helps patients measure the quality of a plan while giving them confidence in knowing that their Medicare Advantage provider is committed to delivering an exceptional patient experience.

Patients with a Medicare Advantage plan may switch to another Medicare Advantage plan with a 5-star rating one time outside of the open enrollment period (typically mid-October through early December). This means the number of Medicare Advantage patients you care for could increase.

Provider offices also can receive a quarterly incentive based off their post-visit survey scores.

What are Some Ways to Improve Performance?

Below are some tips for improving the overall experience. More detailed tips can be accessed on the provider portal under **Forms & Resources/Patient Experience**.

Focus	Tips to Improve
General Conversation	• Greet member warmly – *Good morning/afternoon! How may I help you!* • Give the opportunity to ask questions – *Is there anything else you would like to discuss?*
Care Coordination	• Explain the "WHY" behind a diagnosis, treatment, etc • Use common language so members can understand. Try to stay away from technical medical terminology. • Provide thorough instructions for what the member needs to do next, such as follow-up appointments, taking medications, etc. • Give the member a printed copy of instructions to take home, if possible. • Avoid interrupting or rushing the member. • Use teach-backs
Access to Care	• Implement best-practices such as open access/same day scheduling, online scheduling, and scheduling up to ensure members have needed access to a provider.
Health Outcome Survey (HOS)	• Identify patients who have had a fall or problems with balance or walking and talk with them about how to address these issues. • Identify patients who experience urinary incontinence and talk with them about how to address the issues. • Discuss the importance of physical activity with patients and encourage them to maintain or increase physical activity as appropriate. • Offer ideas to improve mental health, such as taking daily walks, staying involved with family, doing crossword puzzles, or meditating. • Consider a hearing test when appropriate as loss of hearing can feel isolating.

GLOSSARY

The list below includes terms used to describe Banner Health Network (BHN), including policies, procedures and administrative processes. We have also included additional abbreviations for informational purposes.

- **Accountable Care Organization (ACO):** An ACO is a group of doctors, hospitals, and other health care providers who work together to provide coordinated, high-quality care. Doctors and hospitals in an ACO communicate with patients and with each other to make sure that patients get the care needed when they are sick, and the support needed to stay healthy.

- **ACO-MS:** ACO Management System. Replaces the Health Plan Management System (HPMS) for ACOs. Used by ACOs to submit ACO participant and SNF affiliate change requests, manage marketing materials, and update program information.

- **ACO Participant:** An individual identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together, with one of more other ACO participants compose an ACO, and that is included on the list of ACO participants.

- **ACO Provider/Supplier:** An Individual or entity that is a provider or supplier enrolled in Medicare that bills for items and services furnished to Medicare fee-for-service beneficiaries during the agreement period under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations and is included on the list of ACO providers/suppliers.

- **Adverse Action:** BHN terminating or limiting Provider Agreement.

- **Agreement:** *see Health Plan Agreement or Provider Agreement*.

- **Algorithm:** A formula used to determine to which primary care provider a beneficiary should be attributed.

- **Allied Health Professional (AHP):** Allied Health Professional including Audiologist, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Chiropractor, Certified Clinical Perfusionist, Dentist, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Licensed Social Worker, Nurse Practitioner, Occupational Therapist, Optometrist, Physical Therapist, Physician Assistant, Podiatrist, Psychologist, Registered Dietician, Registered Nurse First Assist, Speech Language Pathologist.

- **Alternative Payment Model (APM):** An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- **AMA:** American Medical Association

- **Appeal:** An oral or written request by the member, or a provider acting on behalf of the member, to challenge denial of precertification requests or claims for services already provided.

- **Attestation:** The process by which BHN confirms it has measured quality performance using the quality metrics established by CMS.

- **Attributed or Attributed Membership:** Members or beneficiaries who have been included in a plan because their physician participates in an agreement with the payer. Often the agreement is shared savings, and the focus is on improving quality and efficiency of care for a more cost-effective solution. Attribution is used in government and commercial plans.

- **Banner|Aetna:** A joint venture between the two companies, Banner Health and Aetna are taking a new approach to the way health care is offered. With this innovative partnership, these two industry leaders aim to provide more efficient and effective patient care at a more affordable cost. By joining the right medical professionals with the right technology, patients receive the benefit of quality, personalized health care. Since 2018, health plans for Banner employees in Arizona have been administered through Banner|Aetna.

- **Banner Health:** Banner Health is one of the largest, secular nonprofit health care systems in the country. In addition to 30 acute-care hospitals, Banner also operates an academic medicine division, Banner – University Medicine, and Banner MD Anderson Cancer Center, a partnership with one of the world's leading cancer programs, MD Anderson Cancer Center. Banner's array of services includes a health insurance division, employed physician groups, outpatient surgery centers, urgent care locations, home care and hospice services, retail pharmacies, stand-alone imaging centers, physical therapy and rehabilitation, behavioral health services, a research division and a nursing registry. To make health care easier, 100% of Banner-employed doctors are available for virtual visits, and Banner operates a free 24/7 nurse line for health questions or concerns. Patients may also reserve spots at Banner Urgent Care locations and can book appointments online with many Banner-employed doctors. Headquartered in Arizona, Banner Health also has locations in California, Colorado, Nebraska, Nevada and Wyoming. For more information, visit bannerhealth.com.

- **Banner Health Network (BHN) Provider Networks:** BHN utilizes two provider entities to serve members assigned through our contracted health plans:
    - **Banner Health Network (BHN):** Comprised of more than 5,000 community specialists and allied providers who are affiliated to BHN through contracts with BHN (including Banner Plan Administration) and individual health plans. This group also includes specialists in cardiology, ophthalmology, orthopedics, radiology and others.
    - **Banner Medical Group (BMG)/Banner University Medical Group (BUMG):** A group of primary care and specialty physicians who are aligned with Banner through an employed model. BMG employs more than 1,900 physicians and advanced practice providers who practice in a variety of settings from small clinics to large, multi-specialty practices to major medical centers. BMG physicians deliver care across the Valley to ensure convenient locations for BHN members and other nearby residents in our many communities. BUMG is the academic medicine affiliation with the University of Arizona medical schools in Phoenix and Tucson.

- **Banner Plan Administration (BPA):** Banner Plan Administration is a Third-Party Administrator (TPA) licensed in Arizona to provide administrative services, including claims adjudication, prior authorization and medical management, member and provider call center support, and enrollment and billing service. BPA is wholly owned by Banner Health and is a separate legal entity. All new provider contracts will be generated with BPA as Banner's legal contracting entity.

- **Banner Plans & Networks: Also known as the Banner Insurance Division**

- **BPHSO:** Banner Population Health Services Organization

- **Banner - University Health Plans (B - UHP):** The organization formed as a merger between the University of Arizona Health Plans and Banner Health. B – UHP directs the Banner Medicaid and the Banner Medicare lines of business.

- **BCCL:** Banner Certification, Credentialing, and Licensure department. BCCL is responsible for conducting onboarding activities for BMG/BUMG providers, Managed Care credentialing including primary source verification for BHN providers and obtaining and maintaining licensure for Banner facilities and clinics.

- **Benefit Plan:** The documents describing the benefits and terms of coverage provided to a member and his/her dependents.

- **Beneficiary Voluntary Alignment:** The process where Medicare Fee-for-Service beneficiaries select, or "voluntary align" with a primary clinician.

- **BHN Population Health Management (PHM):** A multidisciplinary care management team dedicated to the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the needs of a population's medical, behavioral and psychosocial health needs.

- **BHN Rising Risk:** A BHN Medicare Advantage member proactively identified through a predictive analytic algorithm who without interventions are at risk for advanced disease and increased consumption of health care resources.

- **Board of Directors:** Subject to the limitations of the Bylaws and of the Arizona and federal law. The body responsible to make and determine policy for the BPA, manage its affairs, and exercise (or direct the exercise of) all corporate posers of BPA

- **Broad Network:** The group of providers contracted with BHN that are not in the BHN CIN (determined by the presence of Exhibit K in the provider contract). If a group has signed Exhibit K, they are in the CIN. **Care Plan:** A patient-specific individualized document that incorporates the initial assessment, reevaluation and readjustment of long-term and short-term goals to meet the member's needs, serving to facilitate communication, collaboration and continuity of care across settings.

- **Care Conference -** A meeting attended by representatives from the multidisciplinary team involved or who need to be involved with a specific patient and/or his/her healthcare representative to plan future provision of health and/or social services.

- **Case/Care Management:** Care management professionals are engaged in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. May also be referred to as *case management* by other organizations. May also include Population Health Management.

- **Case/Care Managers:** Registered Nurse Care Manager assigned to provide care management services to enrollees

- **CDT Coding System:** The ADA's *Current Dental Terminology* coding system is a listing of descriptive terms and identifying codes for reporting dental services and procedures.

- **Capitated:** A pre-determined fee is paid per member of the plan, regardless of care required.

- **Capitation:** Per Member Per Month (PMPM) payment to providers based on their membership for capitated contracted providers.

- **CCI Edits:** Correct Coding Initiative

- **Centers for Medicare & Medicaid Services (CMS):** An agency within the U.S. Department of Health and Human Services responsible for administration of several key federal health care programs, including Medicare, Medicaid and other health-related programs.

- **Center for Medicare & Medicaid Innovation (CMMI):** With CMS, supports the development and testing of innovative health care payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

- **Change Healthcare:** Formerly known as Emdeon, a vendor contracted with BPA to provide electronic claims processing services.

- **CHF:** Congestive Heart Failure

- **Chronic Conditions:** A condition or disease that is persistent or otherwise long-lasting in its effects

- **Claims Data:** Information provided by CMS that explains what medical services a Medicare beneficiary has received over a specified period.

- **Clean Claim:** A claim for payment, which can be processed for payment without the need for additional information from the service provider. A clean claim does not include a claim that is under review for a coding error or a claim for which services are not medically necessary.

- **Clinically Integrated Network**: A Clinically Integrated Network is a legal arrangement that allows hospitals and physicians to collaborate on cost and quality improvement while remaining independent entities.

- **CMO:** Chief Medical Officer

- **CMS 1500:** The (CMS) Form 1500 (08/05) is used to submit claims for professional services.

- **Coinsurance:** The percentage of the allowed amount that a member must pay for covered services after meeting any applicable deductible. The coinsurance percentage is typically higher when using an out-of-network provider.

- **Cold Connect:** to transfer a caller from one representative to another without explaining the reason for members call.

- **Complaint:** A verbal or written expression of dissatisfaction regarding products or services that is elevated to a complaint resolution system.

- **Complex Condition:** A diagnosis, treatment or procedure that has a high degree of outcome variation and requires specialized skills possessed by a physician or a patient care team to provide care for the patient in order to prevent a serious adverse outcome. *See also Hierarchal Condition Categories (HCC).*

- **Compliance Committee:** The Compliance Committee oversees the Compliance Program and is responsible for reviewing the development, documentation, periodic audit/review of internal controls, and training on risk areas which are annually determined via the risk assessment. The Compliance Committee is accountable to BHN/BPA's senior-most leader and Boards and will meet at least quarterly to ensure that compliance and compliance-related activity is consistent across the company.

- **Compliance Program:** Is a written program that establishes the standards of conduct for an organization to promote honest and ethical behavior and provides a structure for educating and communicating those standards to employees, with the overall objective to prevent, detect and report significant regulatory non-compliance.

- **Complaint:** A verbal or written expression of dissatisfaction or an unmet expectation by a consumer or client regarding an organization's products or services that is elevated to a complaint resolution system. A complaint is noted when an individual is irate or displeased, or if the correspondence needs to be escalated in any way (to a supervisor, etc.)

- **ComplyLine:** A hotline operated by a third-party vendor to ensure confidentiality. It is a toll-free resource available to employees, associates, contractors, agents, managers, directors, first tier, downstream and related

entities (FDR), and other business partners twenty-four hours a day, seven days a week to report violations of –or raise questions or concerns relating to the Banner Code of Conduct, FWA, privacy breaches or other non-compliance issues.

- **Concierge Medicine:** Refers to covered services that are provided through enhancements like expedited appointment times, longer provider appointments and expedited referrals to specialists. A Provider may not require plan member to pay a membership fee or any other fee to access any covered service.

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS):** A randomized patient survey used to evaluate a patient's experience(s) with their health care services, facilities, provider and/or health plan. Questions may assess provider communications skills, ease of accessing services and scheduling appointments, courtesy of staff, and overall rating of providers and facilities.

- **Contracted Provider:** A provider who has an active contract with a BHN provider entity, including Alliance, or is employed by Banner Medical Group or Banner University Medical Group, or is an entity affiliated with or owned by Banner Health. May also be called an Affiliated Provider.

- **COB:** Coordination of Benefits. A method for determining who pays first when two or more health insurance plans are responsible for paying the same medical claim.

- **COB11:** Claims denial message "Claims/Service Transfer to proper payer."

- **Copayment ("Copay"):** A specific dollar amount a member must pay out-of-pocket to the provider for covered services. When a copayment applies to a covered service, the member must provide payment at the time of service.

- **COPD:** Chronic Obstructive Pulmonary Disease

- **Corrective Action Plan (CAP):** A description of the actions to be taken to correct identified deficiencies and to ensure future compliance with the applicable requirements. A CAP usually contains accountabilities and set timelines.

- **Covered Person:** For purposes of this policy includes:
    - Banner Health Network and the BHN Board.
    - All Banner employees, or individuals contracted with BHN (e.g., a contracted network entity or vendor) who, either directly or indirectly, perform administrative services (e.g., compliance management,

network management, medical management, utilization management, quality management, prior authorization) for BHN;
    - All Banner employees, or individuals contracted with BHN (e.g., contracted hospitals and physicians) who, either directly or indirectly, provide patient care items or services to BHN attributed patients; and
    - Any other entity or persons contracted or otherwise representing BHN, or identified by BHN as a delegated entity.

- **Covered Service:** A health care service that is:
    - A covered benefit of the member's benefit plan
    - Medically necessary as defined by the member's benefit plan
    - Not excluded from the member's benefit plan
    - Not experimental or investigational as defined by the member's benefit plan
    - Pre-certified where precertification is required by the member's benefit plan
    - Provided while the member is eligible for benefits and the member's benefit plan is in effect
    - Rendered by an eligible provider under the member's benefit plan acting within the provider's scope of practice

- **CPT® Coding System:** The AMA's *Current Procedural Terminology* coding system is a list of codes and related descriptions that are used to report medical services and procedures.

- **Credentialing:** The process by which the appropriate committee reviews documentation for each individual provider to determine eligibility for participation in the health plan or network. Such documentation may include, but is not limited to, the applicant's education, training, malpractice history and professional competency. The credentialing process includes verification that the information obtained is accurate and complete.

- **Crisis Response Network (CRN):** Contracted with Banner Health to provide telephonic crisis intervention for members within Maricopa County.

- **Culturally Competent:** The ability to understand, appreciate, and interact with people from cultures and/or belief systems other than one's own, based on various factors. Knowledge and understanding of another person's culture; adapting interventions and approaches to health care to the specific culture of the patient, family, and social group.

- **CVD:** Cardiovascular Disease

- **Deactivation/Retire Date:** The date this version of the policy is no longer available to the end user.

- **Delegate/Delegation:** The process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the Delegate.

- **Denial:** Services are denied whole or in part, also known as adverse determination or non-certification.

- **Department of Health and Human Services (DHHS, or HHS):** The federal agency whose mission is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services. HHS is the parent organization to many federal agencies including the CDC, CMS, OCR, and OIG.

- **Disease Staging:** The Disease Staging criterion define levels of biological severity for specific medical diseases-episodes of care- where severity is defined as the risk of organ failure or death. The classification is based on the severity of the patho-physiologic manifestations of the disease. The disease staging methodology seeks to distinguish the etiology of a disease whenever possible.

- **Distress:** Identifying if a member is in immediate need of life-saving or immediate medical services due to choking, heart attack, etc.

- **DocuSign:** An application used by Provider Contracting to generate and track provider contract documents from BHN or BPA to the provider through the final step of contract execution.

- **DOFR:** Division of Financial Responsibility

- **Downgrade:** A request is submitted as expedited but is changed to standard within 72 hour expedited time frame

- **Durable Medical Equipment (DME):** In general, durable medical equipment is equipment prescribed by an eligible provider and designed to withstand repeated use**.** The member's benefit plan will determine what is eligible for coverage. Refer to the Member's DME Medical Coverage Guidelines for more information.

- **Electronic Data Source:** Where claims information is stored and/or where the case manager documents.

- **Electronic Funds Transfer (EFT):** A payment that moves from one bank account to another electronically, without a paper check. It is often a faster way to get paid.

- **Electronic Health Record (EHR) or Electronic Medical Record (EMR):** An electronic system that captures medical and demographic information about a patient, their past, current and chronic conditions, and their care plan or assigned treatment. Because it is electronic, this data can be accessed more easily when and where care is needed by the individual.

- **Electronic Payer Summary Agreement:** A document that requires signature by any staff member who was approved to access the PCS documents. This agreement outlines confidentiality, rules against copying and emailing documents and disciplinary actions to be taken for non-compliance.

- **Electronic Remittance Advice (ERA):** ERA is the electronic equivalent of the provider remittance advice, containing information about claims payments, deductibles, copayments and cost shares. The ERA also provides details on how patients' claims were paid and, if applicable, why they were denied.

- **Emergency:** An illness or condition which requires relief of severe pain or which if not immediately diagnosed and treated, could reasonably be expected to seriously jeopardize life, health or the ability to completely recover, resulting in serious impairment or permanent disability.

- **Enrollee:** A person who is eligible for and is enrolled in a health plan, also known as a member.

- **Episode Severity:** The severity of the episode-i.e., disease stage- is determined by the highest severity substage observed during the episode. Severity is defined in terms of disease progression and prognosis and is not related to treatments. This is documented in the Electronic Medical Record (EMR).

- **Employee Retirement Income Security Act of 1974 (ERISA):** A federal law that sets minimum standards for voluntarily established pension and health plans in private industry to provide protection for individuals in these plans, which includes fiduciary responsibilities for those who manage and control plan assets.

- **Exclusion:** Items or services not covered under a benefit plan.

- **Explanation of Benefits (EOB):** A document sent to a member that shows the services billed on a claim, whether the services are covered or not covered, the allowed amount and the application of the member's cost-sharing amounts. An EOB message code gives further information about any payment rules used, adjustments applied, and disallowances or non-covered amounts of a claim. Providers receive a remittance advice, which includes information similar to that on an EOB.

- **Explanation of Payment (EOP):** A document sent to a provider that shows the services billed on a claim, whether the services are covered or not covered, the allowed amount and the application of the member's cost-sharing amounts. An EOP message code gives further information about any payment rules used, adjustments applied, and disallowances or non-covered amounts of a claim.

- **Federal Health Care Program:** Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded in whole or in part by the United States Government (other than the Federal Employees Health Benefit Program) or any State health care program (as defined in 42 U.S.C. § 1320a-7(h)). Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Indian Health Service, TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.

- **First Tier, Downstream and Related Entities (FDR):** For the purposes of this Policy, FDRs shall include:
    - **First Tier Entity:** Any party that enters into a written agreement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or a Part D Plan Sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
    - **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D Plan Sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
    - **Related Entity:** Any entity that is related to an MAO or Part D Sponsor by common ownership or control and (a) performs some of the MAO or Part D Plan Sponsor's management functions under contract or delegation, (b) furnishes services to Medicare enrollees under an oral or written agreement, or (c) leases real property or sells

materials to the MAO or Part D Plan Sponsor at a cost of more than $2,500 during a contract period.

- **Formulary:** A list of covered drugs provided by the health plan.

- **Fraud, Waste and Abuse (FWA)**
  - **Fraud**: knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
  - **Waste:** practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
  - **Abuse**: actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

- **Gaps in Care:** The predictive modeling application is able to identify when an enrollee has not received health care services (e.g., has a "gap" in care) according to national clinical practice guidelines. Utilizing quality indicators derived from national guidelines (including but not limited to Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Disease Control and Prevention (CDC), and the Americans with Disabilities Act (ADA) the software categorizes missing services into three types of gaps:
  - Screening gaps (e.g., lack of appropriate screening for colorectal cancer);
  - Immunization gaps (e.g., did not receive annual influenza immunization), and
  - Disease-specific gaps (e.g., a diabetic did not receive appropriate screening for diabetic retinopathy).

- **General Services Administration's (GSA) Excluded Parties List System (EPLS) on the System for Award Management (SAM):** An electronic, web-based system that identifies parties suspended, debarred, proposed for debarment or otherwise excluded from receiving Federal contracts, certain subcontracts and certain types of Federal financial and non-financial assistance and benefits.

- **Grievance:** A written complaint by a provider or member to challenge actions that are not subject to an appeal.

- **HCPCS code:** The Health Care Procedure Coding System, released by CMS, is a list of codes and descriptive terminology used to report the provision of supplies, materials, injections, and certain services and procedures. HCPCS codes consist of one alphabetic character followed by four digits. They supplement CPT codes.

- **Health Partner:** A BHN Population Health Management employee who holds either a Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW) and is responsible to provide a variety of support functions which contribute to the overall improvement in the members healthcare quality of life as well as efficient use of resources.

- **Health Plan:** The entities that Banner Plan Administration has been contracted with to provide third party administration (TPA) services to its members.

- **Health Plan Agreement/Contract:** A contractual relationship between a health plan (UHC MA, Cigna Commercial, BCBS, BUHP, BMA, etc.) and a Banner Network (BHN, BNSA) in which the Banner Network provides services to the health plane. These are often value-based care relationships.

- **Health Services Navigator**: (HSN) Member of the BHN Population Health Management care management team. Non-licensed personnel designated to support the multidisciplinary care management team by providing member outreach and navigation support.

- **HPMS:** Health Plan Management System

- **Hierarchical Condition Categories (HCC):** Groupings of clinically similar diagnoses in each risk adjustment model. Medicare Advantage (MA) plans reply on the Hierarchical Condition Categories system for reimbursement. HCC payments are linked to the individual health risk profiles for the members in the plan. MA plans use ICD-10-CM codes as the primary indicators of each member's health status.

- **High Risk:** More likely than others to get a particular disease, condition or injury

- **HIPAA:** Health Insurance Portability and Accountability Act of 1996. Federal legislation that provides data privacy and security provisions for safeguarding medical information.

- **HMO: Health Maintenance Organization:** HMOs are regulated under separate laws from other types of insurance coverage. Features that distinguish HMO plans from PPO or indemnity plans include:
  - The plan must cover a specific set of basic health services.
  - Except for emergencies, urgent care and authorized follow-up care, HMO members must use contracted HMO providers for covered services.
  - The health plan's provider contracts must prohibit providers from billing plan members for amounts other than deductible, copayment, and/or coinsurance amounts and for non-covered services.

- **HMO Monthly Summary:** BPA is required under their delegation agreements with Medicare Advantage Health Plans to create and mail monthly Medicare Part C EOBs to Members who have received services in the prior month.

- **Home Health Care Provider:** An entity that provides intermittent skilled nursing services and other therapeutic services in the home.

- **Home Infusion Therapy Provider:** An entity also licensed as a pharmacy that provides home infusion medication administration therapy services.

- **Hospice:** A Medicare-certified entity that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill patients and their families.

- **Hospitalist:** A physician who specializes in treating patients when they are in the hospital. Hospitalists may coordinate a patient's care when he or she is admitted to a BHN-contracted hospital or skilled nursing facility.

- **ICD-10-CM Codes:** International Classification of Diseases coding system, tenth revision, clinical modification, as outlined by the National Center for Health Statistics. ICD-10-CM codes are used to document diagnoses and/or facility-based procedures.

- **IDX System:** Banner Plan Administration (BPA) claims system and records database.

- **Integrated Denial Notice (IDN):** Medicare health plans are required to issue the Integrated Denial Notice (ICN) upon denial, in whole or in part, of an enrollee's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment.

- **Incidental Procedures:** Incidental procedures are procedures commonly performed by the same provider as a component of a total service.

- **In-Network Banner Hospitals:**
  - Banner Baywood Medical Center
  - Banner Behavioral Health Hospital
  - Banner Boswell Medical Center
  - Banner Casa Grande Medical Center
  - Banner Children's at Desert
  - Banner Del E. Webb Medical Center
  - Banner Desert Medical Center
  - Banner Estrella Medical Center
  - Banner Gateway Medical Center
  - Banner Goldfield Medical Center
  - Banner Heart Hospital
  - Banner Ironwood Medical Center
  - Banner MD Anderson Cancer Center
  - Banner Ocotillo Medical Center
  - Banner Thunderbird Medical Center
  - Banner – University Medical Center Phoenix

- **In-Network Utilization:** The use of BHN providers, services and facilities, including non-Banner owned contracted entities, for the care of members and beneficiaries in BHN-contracted plans.

- **Interactive Voice Response (IVR):** Is the automated phone system callers utilize to interact with computer technology via the telephone keypad and/or speech recognition. IVR systems provide caller/customer serf-service options.

- **Internal Audit:** A department within Banner Health that provides independent, objective and comprehensive reviews designed to evaluate and assess the adequacy and effectiveness of various areas of the company.

- **Intensity:** The amount of care and complexity of care using four major dimensions to intensity – severity of illness, client dependency, complexity and time.

- **Inquiry:** a request for status or question regarding benefits, services or processes that is typically handled in one phone call.

- **List of Excluded Individuals/Entities (LEIE):** The OIG's list of all individuals and entities currently excluded from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from

Federal healthcare programs for any items or services they furnish, order, or prescribe. This includes those that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

- **Licensed Staff:** an individual (Registered Nurse or Health Partner) who has successfully completed a prescribed program of study in a variety of health fields and who has obtained a license or certificate indicating his or her competence to practice in that field

- **Marketing Material:** As defined by 42 CFR 425.50, includes, but is not limited to, general audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, web pages, mailings, social media, or other activities conducted by or on behalf of the MSSP and/or its providers and suppliers, when used to "educate, solicit, notify, or contact Medicare Beneficiaries regarding the Medicare Shared Savings Program".

- **Measures:** Dashboards for best practice

- **Medical Director –** A physician designated as a Medical Director who holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States, with a scope of practice that is relevant to the clinical area.

- **Medically Necessary:** Any service or supply required for the diagnosis or treatment of an active illness or injury that is rendered by or under the direct supervision of the attending physician and is generally recognized and approved by physicians as appropriate in the treatment or management of the illness or injury.

- **Medication Review:** The process of carefully looking at or examining the most accurate list of all medications a member is taking – including drug name, dosage, frequency, and route – and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the member at all transition points.

- **Medicare:** The Federal health insurance program for people 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

- **Medicare Advantage Organization (MAO):** An organization that has entered into a contract with the Centers for Medicare & Medicaid Services (CMS) relating to the provision of one or more Medicare Advantage Plans.

- **Medicare Beneficiaries**: Anyone determined by the Social Security Administration to be eligible for Medicare benefits.

- **Medicare Advantage Plan:** The specific health benefits, terms of coverage and pricing structure of a senior health plan product offered to Medicare beneficiaries by a Medicare Advantage Organization pursuant to a contract with CMS.

- **Medicare Fee-for-Service:** Often referred to as "original Medicare" meaning the Beneficiary benefit, rules and regulations are defined by CMS and the claims are paid directly to the provider by CMS.

- **Medicare Shared Savings Program (MSSP):** The MSSP is a voluntary program, overseen by the Centers for Medicare &Medicaid Services (CMS), that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Organization (ACO) to give coordinated, high-quality care to their Medicare Fee-For-Service patients.

- **MSSP Enhanced Track:** An ACO model in which beneficiaries are prospectively assigned with retrospective reconciliation. There is greater risk for greater reward, including higher sharing rates and performance payment limits, and higher loss rate with loss sharing limit.

- **Member:** An individual covered under a BHN benefit plan.

- **MSSP Quality Measures:** This is the set of quality measures chosen annually by CMS for the MSSP program. The measures focus on four domains: patient/caregiver experience; care coordination/patient safety; preventive health; and at-risk population.

- **Narrow Network:** A health plan's provider network from which a patient and his or her physician can select providers, health care facilities and resources. Those selected outside of this network are not covered and may lead to additional out-of-pocket costs for the patient. Fortunately, BHN is comprehensive in its coverage, allowing plenty of choice and specialty coverage.

- **National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC):** An organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential fraud, waste and abuse in Medicare Parts C and D.

- **National Committee for Quality Assurance (NCQA):** An industry-leading accreditation organization that assesses health plan's structure and process, clinical quality and patient satisfaction. They have developed the Healthcare Effectiveness and Information Set (HEDIS) quality measures.

- **Non-Covered Services:** All health care services that are not authorized for payment under the member's health benefit program.

- **Office of Civil Rights (OCR):** The HHS OCR enforces federal civil rights laws, conscience and religious freedom laws, HIPAA Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect your fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy.

- **Office of the Inspector General (OIG)**: The OIG protects the integrity of the U.S. Department of Health and Human Services' programs, including Medicare, and the health and welfare of its beneficiaries. The OIG operates through a nationwide network of audits, investigations, inspections, and other related functions. The Inspector General is authorized to, among other things, exclude individuals and entities who engage in fraud or abuse from participation in Medicare, Medicaid, and other Federal health care programs, and to impose civil monetary penalties for certain violations related to Federal health care programs.

- **Office Staff:** Staff assisting providers including but not limited to office manager, administrator or practice manager.

- **Opt-Out:** The member has declined enrollment in the Case Management Program or during the course of case management services declines further involvement.

- **Outcomes:** End result of Case Management services

- **Out-of-Area Hospitals:** Hospitals that are not contracted with BHN and are not located within BHN's geographic service area.

- **Out-of-Network Hospitals:** Hospitals that are not contracted with BHN, including non-contracted hospitals that are located within BHN's geographic service area.

- **Participating Provider:** Health care providers who are under contract, directly or indirectly with through one of BHN's provider networks to provide covered services to members of contracted health plans.

- **Patient Protection and Affordable Care Act (PPACA):** The first part of the comprehensive health care reform law enacted on March 23, 2010. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The law provides numerous rights and protections that make health coverage more fair and easier to understand, along with subsidies (through "premium tax credits" and "cost-sharing reductions") to make it more affordable. The law also expands the Medicaid program to cover more people with low incomes.

- **Patient Specific Agreement (PSA):** An agreement to provide a predetermined discount for a single outpatient or inpatient admission or reoccurring outpatient service. In some cases, a PSA may apply to a predetermined episode of care such as in the case of a transplant.

- **Payee:** A person or facility to whom money is paid or is to be paid, especially the person to whom a check is made payable.

- **Payer Contract Summary (PCS):** A document that summarizes contractual terms between Banner Health, Banner Health Network, health plans and/or direct employer groups for all Banner lines of business.

- **Payment Dispute:** Any decision where a provider contends that the amount paid for a Medicare covered benefit is less than the amount that would have been paid under Original Medicare.

- **Performance Year:** The year in which the Medicare Shared Savings Program is operating and being measured for quality performance.

- **Per Member Per Month (PMPM):** A pre-determined payment for each member, each month. This may apply to capitated contracts or delegated services.

- **Percent of Premium:** An agreement between the provider and managed care organization, whereby the managed care organization reimburses the provider a percentage of the premium charged.

- **Pharmacy Coverage Guidelines:** Pharmaceutical and administrative criteria developed from reviews of published, peer-reviewed medical and pharmaceutical literature and other relevant information that are used to help determine whether a medication or other products such as medical devices or supplies are eligible for benefits under a member's retail or mail order benefit.

- **Physical Medicine and Rehabilitation (PMR) Provider (Physiatrist):** PMR is a medical specialty concerned with diagnosis, evaluation, and management of persons of all ages with physical and/or cognitive impairment and disability. This specialty involves diagnosis and treatment of patients with painful or functionally limiting conditions, the management of comorbidities and co-impairments, diagnostic and therapeutic injection procedures, electrodiagnostic medicine, and emphasis on prevention of complications of disability from secondary conditions. BHN has contracted with PMR providers to perform rounds at each skilled nursing facility within the BHN network.

- **Physicians:** MD and DO providers.

- **Plan Sponsor**: An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

- **Plurality:** Greater proportion of primary care services as measured in allowed charges within the ACO than from services outside the ACO (such as from other ACOs, individual providers, or provider organizations).

- **Policy:** Policies are created to provide a high-level overview of process requirements for regulatory reasons and establish accountability for providing quality services to clients and consumers. Policies are formally reviewed and approved each year by several parties. Some policies may be specific to a department; others may be "adopted" from Banner Health Corporate.

- **Population Health Management:** Improving health outcomes across a large population through care coordination, disease management and evidence-based interventions applied broadly.

- **Population Health Specialist:** This position monitors health plan members and patients to ensure they are receiving services they need or are continuing to be offered services if there are any changes in their health.

- **Pre-certification:** The process an applicable plan administrator uses to determine eligibility for certain benefits. Pre-certification is not a pre-approval or a guarantee of payment.

- **Preferred Provider Organization (PPO):** A PPO benefit plan is based on a network of contracted providers in which members have lower out-of-pocket costs when they use a PPO provider for covered services. Members have higher out-of-pocket costs for covered services from out-of-network providers. The differences in cost share can be substantial. Some services

(e.g., most preventive care) are covered only when the member uses an in-network provider.

- **Primary Care Physician (PCP):** A health care professional who is contracted as an internal medicine, family medicine, general practice, or pediatric physician, and is listed in the provider directory as such. All other health care professionals are considered specialists.

- **Prior Authorization:** Approval in advance to provide services or prescribe drugs to Members. All out-of-network and out-of-area services require prior authorization except for emergencies, urgently needed care, and out-of-area renal dialysis. Covered drugs that require prior authorization are marked in the formulary.

- **Process Date:** The date on which a claim is adjudicated or finalized in the claims processing system. When a claim is adjusted or re-adjudicated, it may be assigned a new process date and may be subject to the current pricing logic.

- **Protected Health Information (PHI):** Health information including demographic information that individually identifies a patient or health care member and relates to past, present or future physical, genetic or mental health condition of an individual for the provision of health care; or the past, present or future payment for the provision of health care to an individual, held or transmitted by a covered entity in any form or media, whether electronic, paper, or oral.

- **Provider:** A properly licensed, certified or registered person or facility, acting within the lawful scope of practice, and furnishing health care to members; providers include doctors, hospitals, laboratories and other health professionals and facilities.

- **Provider Agreement/Contract:** A contractual relationship between a Banner Plan (BUHP, BMA, etc.) or a Banner Network (BHN, BNSA, BNC) and a provider group.

- **Provider Data Management (PDM):** Part of BPA Operations, this team is responsible for entry, updating and management of provider data to include management of data quality and provider data electronic/systems interfaces.

- **Provider Experience Center:** A department within BPN responsible for answering questions about your patient's membership and benefits, eligibility, prior authorizations and claims. They can be reached at

ProviderExperienceCenter@BannerHealth.com or by calling (480) 684-7070 option 4 or (800) 827-2464.

- **Provider Network(s)**: A Provider Network is a group of providers who are affiliated through contractual agreements. Examples include Banner Health Network (BHN), Banner University Health Plan (BUHP), Banner Medicare Advantage (BMA), Banner Network Southern Arizona (BNSA), Banner Network Colorado (BNC). Some networks may be health plan networks, which allow a member to access specific providers as In Network. Some networks may be value based networks, which are focused on achieving specific outcomes for incentive payments in addition the payments a provider would receive through their health plan network relationship. BHN is a blending of a health plan network and value based network. Although historically Entity Organizations like Banner Medical Group (BMG) and Banner University Medical Group (BUMG) have been referred to as networks, that is incorrect. Some historical data sets have BMG and BUMG listed as networks, but this was done due to system limitations.

- **Provider Scorecard:** A means to track your personal performance on ACO Quality Measures and other key metrics. PCPs can get a copy of their personal scorecard by contacting their Care Transformation consultant.

- **Quadruple Aim:** The Quadruple Aim is the foundational goal of the ACO model. It balances patient satisfaction, quality care, the cost to deliver care and the work life of health care providers. The intention is to keep high quality care affordable for employers and individuals through care coordination across the continuum of provider services. The term was first coined by the Institute for Healthcare Improvement.

- **Quality Metrics:** The dimensions established by CMS to evaluate quality performance within the Medicare Shared Savings Program.

- **RCBR:** Verification for Coordination of benefits

- **Reconsideration:** second level request sent by a provider due to a Redetermination being upheld and should include additional documentation for the claim.

- **Redetermination:** First level (initial) request sent by a provider to review a denied claim.

- **Referral:** The process by which a primary care physician (PCP) directs a member to seek and obtain covered services from a specialist. BHN members should be referred to BHN-contracted providers.

- **Remittance Advice (RA):** A document supplied by the insurance payer that provides notice of and explanation for payment, adjustment, denial and/or non-covered charges of a medical claim. RAs typically accompany Medicare and Medicaid payments. They may be provided in either electronic or hard copy format.

- **Reopen**: A remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

- **Report2Web (R2W):** A free and secure email-based alert system that notifies physicians when their patients have been seen at a Banner Health hospital, including visits to the Emergency department and hospital admissions/discharges.

- **Risk Adjustment Factor (RAF):** Risk Adjustment Factor includes each member's individual health status and demographic characteristics.

- **Risk Assessment:** The identification, measurement, and prioritization of likely relevant events or risks that may have material consequences on BHN's ability to maintain compliance with BHN policies and procedures, URAC standards, contractual requirements, and applicable state and federal laws and regulations.

- **RLEG:** Eligibility Verification/Add Newborns

- **RPCP:** Eligibility Verification for our senior plan members

- **System for Award Management (SAM):** The centralized government system for certain contracting, grants, and other assistance-related processes, including identification of those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.

- **SBAR** *(situation-background-assessment-recommendation)* – A reporting tool used by health care professionals to summarize and communicate the patient status/issues/concerns for escalation with the multidisciplinary team.

- **Serious Conditions:** Having important or dangerous possible consequences.

- **Service Area:** The area where a health plan accepts enrollees and where services are provided. Only urgent/emergent services, dialysis and a limited

travel benefit (Banner Health Plans only) are provided out of the service area without prior authorization.

- **Service Center:** A department within BPA responsible for answering questions about Banner Health Plan membership and benefits, eligibility, prior authorizations and claims.

- **SF-12 Survey:** A survey that uses 12 established questions to measure functional health and well-being from the member's point of view.

- **Shared Savings:** Shared savings agreements with payers to reward provider networks for providing high quality, efficient care that is well coordinated and meets member experience expectations. Any savings that is achieved, compared to cost benchmarks, is shared by the payer and providers if the other metrics are also met.

- **Skilled Nursing Facility (SNF):** A Medicare-certified facility that provides inpatient skilled nursing care, rehabilitation services or other related health services. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility that primarily furnishes custodial care.

- **SNFist:** A Hospitalist who performs rounds at skilled nursing facilities within the network.

- **Social Services Professional:** The Social Services Professional, aka licensed social worker, involved with the Case Manager as part of the interdisciplinary team in meeting the member's needs.

- **Specialist:** A physician who practices in a specific area other than those practiced by primary care providers.

- **Star Rating:** For plans covering health services, this is an overall rating given by CMS for the quality of many medical/health care services that fall into five categories: staying healthy (screening tests, vaccines), managing chronic (long-term) conditions, member experience with the health plan, member complaints and changes in the health plan's performance and health plan customer service.

- **Subject Matter Expert:** An individual who is closest and most knowledgeable about the topic that is the subject of communication.

- **Subsidiaries:** Legal entities that report to or are owned by a parent company.

- **TIN:** Tax ID Number
- **Third Party Administrator (TPA):** A Third-Party Administrator is an organization that processes insurance claims and/or other aspects of employee benefit plans on behalf of a separate entity. TPAs may also be used to manage provider networks, utilization review or membership functions.
- **Threat:** Intent to cause harm by suicide or harm of others.
- **Triad:** a group or set of three connected people usually a CM, HP and HSN

  TTY: Teletypewriter
- **UB-04:** A standardized institutional claim form used for reporting and billing medical services, as specified by the National Uniform Billing Committee.
- **UHC:** United Healthcare
- **URAC:** Independent leader in promoting health care quality through accreditation, education and measurement. It was founded in 1990 as an independent, third-party health care quality validator.
- **Urgent Care:** Services for conditions that require prompt medical attention but are not emergencies and therefore do not require treatment in an emergency room.
- **Urgent Care Center:** Location, distinct from hospital emergency room, an office, or clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
- **Utilization Management (UM):** The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘utilization review'.
- **Warm Connect:** Remaining on the phone line with the member to connect a call only after announcing the name and call back telephone number of the individual and providing a brief summary of the situation to the receiving person.
- **Value-Based care:** A form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness.

EXHIBIT 1

TIMELINES TO NOTIFY COMMERCIAL AND MEDICARE PLAN MEMBERS OF PRE-SERVICE DETERMINATIONS

Commercial Members

Notification to commercial members should occur:

- As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination, if it is a case involving urgent care; or
- Within 14 calendar days of the receipt of request for a utilization management
  determination, if it is a non-urgent case; and

  For non-urgent cases, this period may be extended one time by the organization for up to 14 calendar days:
  - Provided that the organization determines that an extension is necessary because of matters beyond the control of the organization; and
  - Prior to the expiration of the initial 14 calendar day period, notifies the patient of the circumstances requiring the extension and the date when the plan expects to make a decision; and
  - If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information and the patient must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

Medicare Advantage Plan Members

Notification to Medicare Advantage members should occur:

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	**Within 14 calendar days after receipt of request.** Use the Integrated Denial Notice (IDN) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	**May extend up to 14 calendar days.**	**Use the MA-Extension: Standard & Expedited to notify member and provider of an extension.**

Type of Request	Decision	Notification Timeframes
	Note: Extension allowed ***only*** if member requests or the provider/organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt.** ***Decision Notification After an Extension:*** **Must occur no later than expiration of extension. Use the Integrated Denial Notice (IDN) template for written notification of denial decision.**
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a	**If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice.** ▪ **Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include:**

Type of Request	Decision	Notification Timeframes
	member's request for an expedited decision. **If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:** ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was received for an expedited determination.	**1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations;** **2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination;** **3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and** **4) Provide instructions about the expedited grievance process and its timeframes.**

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If No Extension Requested or Needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – **Oral or written notice must be given to member and provider within 72 hours of receipt of request.** – **Document date and time oral notice is given.** – **If written notice only is given, it must be received by member and provider within 72 hours of receipt of request.** ▪ **Denials** – **When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice.** – **Document date and time of oral notice.** – **If only written notice is given, it must be received by member and provider within 72 hours of receipt of request.** **Use the Integrated Denial Notice (IDN) template for written notification of denial decision.**

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination **-** If Extension Requested or Needed	**May extend up to 14 calendar days.** **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. **When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).** **Documentation of the attempt within 24 hours does not replace the**	▪ **Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension.** ***Extension Notice:*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ **Approvals** – **Oral or written notice must be given to member and provider no later than upon expiration of extension.** – **Document date and time oral notice is given.** – **If written notice only is given, it must be received by member and provider no later than upon**

Type of Request	Decision	Notification Timeframes
	requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	**expiration of the extension.** ▪ **<u>Denials</u>** – **When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice.** – **Document date and time of oral notice.** – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use the Integrated Denial Notice (IDN) template for written notification of denial decision.