Provider Manual

October 2025

Quartz®

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Welcome to Quartz. We are pleased to have your facility in our network of contracted providers and look forward to a long, mutually beneficial relationship.

This manual aims to inform and offer valuable information about Quartz, our policies and procedures, our Quality Improvement Program, and our quality initiatives. If you have questions or concerns after reading the manual, please contact your Provider Engagement Specialist. We welcome and appreciate your ideas for improving our services.

Unless specifically noted, the information in this manual applies to Quartz Medicare Advantage (HMO), Quartz Medicare Advantage Dual Eligible w/Rx, BadgerCare Plus, Medicaid SSI, and Quartz Health Solutions Commercial (including Exchange (QHP) and self-funded (ASO)) plans.

NCQA Accreditation

What is NCQA Accreditation?

Quartz holds an "Accredited" status with The National Committee for Quality Assurance; NCQA is a private, non-profit organization dedicated to improving healthcare quality. The NCQA Accreditation standards establish the principles of continuous quality improvement by looking at an organization's actual practice patterns over time and written policies and procedures. NCQA emphasizes the measurement of quality initiatives and the implementation of opportunities for improvement. It is expected that health plans work to identify and pursue quality improvement opportunities in clinical practice and service areas.

Why is NCQA Accreditation important?

Health plans face increased demands for information about the quality of care provided. NCQA Accreditation is a measurable mark of quality within an organization. Some reasons that NCQA Accreditation is important to include:

- NCQA Health Plan Accreditation is a widely recognized, evidence-based program dedicated to quality improvement and measurement. It provides a comprehensive framework for organizations to align and improve operations in areas that are most important to states, employers, and consumers.
- NCQA requirements provide data and information to help Quartz identify areas of opportunity and initiate programs to improve the quality of care to your patients, our Quartz members.
- Accreditation is used to measure the quality of healthcare organizations. Going through the accreditation process will help your organization highlight strengths, reaffirm your commitment to compliance, and drive continuous improvement.
- State and federal governments require a review of the effectiveness of quality assurance plans. Maintaining full compliance with all NCQA standards is a high priority for Quartz. Please visit ncqa.org for information about Quartz's quality rating and NCQA Accreditation status. For additional Provider education related to health equity please refer to Wisconsin Center For Public Health Education And Training (WiCPHET.org).

Access and Appointment Availability Standards

Quartz has established time and distance access and appointment availability standards for each line of business. Quartz follows each State and/or Federal regulations for these standards, which includes the CMS rules for the plans that fall under Federally facilitated Exchanges. If the state does not have established standards, Quartz follows NCQA standards. All in-network providers are expected to comply with the standards to ensure Quartz members have reasonable access to the care and services, considering the urgency of the need for services they require. To ensure these standards are met, Quartz will use the Quest Analytics tool for time/distance standards and member to provider ratios analysis, and will conduct surveys to ensure appointment and wait time standards are met. Quartz will monitor this through member inquiries, complaints, and annual provider surveys reported as a requirement for the National Committee for Quality Assurance (NCQA).

Upon arriving for a scheduled appointment, in-office wait times shall not exceed 15 minutes without explanation. Providers are encouraged to have signage that members should report to the reception desk if the in-office wait time exceeds 15 minutes. When care is unavoidably delayed, members must be notified of the delay and allowed to reschedule their appointment. Attempts will be made to reschedule the appointment as medically appropriate and close to the original date.

Providers are expected to have appointment standards, protocols, methods of monitoring, reporting, and remediation for the patients they serve, and must be available to Quartz upon request. Any identified issues will be discussed at the Provider Contract Team meeting for resolution and reported to the Quartz Credentialing Committee, as appropriate.

Medicaid/SSI requires the following (DHS HMO Contract Section V.A.2):

- Network providers meet standards for timely access to care and services, considering the urgency of the need for services.
- Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid FFS. Providers must ensure appointment and facility wait time standards do not discriminate against members.
- Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
- Provide medically necessary high risk prenatal care within two weeks of the member's request for an appointment or within three weeks if the request is for a specific HMO provider who is accepting new patients.

After-Hours Care

Providers are responsible to provide services 24 hours per day, 7 days per week. Members must have access to care during and after normal clinic office hours. Quartz ensures our members are able to obtain care or medical advice any time the need arises and measures after-hours services to ensure members have this access.

All providers should have an appropriate after-hours phone message available for patients calling in after normal business hours. We recommend that the provider's telephone greeting includes their name, office hours, and availability of translation services, plus the name and phone number of a hospital or emergency services provider where a member can obtain after-hour care or emergency care.

All network primary care clinics must have a system to ensure that Quartz members have adequate access to care after normal clinic operating hours. The system should include:

Providing information to members about how to access care after normal clinic hours:

- Describing how the system assists members with gaining access to care after clinic hours and responds to those inquiries.

- Describing who is responsible for assuring the system is operational.

Quartz procedures for assuring access to primary care clinics are:

- Informing members through written communication in the Member Guide or other resources on obtaining information about after-hours care.
- Ensuring the clinic has a telephone answering system or a live person answering after-hours calls. The system must either have a person on duty to answer specific medical questions and direct care as appropriate or provide information on how to access care immediately if needed.

Quartz monitors compliance with this measure through our member survey program and after-hour telephone survey.

Providers Responsibility

Quartz contracted providers are responsible to cooperate with Quartz to ensure network access, availability, and capacity expectations are met as required under 42 CFR § 438.206-7, 42 CFR § 438.68, and 42 CFR § 438.14.

Confidentiality

As required by HIPAA and NCQA, Quartz has developed policies and procedures to protect the confidentiality of member information and records. Quartz's Privacy and Security Committee sets standards for some external parties, such as Quartz's subcontractors. The duties of the Privacy and Security Committee include:

- Overseeing Quartz's compliance with HIPAA, including internal and external requests for member information.
- Addressing concerns regarding the use of member data for various purposes.
- Developing strategies to promote the prevention, detection, and correction of privacy or security incidents.
- Ensuring Quartz has policies and procedures relating to the use and disclosure of confidential information.

The following summarizes how Quartz uses, discloses, and protects member information.

General Policy

Quartz's policies and procedures are designed to safeguard the confidentiality of individually identifiable member information, including Protected Health Information (PHI) and Personally Identifiable Information (PII). When we receive a request for confidential information, we will release the minimum amount of information necessary to respond to the request as described below.

Release of Protected Health Information (PHI) without Authorization

Quartz may disclose protected health information without a member's written or verbal authorization for payment and health care operations. "Health care operations and payment" include:

- Payment of practitioners and providers.
- Measurement and improvement of care and services.
- Preventive health and disease management programs.
- Investigation of complaints and appeals.
- Other purposes needed to administer benefits.

Additionally, Quartz may disclose PHI pursuant to a valid court order or subpoena or as otherwise required by law.

Release of Protected Health Information Requiring Authorization

For purposes other than payment and health care operations, the member must sign an authorization before Quartz will disclose PHI. Quartz will accept a verbal authorization for a one-time release of PHI in certain limited circumstances. Examples of disclosures that require an authorization include:

- Release of information to an attorney.
- Data requested for an auto insurance claim.
- Release of information that could result in another company contacting the member for marketing purposes.
- Release certain information to an employer, a family member, or a friend.
- Release of information to a personal representative.

Member Access to Medical Records

Quartz does not maintain original medical records. We advise members to contact their health care practitioner or provider to obtain medical records. The member has the right to access (copy and inspect) PHI maintained by Quartz. The member also has the right to request amendment of such information and place limitations on disclosing such information.

Disclosure of Information to Employers

Quartz provides certain types of information to employers as part of standard health insurance processes. Disclosure of information to employers (acting as plan sponsors) is limited to summary information and limited information that the employer needs to administer, amend, or terminate a health plan. Employers do not have access to individually

identifiable health information about their employees without specific member authorization.

Treatment Setting

Quartz is committed to ensuring the confidentiality of information in all settings. We expect our credentialed practitioners and providers to implement confidentiality policies and procedures that address the disclosure of medical information, patient access to medical information, and the storage, protection, and destruction of PHI. Quartz reviews practitioner confidentiality processes during pre-contractual site visits for primary care providers and some specialists.
All in-network primary care providers are expected to develop a comprehensive treatment plan based on results from internal monitoring and assessed needs of Quartz members. The treatment plan will include assessment and care coordination, follow-up, and care planning strategies.

Providers shall not treat him or herself or a member of his or her immediate family, unless in emergency circumstances. Claims rendered are not covered or payable. Immediate family member means spouse or domestic partner; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Measuring Quality Improvement

Quartz collects data from administrative sources (e.g., claims and pharmacy data) and medical records to measure, monitor, evaluate and improve the quality and care of services provided to members. Quartz protects member information by complying with relevant privacy and confidentiality standards including but not limited to HIPAA, federal and state regulations.

Medicare Advantage Program

Quartz Medicare Advantage (HMO) contracts with the Centers for Medicare and Medicaid Services (CMS) to provide benefits to members. This plan is attractive to Medicare beneficiaries for many reasons, including:

- Quality care
- An affordable price
- Comprehensive provider network
- Ease-of-use
- Member's ability to budget health care costs
- Additional benefits covered

Quartz Medicare Advantage plans allow Medicare-eligible members an alternative to the traditional Fee-For-Service Medicare program.

Provider Responsibilities

Quartz Medicare Advantage (HMO) expects contracted providers to:

- Understand that Quartz Medicare Advantage (HMO) does not deny patient care but simply makes payment decisions based on the member's coverage.
- Act in the best interest of members.
- Address a diverse patient population in a culturally competent manner.
- Communicate thoroughly with members regarding their illness, as well as diagnostic treatment options, medication treatments, and therapeutic options available to them regardless of benefit coverage.
- Allow members to participate in their health care decisions.
- Comply with all state and federal regulations with respect to our member's rights.
- Effectively address and overcome any barriers concerning a member's compliance with prescribed treatments and regimes.
- Provide continuity of care for members by ensuring that there is an appropriate confidential exchange of medical information between all providers involved.
- Refer members for specialty care or second opinions within the Quartz Medicare Advantage (HMO) provider network and obtain written approval from Utilization Management when care is necessary outside of the Quartz Medicare Advantage (HMO) network.
- Assist Quartz Medicare Advantage (HMO) members in obtaining Prior Authorization, as necessary, to facilitate claim payment. View a list of services requiring prior authorization.
- Participate in Quartz Medicare Advantage (HMO)'s utilization management and quality improvement initiatives, including allowing Quartz Medicare Advantage (HMO) members reasonable access to medical records at no cost.
- Recognize that there are multiple, well-accepted means of diagnosis and treatment for many given conditions.
- Inform the Medical Director when the Quartz Medicare Advantage (HMO) procedures or actions are perceived as threatening the health or well-being of the member.
- Communicate with members and Quartz Medicare Advantage (HMO) in a way that assumes that all parties are acting in good faith with the goal being good care for the member.
- Recognize that Quartz Medicare Advantage (HMO) is obligated to develop policies and procedures on benefit administration and to administer these fairly and consistently, even though this occasionally results in denial of payment for individual members.
- Understand that Quartz Medicare Advantage (HMO)'s goal is to improve access and quality of health care.
- Complete a successful credentialing program before contact with Quartz Medicare Advantage (HMO) members.
- Request the member's ID card before services are provided and verify that all demographic and insurance information is correct to ensure correct registration, billing, and reporting processes.
- Ensure that interpreter services are available for members with hearing impairments or who speak a different

language than the provider.

- Provide accessibility for individuals with disabilities as defined by the Americans with Disabilities Act (ADA), the Civil Rights Act, and any state or federal requirements to meet special and cultural needs.
- Contact Quartz Customer Success at (800) 897-1923 anytime verification of eligibility or verification of Primary Care Physician designation is necessary.
- Contact Quartz Customer Success (800) 897-1923 anytime the practitioner or designee becomes aware of incorrect member information.

Quartz Medicare Advantage (HMO) Responsibilities

In-network providers can expect Quartz Medicare Advantage (HMO) to:

- Assist the provider in meeting the expectations of Quartz Medicare Advantage (HMO) participation.
- Pay claims fairly and efficiently.
- Provide due process to the provider when complaints or grievances are lodged against them.
- Support the provider in practice by identifying opportunities to improve care when information is available on a practice basis or an individual member basis.
- Maintain an appeals process that can respond quickly and appropriately to members and providers.
- Educate and encourage members to be seen for appropriate preventive services.
- Inform providers of quality or other initiatives that may affect them or the members.
- Work in all our operational areas to improve service to providers and members.

Quartz Medicare Advantage Plan Year 2026 Service Area

Wisconsin: Buffalo, Columbia, Dane, Green, La Crosse, Monroe, Pepin and Trempealeau counties

Minnesota: Fillmore, Houston and Wabasha counties

Iowa: Allamakee, Fayette and Winneshiek counties

Contact and Service Function	Telephone Numbers
Customer Success for Quartz Medicare Advantage members. Available Monday through Friday, 8 a.m. – 8 p.m. From October 1 through March 31, available seven days a week, 8 a.m. – 8 p.m.	(800) 394-5566
Customer Success for Providers. Available Monday through Friday, 8 am. – 5 p.m. • Verify member eligibility • Provide Quartz Medicare Advantage (HMO) policies and procedures • Provide member schedule of benefits • Provide general information or assistance • Member address or name changes • Provide benefit information • Questions regarding clinic-administered medications requiring prior authorization (Part B) • Record member complaints • Verify member's Primary Care Physician assignment • Coordination of benefits questions • Determine claim status • Adjustment procedure and inquiry • Check for copayments • Member/Provider appeals	**(800) 897-1923**
Configuration • Questions regarding the explanation of payments • Questions relating to electronic claim submissions	(800) 897-1923
Provider Network Management • Network application and credentialing status • Provide administrative support to plan requirements • Contractual issues/fee schedule • Provide education and training assistance	Contact your Provider Engagement Specialist
Utilization Management • Admission review/discharge planning • Care Management • Home Health/IV therapy • Referrals for out-of-plan services • Skilled Nursing Facilities • Procedures/services requiring prior authorization • Hospice	(800) 897-1923
Pharmacy Help Desk • Medications requiring prior authorization (Part D) • Vaccines (Part D)	(800) 506-4614

Member-Related Information

Sales Restrictions

Quartz Medicare Advantage (HMO) has assembled a dedicated sales team who are specifically trained and licensed for sales activities. Due to the complexity of the regulations, Quartz Medicare Advantage (HMO) encourages providers to address their sales questions to the Quartz Medicare Advantage Sales Team at (866) 491-1335.

Quartz Medicare Advantage (HMO) does not allow providers to act in a manner where they might be viewed as sales agents. Reasons why providers should not act as sales agents are listed below:

- Quartz Medicare Advantage (HMO) retains all authority for marketing and sales.
- All materials shared with a member, including newspaper or other articles that reference Quartz Medicare Advantage, require prior approval by CMS.
- Providers may not be the best source of membership information for their patients.
- CMS strictly regulates sales activities for Quartz Medicare Advantage. Discussion of certain topics, including presenting or discussing premiums or benefits, may require state licensure as an insurance agent.
- Providers can distribute materials for several plans.

New Quartz Medicare Advantage (HMO) providers may use general advertising (e.g., radio, television) within the first 30 days of the new contract agreement. An announcement to members of a new contract which names only Quartz Medicare Advantage (HMO) can occur only once when such announcement is conveyed through direct mail, email, or phone. Additional direct mail and/or email communication from providers to their members regarding affiliations must include all plans with which the provider contracts.

Provider websites may provide the CMS Online Enrollment Center link at medicare.gov/find-a-plan/questions/enroll-now.aspx to direct potential members to plan enrollment applications and/or provide downloadable enrollment applications.

Eligibility and Enrollment

Individuals may enroll in Quartz Medicare Advantage (HMO) if they are entitled to Medicare Part A, enrolled under Medicare Part B, and reside in the Quartz Medicare Advantage (HMO) service area at least six months out of the year. Eligible individuals may enroll only during specific election periods, as specified by CMS. The Quartz Medicare Advantage (HMO) service area is defined above.

Effective Date

Quartz Medicare Advantage (HMO) will notify the member in writing of their effective date of coverage.

If a membership application is rejected by CMS or Quartz Medicare Advantage (HMO), the member will be notified in writing of the reason for rejection.

Disenrollment

A member may discontinue coverage from Quartz Medicare Advantage (HMO) only during specific election periods, as specified by CMS. Disenrollment requests must be submitted in writing or may be received directly from CMS. The member must continue to receive all services from Quartz Medicare Advantage (HMO) participating providers/practitioners until the disenrollment date.

Coverage Termination

Quartz Medicare Advantage (HMO) must terminate a member's coverage under the following circumstances:

- When a change in residence (including incarceration) makes the individual ineligible to remain enrolled in the plan.
- When the member loses entitlement to either Medicare Part A or Part B.
- When the member dies.
- When the Medicare Advantage (MA) organization contract is terminated or the MA organization reduces its service area to exclude the member.

- When the member fails to pay their Part D – IRMAA to the government and, CMS notifies the plan to effectuate the disenrollment.

Quartz Medicare Advantage (HMO) may terminate a member's coverage under the following circumstances:

- If premiums are not paid on a timely basis.
- If the member engages in disruptive behavior.
- If the member provides fraudulent information on an election form or if the member permits abuse of an enrollment card in our plan.

Should coverage be terminated for any of the reasons above, a member will receive advanced notice from Quartz Medicare Advantage (HMO). Members have recourse through the Quartz Medicare Advantage (HMO) grievance program and/or CMS if they are terminated and disagree with the Quartz Medicare Advantage (HMO) position.

Quartz Medicare Advantage (HMO) Member Identification Card

Upon receipt of CMS approval, a member will receive their Quartz Medicare Advantage (HMO) identification card, which they must use instead of their traditional Medicare card when obtaining medical services and receiving prescriptions when applicable.

Quartz Medicare Advantage (HMO) Member Grievance and Appeal Process

Grievances

Quartz Medicare Advantage (HMO) members have grievance rights available to them as specified in this section. A grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of Quartz Medicare Advantage (HMO) or its provider's operations, activities, or behavior, regardless of whether remedial action is requested. A grievance may also include a complaint that a plan refused to expedite a coverage determination, reconsideration, or redetermination. Other examples include but are not limited to complaints regarding:

- Timeliness
- Appropriateness
- Access to and/or setting of a provided health service
- Covered health service procedure or item during a course of treatment did not meet accepted standards of delivery of health care
- Involuntary disenrollment issues
- Physician demeanor or behavior
- Quality of service issues

Appeals

Members are entitled to a reconsideration of a denied claim or service. If the reconsideration outcome does not meet the member's desired result(s) in whole or part, the matter is turned over to a Medicare contracted independent appeal review firm. Part C plan adverse reconsiderations will be auto forwarded by Quartz Medicare Advantage (HMO) to MAXIMUS Federal Services. Part D plan adverse redeterminations will be reviewed by C2C per member request.

Important Note: If a Quartz Medicare Advantage (HMO) member gives any indication of finding the provider's assessment unsatisfactory or unacceptable, they can call a Quartz Medicare Advantage Appeals Specialist at (800) 394-5566 as soon as possible, preferably that same day, to advise of the potential appealable issue. If Quartz Medicare Advantage (HMO) issues a Notice of Denial of Coverage letter to the member, it will include the appropriate appeal rights as defined by CMS. CMS considers this letter (or corresponding claims denial) an "organizational determination."

Please remember that an indication of "no-need" or any other direct or indirect denial of need for a requested medical service, implied or stated, constitutes an "organizational determination" regarding Quartz Medicare Advantage (HMO)'s coverage to members, subject to appeal rights.

Please reference the following grid for an overview of the Grievance and Appeals Process. The grid explains the difference between a complaint, a grievance, and an appeal and outlines the responsibilities of the provider, member, and Quartz Medicare Advantage (HMO).

Definitions of what constitutes a grievance and appeal can be referenced in this Grievance and Appeals appendix.

Responsibilities of Appealing Party*	Provider Responsibilities	Quartz Medicare Advantage (HMO) Responsibilities
*A member, provider, or appointed or authorized representative may appeal. • Know member rights and responsibilities. • File an appeal within 65 calendar days of the adverse benefit determination. • Submit standard appeal requests in "writing" or "orally" to a Quartz Medicare Advantage Appeals Specialist. • Submit expedited appeal requests in "writing" or "orally" to a Quartz Medicare Advantage Appeals Specialist.	• Notify members of their appeal rights when requests for services are denied. (Sample of member rights can be found in the appendix labeled Grievance and Appeals.) • Support member appeals, if appropriate. • Provide medical record information for "time sensitive" appeal requests when applicable (i.e., expedited appeal requests, required within 24 hours).	Process expedited and standard appeals/grievances within the CMS required time frames. • Submit upheld Part C appeal denials to MAXIMUS Federal Services (MFS). • Effectuate all MFS decisions within the required time frame. • Pay or provide for service if decisions are overturned and notify member within the required time frame.

For questions or concerns regarding this process, call a Quartz Medicare Advantage Appeals Specialist at (800) 394-5566.

Coordination of Benefits

Definition

Coordination of benefits is a contractual provision intended to avoid claim payment delays and duplication of benefits when a person is covered by two or more insurance plans.

There is no coordination of benefits on a beneficiary-specific basis that would relieve a Quartz Medicare Advantage (HMO) member with employer/union group health plan coverage of their cost-sharing obligation under the Quartz Medicare Advantage (HMO) plan. As a result, the member remains liable for payment of the Quartz Medicare Advantage (HMO) plan's cost-sharing regardless of whether Quartz Medicare Advantage (HMO) is primary or secondary.

Coordination of Benefit Rules: Who Pays First

- If the member is age 65 or older and has coverage under an employer group health plan with 20 or more employees, either through their current employment or the employment of a spouse, that coverage pays before Quartz Medicare Advantage (HMO).
- If the member is age 65 or older and has coverage under an employer group health plan with less than 20 employees either through their own current employment or the employment of a spouse, such coverage pays after Quartz Medicare Advantage (HMO).
- If the member is under age 65 and entitled to Medicare (Quartz Medicare Advantage (HMO) due to a disability (other than ESRD) and has group health coverage under an employer with two to 99 employees, either through

their own employment or the employment of a family member, Quartz Medicare Advantage (HMO) would be the primary payer. The employee group health coverage will be primary if the employer has 100 or more employees.

- If automobile medical or no fault liability insurance is available to the member, then benefits under that plan would be primary.
- If the member is eligible for Quartz Medicare Advantage (HMO) solely based on ESRD and is covered under an employer group health plan, Quartz Medicare Advantage (HMO) pays secondary for the first 30 months, with the employer plan paying primary.
- Quartz Medicare Advantage (HMO) may exercise the same rights to recover from a primary plan, entity, or individual that the U.S. Secretary of DHHS exercises under the Medicare Secondary Payer regulations as they apply to MA plans.

Subrogation

Quartz Medicare Advantage (HMO) maintains subrogation recovery rights when claims have been paid for which a third party is liable, e.g., accidents on private property or motor vehicle accidents. Quartz Medicare Advantage will request information from members to determine if third-party liability exists. Providers should attempt to confirm third-party liability with the member and submit claims for the medical payment amounts. When determination of liability is unresolved, Quartz Medicare Advantage (HMO) will pay claims and pursue reimbursement from the other carrier. Quartz Champions are available to assist members and providers with questions and may refer you to our subrogation specialist if additional information is required.

Non-Covered Services Notification

Quartz Medicare Advantage (HMO) is obligated to follow Medicare policies. If the service is not covered by Medicare Fee-For-Service, it will not be covered by Quartz Medicare Advantage (HMO). If Quartz Medicare Advantage (HMO) covers a service that Fee-For-Service does not, it will be specifically listed in the member's EOC, which is available on the Member page at QuartzBenefits.com/MedicareAdvantage . All providers (medical staff and suppliers) must obtain prior authorization for services listed on the Prior Authorization grid. Additional information concerning which medications require prior authorization, what those criteria are, and the Part D drug formulary, can be found at QuartzBenefits.com/MAFormularyPage.

As a contracted provider with Quartz Medicare Advantage (HMO), you are required to complete the Notice of Denial of Medical Coverage (NDMC) prior to providing a non-covered service to a member. CMS requirements indicate that the member or the beneficiary must be held harmless for plan-directed care. If you provide a non-covered service or referral to our member, you must discuss this with the member prior to the service being rendered and document the discussion in the patient's medical record for you to be able to bill the member. CMS does not allow the Medicare Advantage contracted providers to use the CMS ABN forms for non-covered services.

Quartz Medicare Advantage (HMO) has created the NDMC using the Integrated Denial Notice, Form CMS 10003-NDMCP (Iss. 06/2013) OMB Approval 0938-0829. You can find the notices on our website for use when providing these non-covered services. You should not submit a claim to Quartz Medicare Advantage (HMO) for services that are always non-covered (unless the beneficiary requests a claim to be filed). If a service is typically non-covered but could be covered under certain conditions, then a claim is required to be filed with the appropriate modifier indicating that you have provided the member the NDMC and have a copy on file. Claims submitted without the appropriate modifiers attached will be denied as provider responsibility, regardless of if you obtained the notice or documented in the medical record.

Do not use the Medicare Advanced Beneficiary Notices (ABNs) or ABN-like notices

No ABNs and ABN-like notices shall be utilized with Quartz Medicare Advantage (HMO) members. An ABN or ABN-like notice is not a valid notice for Quartz Medicare Advantage (HMO) members. ABNs can only be utilized with Fee-For-Service Medicare beneficiaries. Use of these forms means your claim may deny for provider liability. You are required to use the Notice of Denial of Medical Coverage form as described above.

How do providers bill to show appropriate notice of non-coverage was provided?

When billing for non-covered services, providers can demonstrate that they issued an appropriate Notice of Medical

Coverage, Form CMS 10003-NDMCP by utilizing one of the following modifiers:

- GY modifier: In the event you file a claim for items or services that are "clearly" always excluded, use the GY modifier to show that the service or item was "clearly" excluded under the member's Quartz Medicare Advantage EOC. If the member appeals any claim associated with a GY modifier and either there is no exclusion in the member's EOC or the exclusion is "not clear," the claim will be reversed and denied as provider liability. You can also utilize the GY modifier if the member refuses to wait to receive an organization determination in favor of having the service completed immediately. You are required to place documentation in the medical record that the member refused to obtain an organization determination and elected to obtain the service or item immediately.
- GA modifier: For items or services that are not always "clearly" excluded from coverage, use the GA modifier to show that appropriate notice of non-coverage (CMS-10003-NDMCP) was provided to the member. If the member appeals a claim associated with a GA modifier and there is no proof that the provider issued the appropriate notice of non-coverage, the claim will be reversed to provider liability, and you will not be able to bill the member for any portion of the denied claim.

Transfer of Member Care

In the event of a change in practice status, practitioners are required to assist Quartz Medicare Advantage (HMO) with transition of member care.

It is the contracted facility or practitioner's responsibility to assure effective communication with members regarding the transfer of the member's care to another practitioner.

Activities associated with transition of member care include:

- Identify and communicate with the practitioner who will be designated as the member's Primary Care Physician. Accepting practitioner must meet criteria for a Primary Care Physician status as previously outlined.
- Effective date of anticipated transfer of care.
- Identification of members in high-risk categories (chronic disease states, members utilizing care management services).
- Assist members in transferring medical record and treatment plan information to accepting practitioner.

In the event the practitioner cannot assist in the transfer of care, Quartz Medicare Advantage (HMO) is required to identify a suitable practitioner for members who have not indicated a preference.

- Quartz Medicare Advantage (HMO), through review of its panel of Quartz Medicare Advantage (HMO) in-network practitioners, will assist members in transition of their care to an appropriate practitioner.
- Quartz Medicare Advantage (HMO) will be responsible for notifying members and other parties regarding any practitioner status changes.
- If you require assistance with this process, please contact your Provider Engagement Specialist.

Practitioner Responsibilities

The Primary Care Physician and other treating practitioners will review information provided by Quartz Medicare Advantage (HMO) to maximize the member's health status and evaluate the continuity and coordination of care furnished to members.

- Facilitate patient's compliance with prescribed treatments or regimens, based on record review and administrative data.
- Identify and avoid duplication in diagnostic or laboratory testing.
- Identify and coordinate opportunities for wellness programs.
- Identify and coordinate community resources and social services.
- Identify and coordinate patient's eligibility and appropriateness for participation in care management or disease management programs (high-risk, chronic disease, frequent hospitalizations, increased utilization of ambulatory

services).

- Coordinate care with Care Manager for those members receiving these or related services (disease management or self-care programs).
- Develop a treatment plan based on identified needs in the health risk appraisal and office assessment.
- Notify members in a timely manner of all abnormal critical test results. The timeliness of the notification is based upon the medical indication and urgency of follow-up care or the need for a change in the treatment plan.
    - Notification may be communicated via letter, telephone, or verbally during a follow-up appointment and will be documented in the member's medical record.
- Ensure appropriate and confidential exchange of patient information among treating health care professionals.
- Ensure that members/patients are informed of specific health care needs that require follow-up care. Members must receive training as appropriate in self-care and other measures they may take to promote their own health.
- Obtain prior written authorization from the Medical Director for all out-of-network services.
- Provide information regarding treatment options in a culturally competent manner, including the option of no treatment.
- Ensure that individuals with disabilities have effective communications throughout the health care network to make decisions regarding treatment options.
- Involve the member in the development of the treatment plan and assist the member by coordinating the services, prior authorization, and if necessary, referrals to Quartz Medicare Advantage (HMO) practitioners as appropriate.

Practitioner/Provider Verification of Eligibility

- The practitioner or provider shall request the member's ID card before services are provided and verify that all demographic and insurance information is correct to ensure correct registration and reduce the possibility of confusion in the billing and reporting processes.
- The practitioner, provider, or designee shall contact a Quartz Medicare Advantage (HMO) Champion at (800) 394- 5566 any time verification of eligibility or verification of Primary Care Physician designation is necessary.
- The Practitioner's office shall contact a Quartz Medicare Advantage (HMO) Champion at (800) 394-5566 any time the practitioner, provider, or designee becomes aware of incorrect member information.

Prohibition of Interference – Advice to Members (MMCM Ch.6 40)

Quartz advocates and upholds the patient/practitioner relationship and does not prohibit or otherwise restrict a health care professional, acting within their lawful scope of practice, from providing advice to an individual who is a patient and enrolled in a Quartz plan. Specifically, Quartz will not interfere with the communications between the provider and patient regarding:

- The patient's health status, medical care, or treatment options (including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options, including no treatment as an option or any alternative treatment that may be self-administered);
- The risks, benefits, and consequences of treatment or non-treatment; or,
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions.

Quartz shall not penalize a provider because the provider, in good faith, reports to the state or federal authorities any act or practice by Quartz that, in the opinion of the provider, jeopardizes patient health or welfare.

Utilization Management Services

The Utilization Management departments perform utilization management and care management services under the direction of the Medical Directors. It is the expectation that Quartz Medicare Advantage (HMO) practitioners/providers review, cooperate, and participate with the Utilization Management requirements outlined below.

Overview of Utilization Management

Utilization Management performs the following services:

- Admission Notifications
- Elective Admissions Out-of-Network
- Concurrent Hospital Review
- Discharge Planning
- Retrospective Review
- Care Management
- Utilization Review
- Referrals
- Prior Authorizations

Admission Notification

- Prior authorization is required for all hospital admissions. Providers should contact Quartz Customer Success at (800) 897-1923.
- Questions related to coverage or benefits should be directed to a Quartz Medicare Advantage Champion at (800) 394-5566.
- An Advanced Written Notice of Hospital Discharge Appeal Rights (The Important Message from Medicare) (OMB #0938) (CMS-R-193) will be issued to Quartz Medicare Advantage (HMO) hospital inpatients. The hospital must deliver this notice at or shortly after admission but no later than two calendar days following the member's admission to the hospital.

Elective (Non-Emergent or Non-Urgently Needed) Admissions Out-of-Network

All elective (nonemergency or non-urgently needed) hospital admissions out of the Quartz Medicare Advantage (HMO) network require prior authorization before hospital admission to ensure that inpatient criteria have been met. This allows for the identification of potential utilization or coverage issues and suggestions of alternative treatment settings, if appropriate.

Questions regarding admission or prior authorization through a written referral can be directed to the Utilization Management department staff at (800) 394-5566.

Concurrent Hospital Review

- Concurrent hospital review is performed for inpatient hospital admissions.
- Concurrent review will consist of written documentation of pertinent information regarding how the member is meeting medical necessity. MCG guidelines will be used as a guide.

Inquiries regarding inpatient hospitalizations should be directed to Customer Success at (800) 394-5566.

Discharge Planning

Discharge planning involves the assessment of a patient's need for medically appropriate treatment after hospitalization. Hospital staff and the attending physician will work with Utilization Management by monitoring and assisting in this process.

- Working in coordination with hospital staff, the attending physician, the member and/or family/caregivers, Quartz Medicare Advantage (HMO) Utilization Management (UM)/ Care Management staff can identify those cases with chronic conditions for which alternative treatment settings might be available within the community.
- Quartz Medicare Advantage (HMO) UM/Care Management staff will review the member's treatment plan with hospital staff to establish the post discharge treatment plan.
- Quartz Medicare Advantage (HMO) UM/Care Management staff will monitor all post discharge services for patient progress and prognosis.
- Questions or concerns regarding the discharge planning process should be directed to the Utilization

Management department at (800) 394-5566.
- Questions or concerns regarding benefit issues should be directed to a Quartz Medicare Advantage Champion at (800) 394-5566.

Retrospective Review

Utilization information is collected on a retrospective basis through chart review, peer review, and claims review. Retrospective review is used to assess specific services or patterns of care for appropriateness, underutilization, overutilization, efficiency, and outcomes.

Utilization Care Management

The Utilization Management Department care manager manages member's health care benefit to ensure the best quality of care and optimize insurance benefits. The care manager is responsible for the following:

- Identifying appropriate alternatives to hospitalization yet achieving cost-effective quality of care.
- Discharge planning of hospitalized patients begins upon receipt of information of the impending admission or upon the initial review of the patient's hospital record.
- The acquisition of needed medical supplies and equipment, as well as home health services (skilled nursing care, physical therapy, speech therapy and occupational therapy), is directed through contracted providers (whenever possible) and negotiates discounts with non-contracted providers.
- Coordinating with reinsurance carrier care manager when applicable.
- Managing prior authorization requests for medical appropriateness and benefit applicability. Requests may include but are not limited to surgical procedures, diagnostic testing, and durable medical equipment.
- Managing concurrent reviews of admissions in and out of network, referrals to out of network facilities for mental health and substance use disorder services, transitional care, and other medical and surgical procedures. Works directly with discharge planners to facilitate transfers to lesser level of care as appropriate.
- Managing prior authorization and continued stay review of home health treatment plans, and skilled nursing facility (SNF) stays in accordance with Quartz Medicare Advantage (HMO) policy.

- Upon initiation of home health services ordered by the attending practitioner, maintaining communication with the home health nurse. The care manager will coordinate care with the home health agency as needed until the patient is discharged from care and resumes care from the attending practitioner.
- Identifying and reporting of quality-of-care issues to Medical Directors.

Utilization Review Criteria

Quartz Medicare Advantage (HMO) will follow Medicare's national coverage decisions as well as specific written medical review determinations of the local Medicare carrier. Determinations of medical necessity and appropriateness may be based upon the following additional sets of criteria:

- MCG Guidelines
- Quartz Medicare Advantage Medical Policy and Procedure Manual
- Quartz Prior Authorization Criteria (for clinic-administered medications)
- CMS Local Coverage Determinations/Local Coverage Articles and National Coverage Determinations

Prior Authorization Process

- Prior authorization requests, including supporting medical record documentation, may be sent in one of the following ways:
    - My Quartz Tool provider portal preferred
    - Faxed to the Utilization Management department at (608) 881-8397
    - Faxed to the Pharmacy department (for clinic-administered medications) at (608) 881-8398
- Prior authorization forms can be obtained online or by calling Customer Success (800) 897-1923.

- Information submitted will be reviewed by a Medical Director or appropriate Utilization Management staff.
- Initial determinations/decisions for medical services/supplies will be made within 14 calendar days of receiving the request (this may be extended up to 14 days if the plan determines it is necessary to obtain all supporting documentation).
- Initial determinations/decisions for clinic-administered medications (Part B drugs) will be made within 72 hours of receiving the request for standard requests or within 24 hours for expedited requests.
- Determinations will be communicated to the provider(s) and the member.
- Written confirmation to the provider and member will follow for all adverse determination decisions.

Our Medical Directors are available upon request to discuss these decisions by calling (800) 897-1923.

The Quartz Medicare Advantage (HMO) Provider Directory is available at QuartzBenefits.com/MAfindadoctor.

Questions or concerns regarding access or availability of Quartz Medicare Advantage (HMO) practitioners or providers should be directed to Provider Network Management at (800) 897-1923.

NOTE: Additions or deletions of procedures requiring prior authorization will be communicated to Quartz Medicare Advantage (HMO) practitioners/providers 60 days prior to their implementation date.

Part D Formulary

Quartz Medicare Advantage

Tier Label	Copay Tier
Preferred Generics	1
Generics	2
Preferred Brand	3
Non-Preferred Drug	4
Specialty	5
Select Care Drugs	6

The purpose of a formulary is to promote the use of the safest and most cost-effective medications. A formulary is an important tool to help Quartz meet its goal of providing coverage for safe and effective medications in an affordable manner. The cost shares of the various tiers can be found at Within the Part D formuary document which can be found at QuartzBenefits.com/PartD. Medications may be restricted, which means that an approved prior authorization from Quartz is necessary before coverage is granted. Other kinds of restrictions include step therapy and quantity limits. When new FDA-approved generic or biosimilar equivalents are approved, the brand product may be removed from the formulary. Otherwise, negative changes to the formulary will only typically occur on January 1 of every year.

Some medications that are administered in the clinic or a practitioners' office require review and an approved prior authorization from the Quartz Pharmacy Program before we will cover medication administration. These medications (and their criteria) can be found at QuartzBenefits.com/MAPartBPA.

How is the Formulary Developed?

Quartz's Pharmacy & Therapeutics (P&T) Committee is responsible for creating and maintaining the prescription drug formulary. This committee is made up of physicians and pharmacists who care for Quartz members in our community. The P&T Committee meets quarterly to review medications and determine their formulary status. The committee considers a variety of factors, such as safety, side effects, drug interactions, how well the drug works, dosing schedule and dose form, appropriate uses, and cost-effectiveness. In making these decisions, the committee obtains the most up-to-date information from a variety of sources, including published clinical trials, data submitted to the FDA for drug approval, and recommendations from local or national treatment guidelines. Additionally, the committee solicits input from local

practitioners who are experts in the use of the medications under review. Questions about drug benefits or medications listed on the formulary can be directed to Quartz Customer Success.

The Quartz Medicare Advantage formulary can be found at QuartzBenefits.com/PartD

Part D Medication Prior Authorization Process

A Part D medication prior authorization request may be started by members, providers, or designated representatives by fax, telephone, mail, or electronic (ePA). We will accept requests from members or their authorized representatives but recommend having the health care practitioner complete the requests as the medical history required to make a timely decision can be more adequately provided. Quartz sends back e-PA criteria questions to the provider staff, which can be answered, and medical records can be attached to the request.

- E-PA requests can be submitted at Benefitrx.com.
- A Coverage Determination form can be filled out and faxed to (844) 403-1028.
- Requests can be submitted via phone at (800) 506-4614.

The prior authorization criteria are available on the Quartz website for reference.

When a prior authorization request is submitted, there are two types of requests:

- Standard –Quartz makes decisions on standard requests within 72 hours. For formulary exceptions, step therapy exceptions, quantity limit exceptions, and tiering exceptions, a prescriber's
    - supporting statement (PSS)* is required. If a PSS is not provided with the original request, our decision may be extended up to a total of 14 days so that we may obtain a PSS.

- Expedited – An expedited (urgent) request is defined as a request in a situation when making routine or non-life-threatening determination could seriously harm the patient's life, health, or ability to regain maximum function.
    - Quartz makes decisions on expedited requests within 24 hours. For formulary exceptions, step therapy exceptions, quantity limit exceptions, and tiering exceptions, a prescriber's supporting statement (PSS)* is required. If a PSS is not provided with the original request, our decision may be extended up to a total of 14 days so that we may obtain a PSS.

*For formulary exceptions, step therapy exceptions, quantity limit exceptions, and tiering exceptions, a **prescriber's supporting statement (PSS)** is required. A PSS is a statement that a drug is medically necessary. If a PSS is not provided with the original request, our decision may be extended up to a total of 14 days so that we may obtain a PSS. If the PSS is not received, the request is likely to be denied as lack of information and will require an appeal for redetermination of initial decision.

- Formulary exceptions, the PSS must indicate that all covered Part D drugs on any tier of the plan's formulary would not be as effective for the member as the requested drug and/or would have adverse effects.
- Quantity limit exceptions, the PSS must indicate that the number of doses available under the quantity limit has been ineffective in the treatment of the member's condition or would likely be ineffective (based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen).
- Step therapy exceptions, the PSS must indicate that the prerequisite drugs have been ineffective or caused an adverse reaction or other harm for the member or that it would likely be ineffective or would cause adverse effects (based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen).
- Tiering exceptions, the PSS must indicate that the drug(s) in the applicable lower cost-sharing tier(s) for the treatment of the member's condition would not be as effective as the requested drug and/or would have adverse effects.

Non-Covered Part D Drugs

Here are some general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug in situations where it would be covered under Medicare Part

A or Part B.

- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan cannot cover drugs or uses that are excluded under Medicare statutes or rules
- Our plan cannot cover "Off-label use," which is any use of the drug other than those indicated on a drug's label as approved by the FDA or supported by Medicare-approved drug compendia. These compendia are the American Hospital Formulary Service Drug Information (AHFS-DI), the DRUGDEX Information System, and the USPDI or its successor.

These categories of drugs and uses are excluded from coverage by Medicare Part D plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs covered under Part D that may be self-administered in a hospital outpatient setting such as an emergency room, observation unit and surgery center, or pain clinic if not required for the medical condition being treated.

Pre-Service Denials

Notice of Denial of Medical Coverage

To comply with CMS rules, Quartz Medicare Advantage (HMO) must cover everything Medicare Part A and Part B covers. If a service is not covered by Medicare Fee-For-Service, it will not be covered by Quartz Medicare Advantage (HMO) and will be listed as an exclusion in the member's Evidence of Coverage (EOC). Refer to our list of benefit exclusions.

As a contracted provider, CMS considers you to be an agent of Quartz Medicare Advantage (HMO). Contracted providers are responsible for knowing what is or isn't covered under Medicare. You have a responsibility to coordinate care with Quartz Medicare Advantage (HMO) prior to providing a service or referring a member to another provider. The member must be fully informed if the service they are about to receive is non-covered.

Notifying Members When a Service is Not Covered

When an item or service is not covered, you must notify the member by issuing them a notice. First, check the Exclusions List and follow the criteria below.

- If the item or service is "clearly" always excluded from coverage, explain to the member that their EOC states that the item or service is not covered, and payment will be 100% of their financial responsibility. No notice needs to be issued, you are required to inform the member verbally that there is a "clear" exclusion and place documentation in the member's medical record. There is no need to file a claim for excluded items or services that are always non-covered, unless requested by the member to do so. Should you file a claim, a GY modifier is required to be used.
- If an item or service is not "clearly" always excluded from coverage, or if it could be non-covered sometimes, the provider must explain to the member that the item or service may not be covered by Quartz Medicare Advantage (HMO) and issue a pre-service notice of non-coverage and retain a copy in the patient record for future retrieval.
    - Quartz Medicare Advantage (HMO) utilizes the Notice of Denial of Medical Coverage, Form CMS 10003-NDMCP, which can be found along with instructions on our website at QuartzBenefits.com/MedicareAdvantage under Benefit Denial Forms. These forms must be issued to the member prior to providing a non-covered item or service to the member. A copy of the notice is required to be kept in the member's medical record.
    - After issuing the notice, the claim should be filed to Quartz Medicare Advantage (HMO) with a GA modifier attached to the item or service that is non-covered.

- If a contracted provider provides a non-covered item or service that is not "clearly" always excluded from coverage and does not issue a pre-service notice of non-coverage or obtain a pre-service decision from Quartz Medicare Advantage (HMO) prior to the service or item being provided, the claim will be denied as provider liability, and you will not be able to bill the member for any portion of the denied claim.
- Your other option is to contact Quartz Medicare Advantage (HMO) Champions at (800) 394-5566 and ask for a pre-service organization determination prior to providing a non-covered service to the member.

Do not use the Medicare Advanced Beneficiary Notices (ABNs) or ABN-like notices

No ABNs and ABN-like notices shall be utilized with Quartz Medicare Advantage (HMO) members. An ABN or ABN-like notice is not a valid notice for Quartz Medicare Advantage (HMO) members. ABNs can only be utilized with Fee-For-Service Medicare beneficiaries. Use of these forms means your claim may go to provider liability. You are required to use the Notice of Denial of Medical Coverage form as described above.

How do providers bill to show appropriate notice of non-coverage was provided?

When billing for non-covered services, providers can demonstrate that they issued an appropriate Notice of Medical Coverage, Form CMS 10003-NDMCP, by utilizing one of the following modifiers:

- GY modifier: In the event you file a claim for items or services that are "clearly" always excluded, use the GY modifier to show that the service or item was "clearly" excluded under the member's Quartz Medicare Advantage (HMO) EOC. If the member appeals any claim associated with a GY modifier and either there is no exclusion in the member's EOC or the exclusion is "not clear," the claim will be reversed and denied as provider liability. You can also utilize the GY modifier if the member refuses to wait to receive an organization determination in favor of having the service performed immediately. You are required to place documentation in the medical record that the member refused to obtain an organization determination and elected to obtain the service or item immediately.
- GA modifier: For items or services that are not always "clearly" excluded from coverage, use the GA modifier to show that appropriate notice of non-coverage (CMS-10003-NDMCP) was provided to the member. If the member appeals a claim associated with a GA modifier and there is no proof that the provider issued the appropriate notice of non- coverage, the claim will be reversed to provider liability, and you will not be able to bill the member for any portion of the denied claim.

Supplier Instructions for Wheelchair Rentals and Purchases

Quartz Medicare Advantage has a defined process for obtaining authorizations for wheelchair rentals and purchases. Detailed instructions can be viewed on Quartz Medicare Advantage's website.

Wheelchair Purchases

To comply with federal regulations of consistency when applying benefits for all members, a Functional Mobility Assessment is required for all (higher-end, complex) wheelchair purchases along with a physician's order. Upon written order for the purchase of a wheelchair, the patient should be directed to a physical or occupational therapist for the assessment. A Functional Mobility Assessment form must be completed. The assessment will enable Quartz Medicare Advantage (HMO) to ensure that the most appropriate equipment is being requested to meet the member's current medical needs. A copy of the Functional Mobility Assessment Form can be obtained from Quartz Medicare Advantage's website.

Serious Reportable Events

Serious Reportable Events, also known as never events, are a set of preventable patient safety events that lead to serious harm to members. Providers must comply with all CMS guidance regarding coding, claims submission, and reimbursement rules; Medicare participating providers must report Serious Reportable Events by populating Present on Admission (POA) indicators. In the instance that the Serious Reportable Event has not been reported, the health plan will attempt to determine if any charges filed meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS as a Serious Reportable Event. If you fail to comply with these requirements, the claim(s) will be denied as

provider responsibility, and the member cannot be billed for the charges.

Quartz Medicare Advantage (HMO) will not cover a surgical procedure or other invasive procedure when the practitioner mistakenly performs: 1) the wrong procedure, 2) the correct procedure but on the wrong body part, or 3) the correct procedure, but on the wrong patient.

In addition, Quartz Medicare Advantage (HMO) will not cover hospitalizations and other services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and, therefore, not covered. All providers in the operating room when the Adverse Event occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. However, related services do not include the performance of the correct procedure.

Services must be billed appropriately when the following Serious Reportable Events occur, including but not limited to wrong procedure; the correct procedure but on the wrong body part; correct procedure but on the wrong patient; and hospital acquired condition.

- Outpatient claims: must be billed with the surgical procedure code and modifier that indicates the type of Adverse Event: modifier PA (wrong body part), PB (wrong patient) or PC (wrong surgery) AND/OR diagnosis code E876.5 (wrong surgery), E876.6 (wrong patient) or E876.7 (wrong body part) must be present as one of the diagnoses codes on the claim.
- Inpatient claims: must be billed with a type of bill 110.

If there are covered services or procedures provided during the same stay as the Serious Reportable Events service, then the facility must submit two claims; one claim with covered services unrelated to the Serious Reportabl Event and the other claim for all services related to the Serious Reportable Event.

*Quartz Medicare Advantage members shall not be responsible for payment and must not be billed for any service related to a Serious Reportable Event.

Quartz Medicare Advantage is obligated to disclose to CMS and other regulatory agencies, quality, and performance indicators for benefits under the Plan regarding disenrollment, member satisfaction, and health outcomes. Providers may be asked to assist Quartz Medicare Advantage staff in meeting these requirements.

In addition to sanctions and complaints, Quartz Medicare Advantage will perform quarterly reviews on Serious Reportable Events found through claims data as required by NCQA.

Non-Covered Services Notification

Quartz Medicare Advantage is obligated to follow Medicare policies. If the service is not covered by Medicare Fee-For-Service, it will not be covered by Quartz Medicare Advantage (HMO). If Quartz Medicare Advantage (HMO) covers a service that Fee-For-Service does not, it will be specifically listed in the member's EOC, which is available on the Member page at QuartzBenefits.com/MedicareAdvantage.

All providers (medical staff and suppliers) must obtain prior authorization for services listed on the prior authorization grid.

Quartz Medicare Advantage (HMO) has created a flow chart for providers to follow for dispensing DME (Quartz Medicare Advantage DME prior authorization Process). It is important to note that medical staff (MD, PA, NP) must also call for prior authorization when ordering DME. This document can also be found on our web site under For agents, employers, & providers Quartz Provider Forms.

As a contracted provider with Quartz Medicare Advantage (HMO), you are required to complete the Notice of Denial of Medical Coverage (NDMC) prior to providing a non-covered service to a member. CMS requirements indicate that the member or the beneficiary must be held harmless for plan directed care. If you provide a non-covered service or referral to our member, you must discuss this with the member prior to the service being rendered and document the discussion in the patient's medical record for you to be able to bill the member. CMS does not allow the Medicare Advantage

contracted providers to use the CMS ABN forms for non-covered services. Quartz Medicare Advantage (HMO) has created the NDMC using the Integrated Denial Notice, Form CMS 10003-NDMCP (Iss. 06/2013) OMB Approval 0938-0829. You can find the notices on our website for use when providing these non-covered services. You should not submit a claim to Quartz Medicare Advantage (HMO) for services that are always non-covered (unless the beneficiary requests a claim to be filed). If a service is typically non-covered but could be covered under certain conditions, then a claim is required to be filed with the appropriate modifier indicating that you have provided the member the NDMC and have a copy on file. Claims submitted without the appropriate modifiers attached will be denied as provider responsibility, regardless of if you obtained the notice or documented in the medical record.

Member Financial Protections Related to Plan-Directed Care

CMS considers a contracted provider an agent of the Medicare Advantage Organization (MAO) offering the plan. As stated in the Medicare Managed Care Manual, Chapter 4, Section 160: "MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

Consequently, when a contracted provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from the plan.

If a contracted provider refers a member to a non-contracted provider for a service that is covered by the plan upon referral, the member is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring a member to a non-contracted provider to ensure, to the extent possible, that members are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

A member (or a provider acting on behalf of the member) always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies a member's (or their treating provider's) request for coverage as part of the organization determination process, the plan must provide the member (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003) and guidance on completing the form, refer to the NDMCP Notice of Denial of Medical Coverage or Pay from the CMS.gov website. As a contracted provider, you are required to use a Notice that CMS has approved for Quartz Medicare Advantage (HMO), available on our website Medicare Advantage Provider Forms & Links under Benefit Denial Forms.

If a service is never covered by the plan and the plan's EOC provided to the member is clear that the service or item is never covered, the plan is not required to hold the member harmless from the full cost of the service or item. For a service or item that is typically not covered but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member liability. In such instances, the appropriate process is for the member or the provider acting on behalf of the member, to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The member has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise members when providing referrals for covered services. This will prevent confusion related to plan coverage and member financial liability as well as ensure coordination of the care furnished.

When the provider or the plan acting on behalf of the provider, can show that a member was notified (via a clear

exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan; or that coverage is available only if the member is referred for the service by a contracted provider, but the member nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the member harmless from the full cost of the service or item charged by the provider.

Non-discrimination to Dual Eligible Members

Medicare Advantage providers must not discriminate against members based on their payment status, i.e., Qualified Medicare Beneficiaries (QMB) or refuse to service members because they receive assistance with Medicare cost-sharing from a State Medicaid program. Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the QMB program, a dual eligible program that exempts members from Medicare cost-sharing liability. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B, low-income subsidy copayments still apply for Part D benefits. Quartz Medicare Advantage (HMO) will use this complaint procedure and issues identified through the CMS complaint Tracking Module to monitor compliance with balance billing rules and provide education to providers not abiding by the rules set forth in the 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, 42 C.F.R. 422.504(g)(1)(iii) and the Medicare Managed Care Manual, Chapter 4, Section 10.5.2.

Medicare Outpatient Observation Notice (MOON)

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to Quartz Medicare Advantage members receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status regarding cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Hospitals and CAHs are required to furnish the Medicare Outpatient Observation Notice (MOON) to a member who has been receiving observation services as an outpatient. You can find this notice on the Medicare Advantage Provider Resources forms and links page at QuartzBenefits.com/Maproviders. Under CMS's final NOTICE Act regulation, published August 2, 2016, hospitals and CAHs may deliver the MOON to members receiving observation services as an outpatient before such member has received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release. An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the paper notice, and a signature must be obtained from the member or a person acting on such member's behalf to acknowledge receipt. In cases where such member or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

Model of Care (MOC) Overview

Under the Medicare Modernization Act (MMA) of 2003, Congress created a new type of Medicare Advantage Plan so that Medicare members with special needs, including those dually eligible with Medicaid and Medicare, would benefit with increased, focused coordination of care. Quartz will provide, either directly or through a companion Medicaid managed care plan, behavioral health services as well as other Medicaid services to its dual eligible enrollees. Dual Special Needs Plans (D-SNP) will focus on monitoring the health status of the target population, identifying their needs, improving access to quality healthcare services and benefits, managing their conditions and comorbidities, avoiding inappropriate hospitalizations or other potentially preventable events, and helping the members decrease their medical, mental, and social risks. Members who have Medicare Part A and B and Medicaid in the Wisconsin counties of Milwaukee, Dane, and La Crosse will be eligible for this D-SNP plan.

Quartz will consider the Interdisciplinary Care Team (ICT) to be member-centric and consist of all those significantly involved in a member's care. The ICT will include the member, caregiver, or legal guardian; the Case Manager (CM); the PCP and/or other specialists; Medical Director(s), Pharmacist, or other Plan staff as needed; and any other individuals or providers the member wishes to include. D-SNP members will have a CM assigned upon enrollment into the D-SNP plan. The CM will follow regulatory requirements of transitions of care protocol to assist in keeping the member from experiencing unplanned transitions and avoiding re-admissions.

After the member's social determinants of health, medical, functional, cognitive, psychosocial, and behavioral needs are collected and assessed utilizing the Health Risk Assessment tool, the CM will work with the member/caregiver/legal guardian to develop the member's Individualized Care Plan (ICP). With the member's permission, the CM reviews the care plan and validated HRA assessment findings with the ICT members, beginning with the submission of the care plan to the PCP/relevant specialist requesting additional feedback and recommendations, including input on self-management objectives and short and long-term goals. Up to two follow-up calls are made to the PCP/Specialist (i.e., Endocrinologist) to obtain their input on the care plan as those most familiar with the member's medical needs.

For members who are unable to be reached or unwilling to participate with the HRA processes, the CM will continue to develop the ICP based on available plan data (claims/encounters, pharmacy, EMR) or information/communication from ICT members.

Individualized Care Plans (ICPs) will be developed for all Quartz D-SNP members (regardless of unable to reach or unwilling to participate status). The ICP is developed to ensure that the member's interdisciplinary care team is aware of the interventions and goals in place and to allow the team to assist the member in achieving their goals. This will be important as both the CM and ICT collaborate and work together with members to help achieve optimal health results.

Quartz has a formal policy and process for updating the ICP and communicating to the ICT members any updates. It is based on the member's risk, and as the CM is working with the member and executing the ICP, updates, and outcomes may shift the member to a different risk level. Updates to the ICP are discussed and/or communicated to the members of the ICT during meetings, ad-hoc calls, email, and/or are available via access to the case management system. If immediate changes to the ICP are required, an ad hoc ICT meeting may be held by key ICT participants, such as the member, their Providers, Care Manager, Behavioral Health staff, Care Coordinator, Chief Medical Officer or Medical Director, UM Manager, and pharmacist, etc. Care plan documentation is maintained in the case management system, so updates are instantly available to the Quartz ICT members. When modifications to a care plan are made, the case management staff will generate an updated ICP and mail or send it electronically through secure channels to the member and/or their caregiver. External ICT participants, including the PCP, may access the care plan by request by mail, secure email, or fax, based on their access and/or preference. Members are encouraged by the case management staff to review their ICP during visits with practitioners involved in their care.

Members will receive verbal updates during scheduled care coordination outreach to ensure understanding and agreement with any modifications. Additionally, the member is provided a toll-free phone line for questions and problem resolution. Conversations between the member and/or their caregiver are documented within the electronic case management system.

Model of Care training for providers

CMS requires that all primary care providers (PCPs) who a Quartz D-SNP member has selected as their PCP completes the Quartz Model of Care (MOC) training for the Quartz D-SNP plan. In addition, in-network and out-of-network providers seen by a Quartz member on a routine basis are also required to complete the training. Quartz will offer the training via a self-paced power point presentation and audio version linked on Quartz's public website https://quartzbenefits.com/providers/provider-resources/.

Quartz will reach out to these providers once they are identified as a PCP or in-network/out-of-network providers seen by a Quartz member on a routine basis.

Quartz has 3 D-SNP plans branded as:

- Aurora Health Quartz Medicare Advantage Dual Eligible w/Rx
- UW Health Quartz Medicare Advantage Dual Eligible w/Rx
- Gundersen Quartz Medicare Advantage Dual Eligible w/Rx

- Our D-SNP training will describe how we work with providers to deliver the Quartz Medicare Advantage Dual Eligible w/Rx MOC. This training is required when Quartz initiates this training the providers noted above.

- Our D-SNP training is available as a self-paced audio course on QuartzBenefits.com and it takes about 20 minutes to complete. You can also review the PowerPoint version under the Provider Training (Dual Special Needs Plans (D-

SNP)). Complete the attestation at the end of the presentation and click submit to receive credit for completing the training. Access the training here.

Quartz BadgerCare Plus and/or Medicaid SSI Program

Quartz does not delegate any decision making to contracted providers.

The next several pages explain Quartz's BadgerCare Plus and Medicaid SSI Program services, including care initiatives such as HealthCheck, blood lead testing, immunizations, outreach, and case management. Services for Quartz BadgerCare Plus/Medicaid SSI members depend on the location of their doctor and if they have dependent children living with them. Please call Quartz Customer Success at (800) 897-1923 if you have questions about the BadgerCare Plus and/or SSI program that are not answered below.

How can I tell if a Quartz BadgerCare Plus and/or Medicaid SSI Program member is subject to copayments?

Quartz BadgerCare Plus and/or Medicaid SSI Program members are not subject to copays for items that Quartz covers. Certain members may be charged copays for items that are covered FFS. Provider can refer to the ForwardHealth portal for enrollment verification. It is important to note that Quartz does not issue ID cards for BadgerCare Plus and/or Medicaid SSI program members.

Cost Sharing

Neither Quartz nor the Provider may collect any payment for cost sharing from a Dual Eligible Member other than what is allowed by federal or state law. The following applies only to those categories of Dual Eligible Members as required by federal or state law:

- Quartz will not impose or permit its Subcontractors to collect cost sharing on Dual Eligible Members that exceeds the cost sharing permitted with respect to the Dual Eligible Member under Medicaid if the Dual Eligible Member were not enrolled in a MA-PD Plan.
- Quartz must notify its Providers that they may not seek payments for Cost Sharing from Dual Eligible Members for health care services rendered to Dual Eligible Members.
- Quartz must notify its Providers to seek payment from the Department for Cost Sharing for Dual Eligible Members according to the State Plan or accept payment from Quartz as a payment in full.

Claims Submission and Medicaid Certificate

When billing Quartz for BadgerCare Plus and/or Medicaid SSI Program members, you must follow the same procedure used when billing the Department of Health Services (DHS) for BadgerCare Plus and/or Medicaid SSI Program members.

Providers must submit claims with the certified Wisconsin Department of Health Services (DHS) national provider identifier (NPI) and Taxonomy codes. Providers should bill with a DHS certified NPI and Taxonomy code that corresponds to the services being billed. Those providers who have multiple taxonomy codes on file with DHS within their provider enrollment file are required to include their provider taxonomy code along with their NPI and their practice location ZIP + 4 code so the provider can be uniquely identified within our system. If the provider NPI and/or taxonomy code information is missing when required, your claims will be denied.

BadgerCare Plus and/or Medicaid SSI Program providers must keep their Medicaid certification up to date. Any lapse in certification may result in denial of claims.

Please refer to Appendix A to obtain information on Quartz's coding policies and procedures. Providers are also required to reference the Forward Health portal, online Medicaid Handbook, and Forward Health updates for additional Medicaid guidelines.

For billing labs, you must be Clinical Laboratory Improvement Amendment (CLIA) certified. Be sure to check that the appropriate modifiers are used for your lab codes. Reference this website www.cms. gov/clia/ for questions.

- Bill all Therapy (PT, OT, and Speech) services on a CMS 1500 claim form. Refer to ForwardHealth Update 2014-72 for more information.
- Bill with a valid NPI and Taxonomy code that is DHS-certified and appropriate for the services being billed.

This includes all emergency room and ambulance claims.

Quartz BadgerCare Plus and/or Medicaid SSI Appeals

Provider appeal is an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: a claim is denied by the HMO for untimely filing. The provider must appeal the denial action to the HMO in which an internal review by the HMO is required.

Provider appeals handled by the Provider Engagement Specialists are Quartz staff that are trained on how to support the providers on resources available to prevent claim processing issues and denials, and to ensure submission of accurate, correct, and timely claims. Quartz periodically sends out notifications to providers regarding billing guidelines via the provider newsletter, ad hoc emails, provider website updates, in addition to the Provider Manual. Quartz encourages the providers to access and use the FowardHealth Portal, including Handbooks and Provider Updates, as the primary resource to avoid denial of claims. The appeal process and information is shared with new providers during the new provider onboarding process conducted by the Provider Engagement Specialists.

Quartz (the HMO) must adhere to the following timelines:

- The HMO must accept written and electronic appeals, including appeals submitted from the HMO's automated programming tools, within 60 calendar days of the HMO's initial payment, nonpayment notice, or notice of recoupment. In exceptional cases, the Department may override the HMO's timely filing limits for submission and appeals when there is a coordination of benefits issue or other exception situation. The Department will not exercise its authority in this regard unreasonably. The HMO will acknowledge receipt of the written appeal within 10 calendar days.
    - Quartz monitors the provider appeals and performs outreach and education/training on trends to prevent future denials/partial payments.
    - Quartz submits to the Department on a quarterly basis the appeal log containing the required information stated in the Provider Appeal Quarterly report data dictionary.

- Before the provider chooses to pursue resolution directly with the Department through the provider appeal process described under item d.4 below, the provider must follow the process below to appeal the HMO's decision once all claim reconsideration action has been exhausted:

    - Submit a completed Quartz designated Appeal form or a separate letter clearly marked "appeal". The HMO Appeal form must include a date field to indicate the date the appeal was submitted.
    - Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, member's name, and BadgerCare Plus and/or Medicaid SSI ID number.
    - Clearly state the reason(s) the claim is being appealed, including all documentation necessary to support the reason.
    - Clearly indicate if medical records are required and need to be submitted with the appeal.
    - Address the letter or form to:

        BadgerCare Plus and Medicaid SSI Managed Care Unit – Provider Appeal
        PO Box 6470
        Fitchburg, WI 53716-0470
    - Send the appeal to Quartz within 60 calendar days of the initial denial or payment notice.

- Quartz will acknowledge receipt of the written appeal within 10 calendar days.

- Quartz must respond in writing within 45 calendar days from the date of receipt of the appeal letter. If Quartz fails to respond within 45 calendar days, or if the provider is not satisfied with Quartz's response, the provider may seek a final determination from the Department.

- Quartz will send a formal notification to the provider of the outcome of the appeal.

    - The notification will include the member's name, Medicaid Member ID number, date of service, date of payment and/or nonpayment.
    - Each page of the payment remittance document must include the date the denial action was taken and

a specific explanation of the payment amount or a specific reason for nonpayment.
    - If the appeal is overturned, an EOP from the reprocessed claim indicating that claim was reprocessed.
    - If the appeal is upheld, Quartz will send a written (or HIPAA 835 transactions) notice to the provider of the decision on the date the appeal is decided.
    - Quartz will provide a statement advising the provider of their right to appeal to the Department once all appeals actions have been exhausted and the provider is still not satisfied with Quartz's decision on the appeal. The provider may also appeal to the Department if Quartz fails to respond to the appeal within 45 calendar days of the date of the receipt of the appeal letter.
        - The provider has 60 calendar days from the HMO's final appeal decision to pursue resolution with the Department.
        - If the provider files an appeal with the Department, the Department:
            - may reach out to the HMO for any additional information needed to conduct their review;
            - has 45 days from the date of receipt of all pertinent information to inform the provider and the HMO of the final decision; and
            - will not review decisions based on contractual requirements between Quartz and the provider, including appeals related to clinical level of care or results of contractually agreed upon reviews of claims or medical records.
        - Provider should file their appeal to the Department and follow the required timelines for doing so. Information can be found on the ForwardHealth Provider Appeal Portal website and should also refer to ForwardHealth Online Handbook topics #384 and #385.
            - Quartz provides a link to the Ombuds Brochure on the Provider Resources - Quartz Benefits page for additional.
            - The Provider Engagement Specialist shares information about the Ombuds Brochure and grievance and appeals process during new provider orientation. Should either the brochure or process in grievance and appeals change, notification is sent to all providers via an eBlast with the updated information.

- Resubmission of a Claim
    - A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information, also known as a Reconsideration of a Claim. This is a request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors. This is **not** a formal appeal.

Policies Related to Medicaid Managed Care Program Providers

Medicaid HMOs are required by DHS to notify their providers of the following DHS policy requirements:

- Providers are allowed to educate/inform their patients about the BadgerCare Plus and/or Medicaid SSI Program with which they contract.
- Providers are allowed to inform their patients of the benefits, services, and specialty care services offered through the HMOs in which they participate.
- Providers are allowed to give patient contact information for a particular HMO, but only at the patient's request.
- Providers are allowed to assist potentially eligible individuals with enrollment in the BadgerCare Plus and/or Medicaid SSI programs by helping them:
    - Apply online at the Access website
    - Complete the online form
    - Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus and/or Medicaid SSI express enrollment process, as described on the ForwardHealth Portal, if they qualify.
- Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at (800) 291-2002.

- HMOs are allowed to conduct orientations, health fairs, or community Quartz baby showers for their members in a private setting at a provider's office.
- Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO. Incentives for the purposes of marketing and member materials are any form of financial compensation, including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.
- Providers are required to have written procedures for describing how patients are informed of denied services and must be available upon request by Quartz and/or the Department of Health Services.
- Providers must assist members with their grievance and appeal rights. For complete details on BadgerCare Plus and/or Medicaid SSI grievance and appeals process, refer to the Ombuds Brochure https://www.dhs.wisconsin.gov/library/collection/p-12002 .
    - Quartz provides link to this document at Provider Resources - Quartz Benefits.
- Providers must have grievance and appeals procedures and make them available to Quartz and/or the Department of Health Services for review upon request.

Provider Preventable Conditions

Providers are required to identify provider preventable conditions as a condition of payment. Quartz will not issue payment for provider-preventable conditions.

Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

Other provider-preventable conditions (for any health care setting) for non-payment are identified as:

- Wrong surgical or other invasive procedure performed on a patient.
- Surgical or other invasive procedure performed on the wrong body part.
- Surgical or other invasive procedure performed on the wrong patient.

HealthCheck

HealthCheck is Wisconsin's implementation of the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, offered through Medicaid for individuals under age 21. Providers need no special forms to deliver the benefit, it covers well-child visits that follow the American Academy of Pediatrics' preventive care guidelines and include components such as physical exams, dental, growth, vision, hearing, immunizations, labs, and nutrition screening. Any identified issues may lead to follow-up or special appointments, which are also covered. No cost is incurred by the member when using their ForwardHealth card. Additionally, the program includes HealthCheck Other Services, which allows coverage, often via prior authorization, for medically necessary items typically not covered by Medicaid, such as behavioral health services, durable medical equipment, orthodontia, over-the-counter supplies, and personal care services. Assistance for finding providers and transportation to appointments is also available to members.

For more information about HealthCheck Services, visit here.

Preventive Medicine Reimbursement

Reimbursement for Preventive care exams (CPT codes 99381-99385 and 99391-99395) is higher than for other preventive exams. It is important to code these visits correctly. Laboratory tests, pelvic exams, and immunization charges may be reimbursed separately.

Frequency of Well Child Screenings

The schedule for Well-Child exams follows the American Academy of Pediatric recommendations:

- Infancy – newborn exam in hospital, within 3-5 days of birth and within 48 to 72 hours after discharge from the hospital (newborns discharged less than 48 hours after delivery must be examined within 48 hours of

discharge), one month, two months, four months, six months, and nine months.
- Early Childhood– twelve months, fifteen months, eighteen months, twenty-four months, thirty months, three years, and 4 years
- Middle Childhood – annually from five years of age through ten years of age
- Adolescence– annually from eleven years of age through 21 years of age

Procedure Codes for Preventive Care Exams

The appropriate codes for preventive care screening are listed below. These are the same as those required by the State of Wisconsin for fee-for-service Medicaid and BadgerCare Plus and/or Medicaid SSI Program recipients. For more details, see the ForwardHealth online handbook.

CPT Codes: New & Established Patients Preventive Medicine Services*

- 99381 – New patient under one year
- 99382 – New patient (ages 1 – 4 years)
- 99383 – New patient (ages 5 – 11 years)
- 99384 – New patient (ages 12 – 17 years)
- 99385 – New patient (ages 18 – 39 years)
- 99391 – Established patient under one year
- 99392 – Established patient (ages 1 – 4 years)
- 99393 – Established patient (ages 5 – 11 years)
- 99394 – Established patient (ages 12 – 17 years)
- 99395 – Established patient (ages 18 – 39 years)

Preventive Care Visit Components

- A comprehensive health and developmental history (including nutritional assessment, developmental-behavioral assessment, health education, and anticipatory guidance).
- A comprehensive unclothed physical exam.
- An age-appropriate vision screen.
- An age-appropriate hearing screen.
- An oral assessment plus referral to a dentist beginning when the first tooth erupts or by age 1.
- Appropriate immunizations (according to age and health history, per the CDC's ACIP guidelines).
- Appropriate laboratory tests (including blood lead level testing when appropriate for age).

According to the Centers for Medicare & Medicaid Services, all Medicaid children are considered at high risk for lead poisoning. That's whyCMS requires that all children who are enrolled in Medicaid/BadgerCare Plus receive a blood lead test at about 12 months and again by the second birthday. In addition, children between the ages of three and five must receive a blood lead test if there is no record of a previous blood lead test.

The Wisconsin Blood Lead Registry, or Lead Registry, is a web-based tool that lets primary care providers and other health care professionals check a child's blood lead testing history online at any time. The Lead Registry is linked to the Wisconsin Immunization Registry and updated with new blood lead test results each week by the WCLPPP. That includes tests performed at all locations, including WIC and Head Start sites, and doctors' offices.
The Lead Registry can help health care providers easily identify children who haven't been tested for blood lead poisoning or are due for a follow-up test.

Quartz reviews data each month to determine the HMO performance rates for HealthCheck exams, blood lead testing, and childhood immunizations. This information is available on request for members attributed to the provider making the request. Providers are responsible for assuring that children receive blood lead level tests at the required ages.

It is imperative that a blood lead test be performed on all one- and two-year-olds.According to the AAP, a low blood level concentration in a 1 year old does not preclude a rise later. Providers are required to repeat blood lead level

testing at about 2 years of age, regardless of the results of the 1 year old test.

A Puretone audiometric screen must be done annually from age three years to eight years and then every four years up to age 16 years. Any child older than age eight who has been exposed to excessive noise, has delayed speech and language development, or who is receiving a HealthCheck screen for the first time should also be administered a Puretone audiometric screen.

The Division of Health Care Access and Accountability recognizes that a pure tone audiogram may not be age-appropriate for all three-year-olds.

According to the Division of Health Care Access and Accountability, ". . . hearing assessment requires documentation of age-appropriate screening. When a child is old enough, pure tone testing should be used. This does not mean an entire audiogram or testing of all possible tones must occur, but instead, a screening of tones (often three levels) is adequate. If a problem is suspected based on this screening, the child should be referred for comprehensive hearing testing."

HealthCheck Resources for Preventive Pediatric Health Care

- ForwardHealth's HealthCheck Information for Providers
- Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care

WIC (Special Supplemental Nutrition Program for Women, Infants, and Children)

WIC can provide your patients, our members, with nutrition and breastfeeding information, along with nutritious foods at critical periods of growth and development. WIC encourages health care providers to inform members who may be eligible for the program.

Services that WIC offers are:

- Nutrition education
- Breastfeeding education and support
- Supplemental nutritious foods and/or infant formula
- Periodic nutrition screening to determine eligibility for WIC
- Immunization screening and referrals for children
- Referrals to other area health and community service programs

Quartz BadgerCare Plus and/or Medicaid SSI Program members who are involved in the WIC program may mistake the WIC screening as a complete HealthCheck exam. The WIC screening does not include all the necessary components of a HealthCheck exam. A Medicaid-certified provider still needs to complete the HealthCheck physical exam.

Your patients may qualify for WIC if they:

- Live in Wisconsin & make a certain amount of money.
- Are pregnant, breastfeeding, or new mother.
- Are an infant or child up to age five.
- Have a health or nutrition need, as determined by WIC risk criteria.

Routine Visits

Routine health care is care that is not urgent or emergent. Quartz views routine visits as health care that allows enough lead time to make an appointment. Quartz BadgerCare Plus and/or Medicaid SSI Program members should choose a primary care provider and get all routine care at their Quartz network provider.

Providers' hours of operation must not discriminate against Quartz BadgerCare Plus and/or Medicaid SSI Program members.

Follow-Up Treatment

For Quartz BadgerCare Plus and/or Medicaid SSI, members who have an emergency medical condition may not be held

liable for payment for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Emergency Transfer

For Quartz BadgerCare Plus and/or Medicaid SSI, Quartz in coordination with the medical professional, is responsible for determining when the member is sufficiently stabilized for transfer or discharge related to post-stabilization of care need.

Interpreter Services

All contracted BadgerCare Plus/Medicaid SSI providers are required to provide interpreter services at no cost to members with limited English proficiency (LEP). The interpreter services must be facilitated for the appointment.

Providers can use the following phone number if a provider does not have an interpreter service to facilitate health care and services. Prior to calling this language line, the member must be present, and the provider will need to have the member's name and Quartz employer group. Dial: 844-447-1581 Indicate language, provide the member's name and Quartz employer group.

Providers may not deny services to members based on their language needs.

Immunizations/Vaccinations

Immunizations and vaccinations are an integral part of routine care. Your clinic must make sure these services are available to Quartz's BadgerCare Plus and/or Medicaid SSI Program members. When these services are done within your clinic, you can:

- Track the status of the member's immunization record.
- Help your patients maintain their records.

When outside sources, such as Public Health Departments, give immunizations or vaccinations, you should attempt to obtain that information and include it within the patient's medical record. Quartz has agreements with Public Health Departments that include language to facilitate this exchange of communication.

Other important considerations for this exchange of communication are:

- Avoiding duplication of services
- Removal of access barriers
- Successful provision of the services to individual recipients

Also, the State of Wisconsin Department of Health Services (DHS) has developed an immunization registry that Quartz strongly encourages all providers to access. To learn more about the registry, contact Wisconsin Immunization Registry (WIR) at (608) 266-9691 or dhs.wisconsin.gov/immunization/wir-healthcare-providers.htm.

Mental Health and Substance Use Disorder Services for BadgerCare Plus and/or Medicaid SSI Program Members

Quartz's BadgerCare Plus and/or Medicaid SSI Program network provides mental health and substance use disorder (drug and alcohol) services to all Quartz BadgerCare Plus and/or Medicaid SSI Program members. If you or your patient(s) need help finding a provider for these services, call Quartz Customer Success at (800) 362-3310.

Clinic-Administered Medications for Quartz BadgerCare Plus and/or Medicaid SSI Program Members

Some medications that are administered in the clinic or a practitioners' office require review and approved prior authorization from the Quartz Pharmacy Program before medication administration in the clinic. These medications are noted on the Quartz Medication prior authorization list. Additionally, providers are responsible for submitting prior authorization requests and claims to the proper entity. Refer to the ForwardHealth policies "Provider-Administered Drugs Carve-Out Policy" and "Select High Cost, Orphan, and Accelerated Approval Drugs" (see Topics #4382 and #21201 in the ForwardHealth Provider online handbook for additional information).

Quartz BadgerCare Plus and/or Medicaid SSI Program Care Coordination

Quartz employs dedicated personnel to coordinate services and provide support to our BadgerCare Plus and/or Medicaid SSI Program providers and members. The Care Management staff (including RN Care Specialists, Social Work Care Specialists, and Care Coordinators):

- Develop and implement programs to improve access to care.
- Create a strong link between Quartz BadgerCare Plus and/or Medicaid SSI Program members and providers to increase adherence to clinical care and to assist members in obtaining needed care and screenings.
- Advocate for and assist members with high-risk health care needs.
- Help providers coordinate patient care.
- Educate Quartz BadgerCare Plus and/or Medicaid SSI Program members and practitioners about HealthCheck exams and other quality care measures.
- Work with members, practitioners, and clinic staff to promote early prenatal care and timely postpartum care.
- Assist members to receive Behavioral Health services as needed.
- Help providers and members resolve barriers to care.
- Inform providers about new State BadgerCare Plus and/or Medicaid SSI Program programs and initiatives.
- If you need assistance working with a Quartz BadgerCare Plus and/or Medicaid SSI Program patient, please call Quartz Care Management at (866) 884-4601, and they will direct you to the appropriate individual. Quartz serves BadgerCare Plus and/or Medicaid SSI Program members in the following 27 counties: Adams, Buffalo, Columbia, Crawford, Dane, Dodge, Fond du Lac, Grant, Green, Iowa, Jackson, Jefferson, Juneau, La Crosse, Lafayette, Marquette, Milwaukee, Monroe, Richland, Rock, Sauk, Trempealeau, Vernon, Walworth, and Wood.

Quartz BadgerCare Plus Complex Case Management

Quartz BadgerCare Plus Complex Case Management service is for members with multiple or complicated medical problems and/or significant psychosocial problems. Our Care Management team (including RN Care Specialists, Social Work Care Specialists, and Care Coordinators):

- Focus on members who have experienced a critical event or diagnosis that requires extensive use of resources.
- Help members access care and resources.
- Address barriers that get in the way of positive health outcomes.
- Support provider care plans and coordinate care.
- Collaboratively develop and implement member-centric case management plans that include specific goals and interventions to promote long-term change and self-management skills.
- Regularly follow-up with members to educate and promote adherence to the developed plan.

The overall goal of Complex Case Management is to help members improve their ability to navigate the healthcare system and increase their self-management skills.

If you have a Quartz BadgerCare Plus patient who could qualify for Quartz BadgerCare Plus Case Management services, please call the Care Management team at (866) 884-4601.

Transportation for Health Services

BadgerCare Plus and/or Medicaid SSI Program members need to contact MTM for all non-emergency medical rides to see their health care provider for covered services. To schedule rides members shouldcontact MTM at (866) 907-1493 or 711 (TTY) Monday through Friday between 7 a.m. and 6 p.m. or schedule online through the MTM Portal.

Members or providers will need to call at least two business days before a routine appointment to schedule a ride. If you cannot call two days before an appointment, you may need to reschedule the appointment. MTM accommodates urgent trips. An urgent trip is an unscheduled episodic situation in which there is no immediate threat, but the member must be seen on the day of the request, and treatment cannot be delayed until the next day. Urgent trips may also be related to a hospital discharge or for a follow-up appointment that is for the same health issue as your last appointment and is scheduled less within two days of that appointment. Please call MTM as soon as possible when an urgent trip is needed. Urgent rides will be provided in 3 hours or less.

If a scheduled ride is more than 15 minutes late, providers or members can call MTM at 1-866-907-1493 for an update on the driver's estimated time of arrival.

Anyone can file a complaint with MTM. Complaints can be made:

- Through MTM's website at https://wi.ridewithMTM.com/complaint-form/
- By calling MTM at 866-907-1493 or 711 (TTY)
- By writing to MTM at the following address: MTM
  Quality Assurance
  8383 Greenway Blvd
  Suite 400
  Middleton, WI 53562

When filing a complaint, please have your/member's name, Forward Health ID, date of the ride or trip number, and description of the issue readily available.

Sterilization, Hysterectomy, Abortion Procedures for Quartz BadgerCare Plus and/or Medicaid SSI Program Members

For elective sterilization, the Consent for Sterilization form (HHS-687) must be fully completed and submitted to Utilization Management. Please refer to the ForwardHealth Online Handbook to view and download the consent form and instructions. A consent form in Spanish is also available.

Sterilization is any surgical procedure performed with the primary purpose of rendering an individual permanently incapable of reproducing. The procedure may be performed in an "open" or laparoscopic manner. This does not include procedures that, while they may result in sterility, have a different purpose, such as surgical removal of a cancerous uterus or cancerous testicles.

Medicaid reimbursement for sterilization is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Consent for Sterilization form HHS-687 There are no exceptions.

Federal and state regulations require the following:

- The member is not an institutionalized individual.
- The member is at least 21 years old on the date the informed written consent is obtained.
- The member gives voluntary informed written consent for sterilization.
- The member is not a mentally incompetent individual. Wisconsin Medicaid defines a "mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:

- In the case of premature delivery, the sterilization is performed at the time of premature delivery, and written informed consent was given at least 30 days before the expected date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
- The sterilization is performed during emergency abdominal surgery, and at least 72 hours have passed since the member gave written informed consent for sterilization.

Consent for Sterilization Form

A member must give voluntary written consent on the federally required Consent for Sterilization form. Sterilization coverage requires accurate and thorough completion of the consent form. The physician is responsible for obtaining consent. Any corrections to the form must be signed or initialed and dated by the physician and/or member, as indicated in the completion instructions.

ForwardHealth requires all of the following individuals to sign and date the completed form by hand (electronic signatures

will not be accepted):

- The individual to be sterilized.
- The interpreter, if one was provided.
- The person who obtained the consent.
- The physician who performed the sterilization procedure.

If any of the required signatures or initials and dates are missing or incomplete, the form will be considered invalid and will be returned to the provider. Failure to comply with any of the sterilization requirements will result in denial of the sterilization claims.

Hysterectomy

An Acknowledgment of Receipt of Hysterectomy Information Form (F-01160) must be completed and submitted to Quartz's Utilization Management Department before the surgery. The form is also available in Spanish (F-01160S) and Hmong (F-01160H). Please refer to the ForwardHealth Online Handbook to view and download a form and instructions.

The Acknowledgement of Receipt of Hysterectomy Information form, F-01160, is not to be used for purposes of consent of sterilization. The form is not required in the following circumstances:

- The member was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the member's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive member eligibility, and one of the following circumstances applied:
    - The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
    - The member was already sterile.
    - The member was in a life-threatening emergency that required a hysterectomy.

If any of the above circumstances apply, providers are required to include signed and dated documentation (e.g., a copy of the preoperative history or physical exam or the operative report for a surgical procedure) with the claim.

Per the Forward Health Handbook: A hysterectomy is not covered for uncomplicated fibroids, a fallen uterus, or a retroverted uterus. ForwardHealth does not cover hysterectomies for the purpose of sterilization.

Abortion

Per §. 20.927, Wis. Stats., abortions will be covered for Quartz BadgerCare Plus and/or Medicaid SSI Program members when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on her or his best clinical judgment, that the abortion meets this condition by signing a certification.
- In the case of sexual assault or incest, provided that prior to the abortion, the physician attests to their beliefs that sexual assault or incest has occurred, by signing a written certification and provided that the crime has or will be reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, provided that prior to the abortion the physician attests, based on their best clinical judgment, that the abortion meets the following condition by signing a certification that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman.

Physicians are required to submit a completed and signed certification statement attesting to one of the circumstances above to Quartz's Utilization Management department as well as when submitting a claim to ForwardHealth. Refer to

the ForwardHealth Online Handbook for the Abortion Certification Statements form (F-01161) that may be used for this purpose.

Per the Forward Health Handbook: When an abortion meets the state and federal requirements for Medicaid payment, office visits and all other medically necessary related services are covered. Treatment for complications arising from an abortion are covered, regardless of whether the abortion itself is a covered service, because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

Coverage of Mifeprex

Per §. 20.927, Wis. Stats., Wisconsin Medicaid reimburses for Mifeprex under the same coverage policy that it reimburses other surgical or medical abortion procedures.

When submitting claims for Mifeprex, providers are required to:

- Use the HCPCS code S0190 (Mifepristone, oral, 200 mg) for the first dose of Mifeprex, along with the E&M code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), for the drug given during the second visit, along with the E&M code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate ICD abortion diagnosis code with each claim submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one in which the abortion is covered.

Physician Counseling Visits Under Wis. Stat. § 253.10

Wisconsin Statute § 253.10, states a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information that is specified in the statue. DHS has issued preprinted material summarizing the statutory requirements and a patient consent form. Copies of these materials may be obtained by writing to the following address:

Administrator Division of Public Health
PO Box 2659
Madison WI 53701-2659

An office visit during which a physician provides the information required by this statute is covered.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered. The below services, including, but not limited to, when directly related to the performance of a noncovered abortion, are not covered.

- Anesthesia services
- Laboratory testing and interpretation
- Recovery room services
- Transportation
- Routine follow-up visits
- Ultrasound services

Notification Regarding Reporting Over/Under Payments

In the event an error in payment is made, Quartz and the provider reserve the right to request and receive an adjustment in payment, to compensate for the error if such a request is made in writing and supported by documentation.

The Federal Medicaid Managed Care Rule requires HMOs to have administrative and management procedures to guard against fraud and abuse. Quartz BadgerCare Plus and/or Medicaid SSI (the HMO) must require the network

providers to report and return any overpayments within 60 days of the provider receiving written notification of the overpayment or, if self-identified by the provider, within 60 days of the provider's discovery of the overpayment. The provider must notify the HMO in writing of the reason for the overpayment. Any treatment of recoveries shall be appropriately reflected in the encounter data.

All BadgerCare Plus and/or Medicaid SSI over and underpayments must be reprocessed unless otherwise stipulated in the provider contract going back four years from date of payment.

If you suspect fraud or abuse of the Medicaid program, you may report it. Please go to reportfraud.wisconsin.gov.

According to 42 CFR § 438.608(d), the HMO must attempt to recover all overpayments that were made to network providers including those overpayments attributed to fraud, waste, and abuse. If the HMO discovers the overpayment, the HMO recovers the payments and retains the funds. If the Department identifies the overpayment, the HMO recovers and subsequently retains the funds. Regarding overpayments identified by the HMO, OIG, or DHS, there are no situations wherein the HMO is not permitted to retain the recovered overpayment. This provision does not apply to recoveries retained through federal False Claims Act cases or other such investigations.

Billing BadgerCare Plus and/or Medicaid SSI Members

Provider must not bill BadgerCare Plus and/or Medicaid SSI members for medically necessary covered services provided during the members' period of enrollment. Provider also agrees not to bill members for any missed appointments while the members are eligible under the BadgerCare Plus and/or Medicaid SSI Programs. This provision will remain in effect even if Quartz becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then Quartz or the provider can bill the member.

The standard release form signed by the member at the time of services does not relieve Quartz or providers from the prohibition against billing a BadgerCare Plus or Medicaid SSI member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI member liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

Prohibition on Billing Members for Covered Services

Quartz or its providers shall not bill a member for covered services in the benefit package provided during the member's enrollment period in the HMO except if the HMO elects to charge copays to members as required under Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR § 447.56 (f). Quartz will provide at least a 6 month notice to DHS and submit a member communication plan for approval before implementation to apply copays to covered services.

This provision applies even if one or more of the following exists:

a. Quartz becomes insolvent;
b. The Department does not pay Quartz for covered services provided to the member;
c. The Department or Quartz does not pay the provider that furnishes the services under a referral or other arrangement; and
d. Payment for services furnished under the contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the provided the service directly.

Prohibition on Billing in Insolvency

In the event of Quartz's insolvency, Quartz will not bill members for debts of Quartz or for covered services in the benefit package and provided during the member's period of enrollment.

Member Information and Coverage

Product Descriptions

This section of the Provider Manual highlights Quartz's products and services. It is designed to save you time while providing you with details on Quartz's products and services. Quartz has several managed health care products available for members:

Health Maintenance Organization (HMO) Plan

Quartz provides a variety of HMO plans, including copayment, deductible, and coinsurance plans. HMO members must select an in-network Quartz primary care clinic and obtain all non-emergent health care services through a defined network of practitioners, hospitals, and other medical professionals.

Preferred Provider Organization (PPO) Plan

Quartz PPO plans offer national network options for members who live in the United States outside of the Quartz commercial selling area. Quartz contracts with Cigna to offer employers domiciled in Quartz's selling area in Wisconsin, Iowa, or Illinois who have employees who ~~reside~~ live outside of the Quartz~~'s~~ selling area. Certain plan designs may not be supported by the Cigna network and are instead paired with the PHCS/Multiplan network.

Point-of-Service (POS) Plan

POS members must select an in-network Quartz primary care clinic; however, they are not required to seek services from or through their primary care clinic. Quartz's POS plan pays benefits at two different levels: In-Plan or Out-of-Plan, depending on the "point" at which the care is accessed.

- In-Plan – Member seeks care from PCC or any in-network specialist available to the member based on their PCC selection.
- Out-of-Plan – These benefits apply when a member receives medically necessary services from a practitioner/provider who is not part of Quartz's provider network. Higher member cost-sharing applies to Out- of-Plan services.

Medicare Select

Medicare Select is a managed care product designed to supplement Medicare Part A & Part B. Quartz covers the portion of Medicare-approved benefits that Medicare may not cover. In addition, Medicare Select will pay for some services that Medicare does not cover, such as routine physicals, eye exams, and hearing exams.

Individual Health Insurance Plan

Individual HMO plans offer a variety of different coverage levels for individuals and families who do not have, or are not eligible for, group health insurance through an employer. These plans include those purchased through the Health Insurance Marketplace or directly from Quartz.

Member Identification Cards

All Quartz subscribers or commercial policyholders receive a member Identification Card. The member Identification Card (ID card) includes the following enrollment-related information:

- Your Network – The ID card will indicate which network to use to search for providers in Find A Doctor. For example, a Quartz member's ID card will indicate "Quartz One" in the "Your Network" section of the ID card. Use "Quartz One" to search for providers in Find A Doctor.
- The subscriber is always the first member named on the ID card. Members on the plan and their unique ID codes will be listed below the subscriber.
- Date Printed – The date in the lower right-hand corner on the back of the ID card is the date the card was printed. This date is not the date coverage starts. Members should log into their MyChart account or contact Customer Success to find out when coverage started. Practitioners may log in to MyQuartzTools.com for that information.
- Group Number – The group number identifies the subscriber's employer group and is usually the same for

all employees and their dependents within that employer group. In a few instances, employees of the same employer will have different group numbers due to different locations and/or benefit coverage.

Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment (DME) and disposable medical supplies must be ordered by a treating provider and must be obtained from Quartz in-network DME suppliers if the member has an HMO plan. Prior Authorization is required for all requests from out-of-network DME suppliers. Providers should send the order to the DME supplier, and the supplier is responsible for obtaining prior authorization when needed.

DME items (e.g., crutches, braces, etc.) dispensed by a hospital, urgent care or clinic during an outpatient procedure or visit to the Emergency Room, are considered "back cabinet" items, and will be reimbursed at the provider's contractual rate.

DME inquiries: Please contact Quartz Customer Success at (800) 897-1923.

Coverage Limitations

DME and medical supplies must be medically necessary and a covered item or service to qualify for coverage. Providers and suppliers may contact Quartz Customer Success to obtain coverage details.

Covered DME and medical supplies are reimbursed at the supplier's contractual rate. Most items are subject to a:

- Maximum dollar allowance
- Maximum length of rental
- Copayment, coinsurance, or deductible amount

Prior authorization is required for purchased DME and medical supplies when the billed amount is $500 or greater for all lines of business. All DME rentals must be prior authorized for lines of business other than Quartz Medicare Advantage. If prior authorization is not obtained, coverage will be denied. You may contact Quartz Customer Success or go to QuartzBenefits.com to verify whether prior authorization is required. If required, you may be asked to submit written documentation to Utilization Management (see Utilization Management Section) for review and determination of medical necessity before providing the equipment or supply to the member.

Coverage exclusions may include: *

- Equipment and appliances that are not prescribed for the treatment of illness or injury.
- Repairs and replacement of DME (some plans may cover this).
- Elastic support stockings (unless they are medically necessary), foot pads, and bunion covers.
- Orthopedic shoes unless they are part of a brace or for the care of diabetes or peripheral vascular disease.
- Items for activities of daily living, such as shower chairs, grab bars, toilet seats, etc.
- Upgraded items that have features that go beyond what is medically necessary.
- Convenience items.

*Additional exclusions may apply depending on the member's certificate of coverage.

In general, supplies and equipment that are not primarily intended for medical use (e.g., air conditioners, exercise bicycles, and filter vacuum cleaners) are not covered. Call Quartz Customer Success with any questions.

Home Health Care

Home Health Care is covered when the member requires skilled nursing care, physical therapy, occupational therapy and/or speech therapy that cannot be provided by a family member or other person and, if not provided, would require the member to be hospitalized or placed in a skilled nursing facility. The member must be homebound, and the attending physician must work with the home health agency to develop a treatment plan. The home health agency must obtain prior authorization from the Utilization Management Department. HMO members must use Quartz in-network providers for home health care services. All Quartz providers are state-licensed, or Medicare-certified. Point of Service (POS) members, when choosing out-of-network providers, must use a state-licensed or Medicare-certified home health provider.

You can verify the type of plan and coverage a member has by calling Quartz Customer Success at (800) 897-1923. In most instances, there is a limit to the number of home health care visits per benefit year. Some Quartz plans may allow additional visits based on medical necessity. See the member's Schedule of Benefits for the applicable limit.

Home Infusion Therapy

Quartz encourages the use of home infusion therapy services rather than inpatient or outpatient administration whenever medically appropriate. Patients with conditions such as osteomyelitis, Crohn's Disease, and cancer may be able to receive treatment at home due to advances in home infusion therapy. This safe and cost-effective therapy can mean an earlier hospital discharge or even eliminate hospitalization. Some examples of appropriate situations are:

- Anti-infectives including antivirals and antifungals
- Total Parenteral Nutrition (TPN)
- Cardiovascular/Inotropic drug
- Hydration
- Chemotherapy
- Immune Globulin (IVIG)
- Pain Management
- Anticoagulants
- Catheter Maintenance

Home infusion providers are usually able to initiate service within a few hours of the request. Some patients do not require inpatient services before initiating home infusion services.

Prior authorization is necessary before initiating home infusion services. Some medications administered via home infusion services also require prior authorization. Refer to the Quartz Medication prior authorization list to determine if the medication itself requires authorization. Authorization may be requested by the ordering provider or the home health agency. If you need assistance finding a contracted Quartz Home Infusion Therapy provider or initiating service, please call Customer Success at (800) 897-1923.

Mental Health and Substance Use Disorder Benefits

For members with HMO plans, mental health and substance use disorder services must be provided by the member's PCP or an in-network behavioral health professional. Members with POS and PPO plans have benefits for services outside of Quartz's provider network. All inpatient services must be Prior Authorized except for emergency admissions. Members may contact Behavioral Health Care Management for a list of services requiring prior authorization and assistance in accessing behavioral health services.

For assistance coordinating your behavioral health services, including substance use disorder treatment services, please contact Quartz Behavioral Health Utilization Management at (608) 640-4450 or (800) 683-2300.

Service limitations vary by benefit plan. For large and small group plans, including State and Local government participants, behavioral health and substance use disorder benefits are the same as for all other medical conditions and are subject to deductible, coinsurance, and co-payments.

- Hypnotherapy
- Relationship counseling
- Court-ordered treatment that does not otherwise qualify for coverage

Note: Not all individual members have behavioral health and substance use disorder coverage, depending on when the policy was originally issued.

Please contact Quartz Customer Success with questions about coverage. Questions about the management process may be directed to the appropriate Utilization Management staff.

Chiropractic Providers

Fulcrum Health, Inc., contracts for chiropractors on behalf of Quartz for the commercial and Medicare lines of business, in addition to massage therapists for Quartz Medicare Advantage (HMO) products. If you are a chiropractor or massage therapist interested in participating with Quartz, contact Fulcrum at info@fulcrumhealthinc.org or (763) 204-8570 for network participation. For more information, visit the Fulcrum Health website.

Emergency Room

Except for life-threatening emergencies, Quartz members should contact their PCP or clinic before seeking treatment.

Definition of "Emergency"

Federal law defines an emergency medical condition as a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who has an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, concerning a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment of the person's bodily functions.
- Serious dysfunction of one or more of the person's body organs or parts.

Procedure

Generally, a member should receive emergency care from a Quartz network hospital. However, if a member is unable to reach a plan hospital, they should go to the nearest hospital emergency room for treatment. Quartz applies the "prudent layperson" standard when determining whether claims for emergency room visits should be covered.

Follow-Up Treatment

The PCP should perform or arrange follow-up evaluation and treatment required after emergency care.

Emergency Transfer

Quartz covers emergent/urgent transportation to the nearest hospital that can provide the required level of care when emergency services are needed, and medical care is required during transport. In non-emergent, non-urgent situations, transportation between hospitals is covered when it is prior authorized by Quartz.

Hospital Emergency Room Copayment

If the member's benefit plan requires a copayment for using the hospital emergency room, the copayment will be waived if the member is admitted as an inpatient to the hospital directly from the emergency room.

Interpreter Services

Quartz contracts with Pacific Interpreters to provide interpreter services for our members who are not able to communicate in English or speak a different language than the provider. When Quartz is informed that a member needs such services, a Customer Success Advisor will connect to Pacific Interpreters; an interpreter will listen to the speaker, analyze the message, and convey its original meaning back to the Customer Success Advisor. The process is repeated until the call is complete.

This service is not available during a patient's office visit.

If a provider does not have an interpreter service to facilitate health care and services, providers can use the following phone number. Prior to calling this language line, the member must be present, and the provider will need to have the member's name and Quartz employer group.

Dial: (844) 447-1581; Indicate: Language; Provide: Member's name and Quartz employer group.

Providers may not deny services to members based on their language needs.

Skilled Nursing Facility (SNF)

Quartz encourages the use of skilled nursing and rehabilitation facilities instead of acute hospitalization whenever medically appropriate. Care that can be safely provided in a home or outpatient setting is not considered skilled care. SNF stays require prior authorization review for medical necessity. When approved, authorization is given in increments of time deemed appropriate for the clinical picture. Additional days may be requested by the facility and will be reviewed for ongoing stay.
Please note that custodial care is not a covered benefit.

Coverage applies only when skilled nursing or skilled rehabilitation services are required daily. Skilled nursing care means care that can only be performed by or under the supervision of licensed nursing personnel. Skilled rehabilitation services include such services as physical therapy performed by or under the supervision of a professional therapist. All SNF admissions require prior authorization.
Generally, care that will not be covered is:

- Domiciliary or custodial
- Available to the insured without charge
- Paid for under a governmental health care program other than Medical Assistance

Coverage for skilled nursing care provided in a licensed skilled nursing facility varies by benefit plan. Call Quartz Customer Success for specific coverage information.

Hearing Aid Coverage

Quartz provides coverage for hearing aids following federally mandated coverage requirements for HMO, Point of Service (POS), and Preferred Provider (PPO) members.

Please note this does not apply to members with State and Local Government Plans or BadgerCare Plus and/or Medicaid SSI plans.

Coverage is allowed for one standard model hearing aid, as determined by Quartz, per ear once every 36 months (except for Illinois, where coverage is one per ear every 24 months). Hearing aids must be obtained from an in-network Quartz provider. In-network hearing aid providers must submit both the appropriate code along with the manufacturer and model on the claim for appropriate coverage determination. The approved model list will be updated annually and is available at QuartzBenefits.com/hearingaids. Please submit the manufacturer and model in the SV101-7 element.

Note: some policies may further limit or exclude coverage of hearing aids. Consult My Quartz Tools secure portal or contact Customer Success to determine coverage under a specific patient's policy.

Reimbursement for prescribed hearing aids that are not on the Quartz approved model list may be approved. Please reference schedule of benefits..

Quartz provides a supplemental hearing aid benefit to Quartz Medicare Advantage and Dual Eligible w/Rx members. This benefit pays for all hearing aid expenses except for dispensing fees and batteries. This benefit is only available to members who obtain services from eligible providers.

Vision Coverage

Coverage for routine vision exams for fully insured large and small groups:

- First routine exam of the year for members with non-HDHP (High Deductible Health Plans) will be covered without cost-sharing when submitted with the following diagnosis codes:
- Z01.00: Encounter for examination of eyes and vision without abnormal findings or
- Z01.01: Encounter for examination of eyes and vision with abnormal findings
- Comprehensive Eye Exam CPT codes 92004 or 92014
- Subsequent exams will be covered according to medical necessity, but may apply cost sharing

- Includes one exam (CPT) code plus/minus a refraction code

Coverage for routine vision exams for Individual ACA plans:

- For WI members aged 18 and under, a routine vision exam is covered and is subject to the cost share as stated on the Summary of Benefits.
- For WI members aged 19 and older, routine vision exams are not covered unless member has a diagnosis of diabetes.
- For members in MN and IL, routine vision exams are covered for all ages.

Vision materials are considered durable medical equipment. When reviewing members' benefits in the provider portal, My Quartz Tools, look in the correct section of their Summary of Benefits. In addition, ACA individual plans have a $100 maximum benefit incorporated into their annual coverage, knowing that it may still require that deductible be met first, or that a set coinsurance is in play up to that $100 maximum benefit. Vision benefits (when they are a covered benefit) are identified below.

Age 18 and under details for PPACA plans: (If a member has any ACA plan, these benefits apply for 18 and younger)

- Limit one pair of glasses OR contact lenses per year
- Single, bifocal, trifocal, and lenticular lenses are covered.
- Glass, plastic, and polycarbonate lenses are covered.
- Designer frames are not covered.

Lens treatments (Scratch-resistant coating, UV coating, Anti-Reflective coating, polarized lenses) are covered and subject to the DME benefit.

In lieu of glasses, one pair of medically necessary contact lenses is covered, without a PA, for certain conditions. (Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniridia, Corneal Disease, Post-Traumatic disorders, irregular astigmatism) No Prior Authorization is needed for the lens coverage for these specific conditions, regardless of the billed amount. (DME billed item over $500 rule does NOT apply).

These same benefits apply to adults 19 and over when they have elected Vision coverage on their plan. Regardless of the member's age, the benefits would be subject to the DME cost sharing, however, there may be different limitations and exclusions.

Note: Please verify coverage at MagnaCare for self-funded plans.

Quartz provides a supplemental vision material benefit to Quartz Medicare Advantage and Dual Eligible w/Rx members. Quartz Medicare Advantage members have a CashCard that they may choose to use to pay for this benefit. The member has the option to pay out of pocket or use all or a portion of their CashCard to cover for the vision materials. A claim will not be allowed for payment of the benefit. Quartz Dual Eligible w/Rx also have a vision material benefit; however, the provider is required to submit a claim to Quartz for payment of the benefit.

Member Satisfaction Surveys

Gaining input from our members is vital to our success. Quartz conducts various member satisfaction surveys. We use survey information to implement initiatives to maintain or improve our members' level of satisfaction.

Surveys may include, but are not limited to:

- Customer Satisfaction Surveys – This survey is distributed to members who have either incurred a claim or contacted Quartz Customer Success.
- Consumer Assessment of Health Plan Survey (CAHPS®) – The CAHPS® survey enables consumers to compare health plans using a similar tool. It is part of the annual NCQA review process.
- New Member Satisfaction Survey – Measures new members' understanding of Quartz information.
- Net Promoter Score (NPS) Survey – This survey is distributed to a random sample of members each month to help understand their likelihood to recommend Quartz.

Customer experience is a Quartz-wide effort and each team is responsible for reviewing all customer satisfaction metrics and recommending work plans or interventions to improve the customer's experience, which would include members, employers, providers, and agents.

Quartz Members Rights and Responsibilities

Our Member Rights and Responsibilities Statement shows our commitment to a mutually respectful relationship with our members and practitioners. This policy assures members that we respect their rights and communicates our expectations of the members' responsibilities as follows:

Your Member Rights

As a Quartz member, you have the right:

- To ask for an interpreter and have one provided to you during any Quartz-covered service.
- To receive information in another language or another format.
- To pick a personal doctor from primary care physicians (PCPs) or primary care clinics (PCCs) who participate in your Quartz plan's provider network.
- To get information about your rights and responsibilities as a Quartz member.
- To get information about your Quartz plan's covered or excluded services and health plan benefits and its primary and specialty care practitioners and providers.
- To know about the doctors you can see.
- To receive health care services as provided for in federal and state laws.
- All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- To receive information about treatment options, including the right to request a second opinion. You have the right to have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To get preventive care information.
- To give us ideas about these rights and responsibilities.
- To make decisions about your health care. You can also refuse care.
- To be treated with dignity and respect, regardless of health status, disability, race, age, gender, sexual orientation, or creed.
- To privacy. You have the right to privacy and confidentiality in all communications and records about your health care.
- To be free from any form of restraint or seclusion used as means of force, control, ease, or reprisal.
- To know how to file a complaint, appeal, or grievance about Quartz and the care it provides.
- To be free to exercise your rights without adverse treatment by your Quartz plan, or the HMO and its network providers.
- You have the right to disenroll from your HMO program or Quartz plan if:
    - You move out of the HMO or plan's service area.
    - Your plan or HMO does not, for moral or religious objections, cover a service you want.
    - You need a related service performed at the same time, not all related services are available within the provider network, and your PCP or another provider determines that receiving the services separately could put you at unnecessary risk.
    - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with your care needs.
    - Quartz BadgerCare Plus and/or Medicaid SSI members:
        - You may switch HMOs without cause during the first 90 days of Quartz enrollment.
        - You have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on Quartz.
        - You have the right to receive information from Quartz regarding any significant changes with Quartz at least 30 days before the effective date of the change.

Your Civil Rights

All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with Quartz that refer or recommend members for services shall do so in the same

manner for all members.

Quartz provides covered services to all eligible members regardless of the following:

- Age
- Color
- Ability
- National origin
- Race/Ethnicity
- Gender identity
- Sexual orientation

Member Responsibilities

As a Quartz member, it is your responsibility:

- To pick a personal doctor from Quartz's list of primary care physicians or primary care clinics who participate in your plan's network.
- To create a relationship with that doctor.
- To read your member handbook and ask questions about information you don't understand.
- To be honest with your doctors and give them the information they need to take care of your health.
- To understand your health problems, ask questions about your health, and to take part in developing mutually agreed upon treatment goals, to the degree possible.
- To follow the instructions your doctor gives you, including the plans and instructions of care you have agreed to.
- To have your Quartz member ID card with you and show them when you go to your doctor or hospital.
    - Quartz BadgerCare Plus/ Medicaid SSI members: It's your responsibility to carry your ForwardHealth ID card with you and show it when you go to your doctor and/or the hospital.
- To make healthy choices.
- To keep your appointments or to give early notice if you must cancel.
- To show consideration and respect to health plan staff and health care providers.

If you're a Quartz Medicare Advantage (HMO) member, you can find more details about your rights and responsibilities of your plan's Evidence of Coverage document, which is available in your Quartz MyChart account.

Members Rights – State of Minnesota

Minnesota 62Q.556 CONSUMER PROTECTIONS AGAINST BALANCE BILLING

Subdivision 1. Nonparticipating provider balance billing prohibition.

(a) Except as provided in paragraph (b), balance billing is prohibited when an enrollee receives services from:

(1) a nonparticipating provider at a participating hospital or ambulatory surgical center, as described by the No Surprises Act, including any federal regulations adopted under that act;

(2) a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility; or

(3) a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act.

(b) The services described in paragraph (a), clauses (1), (2), and (3), as defined in the No Surprises Act, and any federal regulations adopted under that act, are subject to balance billing if the enrollee provides informed consent prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

Subdivision 2. Cost-sharing requirements and independent dispute resolution.

(a) An enrollee's financial responsibility for the nonparticipating provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the nonparticipating provider services with the nonparticipating provider. If the attempt to negotiate reimbursement for the nonparticipating provider services does not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

Subdivision 3. Annual data reporting.

(a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of health:

(1) the total number of claims and total billed and paid amounts for nonparticipating provider services, by service and provider type, submitted to the health plan in the prior calendar year; and

(2) the total number of enrollee complaints received regarding the rights and protections established by the No Surprises Act in the prior calendar year.

(b) The commissioners of commerce and health shall develop the form and manner for health plan companies to comply with paragraph (a).

Subdivision 4. Enforcement.

(a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to the relevant provisions of the No Surprises Act is subject to the requirements of this section and section 62J.811.

(b) The commissioner of commerce or health shall enforce this section.

(c) If a health-related licensing board has cause to believe that a provider has violated this section, it may further investigate and enforce the provisions of this section pursuant to chapter 214.

Advance Directives Overview

As capable adults, patients have the right to accept or refuse medical treatment, including life-sustaining treatment. In addition, a member may appoint someone else to make health care decisions on their behalf should they become mentally or physically unable to do so. To comply with these rights, Quartz provides education to staff about its policy and procedure for advance directives during provider onboarding and annually in the Provider Newsletter. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, which explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known. They can also designate a Health Care Agent who will make health care decisions on their behalf when it is determined that they are no longer capable of making these decisions for themselves. Two types of advance directives that are commonly used:

- Living Will. This written document that allows an individual to select the kind of life-sustaining care they would want if injury or illness leaves them in terminal condition (dying) or a persistent vegetative state with no hope of recovery.
- Power of Attorney for Health Care. This form allows a member to appoint another person or persons to make health care decisions on their behalf should they become unable to make these decisions for themselves. The person (or persons) appointed is called their health care agent. This form does not give the health care agent any authority to make financial or other business decisions on behalf of the member.

As applicable, facilities shall have policies and procedures in place to facilitate advance directives which should be prominently documented in each patient's medical record whether they have executed an advance directive and ensure compliance with any Medicare and state law requirements. Providers cannot refuse care or otherwise

discriminate against a member based on whether the member has executed an advance directive. Quartz will ensure to update this section with any regulatory changes related to advance care planning.

If a member has an advance directive, they are encouraged to provide copies to their health care providers, family, and their health care agent, if they have designated one.

Advance directives resources:

- National Institute on Aging: Advance Care Planning: Advance Directives for Health Care | National Institute on Aging (nih.gov)
- UW Health: Advance care planning | UW Health
- Gundersen Health System: Advance Care Planning | Gundersen Health System
- Aurora Health Care: Advance care planning | Aurora Health Care

Claims & Coding Policies

Medical Claims

Quartz is committed to meeting the standard goal of processing claims within 30 days of receipt. The preferred claim submission process is electronically and provides faster claims processing. If you are not able to submit claims electronically, please contact your Provider Engagement Specialist to discuss barriers, and in the meantime, please submit paper claims via My Quartz Tools or refer to the back of the Member ID card to send the claim to the appropriate location. We thank you in advance for helping us process your claims efficiently and accurately by using the following procedures:

Claim Submission Guidelines

To expedite processing and to ensure that all types of claims are processed accurately, Quartz requests that you do the following:

- Include the member's current person code in the subscriber number field.
- Indicate the current alpha-numeric group number.
- Put all dates of service on one claim form not to exceed six lines, when submitting a 1500 form.
- Submit only one provider of service per claim.
- Therapy services must have individual dates of service; date ranges cannot be used.
- Include the appropriate National Provider Identification (NPI) number.
- Please list the taxonomy codes, when applicable.
- Use current and appropriate CPT-4 procedure codes, ICD-10 diagnosis codes, HCPCS codes, and revenue codes.
- Include a description when miscellaneous codes are used.
- Indicate the DRG in the appropriate box for all inpatient claims when using the UB form.
- Attach the primary insurance carrier's explanation of benefits (EOB) form, if applicable.
- Indicate facility where services were rendered.
- Only chief residents are eligible to bill for services, if resident (non-chief) sees a member, the claim should be billed under the supervising provider. Residents will not be listed in the claim system.
- Only include the Total Claim Amount on the last page of the claim when there are multiple pages.
- Submit only claims for Oral Surgery, Temporomandibular Disorders (TMJ/TMD), and Accident Claims to Quartz. –

  DENTAL CLAIMS ONLY
- Use the most current American Dental Association (ADA) Claim form. - DENTAL CLAIMS ONLY
- Put all dates of service on one claim form, not to exceed ten lines, when submitting an ADA claim form. - DENTAL CLAIMS ONLY
- Use current and appropriate ADA procedure codes. Dental Claims also require the diagnosis codes be submitted on the claim. - DENTAL CLAIMS ONLY
- If services were provided because of an accident, check the accident box and indicate the date of the accident. - DENTAL CLAIMS ONLY
- Indicate "DENTAL Pre-treatment Estimate" on the envelope, when applicable.
- Do not write on the claim form with red ink or dark highlighter.
- If a highlighter must be used, use yellow and send the original claim.
- If a copy must be sent, make the copy, and then highlight with yellow.
- Information should be lined up appropriately on the form when printed so nothing touches the lines on the form.
- Printing should not be light, and characters should be clear and well-formed. This facilitates the imaging process.

Paper Claim Submission

Make sure you are using one of the P.O. Box locations below to ensure your claims are processed.

Where to Submit Claims

The preferred way to submit claims to Quartz is electronically. Go to QuartzBenefits.com/edi to learn more about electronically submitting your claims. If you must submit paper claims, please see below:

All Quartz Paper Claims (excluding self-funded and PPO)	Self- Funded Claims	PPO Claims
Quartz **P.O. Box 211221** **Eagan, MN 55121**	Quartz Align c/o Brighton Health Plan Solutions P.O. Box 1001 Garden City, NY 11530	Refer to member's ID card

When to Submit Claims

Submit the claim with the appropriate referral/certification number or other written statements within the timely filing limit required in the provider contract.

Failure to submit claims within the contract filing limit may result in non-payment.

If you have any questions about the claim submission process, contact Customer Success at (800) 897-1923.

Electronic Claims Submission (EDI)

EDI, also known as Electronic Claims Submission, allows medical providers to send and receive health care claims information. Quartz supports all HIPAA-compliant electronic transactions. For more information regarding EDI claim submission/electronic claim payment/Remittance advice (835) along with the list of Quartz compatible trading partners, please go to Quartz/Authorization Agreement for Electronic Health Care Claim Payment/Advice (835).

For more information on electronic claim submission for coordination of benefits, please see the following document: Coordination of Benefits.

Quartz utilizes Availity as our exclusive 837 claims clearinghouse. (This is not for other transactions such as 270s, 271s, and 835s.) Questions can be directed to our Electronic Data Information (EDI) department at EDI@QuartzBenefits.com.

Electronic Funds Transfer (EFT) is available for you to receive your claim payments electronically. This will allow you to receive payments sooner and will eliminate paper checks being sent through the mail. Electronic payments will be electronically deposited into your checking account weekly. This will include a tracking number to allow for easy posting of payments.

For more ETF information, or if you are interested in signing up, contact Quartz Customer Success or your Provider Engagement Specialist.

If you have questions regarding this process or need assistance, please email our EDI Analysts for more information at: EDI@quartzbenefits.com.

Voided Claim Submissions

Quartz recommends that when voiding claims, they be sent via EDI submission. Quartz's claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to

Claim Frequency Codes

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "claim frequency type codes." Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim.

Quartz requires the use of the following frequency code for replacement/corrected claims.

Code	Description	Claim Type	Filing Guidelines	Action

8	Void of Prior Claim	Professional or Institutional Claim	File electronically, as normal. File the claim in its entirety. Include the original Quartz claim number in REF02 field.	Quartz will void the original claim. The void request being submitted represents a complete void/reversal of the previously processed claim.

Quartz Claim Number

To identify the Quartz claim number, on the 835 view the CLP-07. See below for an example:

CLP*98765*1*999.99*0**HM*12345678*13*3~

Color Code Key:

CLP01- The provider's claim number, CLM 01 shows in the 'Account with Vendor' value. This is what the provider submitted to Quartz.

CLP03-The billed amount from the provider.

CLP04-The paid amount by Quartz.

CLP07-The Quartz claim number. This is the number to use in the REF02 field.

On the paper remit, it is viewed within the Claim # field. This is the same layout if you receive the paper remit via mail or retrieve it from My Quartz Tools. Below is an example:

Remittance Detail Report Vendor: ABC COMPANY
123 MAIN ST
SAUK CITY, WI 53583

* Provider ID#: FAC00000

* Provider Name: ABC Company

==========

Co. Name: Check #: 000000000 Check Date: 01/09/2019

Claim #: 00000000

Submitting Electronic Replacement Claims

When submitting claims noted with claim frequency code 7, the original Quartz claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The Quartz claim number can be obtained from the 835 Electronic Remittance Advice (ERA) or Paper Remittance Advice.

The ANSI 837 CLM segment containing the Claim Frequency Code 7, along with the required REF segment and Qualifier in Loop ID 2300 example is below:

Claim Frequency Code CLM*12345678*500***11:B:7*Y*A*Y*I*P~ REF*F8*(Enter the Quartz Claim Number); the REF02 value noted under filing guidelines

Medicare Crossover

If you have questions regarding this process or need assistance, please contact our EDI Analysts for more information.

Quartz coordinates Medicare Part A and Part B claims with CMS through CMS's Medicare Crossover program. Quartz sends an eligibility file to CMS on a bi-weekly basis (Monday) for all lines of business. Once eligibility is submitted, any claim which meets the selection criteria would crossover to Quartz. Any paid claims will be sent to Quartz after 14 days from the claim receipts has passed, while denied and adjusted claims will be sent to Quartz after CMS has processed the claim.

To determine if a claim has been sent to Quartz, please refer to the CMS remittance advice (RA) for one of the following codes:

- MA07 Alert: The claim information has also been forwarded to Medicaid for review.
- MA18 Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
- MA68 Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or the PLAN ID of the insurer to assure correct and timely routing of the claim.
- N8: Crossover claim denied by the previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of 15 workdays after receiving the Medicare payment.

If you have questions regarding this process or need assistance, please email our EDI Analysts for more information at EDI@quartzbenefits.com or call (800) 897-1923 and ask for EDI.

Coordination of Benefits

Patients may have dual coverage. For example, more than one carrier may be involved or there may be other types of coverage, such as Workers Compensation insurance. To help us determine payment responsibility, please check for:

Coverage	Action
Quartz is the secondary carrier	• Submit claim to the primary carrier first. • After the primary carrier pays, submit claim and the COB primary payor amounts or Explanation of Benefits (EOB)/remit to Quartz for consideration. • Quartz will allow up to one year from the date of service, or 30 days from payment or denial by the other carrier, to submit a claim.
If it is unclear whether Quartz is the primary or secondary carrier, or if Quartz receives an erroneous "primary" carrier claim	• Submit the claim to both carriers. • If review shows Quartz is primary, we will process the claim for benefit determination. • If review shows Quartz is secondary, we will deny and inform you and the member that Quartz is not the primary carrier and that we must have the COB primary payor amounts or an EOB/remit from the primary carrier to determine Quartz's liability.

Quartz is the primary carrier and secondary carrier	• Effective January 1, 2019, the provider will be responsible for submitting both the primary and secondary claims to Quartz. • Provider should send Quartz the primary member ID and NO COB primary payor amounts on the primary claim. • Upon receipt of the primary remit, provider should send Quartz the secondary member ID with the COB primary payor amounts on the secondary claim.

Medical Claims & Coding Policies

As a rule, Quartz follows the American Medical Association coding guidelines as the authoritative source for correct coding applications. As a secondary resource, Quartz will reference industry standards, including a review of Medicare and Medicaid guidelines. Coding Reimbursement Policies can be found in Appendix A at the end of this document.

Remittance Advice

The remittance advice ("Remit") is the information Quartz sends to the provider to explain how submitted claims were processed. The following is a breakdown of the various fields appearing on the Remit:

- Provider ID number assigned by Quartz.
- Provider Name or provider that rendered services.
- Service Dates or date of service.
- Service Code or procedure code/DRG.
- Charged Amt. or amount billed per procedure.
- Allowed Amt. or amount allowed per procedure.
- Deductible amount billable to the patient.
- Co-pay amount billable to the patient.
- Coinsurance amount billable to the patient.
- Not Covered or all non-covered charges. This does not always mean the amounts can be billed to the patient.
- Reserve or contractual agreement of withholding amount.
- Code – Quartz-assigned code to explain procedure denials.

- Line-by-line paid amounts before coordination of benefits.
- Individual Claim information will show:

  - Check Number
  - Check Date
  - Claim Number assigned by Quartz – this number is helpful when calling about a claim
  - Member ID Number
  - Date of Birth
  - Member Group Name and Number
  - Patient's Account Number

If there are questions or problems with a Remit, please contact Quartz Customer Success at (800) 897-1923.

Quartz contracted providers cannot attempt to recover from the member the difference between charges and reimbursement, except for copayments, deductibles, coinsurance, and services that are excluded under the member's health plan. When charges are not covered, the remittance advice message will state whether the patient may or may not be billed by you. The amount not covered can be either the discount amount, charges that exceed the Quartz allowable, or a charge that Quartz does not cover.

The member may be billed for only the "Copayment/ Deductible Amount," "Coinsurance Amount," and "Non-Covered Charges."

For example, charges described as "patient met" or "exceeded number of visits" or "procedures" may be billed to the

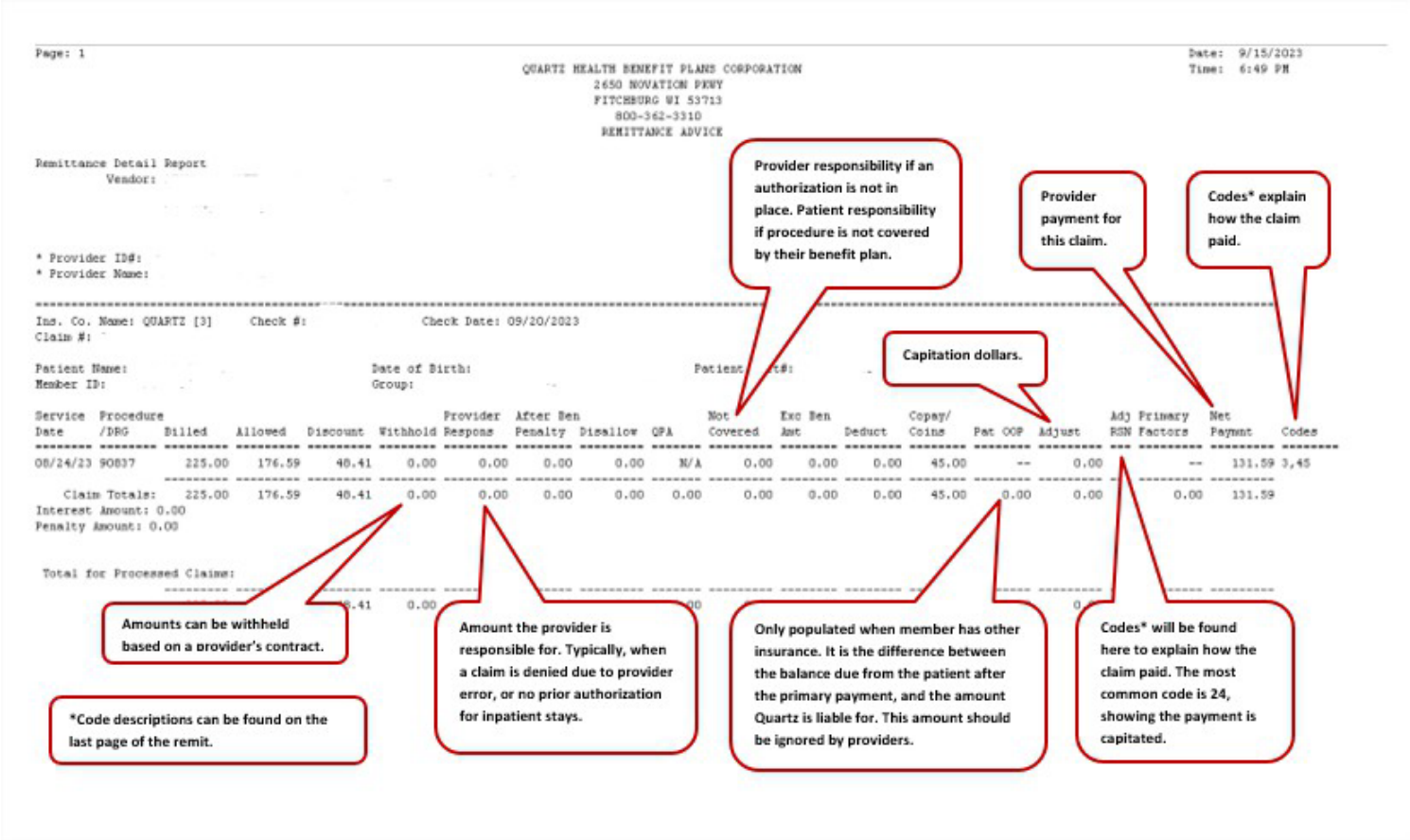
patient.

The member may NOT be billed for any of the following:

- "Charges Exceeding Maximum Allowance"
- "Reserve Amounts"
- "Capitated Procedures"
- Procedures that are in the "not-covered" column which have a line description, stating "member may not be billed"
- Procedures that need further review by the provider, such as a duplicate or incorrect code

- Services requiring a referral or prior authorization but are lacking the referral or prior authorization.

Remit Copy Example



Recoupment

Quartz's most common method of claim payment correction is the recoupment process. This means that any amount owed to Quartz will be offset from future payments. All recoupments will be listed individually and at the end of the remittance advice and will be listed as a negative amount. If an amount is due to Quartz and there are no claims payments due to a provider during a weekly payment cycle, an outstanding liability report will print out showing the amount that is still owed to Quartz.

Example:

A claim was submitted to Quartz and was paid in the amount of $39.43. Quartz then receives notice that the member terminated coverage. In this case, the full amount of the payment will need to be recouped from subsequent remittance advices until the amount is repaid.

- The claim is reprocessed and notification that the member was terminated is sent to the provider on the first payment cycle after the date the claim was reprocessed. On this remittance advice, there was no payment due to

the provider for any other claims. The amount owed to Quartz on the reprocessed claim will show individually and on the last page of the remittance advice.

- On the following payment cycle, the check to the provider contained claims payments totaling – $216.00; however,
    - Since there is $39.43 listed as an outstanding liability, the check is written for $176.57.

- This clears the outstanding liability. Detail of each claim payment amount and the negative amount is included on the remittance advice.
- Commercial products will follow the contract language for over and underpayments, which is generally within one (1) year from the date the payment error was made, or the timeframe determined by state law if the recoupment does not result in cross-plan offsetting. Notwithstanding the foregoing, Quartz may make corrective adjustments at any time relating to fraud, waste, or abuse by provider, or if otherwise required to by law, regulation, or a regulatory agency.

Refund

A request from Quartz requesting compensation for losses incurred due to overpayment for a rendered service; if a provider is not set up for recoupment for claim payment corrections, Quartz Claims Recoveries will send a written request to the provider group for a refund of the overpayment. All refunds should be sent to:

Quartz Health Benefit Plans Corporation
Attn: Collection Department
2650 Novation Pkwy
Fitchburg, WI 53713

Medicare Primary Claims

Conscience Waiver Protection

Quartz Medicare Advantage (HMO) does not object to the provision of any service based on moral or religious grounds. Any such objection would be communicated to CMS, to current members, and to prospective enrollees within 90 days of adopting such policy and prior to implementing the policy.

Providers who have objections to providing care or to carrying out a member's advance directive must notify Quartz Medicare Advantage (HMO) of such objection.

Federal Funds

Payments received from Quartz Medicare Advantage to provide services to Quartz Medicare Advantage members are, in whole or part, from federal funds. Therefore, providers and their subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans with Disabilities Act and the Medicare Modernization Act of 2003.

Medicare Risk Adjustment

Risk Adjustment is the payment model that CMS uses for contracted Medicare Part C plans. The Risk Adjustment model places emphasis on the health status of the patient.

As a Medicare Part C plan, Quartz Medicare Advantage (HMO) is required to submit claim data to CMS on a routine basis. That data is used by CMS prospectively and data collected in the current year, is used to predict the CMS payment to Quartz Medicare Advantage (HMO) for the following year. CMS uses the diagnosis codes submitted for each individual patient in their formula to determine the payment.

Risk Adjustment data is collected from claims submitted, including hospital inpatient stays, hospital outpatient services, and physician encounters. Demographic variables are also components of risk adjustment payment calculation (e.g., patient age, gender, Medicaid eligibility, disabled status, reason for original entitlement to Medicare, community based or long-term based).

The payment is then risk adjusted according to the health status of the patient. Risk Adjustment factors are based on assignment to disease groups, also known as Hierarchical Condition Categories (HCCs). HCCs are determined by the diagnosis code submitted on the claim by the provider.

The level of Medicare payment is directly linked to diagnosis. It is imperative that providers document and submit all diagnosis codes at the highest level of specificity and that each diagnosis is documented in the medical record. Medical records must be signed and dated pursuant to CMS requirements.

Payment Under the RUGS Methodology

All inpatient Part A services are paid under a prospective payment system (PPS) using a patient classification system of Resource Utilization Groups (RUGS) established and maintained by CMS. Reimbursement shall be 100 percent of said stated rate.

All covered Part A services that are considered within the scope or capability of the skilled nursing facility (SNF) are considered part of consolidated billing (CB) and paid under Part A Facility PPS rate. In some cases, the SNF must obtain some services it does not provide directly. Neither the SNF nor another provider or practitioner may bill Quartz Medicare Advantage for services under Part B, except for services specifically excluded from PPS payment and associated consolidated billing requirements.

Covered services excluded from CB and subject to payment consideration by Quartz Medicare Advantage are established and maintained by CMS. The HCPC procedure codes representing these excepted services separately billable under Part B can be found on the CMS website under SNF Consolidated Billing. HCPC procedure codes excluded from CB are updated as frequently as quarterly and are provided via various CMS online resources.

Quartz Medicare Advantage, at its discretion, will consider payment for services included in CB for a network SNF for certain high-cost drugs, oncology services, and other services. Consideration of payment will only be allowed when the anticipated high-dollar service exceeds 60 percent of the daily RUGS payment. Payment for these services will be at 60 percent of the amount that exceeds the daily RUGS payment. Payment will not exceed $125 above the daily RUGS payment for any given service. Each service must be discussed with Quartz Medicare Advantage as soon as possible after the member is admitted to the SNF. See examples of payment consideration.

Example 1

60% of a $500 daily RUGS payment is $300
High-dollar service part of CB is $400, which exceeds 60% of $500
Quartz Medicare Advantage will consider payment of $60, which is 60% of $100 ($400-$300)

Example 2

60% of a $500 daily RUGS payment is $300
High-dollar drug part is $5000 (80 tablets - 2 tablets, 2 times per day = 20 days)
20 days for $5000 = $250 per day
$250 does not exceed 60% of $500
Quartz Medicare Advantage will not consider additional payment

Subrogation

The subrogation provision of Quartz benefit plans and provider contracts entitles Quartz to recover from a responsible third party when Quartz pays benefits on behalf of a member. Members and providers must cooperate to assist Quartz in protecting Quartz's subrogation rights. Providers must advise Quartz of the existence of a potential third party payor when submitting a claim.

Subrogation efforts will not affect your reimbursement. The intent of subrogation is to secure a recovery from the party responsible for the injuries or illnesses of Quartz members.

Quartz uses Claritev to administer its subrogation recoveries. Claritev may contact the provider for needed information.

Three-Month Grace

Individuals who purchase their health plan through the Health Insurance Marketplace and receive tax credits to help pay for their premium will have a new three-month grace period when they don't pay their premium.

An individual who misses a payment will receive a letter indicating they have entered the grace period. If the premium is paid within the first month of grace, the individual will keep their current coverage. If the member doesn't pay, the member will enter month two of the three-month grace. During months two and three of grace, dental and medical claims will be held until the past due premium is paid. Pharmacy claims will not be covered in months two and three; however, individuals may be reimbursed for covered out-of-pocket pharmacy costs once their premium is paid.

If the full amount of the premium owed is paid in full before the end of the third month, then claims will be paid. If premium is not paid, then the individual will lose their coverage. Claims in the first month will remain paid, and all claims in the second and third months will be denied.

Quartz will send a notification to affected providers when we receive a claim for one of their Quartz patients in the second and third months of the grace period. It will let them know that we may deny payment of the claims incurred during the second and third months of the grace period.

If you have any questions about the three-month grace period, contact your Provider Engagement Specialist.

Pharmacy

The following information is provided to help you understand the prescription drug benefit, address concerns you may have regarding medication coverage, answer benefit-related questions from members, and work within the Quartz system to ensure the best possible care for Quartz Commercial and ACA groups. Please refer to the Quartz Medicare Advantage and/or Medicaid sections for details on pharmacy as it relates to those products.

Prescription Drug Formulary

A formulary promotes the use of the safest, and most cost-effective medications. A formulary is an important tool to help Quartz meet its goal of providing coverage for safe and effective medications in an affordable manner.

Quartz's Prescription Drug Formulary is made up of a list of preferred medications, non-preferred medications, and restricted medications. Preferred medications are the most cost-effective drugs covered by Quartz. Non-preferred medications are those that have suitable alternatives on the formulary, or those that are considered less effective or less safe for most patients. Preferred or non-preferred medications may also be restricted, which means that an approved prior authorization from Quartz is necessary before coverage is granted. When new FDA-approved generic equivalents or biosimilars are approved, the brand product or innovator biologic becomes non-formulary (prescription benefit) or not covered (medical benefit). For exceptions to this benefit, refer to the prior authorization section.

Additionally, some medications may be benefit exclusions; these are specifically excluded from coverage by the prescription drug benefit plan. For most members, benefit exclusions consist of cosmetic treatments, weight modification medications, infertility, sexual dysfunction medications, over-the-counter medication, medical food, and nutritional supplements.

Medications categorized as non-formulary typically have less clinical value compared to other medications classified as preferred or non-preferred. Non-formulary drugs are medications that are not excluded from coverage by benefit, but that the Pharmacy &Therapeutics Process has determined do not meet the needed standard to be on the formulary. Non-formulary drugs are not covered unless there are unique circumstances, and other formulary medications are not clinically appropriate or have been tried and failed or were not tolerated. Coverage of non-formulary medications is evaluated for medical necessity. These medications are not listed on the Quartz formulary.

Some medications administered in the clinic or a practitioner's office require review and an approved authorization from the Quartz Pharmacy Program before medication administration in the clinic. These medications are noted on the Quartz Medication prior authorization List.

How is the Formulary Developed?

Quartz's Pharmacy & Therapeutics (P&T) Process is responsible for creating and maintaining the prescription drug formulary. The P&T Process consists of 5 steps.

First Step: Quartz's contracted Pharmacy Benefit Manager (PBM) will operate their Pharmacy and Therapeutics committee (P&T) for the review, development and management of its multiple formularies.

Second Step: Quartz's medical directors, pharmacy, finance, actuary, and consulting analytics team will meet and investigate the drug impact on Quartz's specific population. The team will provide drug decision category recommendations to the internal Quartz Formulary Workgroup to review and assess the clinical evidence, treatment guideline, value, financial reports, and decisions of the PBM's P&T committee. Then, Quartz will provide and present the drug decision category and drug placement recommendations from Step 2 to the Formulary Workgroup (Step 3).

Third Step: The Quartz Formulary Workgroup will meet to discuss the recommendations from the second step. The Formulary Workgroup will consider and assess clinical evidence, treatment guidelines, financial reports, cost effectivness, member and provider impact.

Fourth Step: The Quartz Pharmacy and Therapeutics (P&T) Committee will review and assess the internal QHS Formulary Workgroup's recommendation, formulary-drug decision category of the PBM's P&T committee, clinical evidence, treatment guidelines, etc. The Quartz P&T Committee will provide their decisions on the drug decision categories and utilization management. These decisions are binding.

Fifth Step: The Quartz Formulary Workgroup will review the P&T Committee decisions and discuss final considerations. The formulary Workgroup will make final drug placement decisions within the parameters of the Quartz Pharmacy and Therapeutics (P&T) Committee's drug designation categories.

Quartz's Pharmacy and Therapeutics Committee is responsible for determining the drug decision category and utilization management. This committee is made up of physicians and pharmacists who care for Quartz members in our community. The P&T Committee meets quarterly to review medications. The committee considers a variety of factors, such as safety, side effects, drug interactions, how well the drug works, dosing schedule and dose form, and appropriate uses. In making these decisions, the committee obtains the most up-to- date information from a variety of sources, including the PBM's materials, published clinical trials, data submitted to the FDA for drug approval, and recommendations from local or national treatment guidelines. Also, the committee solicits input from local practitioners who are experts in the drug class under review.

Quartz's formulary is subject to change at any time. There may be co-pay differences between the various Quartz benefit plans. Some benefit plans may not include coverage for all the drugs listed on the formulary. Questions about drug benefits or medications listed on the formulary can be directed to Quartz Customer Success.

To obtain a copy of Quartz's current drug formulary, visit QuartzBenefits.com/drugformulary. There are multiple formularies listed, and vary based on the member's plan and are specific to their state. Most members use the standard or the standard choice formulary listing. The formulary is also available at Surescripts for electronic prescribing systems that connect to the Surescripts hub. Formulary changes are noted on the website.

Pharmacy Benefit Basics

To meet the wide-ranging needs of the marketplace, Quartz has developed a variety of pharmacy benefits for customers to choose from. Understanding a few basics about each type of pharmacy benefit will help you with some of the questions that your patients may have.

Some of the common features of the Quartz drug benefits are described below. To determine an individual patient's coverage, have them refer to their Schedule of Benefits to determine which coverage is included with their pharmacy benefit.

Deductibles – A deductible is the amount paid out of pocket before the plan pays for covered services. The drug benefit may have a deductible that combines costs for both pharmacy and medical services, or it may only count pharmacy costs. In either case, 100% of the covered drug costs are paid by the member until the deductible is met. Once the deductible is met, the member pays a cost share for covered prescriptions until the end of the benefit year. Deductible amounts with these benefits start at around $1,200 for individuals and $2,000 for families and go up to as much as $10,000/$20,000.

With deductible requirements, the member must have their pharmacy submit claims online to Quartz even though they will be paying 100% until the deductible is met. This is important because the member will get a lower negotiated price and the amount the member pays will be applied toward the deductible amount as tracked in our system.

Member cost share – Once the deductible has been met, (if there is one) the drug benefit provides benefits for

covered drugs for the rest of the coverage period. The patient's share of the cost for each claim may be a copayment, or it may be co-insurance. This amount is paid by the patient to the pharmacy. Quartz pays the rest of the cost of the drug.

Fixed dollar co-payments are usually based on the type of drug. Typical copay tiers for Quartz's benefits are as follows:

Type of Drug	Copay Tier
Preferred Generics	1
Preferred Brands	2
Non-Preferred Brands or Generics	3
Specialty Medications	4

Each tier may have a different copay amount. For example, a common pharmacy benefit sold by Quartz may look like:

- Tier 1 copay of $10
- Tier 2 copay of $35
- Tier 3 copay of $60
- Tier 4 copay of $100

Copayment amounts for each tier will vary among members depending on what benefit plan the employer purchased, however, most Quartz members have a 4 or 5 Tier benefit with a copay structure of $10/$25/$50/$100, with or without a specialty tier. The tier of a medication can be determined by reviewing Quartz's formulary. Copayment tiers are fixed based on formulary status and brand/generic status and are not adjusted based on individual circumstances. A member may have a benefit plan that uses a mixture of flat copays and coinsurance.

Coinsurance is the percentage of the total cost of the drug that a member is required to pay. Coinsurance may range from 0 to 50%, depending on the benefit. Since the prices of drugs can change, the cost share for that drug may also change from time to time. When the patient receives the prescription medication, the pharmacy staff will inform them of the amount of cost share.

Out-of-Pocket Maximums – The prescription benefit may include an out-of-pocket maximum. This is a limit on the share of the cost of covered services during a coverage period. The limit on the benefit may combine out-of-pocket costs for both pharmacy and medical services. Alternatively, it may only count the pharmacy costs.

There are typically individual and family out-of-pocket limits. Meeting the individual limit will result in zero out-of-pocket for that individual for the rest of the coverage period. Meeting the family out-of-pocket limit will result in zero out-of- pocket for the entire covered family for the rest of the coverage period.

So, if the benefit includes a deductible, cost share, and out-of-pocket maximum, there could be three phases during a coverage period:

Deductible ➔ Cost Share ➔ Out-of-Pocket Maximum

Coverage of Drugs – Not all drugs are covered by the Quartz prescription benefit. Some are covered only under specific circumstances. Categories of non-covered drugs are described below.

Exclusions – Some drugs or groups of drugs are excluded from coverage under the Quartz drug benefit. Examples include a drug for cosmetic use or a drug that is classified as a medical food.

Restrictions – Restricted drugs are those that require prior authorization or Step Therapy before you can receive coverage.

Restricted drugs may be preferred or non-preferred. Restrictions are noted on Quartz's formulary.

Non-preferred drugs – Some of Quartz's drug benefits provide coverage for non-preferred drugs at higher copays or the coinsurance amount. Other benefits do not provide coverage for non-preferred drugs without prior authorization. Refer to your patient's Quartz Prescription Drug Rider to find out if your patient's benefit requires prior authorization for non- preferred drugs.

Specialty Pharmaceutical Benefit

Some medications are included in the Quartz Specialty Pharmaceuticals Program. Medications included in the Specialty Pharmaceutical Program are denoted with an "SP-QTZ" on the formulary listing. Medications included in the Specialty Pharmaceutical Program are required to be filled by a pharmacy in the Quartz Specialty Pharmaceutical Network. For additional information on participating pharmacies and the Specialty Pharmaceuticals Program visit the Quartz website at QuartzBenefits.com/pharmacy.

Self-Administered Drugs

Select injectable drugs must be administered by the member or family at home for coverage under the pharmacy benefit. Self-administered drugs (SAD) are not covered under the pharmacy benefit when given by a health care professional in the clinic. Prior authorization is required for SAD drugs to be given by a health care professional in the clinic for coverage under the medical benefit (e.g., Adalimumab, etc.).

Value List

Some employers have purchased a benefit plan that provides a lower copay for selected medications on a Value list that may have a greater impact on medical outcomes. Medications included on the Value list are intended to provide an incentive for staying on therapy by reducing the copayment. These medications are noted by "Value" on the formulary listing.

Quantity Limits

- Some maintenance drugs are covered up to a 100-day supply. The member pays 1 copay for 1-30 days supply, 2 copays for 31-60 days supply, and 3 copays for 61-90 days supply.
- Maximum days supply is 30 days for most other drugs and most Specialty Medications.
- Individually Packaged Items – limited to two packages per copayment (Examples: two insulin vials, two inhalers, two ophthalmic bottles).
- Some maintenance drugs in unbreakable packages may be billed for the days' supply needed (e.g., insulins, inhalers, test strips).
- Certain medications have specific quantity limits as noted specifically on the formulary listing.

Safe Harbor Medications for High-Deductible Plans

Per the internal revenue service (IRS) safe harbor rules, some high-deductible health plans (HDHPs) include coverage of safe harbor medications at $0 copay before the minimum deductible is met. Safe harbor rules include some medications used for hypertension, heart disease, osteoporosis, asthma, diabetes, and depression. Safe harbor medications and supplies are listed on the Quartz Formulary (denoted by [HDHP]). Please contact Quartz Customer Success to find out which plans include $0 HDHP medication coverage.

Pharmacy Program Coordination

The Pharmacy Program is coordinated by pharmacists, pharmacy specialists, and pharmacy coordinators. The program staff develops, and coordinates medication use policy and drug information.. Also, the staff provides the Quartz P&T Committee with scientific support, drug use evaluation services, medication use policy analysis, physician profiling, physician education, and assistance with disease management programs and outcomes research.

Review of Drugs

All new FDA-approved medications, including new molecular entities and new dosage forms or new FDA indications that are not specifically excluded from coverage, are reviewed by staff within 90 days of release to the market or as

updated by the FDA.

- A coverage decision will be made by the P&T committee within 180 days of release to the market.
- Providers may request a review.
- P&T committee members may request a review.

If a review is not possible or desirable within 90 days of market approval or a new drug indication, the P&T Committee will be appraised of the situation and clinical justification of the delay in review will be presented.

Drugs or drug classes not meeting the criteria for a review trigger will be reviewed by the Quartz P&T Committee at the discretion of the Pharmacy Program Director or the P&T Committee Chairperson. Prioritization of the timing of drug reviews by the P&T Committee is based on a variety of factors, including:

- Presence or absence of safety signals, depth, and duration of available safety data.
- Depth and duration of available efficacy data, presence of head-to-head comparisons with existing products.
- Relevance of the indication(s) for Quartz's population.
- Volume of prior authorization requests or volume of non-formulary utilization.
- Opportunities to improve the cost-effectiveness of care.
- Provider or P&T Committee member request.

Pharmacy Program staff monitor a variety of information sources on an ongoing basis to identify triggers for P&T review. Sources of information may include FDA email updates for approvals and safety warnings, review of table of contents for top medical journals and a variety of daily health news email services, drug database updates, interactions with practitioners, HCPCS and CPT published lists.

When a possible opportunity is identified, Pharmacy Program staff discuss the relevance and determine if the criteria for a review have been met. Based on this assessment, the timing of the review is established. Reviews are assembled by clinical pharmacists and consist of a three-stage process. The reviews incorporate biomedical evidence from clinical research in the primary literature, FDA documents, expert opinion, and established national treatment guidelines to determine the efficacy, safety, compliance implications, and cost-effectiveness of the medication. Claims data from Quartz's insured population are used to understand utilization patterns.

Comparisons between the drug being reviewed and existing medications help to determine whether it offers a different or better treatment modality and the place in therapy. The drug's cost is then factored in to determine its relative value as compared to other available therapies.

Based on the review, the Pharmacy Program staff recommends an appropriate formulary status and restriction status for the drug, as well as any applicable prior authorization criteria. The Quartz P&T Process occurs quarterly to review staff recommendations. Based on committee and workgroup consensus, formulary status and restriction is assigned . For medical benefit medications, a formulary status is not determined by the P&T Committee as the medical benefit does not utilize a formulary. Restriction status, quantity limitations, and any prior authorization criteria or other coverage requirements for medical benefit medications may be determined by the P&T Committee.

Factors and ratings of factors used to analyze drug products include:

- Efficacy/effectiveness – Has the drug been proven to be effective in clinical trials? Do the medical experts and the FDA view the new medication as an improvement?
- Safety and side effects profile – What is the difference in toxicity and tolerability compared to alternatives?
- Pharmacokinetics – Are there advantages/disadvantages to specific patient populations (e.g., patients with kidney failure or liver disease)?
- Monitoring parameters – Does the drug have special monitoring parameters (e.g., blood tests)?

- Compliance issues – Does the dosing frequency or duration of therapy offer advantages in compliance over existing therapies?
- Indications/therapeutic need – Does another covered medication deliver similar benefits?
- Cost – What is the incremental cost versus the incremental benefit of this drug compared to alternative therapy?

The factors weighing most heavily in drug evaluations are efficacy and safety. Cost is considered in terms of the value a product provides from outcomes or when two or more products have similar efficacy and safety profiles or when the benefits provided by the drug are small relative to the cost. When reviewing cost as a factor in the decision, a long-term perspective will be taken for the cost analysis (three to five years). Using a longer-term perspective account for anticipated changes to the marketplace (new entrants, utilization shifts) as well as pricing (generic availability, more aggressive pricing due to additional competition) and results in a more stable formulary for members and providers.

The P&T Committee evaluates the clinical quality of drug products. The following examples illustrate the way distinct factors are used in determining how a drug is placed on the formulary.

- Drugs that are less costly and provide better outcomes than current therapies are preferred.
- Drugs that are more costly and are not better than current products are non-preferred.
- Drugs that are less costly and are not better than alternative therapies require deeper analysis. In some cases, when the drug is only slightly less effective than alternatives, the consequences of treatment failure are not serious, and the cost difference is significant, patient, provider, and Quartz cost become considerations.
- Drugs that are more costly and provide better outcomes than current medications require deeper analysis. In some cases, when the drug provides only slightly better outcomes that are not considered significant in terms of a patient's overall treatment results, and the drug is significantly more expensive than alternatives, patient, provider, and Quartz cost become considerations.

Formulary Decision-Making Process

Medication Prior Authorization

A medication prior authorization request may be started by members, providers, or designated representatives. Quartz strongly recommends that you, the health care provider, initiate the prior authorization request process on behalf of your patient. This ensures that relevant medical history and information are included with the request, allowing for timely decision making based on all the relevant information. The prior authorization criteria are available on the Quartz website.

For prescription authorization requests, this can be initiated electronically on Quartz's website, by using e-PA, by telephone, or by mail. Electronic (e-PA) via Surescripts verifies member eligibility and member benefit information. The PBM sends back e-PA criteria questions to the provider staff which can be answered, and medical records can be attached to the request.

Alternatively, for medical benefit medications, authorization requests can be initiated by Health Link, or MyQuartz Tools.When a prior authorization request is submitted, including any case-specific circumstances that can be considered, there are two types of requests:

- Standard – for a standard request, the Medication Coverage Request Form should be completed by the prescriber and submitted online or via fax. We will accept standard request forms from members or their authorized representatives but recommend having the health care practitioner complete the forms as the medical history required to make a timely decision can be more adequately provided. Quartz makes decisions on standard requests within 72 hours up to 15 calendar days depending on how quickly the information is received and based on state-specific regulatory timelines. Notification of the decision will be provided to the requesting provider via fax and members via mail.

- Urgent – An urgent request is defined as a request in a situation when making routine or non-life-threatening determination could jeopardize the patient's life or, health, or safety of the patient or others, due to the patient's psychological state, or in the opinion of the practitioner (as provided in documentation) would subject the patient to adverse health consequences without the medication being requested being available in an expedited manner.

    - For an urgent request, the Medication Coverage Request Form should be completed by the prescriber and submitted online or via fax. We will accept standard request forms from members or their authorized representatives; however, the clinical reason for urgent need must be documented. If the urgent need is not documented, it may be treated as a standard request.

    - Coverage determination for an urgent request for new medication therapy will be decided within 24-72 hours, depending upon regulatory timelines based on individual state unless more information is needed and in which case, the provider will be given an additional 48 hours to respond. Additional information will not be requested if not provided for exception requests.

    - Coverage determination for an urgent request for a medication the patient is currently taking will be decided within 24 hours. Another option is to file a standard request and use Quartz's Emergency Drug Supply or New Member Drug Supply to obtain the medications while prior authorization is in process.

Step Therapy Exceptions – Step Therapy Exception Requests are submitted via the prior authorization process. Step therapy requires members to try the more cost-effective medication before "stepping up" to coverage of more expensive medications. Requests are reviewed based on specific prior authorization criteria and conditions established by state or federal law. Documentation to support an exception to the step therapy protocol may include that required first-line drug(s) were previously tried for an adequate time and were not effective, not tolerated or contraindicated; or, information about the clinical situation makes required first-line drug(s) likely to cause mental or physical harm and are not appropriate due to unique patient characteristics or drug characteristics; or, if the person is currently stable on the requested medication and it was covered under the immediately preceding health plan.

Non-Formulary Exceptions – Non -Formulary Medications Exceptions Requests are also submitted via the Medication Coverage Request Form. Requests are reviewed by pharmacists or physicians, based on individual state requirements,

and considered for medical necessity.

Emergency Drug Supply Policy – Quartz members can get a five-day supply of restricted medication at no copay for emergency or urgent situations in which a prior authorization cannot be obtained, unless prior authorization was denied within the past month, the medication is excluded, or the medication is in the Quartz Specialty Program (e.g. TNF inhibitors, Hepatitis C medications, Multiple Sclerosis disease-modifying agents, etc.). Members, pharmacy staff, and provider staff can call Optum Rx Member Services at (800) 496-7509 to get this authorization. A prior authorization still needs to be submitted for consideration of coverage beyond these five days and a five-day supply does not guarantee continued coverage.

New Member Drug Supply Policy – Members who are new to Quartz and are currently taking a restricted medication can get three one-month fills within the first 90 days of eligibility. Members, pharmacy staff, and providers can call Optum Rx at (800) 496-7509 to get this authorization. Members who are new to Quartz Medicare Advantage and are currently taking a restricted medication can get a 30-day supply within the first 90 days of eligibility. Members will automatically have this benefit applied at the pharmacy, and a call is not necessary. A prior authorization still needs to be submitted and approved for consideration of coverage after the three month allowance.

Comments, Questions, or Suggestions?
Call Quartz Customer Success: (800) 897-1923

Provider Network Management

Provider Office Changes

Quartz requests timely notification of significant changes within your organization so that we can ensure accurate claims processing, notification to providers and members, and continuity of care processes. You can complete the appropriate change form at QuartzBenefits.com/providerforms. All forms are submitted electronically through our website. Follow-up communication is not sent once the submitted form has been processed unless credentialing is required.
Please notify Quartz as soon as possible of any changes.

Practitioner Changes

- If a new practitioner joins your clinic, notify Quartz via the Practitioner Notification Form. When Quartz receives the completed form, it will be reviewed, and you may be contacted if additional information is needed. If credentialing is required, the credentialing process will commence. If additional information is not needed, Quartz will process the form as submitted without follow-up communication.
- If a practitioner leaves your clinic, notify Quartz via Practitioner Notification Form. If the practitioner is relocating to a location within Quartz's service area, and in some situations, out of the service area as directed under the No Surprises Act, the practitioner may need to follow continuity of care guidelines.
- If you have updates to a practitioner, notify Quartz via the Practitioner Notification Form. Updates may include:
    - If an existing practitioner with your organization is adding or terming a practice location;
    - When a practitioner changes their name, specialty, degree/credentials, licensure; or,
    - Status at a practice location change, such as no longer accepting new patients.

Facility Changes

- If a new facility or location is added, notify Quartz via the Facility Notification Form. Depending on the type of your new facility, a site visit may be required before Quartz members may receive services at the new location.
- If a clinic or facility is no longer available to our members, notify Quartz via the Facility Notification Form.

Initial Practitioner Credentialing

Credentialing is an important process Quartz uses to ensure that we offer quality care to our members. Quartz's credentialing and recredentialing processes follow National Committee for Quality Assurance (NCQA) guidelines for the acceptance, discipline, and termination of practitioners based on the practitioner's education, training, and history.

The Credentialing Committee makes all credentialing and recredentialing decisions. The committee reserves the right to determine, based on a practitioner's credentials, which health care practitioners are eligible to participate in Quartz's network. Practitioners are required to complete the credentialing process and be approved by the Credentialing Committee before treating Quartz members. Practitioners are considered payable providers on their credentialing approval date; Quartz does not back-date the payable date to the practitioner's hire date.

All providers must meet the certifications and requirements set forth within their state, where applicable.

When a new practitioner joins your facility, please complete and submit the Practitioner Notification Form. This form must be completed and submitted for all new practitioners joining your facility. If credentialing is required for the practitioner, Quartz will work with our Credentialing Verification Office (CVO) to gather the practitioner's credentialing application from CAQH (Council for Affordable Quality Healthcare, Inc.) to start the credentialing process.

Quartz requires the practitioner's CAQH identification number to be submitted on each Practitioner Notification Form. If your facility is adding a new practitioner who seeks to join the Quartz network, please ensure the practitioner has created a profile with CAQH before communicating the practitioner to Quartz. The CAQH identification number will be a critical piece of information needed for the Quartz credentialing process. If a practitioner doesn't have a CAQH profile, they are asked to

create a profile at CAQH.org. If the required documentation is incomplete or missing with CAQH at the time of credentialing, this can delay the application process and credentialing approval time.

Typically, the credentialing process will take less than 90 days. If your facility requests to join Quartz, the process may be extended due to a provider agreement also being needed.

Quartz Medical Directors and/or the Quartz Credentialing Committee will review all credentialing applications. Clean credentialing files are approved every week. Unclean credentialing files with malpractice history, license orders, etc. need to be reviewed by the Quartz Credentialing Committee, which meets monthly. The Credentialing Committee and/or Medical Director reviews the completed file and either accepts, accepts with restrictions or conditions, or denies the application.

Credentialing approval notifications are sent to the practitioner or their facility within 14 days of regarding the credentialing approval.

In the event a practitioner is denied credentialing approval, an appeal process is offered to practitioners. This allows the practitioner an opportunity to clarify or correct the information submitted.

Practitioners Subject to Credentialing

- Physicians (MD, DO, DPM, OD)
- Nurse Practitioners and Midwives
- Physician Assistants
- Behavioral Health (MD, PhD, PsyD, ACADC, CADC, CSAC, LADC, LCPC, LCSW, LICSW, LISW, LMFT, LMHC, LMSW, LPC, LPCC, MSSW, SAC)
- Genetic Counselors
- Radiation Oncologists
- Pain Management Anesthesiologists
- Oral Surgeons
- Dentists (who provide sleep apnea appliances only) (DDS, DMD, MD, DO)
- Any practitioner providing telehealth services

Practitioners NOT Subject to Credentialing

- Anesthesiologists (unless they provide pain management services)
- Audiologists
- Autism practitioners
- Behavioral Health in-training providers
- CRNAs
- Dentists: General Dentists, TMD/TMJ practitioners, and Orthodontists
- Dieticians
- Emergency Room providers
- Hospice or Palliative Care providers
- Independent Contractors
- Locum Tenens of credentialed providers
- Pathologists
- Physical Therapists
- Occupational Therapists
- Radiologists (unless they provide radiation oncology services)
- Registered Nurses
- Speech Therapists
- Urgent Care providers

Qualified Treatment Trainee

A Wisconsin 1Qualified Treatment Trainee (QTT), also referred to as an in-training practitioner, will become payable for Medicaid members immediately. A QTT will become a payable provider for commercial members after they have been licensed for a minimum of 12 months and are actively working towards completing supervised training. Quartz does not require notice once the QTT has been licensed for 12 months, as we will monitor this. QTTs are not limited to members; they can render services based on age and location.

Quartz defines a QTT as a person with a graduate degree working on their supervised practice requirements for full clinical licensure. Wisconsin requires 1,000-3,000 hours of supervised training, depending on the type of license being sought, to be eligible for full licensure. Typically, a person is licensed as a QTT for two to three years while completing the needed supervised training. Quartz acknowledges the following types of practitioners as a QTT:

- Professional Counselor Training License
- Substance Abuse Counselor-In-Training
- Marriage and Family Therapist Training License
- Advanced Practice Social Worker

The QTTs will not be eligible for credentialing until they become fully licensed, nor are they eligible to be listed in Quartz's Find a Doctor provider search tool until they are fully licensed and credentialed.

Quartz will process practitioners licensed as an APSW as a QTT following the processes listed above. The APSW will not be listed in the Quartz provider directory, nor will they be subject to credentialing with Quartz while licensed as an APSW. Once the APSW obtains their LCSW license, they will be eligible for credentialing and listed in the provider directory and Find A Doctor provider search upon successful credentialing.

Special Temporary Permits

In accordance with WI Act 10, Quartz will allow the Special Temporary Permit licenses.

- Quartz will accept the Wisconsin Department of Safety and Professional Services license with the Temporary Special Permit issued to practitioners. Only practitioners who hold current, unrestricted licenses in other states are eligible to apply for a Temporary Special Permit license in Wisconsin.

- Practitioners with the Temporary Special Permit license are eligible for credentialing and will become a payable provider upon successful credentialing approval.

- Credentialing Delegates who submit practitioners with the Temporary Special Permit licenses are eligible to be set up as payable providers on the credentialing date as listed by the delegate.

- Practitioners with the Temporary Special Permit licenses are NOT eligible to be listed in Find A Doctor (FAD), nor are they eligible to be a PCP, until their full license is issued.

- Practitioners with the Temporary Special Permit licenses are allowed to be paid for all lines of business under which their facility is contracted.

- Quartz staff will monitor the practitioner to determine when the practitioner is issued their full license.

- Once the practitioner, who was previously approved for credentialing by Quartz, has received their full license, Quartz credentialing staff will notify networkdevissues@quartzbenefits that the practitioner's full license has been issued and that they can now be listed in FAD and be set up as a PCP, if applicable.

- In the event the practitioner doesn't receive a full license by the Wisconsin Department of Safety and Professional Services and their Temporary Special Permit license expires, the practitioner will be removed from the Quartz network and no longer considered a payable provider.

- **Temporary Licenses**
  Providers with temporary licenses (excluding temporary special permits) are not eligible for credentialing with Quartz, but are instead set up as payable providers with Quartz and are not listed in the Quartz Find a Doctor provider directory.

Interim Licensed Psychologists

In accordance with Wisconsin Act 22, the following applies to practitioners who are Interim Licensed Psychologists:

- The Interim Licensed Psychologist can be considered payable for commercial members.
- The Interim Licensed Psychologist can be considered payable for Medicaid, but must be Medicaid certified.
- The Interim Licensed Psychologist can be considered payable for Medicare, but must be Medicare certified.
- The Interim Licensed Psychologist will be considered payable on the date they obtain their license if they were an existing employee, or when they start work with the contracted entity if already licensed as such.
- The Interim Licensed Psychologist will not be eligible for credentialing with Quartz.
- The Interim Licensed Psychologist will not be listed in our Find A Doctor provider directory. Once fully licensed, they are eligible to be listed in the provider directory.
- Once the practitioner obtains their full license, they are asked to notify Quartz of this change, which will then allow them to be listed in the provider directory.

Telehealth Services

Telehealth laws for out-of-state members generally require the practitioner to be licensed in the member's state of location, as care is considered to be rendered there. Practitioners need to verify the specific licensure and regulatory requirements of the state where the member is located before rendering telehealth services. For instance, if the member is physically in Colorado, but the practitioner rendering the telehealth service is physically located in Wisconsin, the practitioner must be licensed in the State of Colorado and in the State of Wisconsin.

Practitioner Recredentialing

Recredentialing takes place every three years. A similar process that is used for initial credentialing is followed for the recredentialing process, using the CAQH application.

Practitioner Rights

Practitioners have the right to review the information submitted in support of their credentialing application and to correct erroneous information that was reviewed by the Credentialing Committee. Quartz's credentialing staff will notify the practitioner of any information obtained during the credentialing process that varies substantially from the information provided to Quartz by the practitioner. The practitioner has up to 30 days to submit corrections to Quartz. The practitioner also has the right to request application status during the credentialing or recredentialing process and has the right to appeal the Committee's decision in the event of a denied application for credentialing or recredentialing.

Credentialing Confidentiality Policy

Access to information obtained during the credentialing process will be carefully monitored and will not be released to outside parties without permission of the practitioner involved, or as permitted by law, including the Health Care Quality Improvement Act of 1986.

Access to the credentialing data in Quartz's provider database is limited to those with "a need to know." This includes the Credentialing Committee, the credentialing staff, and the Quartz Medical Director or appropriate network medical directors.

An individual practitioner may request to review the information contained on file (except for information obtained from the National Practitioner Data Bank or peer review sources). To request a review, please call Quartz's Credentialing Department at (608) 881-8233.

Practitioner Termination

The Wisconsin Department of Health Services (Department) is responsible for monitoring and termination of practitioners from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed

below. The Department will inform Quartz when a practitioner is terminated from the Wisconsin Medicaid program for cause, and Quartz must terminate that provider from its network for the following reasons:

- Criminal Conviction
- Failure to Comply with Screening Requirements
- Failure to Submit Fingerprints
- Failure to Submit Timely and Accurate Information
- Onsite Review
- Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment
- Provider Conduct

Quartz may terminate a practitioner for cause in any of the following circumstances:

- Abuse of Billing Privileges
- Billing with Suspended License
- Improper Prescribing Practices
- Misuse of Billing Number
- Noncompliance with Licensure Standards
- Prescribing Authority

Quartz must notify DHS OIG and the Managed Care Analyst when it terminates a practitioner for cause and report to other entities as required by law (42 USC 11101 et seq.).

Facility Credentialing

Quartz requires initial credentialing and recredentialing of all hospitals, nursing homes, home health agencies, freestanding surgical centers, and behavioral health facilities providing mental health or substance use disorder services in an inpatient, residential, or ambulatory setting, per NCQA standards. Other contracted facilities can be reviewed at the discretion of Quartz. Site visits may need to be performed in the event that the facility is not accredited and has not had a CMS or state survey conducted at its facility within the past 36 months.

The facility must complete a Provider Participation Request form before contracting. Quartz will assess the facility and confirm it has met the following:

- Met all appropriate regulatory requirements.
- Provided copies of the current facility state licensing certification.
- Provided evidence of Medicare and Medicaid certification, including provider numbers.
- Provided copies of their most recent state/Critical Access Hospital/CMS survey results.
- Provided copies of recognized accrediting bodies such as The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAASF), Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Community Health Accreditation Program (CHAP), Council on Accreditation (COA), Det Norske Veritas Healthcare, Inc. (DNV), Healthcare Facilities Accreditation Program (HFAP).

Upon facility credentialing approval, the contracting process may commence. If the facility has not had a state/Critical Access Hospital/CMS survey within the past 36 months, Quartz staff will conduct an on-site audit in lieu of the survey results.

Facilities are required to be recredentialed and successfully approved every 36 months to remain a contracted facility in the Quartz network. A Facility Recredentialing Form will be sent to facilities to conduct the recredentialing process, in which the above-bulleted items will be obtained and reviewed by the Credentialing Committee.

Physician Office Audits

Quartz strives to provide its members with access to quality care. Therefore, Quartz reserves the right to conduct site visits of practitioner offices.

The site visit is a structured review of the quality of key elements of the facility and includes:

- Physical Access and Accessibility
- Waiting, Exam, and Restrooms
- Fire and Safety
- Medical Record-Keeping Practices
- Control of Medications
- Policies and Procedures
- Confidentiality
- Infection Control

An audit may be triggered by member complaints. If a member complaint is made regarding clinic physical accessibility, appearance, or adequacy of waiting room or exam rooms, the Credentialing Specialist will conduct an on-site audit, using a tool approved by NCQA.

If the clinic is found to be deficient in any area, a corrective action plan will be required. The clinic will have the opportunity to make correction(s) and become compliant. The final audit results will be presented to Quartz's Credentialing Committee.

Quartz will make every effort to assist the facility in achieving compliance. However, if compliance cannot be obtained, the Credentialing Committee may act, up to and including a recommendation that Quartz terminate its contract with the facility or provider.

Promotional Marketing Assistance

All marketing materials that reference Quartz Health Solutions, Inc., or other Quartz entities require written prior approval by Quartz's Marketing Department. Quartz's Marketing Department is available to assist you with the proper use and approval of Quartz's references in your promotional materials or links from your website. Please contact your Provider Engagement Specialist.

Marketing activities for Quartz health plans are strictly regulated by the Wisconsin Office of the Commissioner of Insurance, the Iowa Insurance Division, the Illinois Department of Insurance, and the Minnesota Department of Health.

Provider Engagement Specialists and Contract Managers

Quartz has dedicated staff to work with you:

- Provider Engagement Specialist to service your clinic/facility needs.
- Contract Managers to assist with contract needs.

Your representatives are assigned based on the county in which your primary facility or business office is located. Initial inquiries to Quartz can be made to Customer Success via the provider portal My Quartz Tools or by calling the dedicated provider line (800) 897-1923.

My Quartz Tools

My Quartz Tools is a secure, online provider portal that can be used by Quartz providers to perform administrative tasks. Training materials, including user guides and video tutorials, are available within the portal. My Quartz Tools does not house details about members with self-funded plans.

The portal is available 24/7, offering you the latest information and answers to your questions with details pertaining to:

- Patient Eligibility
- Member Demographics

- Submitting and Viewing Prior Authorizations
    - Immediate decisions following MCG guidelines, including the ability to attach documentation electronically.
    - Prior authorizations are required to be submitted through the portal.
    - When submitting through the portal CPT/HCPCS codes are required, Custom Codes cannot be used.
- Viewing Remittance Advice
- Claim Status and Denial Descriptions
    - Claim reconsiderations can be submitted to Customer Success by selecting "Ask a Question".
- Summary of Benefits & Coverage in real-time
- Benefit Riders
- Secure messaging directly to Customer Success

My Quartz Tools offers the ability to message Quartz Customer Success through the – Ask A Question function and receive a response within 24 hours. My Quartz Tools is not meant to replace the services offered by Quartz Customer Success. Should you need to contact Customer Success, please call (800) 897-1923, Monday through Friday, 8 a.m. – 5 p.m. For assistance outside of these hours, we encourage you to use the provider portal My Quartz Tools.

If you are experiencing a trending claim issue; the same issue affecting ten or more claims, please submit a message to Quartz Customer Success via the Ask A Question tool to verify if it is a known issue. Quartz Customer Success will work directly with your Provider Engagement Specialist for a resolution.

Access within My Quartz Tools

If you are a new contracted provider entity, please complete the online form: My Quartz Tools Online Access Request Form. After you have returned the Access Request Form, the Provider Network Management Assistant will set up access for the designated Site Administrator within your organization. This person will be able to access the details referenced above and can add Users within your organization to grant access to the portal.

If you are a current provider and need access, please contact Quartz Customer Success to find the assigned Site Administrator of your organization.

Forgotten Password/Username

If you are the Site Administrator, you will be able to reset your users' passwords at any time. If you have forgotten your password for My Quartz Tools, simply click on the My Quartz Tools login from Quartz's website, enter your username, and choose "Forgot my password." You will be prompted to enter your username again. Next, choose the "Email Password" option. A new password will be emailed to you immediately. If you are a Site Administrator who has not set up challenge questions you will be unable to reset your password and will need to contact Customer Success at (800) 897-1923.

MyPlanTools

MyPlanTools is a secure online tool that is used by Quartz providers to complete the annual Facility Operations Form (FOF) and the quarterly No Surprises Act verification, which also includes compliance with the quarterly CMS verification process. MyPlanTools is also used by our Primary Care Providers to access our vendor tool, Collabor8, for risk management. A separate username and password are used to access Collabor8.

Facility Operations Form (FOF)

Annually, each Quartz provider will be required to go to MyPlanTools to confirm a variety of demographic information that is required to ensure accurate provider directories and to meet regulatory requirements. As a Quartz contracted provider, filling out the annual Facility Operations Form (FOF) provides data accuracy for timely and seamless claims processing. The demographic information also ensures the information you are confirming is the most current data for patients/members when searching for providers and locations on our Find a Doctor provider search tool.

The annual FOF completion confirms that Quartz and you, as a contracted provider, comply with No Surprises Act legislation (H.R.3630 — 116th Congress), CMS rules (Medicare Advantage and Affordable Care Act), DHS rules (WI BadgerCare Plus and Medicaid SSI), NCQA quality assurance measures, and the State of Wisconsin Employee Trust Fund

requirements.

Your assistance in providing accurate and updated data allows us to be a CMS 5 Star Plan, to meet the highest NCQA and HEDIS® standards, and to ensure patients/members are receiving the highest quality care.

If you are the designated point of contact for this task, Quartz will contact you annually via email in January. The email will include further guidance, requesting you to log into MyPlanTools to verify the information and complete the required elements. You will continue to receive an email notification every two weeks until the information has been completed.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

No Surprises Act (NSA) Quarterly Verification

Under Sec. 2799A-5 – Protecting Patients and Improving the Accuracy of Provider Directory Information of the NSA, healthcare providers must comply with regulations that help protect patients/members from unexpected medical bills. Part of this protection falls under Section 116, in which health plans must verify provider directory accuracy every 90 days.

If you are the designated point of contact for this task, Quartz will contact you quarterly via email. The email will include further guidance, requesting you to log into MyPlanTools to complete the verification to comply with the 90-day provider directory verification requirement under Section 116 (a)(2)(A). The annual FOF sent to providers in quarter 1 will meet this NSA quarterly requirement. If you do not complete each quarterly verification by the end of each quarter, you will be subject to removal from the provider directory until the verification is completed, as indicated in Section 116 (a)(2)(B) of the Act: "…that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer…". You will continue to receive an email notification every two weeks until the information has been completed.

The NSA quarterly verification is also the process Quartz uses to comply with Medicare Advantage provider directory update requirements for contracted Medicare Advantage providers outlined in the Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, Section 110.2.2.

Provider Directory Accuracy

Provider directories are an important tool members, potential members, providers, brokers and others use to select and contact physicians and other contracted providers who deliver medical care. In accordance with State and Federal guidelines, plans must maintain accurate online provider directories that include active, contracted providers. Members and their caregivers rely on provider directories to make informed decisions regarding their health care choices. Inaccurate provider directories can create a barrier to care and raise questions regarding the adequacy and validity of the Quartz networks.

State and Federal regulatory bodies, including but not limited to CMS may randomly survey Quartz's on-line provider directory. It is imperative that the office staff can identify if they accept the various Quartznetworks at that location for the provider in question.

National Provider Identifier Enumeration System (NPPES)

As a Quartz contracted provider, we are here to remind you that your National Provider Identifier (NPI) data in the National Plan & Provider Enumeration System (NPPES) needs an annual review to ensure accurate data is displayed. Providers are legally required to keep their NPPES data current. Centers for Medicare & Medicaid Services (CMS) encourages Medicare Advantage Organizations to use NPPES as a resource for our online provider directory. By using NPPES, we can decrease the frequency with which we contact providers for updated directory information and provide more reliable information to Medicare beneficiaries. When reviewing your NPPES data, please update any inaccuracies in modifiable fields. This includes (but is not limited to) provider name, mailing address, telephone and fax numbers, and specialty. Be sure to include all practice addresses where you are actively servicing patients. Along with the phone number, patients can contact to schedule appointments. Remove any addresses and/or phone numbers that are no longer actively used. Once you have updated your information, you will need to confirm it is accurate by certifying it in NPPES. Remember, NPPES has no bearing on billing Medicare Fee-For-Service.

Clinical Care Management Programs & Services

At Quartz, our motivation is to partner with our provider network to keep our members healthy. We offer innovative and inclusive programs to support physical, mental, and social well-being— whole person healthcare . Our portfolio of programs is well-positioned to augment clinical care for the most prevalent chronic conditions: obesity, type 2 diabetes, high blood pressure, congestive heart failure, and high risk conditions like maternal and child health. We also provide an age-specific wellness guide to support members in their engagement in preventive care.

Quartz Clinical Services staff communicate with providers and members throughout the year to offer evidence-informed guidelines, program resources, recommended labs and screenings, self-management tools, and engagement opportunities through Quartz and within their medical home or community. Members are made aware of Quartz Clinical Services and Care Management Programs through curated communications that are sent via e-mail, MyChart, or telephonic outreach.

Quartz's clinical programs are available to eligible members at no additional cost and participation in the programs is voluntary. Each program provides a variety of services for the prevention, management, and/or treatment of prevalent conditions. The overarching goal is to promote member engagement and self-management in their personal health care journey through innovative resources that augment the care from their primary medical team.

General membership resources include:

- Reminders about necessary screenings and exams and recommended frequency of practitioner visits via the age-specific wellness guide.
- Inclusive access to care management programs and complex case management for multiple and/or chronic medical and behavioral conditions.

Quartz Clinical and Care Management Programs include:

- Obesity & Type 2 Diabetes - Quartz works closely with our provider owners to offer integrative care for members with obesity and/or type 2 diabetes. This includes one-on-one coaching, medication support and individualized therapies.
    - Prediabetes/Obesity - Quartz offers support for members to take proactive steps to protect their health before diabetes begins. Eligible members can access proven programs, personalized support, and expert guidance. These resources are designed to help members build healthy habits, manage their weight, and lower their risk of developing Type 2 diabetes. For more information https://quartzbenefits.com/health-wellness-program/
    - Diabetes - Quartz helps members manage their diabetes with confidence. Eligible Quartz members have access to personalized support, necessary devices like a glucose monitor and digital scale, and resources to stay on track with their health goals. For more information, visit: https://quartzbenefits.com/providers/resources-for-your-patients/asthma-and-diabetes-program/
- High Blood Pressure and Congestive Heart Failure – This Care Management program supports members diagnosed with high blood pressure and/or congestive heart failure. Quartz can provide tools and support to members to help them self-manage their chronic condition. For members enrolled, Quartz Registered Nurses can provide insight on how to manage the diagnosis more effectively. Members may receive medical equipment, including a blood pressure monitor or scale. Providers can also order a BP monitor or home scale for their patients by completing the Quartz Self-Monitoring Equipment order form.
- Lifestyle Change program - This program is designed to support members with obesity and prediabetes to prevent type 2 diabetes. We offer supportive, learning opportunities, and resources from recognized diabetes prevention programs. The programs are available at no additional cost to members with prediabetes or an elevated risk. To identify a national diabetes prevention program or Medicare diabetes prevention program visit: https://www.dhs.wisconsin.gov/prediabetes/control.htm .

- Maternal and Newborn - A growing family can be exciting, and it can bring new challenges. The Quartz Care Management team is here for you with resources that support social and mental well—being through your pregnancy and the first 12 months of your child's life. Additionally, all commercial birthing members are eligible to receive non-clinical support from a local or virtual doula. Pregnancy resources are available at www.QuartzBenefits.com/Baby. To sign up, call Quartz Care Management at (866) 884-4601.
- Care Management - Registered nurses, behavioral health specialists and other health care professionals are available to collaborate with members and providers. This service helps members manage their healthcare needs while addressing physical, behavioral, cognitive, social, and financial priorities. Care Management is available to members at no additional costs. Members can opt out of the program anytime by notifying their care manager. To sign up, call Quartz Care Management at (866) 884-4601.
- Quartz Well Rewards – A digital wellness program for eligible members, focused on personalized goals, healthy habits, and tracking smart choices. Sync your favorite tracking device or compatible mobile apps. Earn rewards for creating lasting healthy habits and progress toward a healthier you.
- Quartz mental well-being programs with AbleTo – This program makes it easy for members to find the mental health support they deserve on their time. Eligible members get 24/7 access to digital self-care tools, plus the option to schedule one-on-one coaching or therapy within five business days. For more information, visit: https://member.ableto.com/quartz/
- Quartz Nourishing Meal Program – This food is medicine program supports eligible members with medically tailored heat-and-eat meals upon discharge from the hospital or when experiencing a high risk pregnancy. Medicare Advantage and Medicaid members with cardiovascular disease or diabetes are eligible for meals following a qualifying inpatient stay.

Provider resources and services include:

- Curated reporting from Quartz's Population Health and Clinical Quality teams to depict care gaps for shared patients. Information about how to contact Quartz to ask a question or enroll/remove a member from a health management program is provided on the Quartz Health and Wellness site.

Shared Decision-Making

Shared decision-making is collaboration between patients, their loved ones, and their providers to achieve a care plan that is centered on the patient. It is especially useful when there is no clear "best" treatment option.

Quartz encourages healthcare providers to use shared decision-making methods with their patients and provides some interactive shared decision-making tools. These tools are updated frequently and include different health topics such as:

- Adolescent & adult vaccinations: This Centers for Disease Control (CDC) website houses a wealth of information about vaccinations as well as a quiz that can help adults and teenagers learn about recommended vaccines.
- Alcohol abuse & dependence screening: This tool from the CDC helps patients determine if they have a drinking problem. Patients are encouraged to see a health care provider if they think they may have a problem, no matter what the screening score.
- Asthma control test: These surveys help determine if your patient's asthma is under control. Many other tools are available from asthma.com.
- Breast Cancer Risk Assessment: The Breast Cancer Risk Assessment Tool (BCRAT), also known as the Gail Model, helps health care practitioners estimate a woman's risk of developing invasive breast cancer.
- CAT questionnaire for COPD: The CAT is a short questionnaire for people with chronic obstructive pulmonary disease (COPD) and provides a framework for discussions with patients and enables the provider and patient to gain a common understanding and grading of the impact that COPD has on their lives.
- Depression screening: PHQ-2, PHQ-9: The PHQ-2 and PHQ-9 are simple tools for patients to assess their symptoms related to depression. The survey will help them determine whether further evaluation from a health care practitioner could be helpful.
- Prostate cancer screening: The American Cancer Society has a resource to help patients learn about prostate cancer screening tests, including PSA blood test and digital rectal exam (DRE).

Quartz clinical practice guidelines

The clinical practice guidelines below are resources for in-network providers and members. They are not a substitute for a provider's clinical judgment or recommended plan of care. Coverage of services mentioned in the guidelines may differ depending on the individual's health plan and does not imply or guarantee coverage. Please review the health plan coverage to determine benefits or contact Quartz Customer Success to confirm.

View the clinical practice guidelines and resources adopted by Quartz below.

Organization	Category
American Heart Association	Heart disease
American Diabetes Association	Diabetes
American Psychiatric Association	Behavioral health
US Preventive Services Task Force	Preventive care
American Society of Addiction Medicine (ASAM)	Clinical resource
Bright Futures- Well Child Care	Bright Futures Guidelines and Core Tools
Advisory Committee on Immunization Practices (ACIP)	ACIP Vaccine Recommendations and Guidelines
Advisory Committee on Immunization Practices (ACIP)	Immunization Schedules
American Society of Metabolic and Bariatric Surgery (ASMBS)	Clinical resource

International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)	Clinical resource
National Comprehensive Cancer Network Treatment by Cancer Type	Detection, Prevention, and Risk Reduction Supportive Care Specific Populations Guidelines for Patients
American Society of Hematology Venous Thromboembolism	Clinical resource
World Professional Association for Transgender Health SOC8 Homepage – WPATH World Professional Association for Transgender Health	Clinical resource
American Academy of Sleep Medicine Sleep Medicine Guidelines	Clinical resource

Quartz is committed to the ongoing improvement and evaluation of the quality and safety of medical and behavioral health care services provided to members. Quartz credentials a comprehensive practitioner network that delivers high quality, cost-effective care. The Quartz Population Health & Quality Program team is charged to facilitate this commitment and follows these guiding principles:

- Seek to maximize the quality of care and services received by members.
- Elicit involvement, input, and support from our practitioner network.
- Recognize and value preventive health care and health maintenance.
- Communicate our efforts to members and actively seek feedback for improving care and services.
- Monitor and evaluate the services and care provided to members.
- Committed to providing superior service, without discrimination, to all members including those who have special needs and those who are at high risk of developing special needs.
- Strive to serve a culturally and linguistically diverse membership efficiently and without discrimination.

The Population Health & Quality Program team objectively, systematically, and continuously monitors, evaluates, and improves the delivery of health care and related services provided to members in partnership with our provider network. Collective goals to promote population health and clinical excellence include:

- Provide high-quality, accessible, cost-effective health care.
- Establish outcome measures to monitor the quality of care members receive.
- Participate in annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection and reporting.
- Elicit and support practitioner participation in quality improvement activities and collaborate with provider organizations to enhance and assist with quality improvement programs.

- Assess member satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey.
- Monitor access and availability of practitioner services in collaboration with the Provider Network Management Department.
- Monitor adverse events.
- Promote preventive services and wellness initiatives.
- Identify chronic medical and behavioral health conditions relevant to members and implement Disease Management and Complex Case Management programs for monitoring recommended services, supporting self-management skills, and providing disease-specific education.
- Assess the membership for relevant social determinants of health.
- Identify opportunities for improvement in the areas of clinical and behavioral health practice, service, and safety.
- Advocate and innovate to create equitable outcomes. Develop or adopt evidence-based clinical practice and preventive care guidelines in collaboration with participating practitioners. Disseminate the guidelines and monitor whether members receive care consistent with the guidelines.
- Identify quality of care concerns through evaluation of member grievances, complaints, and appeals.
- Ensure confidentiality of patient information and medical records.
- Ensure best practices for medical record documentation.
- Comply with all quality improvement activities required by Centers for Medicare & Medicaid Services (CMS), the Department of Health Services (DHS), and state regulatory agencies.
- Implement and maintain programs/interventions that support National Committee for Quality Assurance (NCQA) accreditation.
- Monitor and facilitate continuity and coordination of care between medical and behavioral health care practitioners and providers, and between primary care providers and specialists.
- Continually evaluate the effectiveness of programs/interventions.
- Provide superior service without discrimination to all members, including those who have special needs and those who are at high risk of developing special needs.
- Serve a culturally and linguistically diverse membership by performing one or more of the following:
    - Analyze the existence of significant health care disparities in clinical areas.
    - Use practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved.
    - Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language-specific risks.
    - Conduct focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs.
    - Identify and reduce a specific health care disparity.

Provide information, training, and tools to staff and practitioners to support culturally competent communication.

At Quartz, we define quality as the degree of adherence to generally recognized standards of medical practice and anticipated outcomes for a service, procedure, diagnosis, or clinical condition. Continuous quality improvement involves an organization-wide program to objectively monitor and evaluate the quality and appropriateness of patient care and to resolve identified problems.

Quartz utilizes board certified physicians to assist with the review of medical appropriateness and necessity. The Medical Management staff collaborate in making decisions concerning utilization management according to their areas of expertise. The Medical Directors chair various Quality Improvement (QI) committees, and network providers actively participate in these committees, assisting with policy development and participating in review of quality-of-care concerns in their areas of expertise. In addition to Quartz Medical Directors and Associate Medical Directors involvement, providers from our owner systems participate in our quality committee structure.

Several committees exist within Quartz to work on QI initiatives. Membership includes Quartz staff, delegates, and participating practitioners, and may include representatives from other organizations. The Board of Directors has ultimate responsibility for the quality of care and services provided to members and for oversight of the QI Program.

Quality Improvement Program

Each year, Quartz develops a Quality Improvement Program Description and Work Plan. This plan outlines efforts to support and promote the delivery of high-quality care and service to members, providers, and practitioners. Focus areas of improvement reflect Quartz population attributes and needs. Opportunities for improvement are prioritized to focus on disparities, at risk members, member experience, high-volume and high impact conditions, and/or high-cost clinical and service issues. Quality Improvement interventions encompass all product lines, provider, and practitioner networks. We also identify areas for improving service via surveys and through tracking, trending and monitoring member phone calls through Quartz Customer Success.

Providers are required to participate in Quartz's Quality Improvement Program activities to improve the quality of care and services and member experience. This includes the collection of performance measurements, provision of medical records as requested, and responding to requests from Quartz around quality of care complaints. Quartz may use provider performance data for QI activities. Practitioner performance data may be used for public reporting to consumers as required by NCQA, DHS, CMS, etc.

HEDIS®

HEDIS is the Healthcare Effectiveness Data and information Set developed by NCQA. CMS contracts with NCQA to use HEDIS measures to evaluate and improve the quality of care for Medicare and Medicaid beneficiaries. Some of the other measures NCQA and CMS use to monitor quality are Consumer Assessment of Healthcare Providers and Systems (CAHPS ®), Enrollee Experience Survey (EES) and Health Outcome Survey (HOS).

A managed care organization is ultimately responsible for the quality of healthcare provided to its members. The information provided by HEDIS® helps demonstrate the value a health plan offers and how to hold a health plan accountable for its performance. Quartz participates in annual HEDIS®, CAHPS®, EES and HOS reporting based on Department of Health Services (DHS) contractual requirements, Centers for Medicare, and Medicaid Services (CMS) quality regulations, relevant state quality requirements, requirements for the Office of the Commissioner of Insurance (OCI), and other regulatory requirements as needed. Emphasis is placed on those aspects of care that will have the greatest impact on the quality of member care, delivery of care, member safety, satisfaction, and equity.

Collecting data for HEDIS® reports occurs via multiple methods. While claims and other pertinent data are collected by the managed care organization, such data is not always complete for accurate reporting, especially for clinical measurements. Often a review of the medical record is needed to provide accurate reporting of performance levels. To accomplish this, Quartz staff requests that practitioners submit information regarding services provided as part of an annual chart audit. This process allows Quartz to obtain and report data that accurately reflects the quality of care offered by its practitioners and use their performance data for QI activities.

The six major areas of performance measured in HEDIS® are:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk-Adjusted Utilization
5. Health Plan Descriptive Information
6. Measures Reported Using Electronic Clinical Data Systems

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – CAHPS® is a standardized survey performed annually by an NCQA-certified vendor according to the HEDIS® survey protocol. It is designed to capture consumer and patient perspectives on health care quality, access and experience.

The Enrollee Experience Survey (EES) assesses the enrollee's experience with their Qualified Health Plan (QHP) offered through the Health Insurance Marketplace.

The Health Outcomes Survey (HOS) is a member self-reported outcome surveyused in Medicare managed care. The goal of the Medicare HOS is to gather valid, reliable, and clinically meaningful self-reported health status data from Medicare Advantage (MA) members.

Utilization of preventive health services is monitored using HEDIS® measurements in areas such as prenatal and postpartum care, childhood immunizations and timely visits based on age and stage, screening for prevalent preventable cancers including breast, cervical, and colorectal, smoking cessation, chronic condition management (diabetes and hypertension) and screening rates from prevalent conditions.

If you have any questions about the HEDIS®, CAHPS®, EES, or HOS measurement process or Quartz individual results, please contact Quartz at (800) 897-1923 and ask for Quality Programs.

Employer Wellbeing | Quartz Well Rewards

Quartz is well positioned to support employer groups to promote member health and wellbeing. The Promoting Health team offers individual consultations, curated wellness initiatives, programs, evidence-based resources, and challenges based on the employer group needs, interests and health check survey results. Wellness strategies may include environmental assessments, training opportunities, action planning, clinical insights review, integration of care management, clinical program education, educational materials, and other innovative programs and resources based on employer requests. Resources provided by providers and health systems can be integrated with employer programming. Members are encouraged to share their health check survey results with their health care team.

Continuity & Coordination of Care

Quartz expects specialty care providers, as well as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers that provide care to our members to communicate with the member's primary care clinic (PCC). All medical and behavioral health practitioners play a role in providing continuous, quality care in an efficient, cost-effective manner. The role of the PCC is to know the patient's medical history and coordinate all their medical needs, as well as to be aware of the specialty care received by patients, including behavioral health treatment.

Quartz actively works to improve communication between the primary care practitioners and all medical, surgical and behavioral health consultants, hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers. Feedback obtained from practitioners via annual data collection helps Quartz focus these communication improvement efforts.

Quartz Patient Safety

Quartz has a patient safety program with the goal of fostering a supportive environment to provide quality patient health care through reduction in avoidable medical errors. Quartz encourages and endorses patient safety initiatives. Quartz is required to investigate any complaint or concern regarding patient safety and quality of care. Providers and physicians are expected to cooperate with Quartz's patient safety and QI initiatives including (but not limited to) provision of medical records, responding to queries from the Medical Director about a specific case and provision of policies and/or procedures related to patient safety as per the Addressing Quality of Care concerns policy. If a Serious Reportable Event or Adverse Event is identified, reimbursement policies will be in accordance with regulatory and/or CMS guidelines.

Objectives

- Support of an ongoing collaboration with participating health care practitioners and facilities to encourage and endorse external patient safety activities.
- Work with external accrediting agencies toward a safe healthcare system.
- Encourage participation in national and local collaborative efforts to encourage safe practices.
- Educate practitioners and members about safe practices.

Resources Available

The following resources provide information that can help promote patient safety. Quartz encourages all participating providers to be actively involved in patient safety practices

Wisconsin Health Reports

This website is supported by the following Wisconsin non-profit organizations:

- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Hospital Association
- Wisconsin Medical Society

The goal of the website is to help patients understand the quality of care they receive from doctors, hospitals, or clinics related to diabetes, hypertension, and colon cancer screenings.

Medwatch Safety Program

This website is maintained by the U.S. Food and Drug Administration (FDA) and provides resources to pharmacists, practitioners, and others, allowing users to keep current with medication safety.

Wisconsin Price Point

A subsidiary of the Wisconsin Hospital Association (WHA), the WHA Information Center's Price Point website is dedicated to collecting and providing information about services provided by Wisconsin hospitals. The website provides information about hospital charges for specific procedures.

MetaStar

MetaStar is the Medicare Quality Improvement Organization for Wisconsin, under contract with the Centers for Medicare & Medicaid Services (CMS). MetaStar works with physicians, patients, and the community to improve immunization and cancer screening rates and improve outpatient cardiovascular care. MetaStar has a separate division, the Wisconsin Health Information Technology Extension Center (WHITEC), that focuses on improving Electronic Health Record quality and utilization in Wisconsin.

Quintuple: Better Health and Better Care at Lower Cost

Quintuple Aim is a framework developed by the nonprofit Institute for Healthcare Improvement (IHI), a global organization that focuses on optimizing health care through the Quintuple Aim of:

- Improving Patient Experience
- Improving Population Health
- Reducing Health Care Costs
- Improving Provider Work Life Wellbeing
- Advancing Health Equity

The organization helps provide training for health care providers in order to improve the health care of individuals and populations.

Care Management

Using the health care system can be confusing, especially for patients with many health-related needs. That is why Quartz offers Care Management. The goal of Care Management is to work closely with members to coordinate healthcare services and resources to help ensure members get the best care possible.

How does Care Management work?

A Care Management interdisciplinary team (Registered Nurse, Behavioral Health/Social Work Care Specialist, or Member Care Coordinator) works with members and their care team. The case manager helps members by:

- Providing education about health conditions and care
- Supporting and reinforcing treatments and therapies recommended by health care providers.
- Coordinating health services and clarifying insurance benefits

- Developing and implementing member-centered goals and interventions to promote long-term change and self-management.
- Connecting members to community services or programs

Who is eligible?

This program is for Quartz members who have experienced:

- Multiple medical conditions and/or trauma
- Multiple hospital or emergency room visits
- Health conditions that are high-cost or high risk
- Members who are struggling to navigate a new and/or chronic diagnosis
- Multiple needs (physical, behavioral, cognitive, social, and/or financial) impacting their ability to achieve optimal health.

Is there a cost?

No. Our services and materials are provided at no cost to eligible members.

Would you like to learn more or enroll a Quartz member in Care Management?

Call Quartz's Care Management Department at (866) 884-4601 or Customer Success at (800) 897-1923 or go to QuartzBenefits.com, Providers, Resources for Your Patients, Care Management and click on 'Refer a Patient' to complete the form.

Medical Record Documentation Audit
Quartz medical record documentation standards

Medical records contain valuable information about the patient's health status, facilitate communication, continuity, and coordination of care, and promote efficiency and effectiveness of treatment. Medical record documentation audits are conducted based on state requirements.

If you have questions regarding medical records, call Customer Success at (800) 362-3310.

Criteria for medical record documentation

All practitioners must establish a process and meet the following criteria for medical record documentation:

- All medical record pages must contain the patient's name and/or ID number.
- The medical record contains documentation of all services provided by the primary practitioner.
- All entries must be dated and include an author identifier (a handwritten signature, an initialed stamped signature, or a unique electronic identifier).
- Patient demographic information must include name, date of birth, address, gender, and telephone number.
- Include a medical history containing immunizations, preventive screenings, and illnesses.
- Denote known past surgical procedures.
- Contain a problem list, including medical and/or behavioral health conditions.
- All medication allergies and adverse reactions must be prominently documented in the medical record. If there are no known allergies (NKA), this must be noted as well.
- Each episode of care should include the following:
    - The reason for the encounter
    - Evidence of assessment of enrollee's health problems
    - Current diagnosis of enrollee along with results of any diagnostic tests
    - Plan of treatment, including any therapies and health education
- Document and review all outcomes of ancillary reports, such as lab tests, X-rays, etc., by the provider who ordered them. Document follow-up actions taken regarding report results deemed significant by the ordering provider.
- All Quartz contracted providers are required to have policies and procedures in place to facilitate advance care directives

on behalf of Quartz members. The following documentation must be in a prominent part of the medical record of a member:

- Documentation of advance directives
- Documentation of whether or not a member has executed an advance directive

Education will be given to primary care physicians identified as having deficiencies in recordkeeping following the audit. A follow-up records audit will take place within 6 months for those providers who were determined to have deficiencies in their records and subsequently given education. If after the 2nd audit the provider is not compliant, a report will be submitted to Quartz Provider Network Management and a corrective action plan will be developed by the designated Quartz Contract Manager.

Utilization Management & Medical Management

Importance of Medical Records

The medical record communicates the member's current and past health status, past medical treatments, and treatment plans for future health care. Therefore, the medical record may reflect all services provided by the primary care practitioner, specialty care providers, ancillary services, diagnostic tests, and therapeutic services that the member receives and may be billed. Sometimes medical records need to be reviewed by Quartz to determine claims payment or approval for coverage.

The content and quality of information documented in the medical record are important in facilitating communication, continuity, and coordination of care and promoting efficiency and effectiveness of treatment. The member's medical record must be available to the practitioner at the time of the member's appointment. The confidentiality of the medical record information must be assured.

Referrals

Quartz requires all members to choose a primary care clinic (PCC). The PCC is responsible for providing primary care services and for coordinating health care needs. In most cases, providers at the PCC can provide the medical care needed; however, when necessary, the PCC will refer a member to an in-network Quartz specialist for specialty care. Quartz does not require written approval before accessing specialty care from an in-plan specialist (unless specified in your provider contract). However, please note that some medical services, supplies, and equipment, and all out-of-plan requests for HMO members require prior authorization (see section below on prior authorization). If you require further clarification, please contact Quartz Customer Success at (800) 897-1923.

Out-of-Plan Referrals

When the PCP or treating provider recommends services from a practitioner or provider who is not part of the Quartz provider network, the provider must complete a Prior Authorization Request Form. This request must be submitted to and approved by Quartz before a non-participating provider renders care. Please note approval to obtain services from a non-participating practitioner or provider will be granted only when such services are medically necessary and not available from a plan practitioner or provider.

Prior Authorization

Some medical procedures, clinic administered medications (see Pharmacy Section), behavioral health services, supplies, and equipment require prior authorization. The provider or supplier requesting the service must obtain approval from Quartz before services are provided by submitting the Prior Authorization Request Form with supporting medical documentation. All prior authorization requests must be submitted via the provider portal, My Quartz Tools. Fax requests are no longer accepted when providers are able to use MyQuartz Tools, except for Quartz Medicare Advantage members.

For a list of services requiring prior authorization, please review the prior authorization list for Medicare Advantage or commercial plans. Note that if the required prior authorization is not obtained and you provide the service, those services will be denied as provider liability and the member may not be billed. If an approved prior authorization is not obtained for a member to obtain services out of network, the member could be held financially responsible for those charges.

Note: Quartz will not review requests for authorization retrospectively unless allowed under the provider's contract.

If you have specific questions about prior authorization or would like to submit a written Prior Authorization Request Form, please contact:

Quartz Utilization Management (medical)

Toll-Free	(888) 829-5687
Local	(608) 821-4200
Fax	(608) 821-4207 (Commercial only)
Fax	(608) 881-8397 (Government Team)

Quartz Utilization Management (behavioral health)

Toll-Free	(800) 683-2300
Local	(608) 640-4450
Fax	(608) 471-4391

Medical and Behavioral Health Management

The health care industry recognizes that the best way to offer efficient care is to provide appropriate preventive and medical care from the outset. The goal of utilization management (UM) is to help guide the best medical care in the most efficient and economical manner. Quartz uses a variety of processes to evaluate the utilization and quality of health care services provided to Quartz members. Quartz has medical and behavioral health departments who perform utilization management functions.

All Quartz members are managed by Quartz utilization management teams:

- Utilization Management: medical/surgical
- Utilization Management: behavioral health (mental health/substance use)
- Pharmacy Benefit Management

Information regarding which clinic department to call can be found within the Coverage Section.

The Quartz Pharmacy Benefit Management Program offers comprehensive pharmacy services for all members receiving prescription benefit coverage through Quartz. Additionally, medication utilization management services are provided for selected medications covered under the medical benefit for all members. The Quartz Pharmacy Benefit Management Program uses internally-derived criteria specific to each individual drug requiring prior authorization. The criteria are developed, approved, and adopted by a committee of pharmacists and physicians from Quartz's provider network.

All UM programs are supported by qualified health professionals who are in turn supported by physicians whose education, training, and experience are commensurate with the UM reviews they conduct.

Utilization Management and Clinical Criteria

To assess the clinical appropriateness of hospital and other services, the utilization management staff uses evidence-based decision support criteria, such as Milliman Care Guidelines (MCG). Decisions are also made based on Quartz's

internally derived policies and procedures. Behavioral Health Utilization Management also utilizes MCG for mental health and substance use disorder services which require prior authorization (unless alternate criteria is required to be used under state law).

MCG guidelines are a set of clinical practice benchmarks for treating common conditions. They describe the most efficient treatment for a given condition and the typical progress that can be expected. Physicians, nurses, and other health care professionals developed the guidelines based on the actual practices of clinical care throughout the United States.

These guidelines are typically used in planning inpatient care, projecting the length of stay, and monitoring care a patient may require. They are also used for outpatient services. The physicians and other medical experts in our community review them annually and modify them as necessary to meet individual needs and the local delivery system.

Other care guidelines or criteria utilized are:

- Quartz Medical Policies
- The Member's Certificate of Coverage
- American Society of Addiction Medicine (ASAM) criteria
- BadgerCare Plus and Medicaid On-Line Handbook (ForwardHealth)
- Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

The guideline-based system eliminates reviewer subjectivity, guides decisions about clinical appropriateness that support cost-effective, appropriate level of care decisions, and ensures quality of care and service. The utilization management teams have full disclosure capabilities of the care guidelines. All criteria can be found in on the Quartz website here https://quartzbenefits.com/providers/provider-medical-policies/ .

The guideline/criteria are evidence-based and in line with how health care providers across the United States are practicing. They are supported by the latest publications regarding medical management and are not considered financially derived utilization controls. Quartz monitors the UM decision-making processes to ensure appropriate utilization and prevent inappropriate denials. Also, Quartz's quality committees consist of plan physicians who oversee UM activities including assessments of new technology and new applications of existing technology.

Quartz does not provide financial incentives based on utilization management denials/decisions. All UM decision making is based solely on appropriateness of care and service. Quartz does not offer incentives to encourage inappropriate underutilization, nor does it provide rewards for issuing denials.

Quartz is committed to a fair and thorough process for making utilization decisions. As a practitioner, you may contact a Medical Director (physician reviewer) to discuss any medical determinations. A Medical Director is available to you to discuss any UM decision, Monday – Friday during normal business hours, at the numbers noted below.

For utilization management inquiries, assistance, or to request a free copy of UM criteria, please contact the medical, behavioral health, or pharmacy management personnel. Staff is available weekdays during normal business hours (8 a.m. to 5 p.m.). UM staff can also receive inbound communication after normal business hours. Physician-to-physician or pharmacist consultation is available to discuss medical necessity determinations.

Medical Management and Behavioral Health Management staff are available Monday through Friday 8:00 a.m. –

5:00 p.m. on business days to receive and return calls regarding medical/behavioral health management issues. After normal business hours, calls are answered by an answering machine or service and are returned the next business day. Staff members identify themselves by name, title, and organization when receiving or returning calls relating to medical/behavioral health management issues. A toll-free number is also available to accept and address any concerns.

Quartz Utilization Management (medical)
(888) 829-5687

Quartz Utilization Management (behavioral health)
(800) 683-2300

Quartz Pharmacy Benefit Management Program
Contact Quartz Customer Success at (800) 897-1923

Quartz Health Benefit Plans Corporation
(800) 897-1923

Chiropractic Care
Contact Fulcrum at (763) 204-8570 or info@fulcrumhealthinc.org

Hospital Admissions Policy

When arranging for elective hospital admission, remember that all Quartz members must be admitted to an in-network hospital. Exceptions are emergencies, or when the member has a point-of-service (POS) or PPO product and has benefits for medical care services outside of Quartz's provider network. For HMO members, if a participating hospital cannot provide the needed services, the admitting physician should obtain written prior authorization for an out-of-plan admission from the appropriate utilization management department.

Notification Requirements

Quartz requires notification of all inpatient hospital admissions of its members. This requirement applies when Quartz is considered the primary insurer, secondary insurer, or insurance is supplementary to Medicare. Notifications can be made via our toll-free numbers:

Quartz Customer Success
(800) 897-1923

Quartz Utilization Management (medical)
(888) 829-5687

Quartz Utilization Management (behavioral health)
(800) 683-2300

Prior Authorization

Coverage for all elective or planned inpatient admissions that require prior authorization must be requested at least 15 days in advance by the admitting physician. Cases are reviewed for prior day surgery admissions, out-of-plan admissions, procedures that could be performed on an outpatient basis, benefit coverage, and general admissions that may not meet

criteria for inpatient status. The UM team also identifies cases for long-term care management (Inpatient and outpatient rehabilitation, Long Term Acute Care, and Skilled Nursing Facility admissions) and assigns an initial length of stay. Failure to have elective/planned hospitalizations prior authorized may result in sanctions to the admitting physician/provider.

Appeals Process

Quartz is committed to a fair and thorough process for making utilization management decisions. To ensure fair decision-making, Quartz invites practitioners to discuss such decisions with the Medical Director if necessary.

Expedited Appeal Reviews

An expedited review process is available when a delay in decision-making might seriously jeopardize the life or health status of a Quartz member. We provide a decision no later than 72 hours after the request is received. A Quartz member, or practitioner acting on behalf of a member, may request an expedited appeal. The member does not need to sign an appointment of authorized representative form for a practitioner to appeal on behalf of the member in expedited situations. Expedited reviews will be granted for requests concerning:

- Preauthorization of treatment for urgent clinical situations (patient has a high potential for deterioration to an emergent condition within 48 hours);
- Admissions, concurrent review, and continued inpatient/residential stays;
    - Potential interruptions of active course of treatment.

Standard Appeal Reviews

For non-expedited appeals, the following timeline applies:

The appeal will be acknowledged in a letter to the member and the practitioner, if the member has given authorization, within five (5) business days.

All efforts will be made to resolve the appeal within fifteen (15) to thirty (30) calendar days of receipt, depending on what state the member's policy is in. However, if the appeal cannot be resolved within this time frame due to circumstances beyond Quartz's control (e.g., medical records are not received from the provider), Illinois, Iowa, and Wisconsin insurance regulations provide for an additional thirty (30) calendar days within which to resolve the appeal. Minnesota insurance regulations provide for an additional fourteen (14) calendar days within which to resolve the appeal.

If the appeal requires Committee review, the Appeals Specialist will send the member and authorized representative written notice of the time and place of the Committee meeting at least seven (7) calendar days in advance of the meeting.

Once the appeal is reviewed by the Reconsideration Committee, the Appeals Specialist will compose a letter and provide attachments, as appropriate to the member and authorized representative that will contain the decision with the specific reason(s) for the decision, in easily understandable language. This is sent within the appropriate notification period depending on if an extension had been filed and the state the members policy is in.

For further information regarding the formal appeals process, please contact the Quartz Appeals department at (800) 362-3309, ext. 101901.

Provider Appeal

A provider appeal is defined as any written inquiry about a denied claim where there is no member liability. All

practitioners/providers participating in Quartz will be afforded a formal process for expressing inquiries/queries, complaints, and/or appeals related to aspects of administrative or contractual procedures/processes. Examples include, but are not limited to:

- Claims payment/reimbursement/recoupments
- Capitation Rates
- Other contractual provisions

The Provider Network Management Department at Quartz will respond to all appeals within 30 days upon receipt of the appeal. Non-par providers will not be processed per this document, but forwarded as appropriate (member advocate, medical mgmt., etc). If denied claim was referred by par provider, then Provider Engagement Specialist will research for appropriate resolution.

To File an Appeal

The written appeal should include an explanation as to what action the provider is asking Quartz to take and to provide any documentation to substantiate the need to reconsider the original denial.

- Except for Quartz BadgerCare Plus/Medicaid SSI, provider appeals must be submitted to Quartz within six months from the occurrence of the event that is the basis for the appeal, unless specifically stated otherwise in the provider agreement.
    - Refer to the Quartz BadgerCare Plus and/or Medicaid SSI Program section of this Provider Manual for instructions on the appeal process for this line of business

- All provider appeals will be sent to Quartz Provider Network Management. Mail: Quartz, Attn: Provider Network Management-Appeal, 2650 Novation Parkway, Fitchburg, WI 53713. Fax: (608) 643-2564 Attn: Provider Network Management Appeals

- The Provider Engagement Specialist will work with the appropriate Department and/or Leadership based on the nature of the appeal received for assistance in resolving the appeal. A decision will be made within thirty (30) days.

If the decision is made to uphold the denial, the provider will receive a letter explaining the reason for the denial. All denials will be provider liability and the provider must not bill the member or otherwise hold the member liable for the denied services.

Outpatient Procedures

Many procedures and surgeries are appropriate for the outpatient/ambulatory setting. Quartz uses MCG level of care to determine if procedures/surgeries, under normal circumstances, can be safely performed in an outpatient setting, thereby avoiding admission to the hospital.

Quartz members may be required to obtain prior authorization for certain outpatient procedures or surgeries. Please review the prior authorization list for Medicare Advantage or commercial plans, contact the utilization management

team, or call Quartz Customer Success if you have a question about prior authorization requirements.

Concurrent Review

All hospital admissions must be reported by the hospital to Quartz or the appropriate utilization management team within 24 hours of admission or the first business day after admission. Medical information regarding any emergent/urgent admissions and elective/planned admissions that are continued beyond the initial length of stay assigned must be communicated to the utilization management staff.

Length of Stay

Length of stay (LOS) assignments are projections/guidelines rather than rigid authorization limits. Although it is anticipated that many or most patients will be discharged within the LOS time frame, Quartz authorizes longer stays based on medical necessity. We will authorize inpatient days whenever standard intensity and severity criteria for medical necessity exist. At times, Quartz will require Medical Director's input to make decisions regarding LOS authorizations.

Retrospective Review

Medical record reviews occur retrospectively on selected cases to:

- Review for medical necessity for inpatient days not reviewed concurrently.
- Validate the accuracy of concurrent information.
- Reconsider medical necessity during the appeal process.
- Perform clinical quality studies.
- Verify claim payment.

New Health Care Technology Evaluation

The health care industry changes rapidly. The health care community develops new treatments and procedures daily. To ensure Quartz members receive the safest and most effective care possible, Quartz reviews and assesses new health care technologies as well as new applications of existing technologies.

If you believe that a new technology or a new application of existing technology is medically necessary for the treatment of a Quartz member, you may submit supporting documentation with a prior authorization request for your patient.

Upon receipt of the prior authorization request, the utilization management clinical team will review the request and render a determination. Quartz benefit plans do not cover experimental or investigational treatments.

Requesting a New Health Care Technology Evaluation

To request a general review of new technologies for consideration for coverage by Quartz, contact Quartz to initiate a preliminary clinical review and obtain information about the process. Upon review of the information submitted, a Quartz clinical team will initiate a thorough investigation. In addition to reviewing the information submitted, Quartz will research additional in-house and external resources and consult with experts in the specific medical field as needed.

Evaluation Factors

When evaluating new treatments and procedures for determination of coverage, the Medical Director considers:

- The technology must have final approval from the appropriate government regulatory bodies.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside investigational settings.

After conducting the review, the Medical Director determines if the service or treatment is experimental and/or investigational (as defined by Quartz policy and Quartz's certificate of coverage), or if it is medically necessary, and is not otherwise excluded from coverage. After the review is complete, the medical director will determine if a medical policy needs to be developed or if an existing policy will require revision. Quartz reviews medical policies and published criteria at least annually. Any changes to requirements for prior authorization will be communicated to providers as appropriate. Subsequent medical reviews will take the decision from each request into account when reviewing future requests for coverage and benefits.

Quartz members have the right to appeal a coverage decision if they disagree and are encouraged to contact Quartz Customer Success with any questions or concerns at (800) 897-1923

Contact Us

Quartz 7 a.m. to 6 p.m., Monday through Thursday and 7 a.m. to 5 p.m. Friday

Customer Success	(800) 897-1923
Hearing impaired	(608) 643-1421
General Information	Fax (608) 643-2564
Website	QuartzBenefits.com
Email	customerservice@QuartzBenefits.com
Claims Submission Address and Correspondence	Quartz P.O. Box 211221, Eagan, MN 55121

Electronic Claims Submission

Availity	(800) 282-4548

Marketing & Use of Quartz's Promotional Materials

Local	(608) 471-4766

Care Management 8 a.m. to 5 p.m., Monday through Friday

Toll-free	(866) 884-4601
Fax	(608) 821-4884

Utilization Management (medical)

Toll-free	(888) 829-5687
Local	(608) 821-4200
Fax	(608) 821-4207 (Commercial plans)
Fax	(608) 881-8397 (Government Team)

Utilization Management (behavioral health)

Toll-free	(800) 683-2300
Local	(608) 640-4450
Fax	(608) 471-4391

Appendix A Coding and Reimbursement Policies

Policy Name	Last Update
Adaptive Behavior Assessment & Treatment	10/01/2025
Add-on Codes	10/01/2025
Bilateral & Anatomic Modifiers	10/01/2025
Condition Code 45- Gender Incongruence	10/01/2025
Coordination of Benefits	10/01/2025
Drug Waste	10/01/2025
G2211 - Visit Complexity Associated with Evaluation and Management Services	10/01/2025
General Anesthesia	10/01/2025
General Coding Guidelines	10/01/2025
Global Surgical Package	10/01/2025
Increased Procedural Services	10/01/2025
Intraoperative Neurophysiological Monitoring (IONM)	10/01/2025
Medically Unlikely Units (MUE)	10/01/2025
Modifier 62 66 – Team and Co-Surgery	10/01/2025
Modifier 25 – Significant Separate Evaluation and Management Service	10/01/2025
Modifier 26 & TC – Professional and Technical Components	10/01/2025
Modifier KX	10/01/2025
Modifiers 54, 55, 56 – Shared Care	10/01/2025
Multiple Procedure Reduction (MPR)	10/01/2025
Pylarify PET Imaging	10/01/2025

Reduced and Discontinued Service Modifiers	10/01/2025
Robotic Assist	10/01/2025
Sacroiliac Joint Injections in an ASC	10/14/2025
Timed Codes (8-Minute Rule)	10/01/2025
Use of Unlisted Codes	10/01/2025

Adaptive Behavior Assessment and Treatment

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Adaptive Behavior Assessment and Treatment (ABA): Therapeutic services aimed at improving the daily functioning of individuals, typically with autism spectrum disorder (ASD) or related developmental conditions. Services include assessments to identify challenging behaviors and individualized treatment services.

Supervision: Ongoing oversight by a qualified clinician to ensure that services are delivered safely and effectively

Technician: A paraprofessional delivering services under the supervision of a qualified health care professional

Policy

Services must be ordered and supervised by a qualified healthcare professional such as a licensed psychologist or Board-Certified Behavior Analyst (BCBA). Only those services outlined in the member's benefit plan are eligible for reimbursement.

Documentation must include:

- Diagnosis, assessment results, goals, and individualized treatment plan
- Details of each session including participants, location, duration, and content
- Supervisory notes and treatment plan updates

Limits and Exclusions:

- Time-based codes must be reported based on actual face-to-face time
- Billing for supervision only, without direct care, is not reimbursable
- Services solely for academic or educational goals are not covered

Quartz will reimburse for adaptive behavior services that:

- Are supported by adequate documentation
- Are submitted with accurate coding and modifiers as needed

Unbundling, duplicate billing, or billing beyond established frequency or duration limits may result in denial or recoupment. Quartz may follow National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE) edits for service limits.

References

MLN1986542 Medicare and Mental Health Services
https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf

Behavioral Health Treatment Coverage, ForwardHealth Wisconsin
https://www.forwardhealth.wi.gov/WIPortal/content/html/btb/Behavioral_Treatment_Benefit.htm.spage

Related Policies

None

Compliance and Audit

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025		Document created	Coding Integrity Unit

Add-on Codes

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Add-On Code: A CPT code designated by a "+" symbol in the CPT manual, identifying a procedure that is performed in addition to a primary procedure. These codes are not to be used as stand-alone services. Add-on codes may include phrases such as "each additional" or "(List separately in addition to primary procedure)" in their descriptors.

Policy

Add-on codes must always be reported with their associated primary procedure codes on the same claim. The relationship between primary and add-on codes is defined by the CPT manual Appendix D, CMS National Correct Coding Initiative (NCCI) Add-on Code Edits. Quartz follows the American Medical Association (AMA), CMS, and ForwardHealth guidelines for the appropriate reporting of add-on codes.

Examples of appropriate application include:

- Additional vertebral segments (spinal surgery)
- Additional lesions or digits (dermatologic or orthopedic procedures)

Add-on codes may only be considered for reimbursement when:

- The associated primary code is also reimbursed

- The service was rendered by the same provider or specialty group on the same date (unless otherwise specified)

Add-on codes are not subject to multiple procedure reductions and should not be reported with Modifier 51.

References
Medicare NCCI Add-on Edits
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-add-code-edits

Related Policies
None

References
Medicare NCCI Add-on Edits
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-add-code-edits

Compliance
Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Bilateral/Anatomic Modifiers

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Anatomical Modifier: A two-character code used to indicate the specific part of the body where a service was performed

Medically Unlikely Edit (MUE): Limits the number of units that can be reported per day per patient

Policy

Quartz requires the use of anatomical modifiers when billing services that involve paired organs, limbs, or distinct anatomical sites. These modifiers are used to indicate the specific side or location of the service and are critical for correct adjudication, especially for procedures involving the eyes, ears, hands, feet, breasts, and extremities.

Incorrect or omitted anatomical modifiers may result in:

- Claim denial
- Incorrect bundling of bilateral procedures
- Triggering of medically unlikely edits (MUEs)

Appropriate modifiers must be used when performing procedures on a paired organ or body part and must match the procedure, diagnosis, and clinical documentation:

- RT – Right side
- LT – Left side
- 50 – Bilateral procedure

RT or LT modifiers are appropriate when performing a unilateral procedure on a single side. Modifier 50 is used when the same procedure is performed bilaterally during the same session. Do not report RT + LT modifiers together on the same line; use modifier 50 with one unit.

Examples of additional anatomic modifiers:

- Fingers (FA–F9)
- Toes (TA–T9)
- Eyes (E1-E4)

Quartz recognizes these modifiers when HCPCS or CPT code descriptions do not already indicate laterality.

Medical records must support:

- The specific anatomical location or side of the service
- Documentation, diagnosis, procedure code, and modifier must all correspond

Anatomical modifiers play a role in:

- Bypassing MUE edits when services are appropriately distinct
- Separating bundled services when performed on different anatomical sites

Reimbursement

Quartz reimburses services billed with the modifier 50 in accordance with the Medicare Physician Fee Schedule (MPFS) bilateral indicators as follows:

- 0 or 2 – 100% of provider's contracted rate for both left and right (no increase or adjustment made)
- 1 – 150% increase applies
- 3 – 100% of provider's contracted rate for each side

References

CMS MUE and Bilateral Surgical Procedures
https://www.cms.gov/files/document/se1422-medically-unlikely-edits-mue-and-bilateral-surgical-procedures.pdf

Related Policies

Medically Unlikely Edits (MUE)

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025		Document created	Coding Integrity Unit

Condition Code 45 – Gender Incongruence

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Condition Code 45: Indicates that the reported diagnosis and/or procedure is inconsistent with the patient's recorded gender but is appropriate for the patient's clinical situation

Administrative Gender: The gender recorded in systems, often based on enrollment or legal documents that may not match gender identity

Gender Incongruence: A clinical term used when an individual's gender identity does not align with their sex assigned at birth

Transgender and Nonbinary Patients: Individuals whose gender identity differs from traditional binary categories, or the gender listed in administrative systems

Policy

When there is gender incongruence, condition code 45 should be applied to the claim. Condition Code 45 only applies to facility claims.
For claims submitted on a CMS 1500 form please refer to Modifier KX policy.

References
CMS Transmittal 1877
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1877CP.pdf

Related Policies
Modifier KX

Compliance
Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

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Coordination of Benefits

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Coordination of Benefits (COB): A process by which two or more insurers determine their respective payment responsibilities for a member's covered healthcare services

Medicare Secondary Payer (MSP): Medicare pays secondary when other coverage is primary

EOB: Explanation of Benefits statement from the primary insurer

Crossover Claim: A claim initially submitted to Medicare (as the primary payer) that is automatically forwarded to Quartz (as the secondary payer)
ABN (Advance Beneficiary Notice): A notice to Medicare beneficiaries that a service may not be covered and that the patient may be responsible for payment

Statutorily Excluded: A service that Medicare never covers under any circumstances

GA Modifier: Service may not be covered, ABN signed

GY Modifier: Service is statutorily excluded from coverage, ABN not applicable
GZ Modifier: Service may not be covered, no ABN on file
GX Modifier: ABN voluntarily provided for excluded service

Policy

This policy applies only to Quartz's Medicare Advantage line of business. Providers are required to follow Medicare billing guidelines when submitting primary claims. Once processed, Medicare will automatically forward the claim to Quartz through the standard crossover process. Quartz does not alter or override Medicare's adjudication and requires providers to rebill Medicare directly if there are issues with coding or payment on the primary claim.

Quartz adjudicates crossover claims based solely on the Medicare remittance data received. If a claim is denied due to Medicare billing errors, providers must correct and resubmit the claim to Medicare. Quartz will deny any non-compliant crossover claims and will not manually reprocess claims that do not align with this policy.

Quartz follows CMS guidelines for the use of ABNs and non-covered service modifiers (GA, GY, GZ, GX). These modifiers are used to indicate services that may not be reimbursed due to coverage restrictions and to support beneficiary financial liability under specific circumstances.

ABNs must:

- Be issued prior to delivery of the service
- Be signed and dated by the beneficiary (or representative)
- Clearly state the service, reason for expected denial, and estimated cost
- Be retained in the patient's medical record

ABNs are not required for services that are statutorily excluded (e.g., routine foot care, cosmetic surgery, hearing aids). Modifiers for non-covered services communicate the provider's knowledge of potential coverage denial and the presence or absence of a signed ABN. ABNs are only applicable for Quartz Medicare Advantage line of business.

Reimbursement

- Claims with modifier GZ will automatically deny with no patient liability
- Claims with modifier GA will deny with patient liability
- Claims with modifier GY will deny with patient liability

References

CMS – Medicare Learning Network (MLN) Booklet: Advance Beneficiary Notice of Noncoverage
https://www.cms.gov/files/document/mln006266-medicare-advance-written-notices-non-coverage.pdf

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Drug Waste

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

JW Modifier: Used to report the portion of a single-dose vial discarded and not administered

Policy

Quartz follows CMS guidelines for billing drug wastage using the JW modifier. When a single-dose vial of a drug or biological is used, and a portion of the product is discarded and not administered to any patient, providers must report the amount discarded using modifier JW. Use of the modifier applies only to drugs separately payable under Part B and other outpatient settings. Refer to the Medically Unlikely Edits (MUE) policy for information when billing a drug over the CMS assigned limit.

When to Use Modifier JW

- The drug is from a single-dose vial or single-use package
- A portion of the drug is discarded and not administered to any patient
- The discarded amount must be documented in the medical record

Documentation Requirements

- Exact amounts administered and discarded (in units) must be documented
- Drug name, dosage, lot number, and vial size must be recorded

- Clearly indicate in the medical record that the remainder was discarded

Billing Guidelines

- For single-dose container drugs with a discarded amount, you must bill the wastage on a separate line
- When billing on a UB claim form, charges associated with the modifier JW should be listed in the non-covered charges field

Non-Covered Scenarios

- Multi-dose vials are not eligible for JW modifier reporting
- Wastage due to error (spillage, improper storage) is not reimbursable
- Estimating wastage is not acceptable; only actual, measurable discarded amounts may be billed

References

Billing and Coding Article A55932
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55932#:~:text=The%20JW%20modifier%20is%20only,less%20than%20the%20billing%20unit

Related Policies

Medically Unlikely Edits (MUE)

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

G2211 – Visit Complexity Associated with Evaluation and Management Services

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

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- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Evaluation and Management (E/M): Refers to visits and consultations provided by qualified healthcare professionals that involve evaluating a patient's health condition and making decisions about their care. Services typically include obtaining a history, performing a physical examination, and engaging in medical decision-making (MDM). E/M codes are used to document and bill for office visits, hospital visits, and other face-to-face or non-face-to-face assessments of a patient.

G2211: A Healthcare Common Procedure Coding System (HCPCS) code used to reflect additional complexity inherent to office/outpatient E/M visits related to ongoing, longitudinal care or treatment of serious or complex conditions

Longitudinal Care Relationship: An ongoing clinical relationship between a practitioner and patient that extends beyond sporadic treatment

Policy

G2211 is intended to be reported with office or other outpatient E/M visits (e.g., 99202–99215) when the visit is part of:

- Longitudinal care over time, or
- Management of a serious or complex condition

Inappropriate Use Includes:

- One-time, episodic visits
- Lack of documentation supporting longitudinal or complex care
- E/M visits not listed as acceptable companions to G2211
- Place of service types not permitted under CMS rules

The following place of service codes are not eligible for reimbursement of G2211 per CMS:

- 17 – Walk-in Retail Health Clinic
- 20 – Urgent Care Facility
- 21 – Inpatient Hospital
- 23 – Emergency Room
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility
- 50 – Federally Qualified Health Center
- 72 – Rural Health Clinic

Commercial Plans:
Quartz commercial plans consider G2211 not separately reimbursable. The work described is considered part of the E/M code and is bundled into the base E/M reimbursement.

Medicare Advantage:
G2211 is reimbursed in accordance with CMS guidelines. Claims must be submitted with a supporting E/M visit code and an eligible place of service. Documentation must support the complexity or longitudinal nature of care.

Medicaid Plans:
Quartz follows ForwardHealth and considers G2211 noncovered for Medicaid members.

References

MLN - MM13473
https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

General Anesthesia

Disclaimer

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- Reject or deny the claim
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- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Anesthesia Services: Anesthesia services include administration of general, regional, monitored anesthesia care (MAC), or other types of anesthesia by qualified anesthesia providers during surgical, diagnostic, or therapeutic procedures

Anesthesia Time: Anesthesia time begins when the anesthesia provider starts preparing the patient for anesthesia and ends when the provider is no longer in personal attendance. Time is reported in minutes.

Physical Status Modifiers (P1–P6): Modifiers used to indicate the patient's preoperative physical condition

Policy

Reporting Anesthesia Services:

- Report anesthesia services using CPT codes 00100–01999
- The legal medical record should support the following for anesthesia services
    - Total time in minutes
    - Start and stop times
    - Provider involvement (personal performance, direction, or supervision)

    - Preoperative assessment must support P modifier selection
- Report the appropriate Physical Status Modifier (P1–P6)
    - One Physical Status Modifier is allowed per anesthesia service line
    - The modifier must reflect the patient's preoperative condition, supported by documentation

- Report the appropriate provider modifier to reflect the type of provider and medical direction status
    - AA when the anesthesiologist personally performs the service
    - AD when there is medical supervision by a physician of more than four concurrent anesthesia procedures
    - QK when the anesthesiologist medically directs 2–4 CRNAs
    - QY when the anesthesiologist medically directs one CRNA
    - QX when a CRNA performs the service under medical direction
    - QZ when a CRNA performs the service without medical direction

Use of Modifier 23:

- Modifier 23 indicates that anesthesia was required due to unusual patient circumstances
- Append Modifier 23 to the surgical/procedural CPT code
- Documentation must clearly describe the reason for unusual anesthesia

Incorrect Use:

- Reporting multiple Physical Status Modifiers on one line
- Reporting Modifier 23 on anesthesia codes
- Using AA when medical direction was provided
- Using QZ for CRNA services when medical direction occurred but was not reported

References

CMS Medicare Claims Processing Manual Chapter 12, 140.3.4 - General Billing Instructions
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Related Policies

Reduced and Discontinued Service Modifiers

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

General Coding Guidelines

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

CPT Codes: Numeric codes describing medical, surgical, and diagnostic services

HCPCS Codes: Alphanumeric codes representing supplies, services, and procedures not found in CPT

ICD-10-CM Codes: Alphanumeric diagnosis codes assigned to patient conditions

Unbundling: The practice of billing separately for services that should be reported as a single code

Upcoding: Billing a procedure code that indicates a higher level of service than provided or documented

Policy

Coding Standards

- All claims must use the most current and valid versions of CPT, HCPCS Level II, ICD-10-CM, and revenue codes
- CPT and HCPCS codes must represent services performed
- ICD-10-CM codes must reflect the patient's documented condition(s)

- Diagnosis and procedure codes must be coded to the highest level of specificity
- Diagnosis codes must be appropriate for the patient's age and gender

Documentation Requirements

- The medical record must support all services billed
- Services not documented are considered not performed
- Records must include legible signatures, dates of service, clinical findings, and other elements necessary to support coding

Correct Coding

- Providers are responsible for selecting codes that are supported by documentation
- Codes submitted must align with policies from CMS, ForwardHealth, and industry-recognized references

Modifiers and Multiple Services

- When applicable, modifiers must be used to indicate procedural circumstances or exceptions
- Modifiers must be supported by documentation
- Inappropriate or excessive use of modifiers may trigger an audit or claims denial

Code Unbundling and Upcoding

- Unbundling codes that should be reported together and upcoding (billing for a more intense or costly service than documented) are not permitted
- Unbundling and upcoding are considered fraudulent billing practices and may result in claim denials, recoupments, program integrity audits, or other consequences

Diagnosis Sequencing and Primary Diagnosis Rules

- The primary diagnosis should be the main reason for the encounter or procedure
- Sequencing must reflect coding conventions and the correct order of diagnoses according to ICD-10-CM and CPT guidelines

References

ICD-10-CM Official Guidelines for Coding and Reporting
https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf

Related Policies

None

Compliance

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History

10/1/2025	Document created	Coding Integrity Unit

Global Surgical Package

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Global Surgical Package (GSP): A bundled payment model that includes pre-, intra-, and post-operative care related to a surgical procedure

Global Period: The time frame around a procedure during which related services are included in the surgical payment

Return to OR: A related surgical intervention performed in an operative suite during the global period

Policy

Quartz follows CMS guidelines for the Global Surgical Package (GSP), which includes services provided by the same physician or other qualified health care professional before, during, and after a surgical procedure. These services are considered bundled into a single payment and are not separately reimbursed unless specific criteria and modifiers apply.

Global Periods

Surgical procedures are assigned a global period based on CMS guidelines:

- 000-day (Minor): Only the day of surgery is included
- 010-day (Minor): Includes the day of surgery and 10 post-op days

- 090-day (Major): Includes 1 day pre-op, the day of surgery, and 90 post-op days

Bundled Services Include:

- Preoperative visits (standard evaluation before surgery)
- Intraoperative services (performed during the surgery)
- Postoperative visits related to recovery
- Routine pain management (excluding anesthesia)
- Typical wound care (e.g., dressing changes, suture removal)
- Writing orders and prescriptions related to recovery

Services Not Included:

- Unrelated E/M services (modifier 24)
- Diagnostic tests (labs, imaging)
- Return to OR for complications (modifier 78)
- Staged or planned procedures (modifier 58)
- Treatment of underlying conditions (when distinct from the surgery)
- Post-op care by different provider (must be clearly documented)

Modifier Usage

To submit a claim for services during the global period that are eligible for separate reimbursement, the following modifiers must be used appropriately:

- 24 – Unrelated E/M service by the same physician during post-op period
- 25 – Significant, separately identifiable E/M on the same day as a procedure
- 57 – Decision for surgery made during E/M visit
- 58 – Staged or related procedure during post-op period
- 78 – Return to OR for related complication
- 79 – Unrelated procedure during post-op period

Documentation Expectations

- Medical records must clearly show why the service or procedure is unrelated, staged, or part of a treatment plan
- Dates of service must align with the global period timeline
- Modifiers without clear support will result in denial or recoupment
- Each visit or procedure must be distinctly documented with diagnosis-specific justification as appropriate

Reimbursement

Quartz aligns with CMS/NPFS designations for global days (e.g., 000, 010, 090), determining how many days surrounding the procedure are included in the global package. If multiple physicians within the same TIN/CMS recognized specialty participate, Quartz treats them as a single provider. Post-operative care may be split only if documented transfer agreements exist, and appropriate modifiers are used. When appropriate modifiers are appended, additional services will be reimbursed at their contracted rate.

References

Global Surgery Booklet (MLN907166)
https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

Related Policies
Modifier 25 – Significant & Separate Evaluation and Management Service

Compliance
Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Increased Procedural Services

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Modifier 22: A modifier appended when the work is substantially greater than typically required. Examples include increased intensity, time, and severity of patient's condition.

Modifier 63: Procedure performed on infants less than 4 kg

Policy

Modifier 22 should only be used when the work effort was significantly more complex than described by the standard CPT code. Supporting documentation must clearly justify the increased work involved and describe why that work exceeds the standard code definition.

Appropriate uses include, but are not limited to:

- Significant anatomical variations or complications (e.g., dense adhesions, severe inflammation)
- Prolonged operative time with documented justification
- Extensive dissection or hemostasis due to intraoperative findings

Inappropriate uses include, but not limited to:

- Obesity without documented surgical complication
- Extended pre- or post-operative care
- Use of specialized equipment or technology
- Additional time due to surgeon's choice of approach
- Additional time unrelated to complexity (e.g., due to teaching or training)
- Appended to an E/M code
- Service performed by a specialist

Example (appropriate): Laparoscopic cholecystectomy with dense adhesions, excessive bleeding, and prolonged dissection due to obliterated anatomy. Procedure lasted 90 minutes versus typical 45 minutes.

Example (inappropriate): Laparoscopic cholecystectomy in an obese patient with no complications and routine duration.

Reimbursement

Quartz's standard for additional reimbursement of Modifier 22 is 25% of the standard contracted rate for CPT code. Quartz's standard for additional reimbursement of Modifier 63 is 20% of the standard contracted rate for the CPT code. Claims submitted without medical records identifying the above criteria will be reimbursed in accordance with their standard contracted rate.

References

None

Related Policies

None

Compliance

Quartz may conduct periodic post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to recoupment, provider education, or corrective action. Providers may be asked to submit supporting documentation as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Intraoperative Neurophysiological Monitoring (IONM)

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

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Definitions

Intraoperative Neurophysiological Monitoring (IONM): A specialized technique that employs various electrophysiological techniques during neurosurgery, orthopedics, and vascular surgery to monitor the functional integrity of the nervous system in real-time

Monitoring Provider: The physician or qualified health care professional who interprets and provides real-time feedback to the surgical team during the procedure

Policy

IONM is typically used when there is significant risk of neurological injury during surgery, such as procedures involving the brain, spine, spinal cord, and/or major peripheral nerves.

Monitoring must be performed in real-time by a physician or a qualified provider who is immediately available, either on-site or via synchronous telemedicine technology.

Interpretation of the monitoring must be synchronous with the surgery.

The monitoring provider may not be the surgeon or anesthesiologist involved in the procedure unless permitted by CMS.

Quartz follows CMS guidelines for time-based codes. Timed codes should reflect the start/stop or total time spent in continuous monitoring. The number of units billed must reflect the actual duration of monitoring. Over-reporting will result in denial or recoupment.

Documentation must support:

- Duration and modality of monitoring
- Real-time feedback provided
- Provider performing interpretation

This policy applies to all professional claims submitted for IONM services across Commercial and Medicare Advantage lines of business.

References

NIH National Library of Medicine
https://www.ncbi.nlm.nih.gov/books/NBK563203/

Related Policies

Timed Codes (8-Minute Rule)

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Medically Unlikely Edits (MUE)

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Medically Unlikely Edits (MUEs): Claim edits developed by CMS to prevent payment for services that are very unlikely to be correct, such as claims that report an excessive number of units for a procedure on the same patient on the same day

MAI (MUE Adjudication Indicator): CMS assigns each MUE a type (1, 2, or 3) indicating how strictly the edit is applied and whether medical record review is allowed

NCCI: National Correct Coding Initiative, the CMS program that establishes MUEs and other coding policies to promote proper coding methods and control improper coding

Policy

Quartz follows CMS National Correct Coding Initiative (NCCI) and ForwardHealth standards for MUEs. MUEs help ensure that billing reflects medically reasonable and appropriate services.

There are three categories of MUE adjudication indicators:

- MAI 1 – Claim Line Edit (May be overridden): These edits are based on clinical benchmarks and can be overridden with proper documentation. Appeals are considered with supporting evidence.
- MAI 2 – Absolute Date of Service Limit (Cannot be overridden): These edits are hard limits set by CMS based on anatomical or clinical realities. No number of modifiers or documentation will result in payment above the limit.
- MAI 3 – Date of Service Edit (May be overridden): These edits are based on clinical scenarios where higher units may be applicable. Additional units may be payable if sufficiently documented. Quartz will review these claims when appealed with supporting documentation.

Quartz applies MUEs across all professional, outpatient facility, and DME claims. When submitting claims, Quartz expects that units at or below the MUE be billed on one line and all units exceeding the MUE should be billed on a second. Charges associated with the units exceeding MUE billed on a UB claim form should be placed in the appropriate non-covered charges field. Claim lines that exceed the MUE limit will be denied, however, these may be appealed with supporting documentation if the MAI allows.

When submitting claims for DME and Supplies intended as a multi-day supply, Quartz expects these items to be date-spanned to reflect the full duration of use. Instead of submitting single-day claim lines, providers should indicate the full supply period by future-dating the claim.

For example, if a patient requires a supply for three months, the billing should reflect the entire coverage period:

- Example: If the supply period begins on February 1, 2025, and extends through April 30, 2025, the claim should be submitted with the date range 2/1/2025 – 4/30/2025

References

Medicare NCCI Medically Unlikely Edits (MUEs)
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits

ForwardHealth, National Correct Coding Initiative MUE Information
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=130&s=4&c=24&nt=National%20Correct%20Coding%20Initiative&adv=Y

Related Policies

Drug Waste

Compliance

Quartz may conduct periodic post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to recoupment, provider education, or corrective action. Providers may be asked to submit supporting documentation as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Modifier 62 and 66 – Team and Co-Surgery

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Modifier 62 – Two Surgeons: Indicates that two surgeons, each from different specialties, performed distinct parts of the same procedure

Modifier 66 – Surgical Team: Indicates that a complex, multidisciplinary procedure was performed by a coordinated surgical team with distinct expertise

Policy

Quartz follows CMS and CPT guidelines for surgical billing when multiple providers are involved in complex procedures. CPT codes billed with Modifier 62 must be eligible for co-surgeon billing according to the Medicare Physician Fee Schedule (MPFS). A co-surgeon indicator of "1" or "2' is required.

Modifier 66 is appended when three or more providers work together as a team during a highly complex procedure that could not reasonably be completed by a single provider. A team surgeon indicator of "1" or "2' is required.

Documentation must include:

- The full names and specialties of each provider involved
- A separative operative report from each performing surgeon documenting their specific contribution to the procedure
- Rationale for the team-based approach
- Description of the clinical complexity requiring this approach

Reimbursement
When a service is billed with a 62 modifier, Quartz will reimburse at 62.5% of the standard contracted rate.

References
Medicare Physician Fee Schedule
https://www.cms.gov/medicare/payment/fee-schedules/physician

Medicare Status Indicators
https://www.cms.gov/status-indicators

Related Policies
None

Compliance
Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Modifier 25 – Significant and Separate Evaluation and Management Service

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Modifier 25: Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day as the procedure or other service

Policy

Quartz recognizes modifier 25 when appended to an E/M service that meets the criteria for being significant and separately identifiable from a procedure or service provided on the

same date of service by the same provider or provider group. Modifier 25 may only be reported in conjunction with an E/M code when the documentation clearly supports the additional service as distinct from the usual pre- or post-procedure work.

Documentation must reflect:

- A medically necessary E/M service that goes above and beyond the usual work associated with the procedure
- The E/M service was provided on the same day as a procedure
- The services were rendered by the same provider (or group) and were both necessary and distinct

Examples of appropriate use of modifier 25 include:

- An established patient presents for a scheduled procedure but reports a new complaint requiring the provider to evaluate and manage the new condition
- A provider performs a scheduled E/M service to assess and manage a separate condition unrelated to the scheduled procedure

Inappropriate use of modifier 25 includes:

- Appending modifier 25 to justify routine E/M work associated with a procedure
- Billing an E/M service solely for obtaining consent prior to a procedure
- Using modifier 25 to bypass edits when no additional, medically necessary work is documented

Clinical documentation must specifically describe the E/M work that is significant and separate from the procedure.

References

CMS Medicare Learning Network MLN006764
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

Related Policies

Global Surgical Package

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Modifiers 26 and TC

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Modifier 26 – Professional Component: This modifier is used when the provider is billing only for the professional component of a global service

Modifier TC – Technical Component: This modifier is used when the provider or facility is billing only for the technical component, such as use of equipment, supplies, and clinical staff required to perform the test

Policy

Quartz accepts modifiers 26 and TC to identify the professional and technical components of diagnostic services when they are provided in part by one provider and in part by another (e.g., one provider performs the test, and another interprets the results). Modifiers should be used to clarify which portion of the service is being reported. If the same provider performs both the professional and technical components, the global service should be billed with the appropriate CPT code.

Billing Guidelines:

- Modifiers 26 and TC should only be used on codes designated as having a separate professional and technical component, per the Medicare Physicians Fee Schedule (MPFS)

- Do not append both modifiers to a single claim line
- Ensure correct place of service is reported

Examples of Correct Usage:

- A radiologist interprets a chest X-ray performed at a hospital imaging department. The radiologist bills 71045-26. The hospital bills 71045-TC for the use of equipment and technicians.
- A cardiology clinic performs and interprets an EKG in-office and bills the global 93000

Incorrect usage includes:

- Reporting modifier 26 or TC on codes that do not allow component billing
- Appending both 26 and TC to the same line
- Billing the global code when only one component was provided

References

Medicare Physician Fee Schedule Status Indicator Information
https://www.cms.gov/status-indicators

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Modifier KX

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

KX Modifier: HCPCS modifier indicating that documentation supporting medical necessity is on file and the service meets coverage policy requirements

LCD (Local Coverage Determination): Policy established by Medicare Administrative Contractors to define coverage criteria for specific services

NCD (National Coverage Determination): Nationwide Medicare coverage policy for services and procedures

Policy

Quartz follows CMS guidelines regarding the use of the KX modifier. The KX modifier is used to indicate that specific documentation and medical necessity requirements outlined in an applicable coverage policy, such as a Local Coverage Determination (LCD), National Coverage Determination (NCD), or ForwardHealth, have been met. The presence of the KX modifier on a claim serves as an attestation that all conditions for coverage have been satisfied and are supported by documentation in the patient's medical record.

Providers should append Modifier KX only when all documentation and medical policy requirements have been fulfilled and are available for review.

The modifier must be appended to each line item that meets policy requirements. This modifier is commonly used for durable medical equipment (DME), therapy services, and gender-specific procedures requiring documentation override. Improper or unsupported use may result in claim denial or recoupment.

Use of Modifier KX does not guarantee payment but is a necessary step for certain claims to be considered for reimbursement where policy criteria are met. Services billed with Modifier KX may be subject to pre- or post-payment review.

References

CMS Transmittal 1877
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1877CP.pdf

Related Policies

Condition Code 45 – Gender Incongruence

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Modifiers 54/55/56 - Shared Care

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

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If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

Modifier 54 - Surgical Care Only: Indicates that the provider performed the surgical procedure but is not providing the related postoperative care

Modifier 55 - Postoperative Management Only: Indicates that the provider did not perform the surgical procedure but is responsible for only the postoperative follow-up care

Modifier 56 - Preoperative Management Only: Indicates the provider performed only the pre-operative evaluation and management service(s) prior to surgery

Policy

CPT® defines global surgical packages as encompassing preoperative, intraoperative (surgical), and postoperative care. When different providers from different group practices or specialties deliver different components of the surgical package, the appropriate modifier must be used to clarify which portion of the global package was provided.

Use of Modifier 54 (Surgical Care Only):

- The service must be billed with the date of the surgery

- Relinquished date must be documented
- Documentation of the patient's request and/or agreement to the transfer of care is required

Use of Modifier 55 (Postoperative Management Only):

- Append to the surgical procedure code (billed by the surgeon) to indicate the provider is managing only the postoperative portion of care
- The service must be billed with the date of the surgery
- Include the start and end dates of postoperative care in Box 19 of the CMS-1500 form or equivalent field in electronic claims
- Post-operative care by the postoperative provider may not be performed before the relinquished care date of the surgeon

Modifier 56 (Preoperative Management Only):

- Append to the surgical procedure code (billed by the surgeon) to indicate the provider is managing only the postoperative portion of care
- The service must be billed with the date of the surgery
- Documentation should clearly support that only preoperative services were provided

Reimbursement

When billing services for shared care to Quartz, services with modifier 54 appended will receive a 30% reduction to provider's contracted rate. Services with a modifier 55 appended will receive an 80% reduction to provider's contracted rate, and services with a modifier 56 modifier will receive a 90% reduction to provider's contracted rate.

References

MLN 907166 – Global Surgery
https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Multiple Procedure Reduction (MPR)

Disclaimer

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definition

Multiple Procedure Reduction (MPR): A CMS payment policy that reduces payment for additional procedures performed during the same session

Modifier 51: CPT modifier indicating multiple procedures performed during the same session by the same provider

Policy

Procedures eligible for a multiple procedure reduction are noted in the Medicare Physician's Fee Schedule (MPFS) with indicator of 2 or 3. Quartz follows the CMS multiple procedure reduction (MPR) policy for professional services when multiple procedures/endoscopies are performed during the same operative session. Modifier 51 should be appended to the secondary and subsequent procedures.

When multiple procedure rules apply, the MPFS uses Total RVUs to rank procedure codes and determine the primary and secondary procedures on all professional claims.

The procedure code with the highest Total RVU is determined to be the primary procedure regardless of the order in which the procedure codes are billed on the claim, which code has modifier 51 appended, or which procedure code has the highest billed

charges.

Multiple procedure fee reductions are not waived when:

- Modifier SG is appended
- Modifiers 59, XE, XS, XP, or XU are appended
- Modifier 77, 78, or 79 is appended
- Maternity surgical procedures are performed during the operative session

Providers should not append Modifier 51 to:

- Add-on procedures
- Codes listed in CPT Appendix D (Modifier 51 Exempt List)
- Procedures that are bundled per the National Correct Coding Initiative (NCCI)

References

Medicare Physician Fee Schedule
https://www.cms.gov/medicare/payment/fee-schedules/physician

Medicare Physician Fee Schedule Status Indicator Information
https://www.cms.gov/status-indicators

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

PYLARIFY® PET Imaging

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

PYLARIFY®: A radioactive diagnostic agent targeting prostate-specific membrane antigen (PSMA or PSA), used for PET imaging in prostate cancer management

PSMA or PSA: Prostate-specific membrane antigen, a protein highly expressed in prostate cancer cells

Policy

PYLARIFY® is a PSA-targeted positron emission tomography (PET) imaging agent used in the evaluation of prostate cancer. Claims for PYLARIFY PET imaging must be appropriately coded, documented, and submitted in accordance with Quartz billing guidelines. Claims that do not meet these requirements may be subject to denial or recoupment.

PYLARIFY may be used in prostate cancer patients who:

- Are being evaluated for suspected metastasis and are candidates for definitive therapy; or
- Have a suspected recurrence based on elevated serum prostate-specific antigen (PSA) levels

Documentation Requirements

- Diagnosis of prostate cancer and referring diagnosis related to prostate cancer and recurrence/metastasis
- Include the word PYLARIFY and/or the NDC number for PYLARIFY on the claim (paper or electronic) in the additional information field

Inappropriate Use

- PET ordered for screening purposes or general surveillance without evidence or suspicion of recurrence
- PET studies lacking a documented indication and order

References

None

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Reduced and Discontinued Service Modifiers

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Reduced and discontinued services describe procedures that were not fully completed as planned.

Policy

Quartz may reimburse procedures that are reduced or discontinued due to clinical circumstances when submitted with appropriate modifiers and supported by documentation. The following modifiers indicate that the full service described by the CPT/HCPCS code was not performed.

Reduced Services (Modifier 52)

- Modifier 52 is used to report a service when the provider does not complete all portions of the code description
    - Most commonly used for diagnostic procedures (e.g., sigmoidoscopy converted to a limited exam)

Discontinued Outpatient Procedures (Modifiers 73 and 74)

- Modifier 73 is used to report a procedure discontinued prior to the administration of anesthesia
    - Applicable only in outpatient hospital or ambulatory surgical center (ASC) settings
- Modifier 74 is used to report a procedure discontinued after the administration of anesthesia
    - Applicable in the same settings as modifier 73

Discontinued Procedures (Modifier 53)

- Modifier 53 is used to report a procedure that was started but discontinued due to extenuating clinical circumstances or risk to the patient
- This modifier may be appended to professional claims only
- Not used for elective cancellations or when no service was initiated

For use of any of these modifiers, documentation must clearly indicate what portion of the service was completed, when, and why the procedure was discontinued or not fully performed.

Reimbursement

Services billed with modifier 74 are not subject to reimbursement reduction. Services billed with modifiers 52 and/or 73 are reimbursed at 50% of the allowed amount. Services billed with modifier 53 may be subject to a special handling reduction in accordance with CMS guidelines.

References

CMS Claims Processing Transmittal 442
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r442cp.pdf?utm

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Robotic Assist

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Robotic Assist: The use of robotic technology or computer assisted navigational devices to facilitate surgical procedures. An example of this technology is the da Vinci Surgical System. The technology enhances the precision and control of the operating surgeon but does not replace or significantly alter the underlying surgical procedure.

Policy

Quartz does not separately reimburse for robotic surgical assistance. Robotic assist is considered a tool used during surgery, and not a distinct reimbursable service.
The following codes are not covered on professional claims (CMS 1500 form):

- 0054T
- 0055T
- 0869T
- 20985
- 61782
- 61783
- S2900

References
None

Related Policies
Use of Unlisted Codes

Compliance
Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Sacroiliac Joint Injections in an ASC

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities, unless a specific exception is stated in the policy.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

27096: Injection procedure for sacroiliac joint, anesthetic/steroid, with or without arthrography, performed under imaging guidance

G0260: Injection procedure for sacroiliac joint, provision of anesthetic, steroid, or other therapeutic agent; performed in a facility setting

Ambulatory Surgical Center (ASC): A freestanding facility where outpatient surgical procedures are performed, typically not requiring hospital admission

CMS-1500: The standard claim form used by individual professional providers and suppliers to bill for medical services rendered

Policy

Quartz requires that services for sacroiliac joint injections performed in an Ambulatory Surgical Center (ASC) setting are billed using the following structure:

- Professional Component: CPT code 27096 must be billed by the performing provider on a CMS-1500 claim form to represent the professional service.
- Facility Component: HCPCS code G0260 must be billed by the ASC to represent the facility fee for the same service date. This applies to both the UB and CMS 1500 forms.
    - For facility charges billed on a CMS 1500 form, Quartz expects the SG modifier to be appended to all codes billed on the claim to indicate the charge(s) represents the ASC facility service.

This policy applies to both the Commercial and Medicare Advantage lines of business. Medicaid does not recognize G0260, therefore the facility component should continue to be billed using 27096 for patients with Medicaid as their primary insurance.

Quartz expects that documentation supports medical necessity, appropriate imaging guidance, and compliance with CMS and Quartz billing guidelines when reporting either code.

The professional and facility components must not be billed by the same entity under the same tax identification. Claims submitted with 27096 and G0260 outside of this structure may be denied.

Reimbursement

Quartz reimburses CPT 27096 under the Medicare Physician Fee Schedule (MPFS) at the professional rate for services performed by the provider in the ASC setting. Quartz reimburses HCPCS G0260 to the ASC facility per CMS ASC payment guidelines. Both services are subject to applicable multiple procedure reductions, bundling edits, Medically Unlikely Edits, and Quartz's standard contractual rates.

References

Centers for Medicare & Medicaid Services (CMS) – ASC Payment and Addenda: Ambulatory Surgical Center (ASC) Payment | CMS

License Agreement | CMS

CMS Directive for coding Sacroiliac Joint Injections: Article - Billing and Coding: Sacroiliac Joint Injections and Procedures (A59246)

Related Policies

None

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

History

10/14/2025	Document created	Coding Integrity Unit

Timed Codes (8-Minute Rule)

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- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

8-Minute Rule: A billing guideline used by CMS and other payers to determine when a time-based service qualifies for billing one full unit. The minimum threshold for one billable unit is 8 minutes.

Timed CPT Codes: Codes that are reported per 15-minute increments of direct contact or attendance with the patient, commonly seen in therapy, outpatient, or office-based procedures

Policy

When billing time-based codes, providers must document the total time spent performing the service. The CMS 8-minute rule applies to codes that are billed in 15-minute increments.

Under the 8-minute rule, at least 8 minutes of a time-based service must be performed and documented to report one unit. The total time spent on all timed services during the visit should be combined, and units should be assigned based on CMS established time ranges for each billing increment.

Below is a reference table used for determining the correct number of units based on total minutes of direct contact time:

Total Minutes	Billable Units:
8 – 22	1
23 – 37	2
38 – 52	3
53 – 67	4
68 – 82	5
83 – 97	6
98 – 112	7
113 – 127	8

Quartz reimburses time-based services according to the total billable time documented and reported on claims, in accordance with CMS guidance. Claims not aligned with the 8-minute rule or lacking adequate documentation of time may be denied or adjusted.

References

CMS Medicare Claims Processing Manual, Chapter 5, pp. 40–46
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf

MLN905365 CMS 8-Minute Rule
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OutptRehabTherapy-Booklet-MLN905365.pdf

Related Policies

Adaptive Behavior Assessment & Treatment

Compliance

Quartz may conduct periodic post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to recoupment, provider education, or corrective action. Providers may be asked to submit supporting documentation as part of claim review processes.

History

10/1/2025	Document created	Coding Integrity Unit

Use of Unlisted Codes

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Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

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- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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Definitions

NDC: The National Drug Code (NDC) is a unique 10-digit or 11-digit, 3-segment number assigned to each. The NDC identifies the manufacturer, product, and package. It is used to identify drugs for claims processing and other uses.

Policy

Unlisted codes may only be used when no current code appropriately describes the service rendered. The use of an unlisted code must be substantiated by a clear and thorough explanation of the service or item provided.

Each claim that includes an unlisted code should be accompanied by detailed documentation that accurately reflects the nature and complexity of the service performed. This documentation should include a description of the service, the clinical indication or medical necessity for the service, and any supporting evidence that may assist in determining appropriate code selection.

In lieu of medical records or invoice, a description of the service or item should be included on the claim (paper or electronic) in the additional information field. For claims involving unlisted devices or supplies, a manufacturer's invoice or product description is required. For claims with unlisted drugs, a description and/or valid NDC number is required. Failure to submit adequate documentation will result in claim denial.

References

Transmittal 1657 –Reporting Unlisted Services or Procedures
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r1657cp.pdf

Related Policies

None

Compliance

Quartz may conduct periodic post-payment reviews and audits to ensure policy compliance. Misuse of codes or modifiers may lead to recoupment, provider education, or corrective action. Providers may be asked to submit supporting documentation as part of claim review processes.

History

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