



MEDICARE ADVANTAGE

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# Provider Manual

Your guide to partnering with eternalHealth

## PROVIDER MANUAL

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## INTRODUCTION

# Welcome

### IN THIS SECTION

- › About eternalHealth
- › Our Mission
- › Provider Partnership Commitment
- › How to Use This Manual
- › Contact Information

Welcome to eternalHealth. We are honored to partner with you in delivering high quality, accessible, and member-centered healthcare to our Medicare Advantage members.

This Provider Manual serves as a reference guide for participating physicians, hospitals, facilities, ancillary providers, and office staff who support eternalHealth members. The manual outlines the administrative, operational, clinical, and compliance requirements associated with participation in the eternalHealth provider network. It is designed to help providers understand plan requirements, access resources, and successfully navigate the processes necessary to deliver coordinated, high-quality care.

## The manual contains information regarding:

- Member eligibility and benefit verification
- Access to care and care coordination standards
- Utilization management and prior authorization requirements
- Medical record documentation standards
- Claims submission and billing procedures
- Payment integrity and dispute resolution processes
- Fraud, Waste, and Abuse (FWA) requirements
- Credentialing and provider rights
- Provider termination and continuity of care requirements

Providers should use this manual in conjunction with their Provider Agreement, applicable federal and state laws, Centers for Medicare & Medicaid Services (CMS) regulations, and any additional guidance or notifications issued by eternalHealth. If any provision within this manual conflicts with a Provider Agreement, the terms of the Provider Agreement will govern.

## About eternalHealth

eternalHealth is a Medicare Advantage organization dedicated to improving the health, well-being, and healthcare experience of the communities we serve. Through strong partnerships with providers, healthcare facilities, and community organizations, we strive to deliver coordinated, high-quality, and cost-effective care that supports positive health outcomes for our members.

## Our approach emphasizes:

- Quality and patient-centered care
- Care coordination across the continuum of care
- Improved access to preventive and preventive-focused services
- Collaboration between providers and health plan partners
- Regulatory compliance and program integrity
- Health equity and cultural competency

We believe that providers are our most important partners in helping members achieve their healthcare goals and maintain their quality of life.

## Our Mission

To be your forever partner in healthcare by delivering high-quality, coordinated, and member-focused Medicare Advantage coverage while fostering strong partnerships with the providers who care for our members.

## Provider Partnership Commitment

eternalHealth is committed to creating a collaborative relationship with our participating providers through:

- Timely and accurate claims processing
- Access to provider tools and resources
- Transparent communication
- Provider education and support
- Compliance with CMS and state regulatory requirements
- Continuous improvement of member and provider experiences

We encourage providers to utilize the eternalHealth Provider Portal and online resources whenever possible to verify eligibility, check claim status, obtain prior authorization information, access forms, and stay informed of policy updates.

## How to Use This Manual

This manual is organized to follow the provider experience from enrollment and participation through claims administration, compliance, credentialing, and ongoing network management.

Providers are encouraged to review the manual carefully and refer to the appropriate section when seeking information regarding:

- Provider operations and administrative requirements
- Member eligibility and covered services
- Authorization and utilization management requirements
- Clinical documentation standards
- Claims submission and payment policies
- Compliance obligations and reporting requirements

The information contained within this manual is subject to change as a result of CMS guidance, regulatory updates, contractual requirements, or operational enhancements. Providers are responsible for complying with all current requirements and policies communicated by eternalHealth.

## Contact Information

For questions regarding information contained within this manual, providers may contact:

- Provider Services
- Phone: 1-800-680-9255
- Fax: 1-866-347-8864

### Provider Portal

- [provider.eternalhealth.com](https://provider.eternalhealth.com)

### Website

- [www.eternalhealth.com](https://www.eternalhealth.com)

Additional contact information, department-specific resources, claims addresses, prior authorization resources, and provider portal tools can be found in the Quick Reference Guide that follows this section.



## AT A GLANCE

# Quick Reference Guide

## IN THIS SECTION

- › Provider Contact Directory
- › Claim Submission
- › Provider Resources
- › Electronic Payments (EFT)
- › Prior Authorization Resources

### The Provider Portal is the fastest and most efficient way to:

- Verify member eligibility and benefits
- Review copays and cost-sharing responsibilities
- Submit and check authorization requests
- Check claim status
- Access provider forms and documents

### Provider Portal:

[provider.eternalhealth.com](https://provider.eternalhealth.com)

## Provider Contact Directory

| Department        | Phone          | Fax            |
|-------------------|----------------|----------------|
| Provider Services | 1-800-680-9255 | 1-866-347-8130 |
| Care Management   | 1-800-787-5076 | 1-855-708-2735 |

| Department                            | Phone          | Fax            |
|---------------------------------------|----------------|----------------|
| Expedited Authorization Requests (UM) | 1-800-680-9255 | 1-866-215-4297 |
| Authorization Requests (UM)           | 1-800-680-9255 | 1-866-337-8686 |
| Pharmacy (Optum RX)                   | 1-800-891-6989 | 1-800-527-0531 |
| Appeals and Grievances                | 1-800-651-9613 | 1-888-692-7270 |
| Member Services                       | 1-800-680-4568 | 1-888-347-8130 |

## Claim Submission

| Method            | Information                                                             |
|-------------------|-------------------------------------------------------------------------|
| Electronic Claims | Change Healthcare                                                       |
| Payer ID          | RP037                                                                   |
| Paper Claims      | eternalHealth Billing Department, PO Box 1263,<br>Westborough, MA 01581 |

## Provider Resources

| Resource                    | Website                                                                                                                                            |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Find a Provider or Pharmacy | <a href="http://www.eternalhealth.com/for-members/find-a-provider-or-pharmacy/">www.eternalhealth.com/for-members/find-a-provider-or-pharmacy/</a> |
| Provider Forms & Documents  | <a href="http://www.eternalhealth.com/for-providers/forms-and-documents/">www.eternalhealth.com/for-providers/forms-and-documents/</a>             |
| Eligibility Verification    | <a href="http://provider.eternalhealth.com">provider.eternalhealth.com</a>                                                                         |
| Claims Status               | <a href="http://provider.eternalhealth.com">provider.eternalhealth.com</a>                                                                         |

## Electronic Payments (EFT)

| Resource | Information                                      |
|----------|--------------------------------------------------|
| Vendor   | Zelis                                            |
| Phone    | 1-877-828-8770                                   |
| Website  | <a href="http://www.zelis.com">www.zelis.com</a> |
| Payer ID | RP037                                            |

## Prior Authorization Resources

| Resource                                         | Access Information                                                                                                                                                       |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part B Prior Authorization List                  | <a href="#">eternalHealth Part B Prior Authorization List</a>                                                                                                            |
| Part C Prior Authorization List                  | <a href="#">eternalHealth Part C Prior Authorization List</a>                                                                                                            |
| Prior Authorization Request Form                 | <a href="#">eternalHealth Prior Authorization Request Form</a>                                                                                                           |
| Part D Coverage Criteria                         | <a href="http://www.eternalhealth.com/for-members/prescription-drugs/#Prior-Authorization">www.eternalhealth.com/for-members/prescription-drugs/#Prior-Authorization</a> |
| Electronic Part D Prior Authorization Submission | <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a>                                                                                               |

Questions? Contact Provider Services at 1-800-680-9255 or visit [provider.eternalhealth.com](http://provider.eternalhealth.com) for additional resources.



PLEASE READ

## Important Notice

This Provider Manual is intended as a general reference guide for participating providers and facilities. It does not replace, amend, or supersede the Provider Agreement. In the event of any conflict between this Provider Manual and the Provider Agreement, the terms of the Provider Agreement shall govern.

The information contained in this manual is subject to change based on Centers for Medicare & Medicaid Services (CMS) guidance, regulatory requirements, operational updates, and plan policies. Providers are responsible for complying with the most current version of this manual and all provider communications issued by eternalHealth.

Coverage determinations, reimbursement decisions, authorization requirements, and provider participation requirements are subject to applicable federal and state laws, CMS regulations, member benefit provisions, medical necessity requirements, and contractual obligations.

For questions regarding this manual, providers may contact Provider Services at 1-800-680-9255 or visit [provider.eternalhealth.com](https://provider.eternalhealth.com).



## SECTION 01

# Provider Administrative Information

### IN THIS SECTION

- › Overview
- › Provider Participation Standards
- › Provider Responsibilities
- › Provider Information Requirements
- › Provider Cooperation
- › Network Participation
- › Compliance with Participation Standards
- › Acceptance of New Patients
- › Hospital Privileges
- › Provider Data Maintenance
- › Provider Roster Submission
- › Provider Directory Requirements
- › CAQH Profile Requirements

## Overview

This section outlines the administrative requirements for participation in the eternalHealth provider network. Participating providers are responsible for maintaining accurate provider information, complying with network participation requirements, supporting provider directory accuracy, and meeting credentialing and regulatory obligations.

The information contained in this section is intended to help providers understand the operational responsibilities associated with network participation and maintain compliance with applicable contractual, regulatory, and Medicare Advantage program requirements.

## Topics addressed in this section include:

- Provider participation standards
- Hospital privileges
- Provider directory requirements
- Provider responsibilities
- Provider data maintenance
- CAQH profile requirements
- Acceptance of new patients
- Provider roster submissions

Providers are expected to notify eternalHealth of changes affecting their practice, professional status, or provider directory information to ensure accurate member access, timely claims processing, and compliance with Centers for Medicare & Medicaid Services (CMS) requirements.

## Provider Participation Standards

Participating providers play a critical role in ensuring eternalHealth members receive high-quality, accessible, and coordinated healthcare services. Providers are expected to comply with the terms of their Provider Agreement, applicable federal and state laws, Centers for Medicare & Medicaid Services (CMS) requirements, and the policies and procedures outlined in this Provider Manual.

Providers are expected to maintain the professional, administrative, and operational standards necessary to support quality care delivery and an effective provider network.

## Provider Responsibilities

### Participating providers must:

- Maintain all applicable professional licenses, certifications, registrations, accreditations, and credentials required to practice within their scope of service.
- Comply with all Medicare Advantage program requirements and applicable regulatory standards.
- Provide medically necessary services in accordance with accepted standards of medical practice.
- Cooperate with quality improvement, utilization management, credentialing, compliance, and audit activities conducted by eternalHealth.
- Maintain complete and accurate medical records in accordance with applicable state and federal requirements.
- Protect the confidentiality of member health information and comply with HIPAA privacy and security requirements.

- Facilitate continuity and coordination of care for members.
- Comply with appointment access and availability standards established by eternalHealth and applicable regulatory agencies.
- Participate in provider education, quality improvement, and population health initiatives when requested by eternalHealth.

## Provider Information Requirements

Providers are responsible for ensuring that all information maintained by eternalHealth is accurate and current. Timely notification of changes helps ensure accurate provider directory information, proper claims adjudication, regulatory compliance, and member access to care.

Providers must promptly notify eternalHealth of changes including, but not limited to:

- Practice or billing address
- Telephone or fax number
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Group affiliation
- Practice ownership
- Office hours
- Medicare participation status
- Licensure status
- Hospital privileges
- Sanction, suspension, exclusion, or disciplinary actions
- Practice closures or relocation
- Provider additions or terminations within a participating group

Failure to maintain accurate provider information may result in inaccurate provider directory listings, claims processing delays, payment issues, or regulatory noncompliance.

## Provider Cooperation

Participating providers are expected to cooperate with requests from eternalHealth related to:

- Credentialing and recredentialing activities
- Claims investigations and payment integrity reviews
- Quality improvement initiatives
- Compliance monitoring activities
- Risk adjustment and medical record reviews
- Regulatory audits and oversight activities
- HEDIS® and other quality reporting activities

Providers must furnish requested documentation within the required timeframes and respond promptly to communications from eternalHealth regarding operational or member care matters.

## Network Participation

As a participating provider, you agree to support the goals of coordinated, member-centered care and to collaborate with eternalHealth and other network providers to improve quality, safety, and health outcomes for members. Providers should make reasonable efforts to refer members to participating providers and facilities whenever clinically appropriate and consistent with member benefit requirements.

## Compliance with Participation Standards

eternalHealth reserves the right to monitor compliance with provider participation standards and may take corrective action when a provider fails to meet contractual, operational, quality, or regulatory requirements. Corrective actions may include education, corrective action plans, focused monitoring, credentialing review, or other actions permitted under the Provider Agreement and applicable law.

## Acceptance of New Patients

Participating providers are expected to maintain reasonable access to care for eternalHealth members. Providers who are accepting new patients should make appointments available in accordance with the access standards outlined in this manual and applicable regulatory requirements.

Providers who decide to close their practice to new eternalHealth members must provide written notice to eternalHealth at least sixty (60) days prior to the effective date of the closure. This advance

notice allows eternalHealth to maintain accurate provider directory information and ensure members have appropriate access to participating providers.

Providers must continue to treat existing members in accordance with the terms of their Provider Agreement and applicable continuity of care requirements. Temporary restrictions on new patient acceptance must also be reported to eternalHealth.

## Hospital Privileges

Participating providers are responsible for maintaining hospital privileges appropriate to their specialty when required by applicable laws, accreditation standards, credentialing requirements, or the terms of the Provider Agreement.

eternalHealth reserves the right to require hospital admitting privileges or alternative arrangements that ensure continuity and coordination of care for members. Providers who lose, voluntarily surrender, have restricted, or otherwise experience changes to hospital privileges must notify eternalHealth within ten (10) business days of the effective date of the change.

Failure to maintain required hospital privileges or timely report changes may result in credentialing review or other actions consistent with the Provider Agreement and applicable regulatory requirements.

## Provider Data Maintenance

Accurate provider information is essential to claims processing, member access to care, provider directory accuracy, regulatory compliance, and network operations. Providers must promptly notify eternalHealth whenever changes occur to practice or provider information.

### **Providers must report updates including, but not limited to:**

- Practice location addresses
- Billing addresses
- Telephone and fax numbers
- Office hours
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Group affiliations
- Medicare participation status

- Licensure status
- Hospital privileges
- Practice ownership changes
- Provider additions and terminations
- Sanctions, exclusions, disciplinary actions, or investigations that could affect participation status

Timely updates help ensure accurate claims payment and provider directory information and support compliance with CMS provider directory requirements.

## Provider Roster Submission

Provider roster submissions are used to maintain accurate network records and provider directory information. Physician groups, health systems, facilities, and other contracted entities are responsible for notifying eternalHealth of provider additions, terminations, demographic changes, and practice updates.

Large provider groups should submit roster updates on a monthly basis. Smaller provider organizations may submit updates as needed; however, all contracted groups must provide a complete roster at least quarterly. More frequent submissions are encouraged to ensure information remains current.

### Provider roster submissions should include:

- New provider additions
- Specialty updates
- Changes in provider participation status
- Provider terminations
- Contact information changes
- Practice location changes
- New service locations

Providers must maintain an active CAQH profile and submit all required documentation before new providers can be added to the network. An updated W-9 is required when adding a new service location.

### Submit all roster updates to:

Provider Relations

[providerrelations@eternalhealth.com](mailto:providerrelations@eternalhealth.com)

## Provider Directory Requirements

eternalHealth maintains provider directory information to support member access to care and comply with CMS and state regulatory requirements. Participating providers are responsible for ensuring all provider directory information remains complete, accurate, and current.

### Provider directory information includes:

- Provider name
- Specialty
- Practice location
- Telephone number
- Telehealth Options
- Acceptance of new patients
- Hospital affiliations
- Languages spoken
- Accessibility accommodations, where applicable

Providers may be contacted periodically by eternalHealth to validate directory information. Providers are expected to respond promptly to validation requests to assist with regulatory compliance and directory accuracy.

Failure to provide timely updates may result in inaccurate provider listings, member access issues, claims processing delays, and potential regulatory findings.

## CAQH Profile Requirements

Providers are responsible for maintaining a complete, current, and accurate CAQH ProView profile. An active CAQH profile supports credentialing, recredentialing, provider directory accuracy, and network management activities.

Providers should review and update their CAQH profile regularly and must complete CAQH attestation requirements in accordance with CAQH standards. eternalHealth recommends reviewing and reattesting profile information whenever updates occur and no less frequently than required by CAQH.

### To maintain an accurate CAQH profile:

- Log in to CAQH ProView.
- Review all demographic and practice information.
- Update any outdated or incomplete information.
- Complete all required attestations.
- Resolve any profile errors or deficiencies.
- Submit profile updates as necessary.

Questions regarding the CAQH Provider Data Portal may be directed to DataSpring, powered by CAQH, through the support and clinician resources available at [DataSpring.com](https://DataSpring.com).



## SECTION 02

# Member Eligibility and Benefits

### IN THIS SECTION

- › Overview
- › Member Identification and Eligibility Verification
- › Member Identification Cards
- › Service Area
- › Referrals and Use of Network Providers
- › HMO Plans
- › PPO Plans
- › Services Not Requiring Prior Authorization
- › Covered Benefits
- › Coordination of Benefits (COB)
- › Medicare Advantage Members with Medicaid
- › Subrogation

## Overview

Participating providers are responsible for verifying member eligibility, benefits, and applicable cost-sharing requirements before rendering non-emergent services. Eligibility verification helps ensure claims are submitted correctly, members receive services consistent with their plan benefits, and prior authorization requirements are identified before services are rendered.

This section provides information regarding member identification, eligibility verification, service areas, covered benefits, coordination of benefits, and subrogation requirements.

## Member Identification and Eligibility Verification

Providers should verify member eligibility and benefits through the eternalHealth Provider Portal prior to each date of service.

### Provider Portal:

[provider.eternalhealth.com](https://provider.eternalhealth.com)

## Verifying eligibility before services are rendered helps providers:

- Confirm active member enrollment.
- Verify benefit coverage.
- Identify applicable copayments or cost-sharing obligations.
- Determine whether prior authorization requirements apply.
- Reduce claim denials related to eligibility or coverage issues.
- Confirm the appropriate payer for covered services.

Eligibility and benefit verification does not guarantee payment. Payment remains subject to member eligibility on the date of service, benefit limitations, medical necessity requirements, prior authorization requirements, and all applicable claims processing policies.

## Member Identification Cards

All eternalHealth members receive a member identification card that contains information necessary to access healthcare services and verify eligibility. Members may also access a digital identification card through the member portal.

Providers should request and review the member identification card at each visit to confirm eligibility and ensure member information is current.

### The member identification card includes information such as:

- Member name
- Member identification number
- Plan information
- Effective dates, as applicable
- Important provider and member contact information

eternalHealth utilizes a unique member identifier and does not use Social Security Numbers as member identification numbers. Member IDs follow the format:

**EHXXXXXXXXXX**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                          |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
|  <p><b>H1280-001</b><br/> <b>Issuer ID:</b> 80840<br/> <b>Effective:</b> xx/xx/xxxx</p> <p><b>HMO</b></p> <p><b>Jane Doe</b><br/> <b>eternalHealth Forever (HMO)</b><br/> <b>Member ID:</b> EH-000000000</p> <p><b>Primary Care Provider:</b> Dr. John Smith</p> <p><b>Copay (In-Network)</b><br/> <b>PCP:</b> \$X<br/> <b>Specialist:</b> \$X<br/> <b>Emergency:</b> \$X<br/> <b>Urgent Care:</b> \$X<br/>         Medicare limiting charges apply.</p>  <p><b>RXBIN:</b> 610011<br/> <b>RxPCN:</b> CTRXMEDD<br/> <b>RxGrp:</b> ETHMEDD</p> | <p><b>Member Services:</b> 800-680-4568      <a href="http://www.eternalHealth.com">www.eternalHealth.com</a><br/> <b>Pharmacy Services:</b> 800-891-6989<br/> <b>Urgent 24-Hr Nurse/Behavioral Health Crisis:</b> 800-892-1361<br/> <b>Clinical/Behavioral Case Management:</b> 800-787-5076<br/> <b>Vision:</b> 866-944-0347<br/> <b>Hearing:</b> 866-559-0158<br/> <b>Transportation:</b> 888-617-0350</p> <p><b>For Providers</b><br/>         Provider Services &amp; Prior Authorizations: 800-680-9255</p> <table border="0"> <tr> <td> <b>Medical Claims</b><br/> <b>Payer ID:</b> RP037<br/>                 eternalHealth<br/>                 PO Box 1263<br/>                 Westborough, MA 01581             </td> <td> <b>Pharmacy Claims</b><br/>                 OptumRx<br/>                 3515 Harbor Blvd.<br/>                 Costa Mesa, CA 92626             </td> </tr> </table>  | <b>Medical Claims</b><br><b>Payer ID:</b> RP037<br>eternalHealth<br>PO Box 1263<br>Westborough, MA 01581 | <b>Pharmacy Claims</b><br>OptumRx<br>3515 Harbor Blvd.<br>Costa Mesa, CA 92626 |
| <b>Medical Claims</b><br><b>Payer ID:</b> RP037<br>eternalHealth<br>PO Box 1263<br>Westborough, MA 01581                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Pharmacy Claims</b><br>OptumRx<br>3515 Harbor Blvd.<br>Costa Mesa, CA 92626                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                          |                                                                                |

Sample eternalHealth member ID card

The member ID consists of an eleven-character alphanumeric identifier assigned exclusively to the member.

## Service Area

At the time of publication, eternalHealth serves Medicare Advantage members in designated counties within Massachusetts and Arizona.

### Massachusetts Service Area

- Suffolk County
- Worcester County
- Middlesex County
- Norfolk County
- Bristol County
- Plymouth County

### Arizona Service Area

- Maricopa County
- Pima County
- Pinal County
- Graham County

Providers should refer to current plan materials and annual plan updates for the most current service area information.

## Referrals and Use of Network Providers

eternalHealth encourages the use of participating providers and facilities to promote coordinated, high-quality, and cost-effective care while improving member access to covered services.

### HMO Plans

Members enrolled in an HMO product select a Primary Care Provider (PCP) from the eternalHealth network. While referrals are generally not required, primary care providers are encouraged to coordinate care and communicate with participating specialists and facilities whenever appropriate.

Providers should make reasonable efforts to direct members to participating providers whenever medically appropriate and available.

### PPO Plans

Members enrolled in a PPO product are not required to select a Primary Care Provider; however, eternalHealth strongly encourages members to establish care with a participating PCP to support care coordination and preventive health management.

Providers should encourage members to utilize participating providers whenever possible to reduce out-of-pocket expenses and support continuity of care.

## Services Not Requiring Prior Authorization

The following services generally do not require prior authorization when provided in accordance with plan benefits and applicable regulations:

- Routine preventive services.
- Breast examinations.
- Screening mammograms.
- Pap tests.
- Pelvic examinations.
- Influenza vaccinations.
- COVID-19 vaccinations.
- Hepatitis B vaccinations.
- Pneumonia vaccinations.

- Emergency services.
- Urgently needed services when network providers are unavailable or inaccessible.
- Medicare-covered dialysis services received while temporarily outside the service area.

Additional prior authorization requirements are addressed in Section 4: Utilization Management and Prior Authorization.

## Covered Benefits

eternalHealth provides comprehensive Medicare Advantage benefits that include preventive services, primary care, specialty care, and other medically necessary services covered under the applicable plan benefit package.

### Coverage is subject to:

- Member eligibility.
- Plan benefit provisions.
- Medical necessity requirements.
- CMS coverage guidelines.
- Applicable prior authorization requirements.

Providers should review plan-specific Evidence of Coverage (EOC) documents and benefit materials to verify covered services and member cost-sharing obligations.

Services excluded by Medicare or specifically excluded under a member's benefit plan are not eligible for reimbursement unless otherwise required by law or plan policy.

When a member elects to receive a non-covered service or a service determined not medically necessary, the provider should:

- Inform the member of financial responsibility prior to rendering the service.
- Obtain appropriate documentation acknowledging the member's responsibility.
- Maintain documentation in the medical record.
- Submit a request for an organizational determination when appropriate.

Applicable member cost-sharing may apply to covered services in accordance with the member's plan benefits.

## Coordination of Benefits (COB)

Coordination of Benefits (COB) is the process used when a member has healthcare coverage under more than one health plan or insurance arrangement. COB helps ensure proper payment of claims and prevents duplicate payment for services.

Participating providers must cooperate with COB activities and submit claims to the appropriate primary payer when applicable. Providers may be asked to supply additional information regarding other insurance coverage maintained by the member.

Members may not be billed for covered services except for applicable copayments, coinsurance, deductibles, or other member financial responsibilities established by the plan. Participating providers must accept eternalHealth payment and applicable member cost sharing as payment in full in accordance with the Provider Agreement.

## Medicare Advantage Members with Medicaid

For members who are eligible for both Medicare and Medicaid, providers should follow applicable federal and state coordination of benefits requirements.

Providers should not collect member cost-sharing amounts when prohibited by Medicaid program requirements.

## Subrogation

Subrogation is the process through which eternalHealth may recover healthcare expenses when another party is responsible for the member's illness, injury, or medical condition.

If a third party may be responsible for a member's medical expenses, providers should cooperate with requests for information related to the member's condition, treatment, or claims associated with the injury or illness.

To the extent permitted by law, eternalHealth or its designated recovery vendors may pursue recovery of amounts previously paid for healthcare services related to third-party liability claims.



## SECTION 03

# Access to Care and Care Coordination

### IN THIS SECTION

- › Overview
- › Appointment Access Standards
- › Office Waiting Times
- › Office Hours
- › Accessibility Requirements
- › After-Hours Access Requirements
- › Care Coordination
- › Member Referrals
- › Use of Participating and Non-Participating Providers
- › Continuity of Care
- › Non-Adherent Members

## Overview

eternalHealth is committed to ensuring members have timely access to medically necessary healthcare services. Participating providers play an essential role in supporting access to care, coordinating services across the healthcare continuum, and promoting positive health outcomes for members.

Providers are expected to maintain appointment availability, coordinate care appropriately, support continuity of care, and comply with all applicable access standards and regulatory requirements.

## Appointment Access Standards

Participating providers must maintain appointment availability standards that support timely access to care and comply with applicable Centers for Medicare & Medicaid Services (CMS), state regulatory, and accreditation requirements.

Providers are expected to schedule appointments within the following timeframes:

| Appointment Type             | Appointment Standard |
|------------------------------|----------------------|
| Emergency Services           | Immediately          |
| Urgent Care                  | Within 24 Hours      |
| Routine Symptomatic Care     | Within 7 Days        |
| Wellness / Preventative Care | Within 30 Days       |

Emergency situations should be directed to 911 or the nearest emergency department.

## Office Waiting Times

Providers should make every reasonable effort to minimize wait times for members.

Office waiting times should not exceed thirty (30) minutes from the member's scheduled appointment time, except in circumstances involving medical emergencies or unforeseen clinical situations.

## Office Hours

Participating providers must maintain sufficient office hours to meet member needs and support access to care.

Providers must notify eternalHealth of any changes to office hours, office locations, or appointment availability as soon as possible, but no later than three (3) business days after the change becomes effective.

## Accessibility Requirements

All provider offices must comply with applicable federal and state accessibility requirements, including the Americans with Disabilities Act (ADA).

Provider offices should ensure reasonable accommodation and accessibility for members with physical, sensory, cognitive, developmental, and communication-related disabilities.

## After-Hours Access Requirements

Participating providers are responsible for ensuring members have access to healthcare guidance and assistance twenty-four (24) hours a day, seven (7) days a week, including weekends and holidays.

### **After-hours coverage may be provided through:**

- The provider directly.
- A designated covering provider.
- A professionally staffed answering service capable of contacting the provider or covering provider.

If voicemail services are utilized, the message must provide clear instructions that allow members experiencing urgent medical concerns to contact the provider or covering provider directly.

Voicemail messages should not instruct members to seek emergency department services for all after-hours concerns unless an emergency condition exists.

## **Care Coordination**

Care coordination is a fundamental component of the eternalHealth model of care. Providers are encouraged to communicate with other treating practitioners, facilities, care managers, and community resources to support efficient and effective care delivery.

### **Care coordination may include:**

- Sharing clinically relevant information.
- Coordinating referrals and follow-up care.
- Transition planning following hospitalization.
- Medication reconciliation.
- Communication with care management staff.
- Coordination of preventive and chronic care services.

Providers are encouraged to work collaboratively to reduce fragmentation of care and improve member outcomes.

## **Member Referrals**

When medically necessary services are required beyond the provider's scope of practice, providers are expected to coordinate referrals to qualified participating providers whenever possible.

### **Providers should consider:**

- The member's clinical needs.

- Specialty requirements.
- Geographic accessibility.
- Continuity of care considerations.
- Network participation status.

#### **Referral documentation should clearly identify:**

- Reason for referral.
- Relevant diagnoses.
- Clinical findings.
- Recommended follow-up care.
- Supporting medical records when appropriate.

## **Use of Participating and Non-Participating Providers**

Providers should refer members to participating providers and facilities whenever medically appropriate and reasonably available. Utilization of participating providers supports care coordination, continuity of care, and member affordability.

Referral to a non-participating provider may be appropriate under circumstances including:

- A participating provider is not reasonably available.
- A required specialty service is unavailable within the network.
- Emergency services are required.
- An out-of-network referral is approved by eternalHealth.
- Referral is determined to be in the member's best clinical interest.

Providers should follow applicable authorization and referral requirements when arranging care outside the network.

## **Continuity of Care**

eternalHealth supports continuity of care for members receiving ongoing treatment or services.

Participating providers are expected to cooperate with continuity-of-care efforts when:

- Members transition between providers.
- Members are discharged from hospitals or facilities.
- Providers leave the network.
- Changes in network participation occur.
- Members require ongoing treatment for acute or chronic conditions.

Providers should ensure the timely transfer of medical records and communicate clinically relevant information to receiving providers to promote safe and uninterrupted care.

## Non-Adherent Members

eternalHealth recognizes that providers occasionally encounter members who do not follow treatment recommendations, miss appointments, or decline medically recommended care.

### Providers should document:

- Missed appointments.
- Refusal of recommended treatment.
- Failure to follow care plans.
- Inability to reach the member.
- Education provided regarding treatment recommendations.

When concerns arise regarding a member's adherence to treatment plans or participation in recommended care, providers are encouraged to contact eternalHealth Provider Services or Care Management for assistance.

eternalHealth may be able to assist with outreach, care coordination, education, transportation resources, and other interventions designed to help members overcome barriers to care and improve treatment adherence.



## SECTION 04

# Utilization Management and Prior Authorization

### IN THIS SECTION

- › Overview
- › Key Definitions
- › Provider Rights Under Utilization Management
- › Utilization Management Program
- › Prior Authorization Requirements
- › Services Requiring Prior Authorization
- › Standard Authorization Requests
- › Expedited Authorization Requests
- › Clinical Information Requirements
- › Part B Prior Authorization
- › Part D Prior Authorization
- › Part D Prior Authorization Resources
- › Authorization Determinations
- › Provider Responsibilities

## Overview

The eternalHealth Utilization Management (UM) Program is designed to ensure that members receive medically necessary, appropriate, and cost-effective healthcare services in accordance with Centers for Medicare & Medicaid Services (CMS) requirements, nationally recognized clinical guidelines, and plan policies.

Utilization Management activities support quality healthcare delivery by evaluating the medical necessity, appropriateness, and efficiency of healthcare services while promoting positive member outcomes.

Participating providers are expected to comply with utilization management requirements, including prior authorization requirements, clinical documentation requests, and medical necessity review processes.

## Key Definitions

The following definitions apply to the Utilization Management and Prior Authorization processes described in this section.

**Prior Authorization:** Prior Authorization is the process by which eternalHealth reviews certain services, procedures, medications, or items before they are provided to determine whether they meet applicable coverage, medical necessity, and benefit requirements. Prior authorization is not a guarantee of payment and is subject to member eligibility, benefit coverage, and all applicable claims adjudication requirements.

**Medical Necessity:** Medical Necessity refers to healthcare services, procedures, supplies, or medications that are appropriate, reasonable, and necessary for the diagnosis or treatment of a member's medical condition and are consistent with generally accepted standards of medical practice, CMS coverage requirements, and eternalHealth policies.

**Standard Authorization Request:** A Standard Authorization Request is a prior authorization request that does not meet criteria for expedited review and is processed within applicable regulatory and operational timeframes. Providers should submit all relevant clinical information necessary to support review and determination.

**Expedited Authorization Request:** An Expedited Authorization Request is a request for an accelerated review when applying the standard review timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function. Expedited requests must be supported by appropriate clinical documentation.

**Concurrent Review:** Concurrent Review is the evaluation of ongoing medical care, treatment, or services while the member is actively receiving care. Concurrent reviews may be performed to assess continued medical necessity, appropriateness of care, discharge planning needs, and coordination of services.

**Retrospective Review:** Retrospective Review is the evaluation of services after they have been rendered to determine medical necessity, appropriateness of care, compliance with coverage requirements, coding accuracy, and payment eligibility. Retrospective reviews may include requests for medical records and supporting clinical documentation.

**Utilization Management (UM):** Utilization Management is a structured process used to evaluate the medical necessity, appropriateness, quality, and efficiency of healthcare services while supporting positive health outcomes and compliance with Medicare Advantage requirements.

**Adverse Determination:** An Adverse Determination is a decision to deny, reduce, terminate, or limit coverage of a requested service, item, or treatment based on applicable coverage criteria, medical necessity requirements, benefit limitations, or other plan requirements. Providers and members will receive notification of adverse determinations in accordance with regulatory requirements.

**Reconsideration:** A Reconsideration is the process through which a provider or member may request a review of an adverse determination and submit additional information for consideration.

Reconsideration rights are communicated in accordance with CMS requirements and applicable plan procedures.

## Provider Rights Under Utilization Management

Provider participation in the Utilization Management process includes certain rights and protections. Participating providers may:

- Discuss utilization management determinations with appropriately qualified clinical reviewers.
- Submit additional clinical information to support a review request.
- Request expedited review when applicable criteria are met.
- Receive notification of utilization management determinations in accordance with regulatory requirements.
- Receive information regarding appeal and reconsideration rights when an adverse determination is issued.

eternalHealth does not reward individuals for issuing denials of coverage or create financial incentives that encourage underutilization of medically necessary services. Utilization management decisions are based on applicable benefit coverage, medical necessity criteria, CMS requirements, and supporting clinical information.

## Utilization Management Program

**The Utilization Management Program supports:**

- Appropriate utilization of healthcare services.
- Evidence-based medical decision-making.

- Timely access to medically necessary care.
- Compliance with CMS Medicare Advantage requirements.
- Efficient use of healthcare resources.
- Improved quality and member outcomes.

#### **Utilization Management decisions are based on:**

- Member eligibility and benefits.
- Medical necessity.
- Applicable CMS coverage determinations.
- Nationally recognized clinical guidelines.
- Plan policies and procedures.
- Supporting clinical documentation.

Medical necessity determinations are made by appropriately qualified healthcare professionals and do not reward individuals for issuing denials of coverage or service.

## **Prior Authorization Requirements**

Certain services require prior authorization before services are rendered. Prior authorization allows eternalHealth to verify:

- Medical necessity.
- Appropriateness of care.
- Compliance with benefit requirements.
- Availability of participating providers and facilities.
- Applicable CMS coverage criteria.

Prior authorization is not a guarantee of payment.

#### **Payment remains subject to:**

- Member eligibility on the date of service.
- Benefit coverage.

- Medical necessity.
- Accurate coding and billing.
- Timely filing requirements.
- Compliance with all applicable policies and procedures.

Providers are responsible for obtaining required authorizations prior to delivering services unless the service qualifies as an emergency or otherwise does not require prior authorization under applicable regulations.

## Services Requiring Prior Authorization

Prior authorization requirements are subject to change based on CMS guidance, benefit changes, and plan policy updates.

Providers should consult the most current Prior Authorization Lists and provider resources available through the Provider Portal and eternalHealth website before rendering services.

### Examples of services that may require authorization include:

- Selected inpatient admissions.
- Certain outpatient procedures.
- Advanced diagnostic imaging.
- Durable medical equipment.
- Post-acute care services.
- Home health services.
- Skilled nursing facility services.
- Specialty medications.
- Other services designated by eternalHealth.

## Standard Authorization Requests

Standard prior authorization requests should be submitted before services are rendered whenever authorization is required.

### Providers may submit requests through:

- The eternalHealth Provider Portal.
- Fax submission.
- Telephone submission, when applicable.
- Designated pharmacy authorization platforms for Part D requests.

Authorization requests should be submitted with sufficient clinical information to support review and avoid delays in processing.

## Expedited Authorization Requests

Providers may request an expedited review when applying standard review timeframes could seriously jeopardize the member's:

- Life.
- Health.
- Ability to regain maximum function.

Expedited requests should include clinical documentation supporting the need for expedited review.

Expedited Authorization Contact Information

Phone: 1-800-680-9255

Fax: 1-866-215-4297

Requests submitted as expedited that do not meet expedited criteria may be processed under standard review timeframes. Based on the provider contact information maintained by eternalHealth.

## Clinical Information Requirements

To facilitate timely review, providers should submit all available clinical documentation relevant to the requested service.

### Documentation may include:

- Office notes.
- History and physical examinations.
- Diagnostic test results.

- Imaging reports.
- Treatment plans.
- Medication history.
- Hospital records.
- Specialty consultation reports.

Incomplete submissions may delay review or result in requests for additional information.

## Part B Prior Authorization

Certain Medicare Part B services require prior authorization.

Providers should consult the current Part B Prior Authorization List available through eternalHealth resources before rendering services.

The list identifies services, procedures, and items requiring authorization and may be updated periodically to reflect CMS guidance and plan requirements.

Providers are responsible for verifying current requirements at the time services are scheduled or rendered.

## Part D Prior Authorization

Certain Medicare Part D prescription drugs require prior authorization before coverage may be approved.

Providers should review current formulary requirements and Part D prior authorization criteria available through eternalHealth pharmacy resources.

## Part D Prior Authorization Resources

- Prescription Drug Information and Criteria
- Part D Prior Authorization Requirements
- Electronic Submission Through CoverMyMeds®

Providers should submit all relevant supporting clinical documentation with requests to help ensure timely review.

## Authorization Determinations

Following review of all submitted information, eternalHealth will issue one of the following determinations:

- Approval.
- Partial Approval.
- Denial.
- Request for Additional Information.

Providers will be notified of authorization decisions in accordance with CMS and regulatory requirements.

If a request is denied, notification will include applicable appeal rights and instructions for requesting reconsideration, as required.

## Provider Responsibilities

**Participating providers are responsible for:**

- Verifying whether services require prior authorization.
- Obtaining required authorizations before services are rendered.
- Providing complete and accurate clinical information.
- Responding promptly to requests for additional information.
- Documenting authorization numbers in the medical record when applicable.
- Complying with utilization management policies and procedures.
- Coordinating services with participating providers whenever appropriate.

Failure to obtain required prior authorization may result in administrative denials, payment reductions, or non-payment of services, subject to applicable laws, regulations, CMS requirements, and provider contract provisions.



## SECTION 05

# Medical Records and Documentation

### IN THIS SECTION

- › Overview
- › Access to Medical Records
- › Medical Record Standards
- › Medical Record Documentation Requirements
- › Record Corrections
- › Telephone and Verbal Communications
- › Confidentiality and Record Security
- › Medical Record Reviews and Audits
- › Electronic Medical Record (EMR) Integration
- › Risk Adjustment and HEDIS Documentation Support
- › HEDIS® Support

## Overview

Accurate, complete, and timely medical record documentation is essential to the delivery of quality healthcare services and supports care coordination, regulatory compliance, quality improvement initiatives, risk adjustment activities, utilization management reviews, and claims payment processes.

Participating providers are responsible for maintaining medical records that accurately document services rendered to eternalHealth members and comply with applicable federal and state laws, CMS requirements, accreditation standards, and professional practice guidelines.

Medical records must be readily accessible, securely maintained, and available upon request to support healthcare operations, quality activities, audits, and regulatory reviews.

## Access to Medical Records

**eternalHealth may request medical records to support:**

- Claims review and payment determination
- Utilization management activities
- Quality improvement initiatives
- HEDIS® data collection
- Risk adjustment reporting
- Regulatory compliance reviews
- Medical necessity determinations
- Care coordination activities
- Payment integrity reviews
- CMS, federal, or state audit requirements

Unless otherwise specified in the Provider Agreement, providers must furnish requested medical records at no charge to eternalHealth and within the timeframe specified in the request.

Providers must cooperate fully with all authorized requests for records and supporting documentation.

## Medical Record Standards

Medical records must be complete, accurate, legible, and maintained in a manner that facilitates continuity of care and supports the services billed.

**Medical records should:**

- Be organized in a logical and consistent format.
- Be readily retrievable upon request.
- Contain documentation supporting all diagnoses and services billed.
- Comply with federal and state record retention requirements.
- Be secured to protect member privacy and confidentiality.

Each member record must clearly identify the member and contain sufficient documentation to allow another healthcare professional to understand the member's medical history, treatment provided, and ongoing care needs.

## Medical Record Documentation Requirements

Medical records must include complete documentation for each encounter and service provided.

### Documentation should include:

- Member name
- Date of birth
- Member identification number, when applicable
- Date of service
- Provider name and credentials
- Practice or facility name
- Chief complaint or reason for visit
- Relevant history and examination findings
- Diagnoses and medical conditions assessed
- Treatment provided
- Medications prescribed or reviewed
- Referrals and consultations
- Follow-up recommendations
- Preventive screenings performed or recommended
- Health education provided
- Advance directive documentation, when applicable

Documentation should clearly support all diagnosis codes, procedure codes, and services submitted for reimbursement.

Providers should ensure all entries are dated, authenticated, and attributable to the individual providing care.

## Record Corrections

Medical records must not be altered, falsified, or destroyed.

### When corrections are necessary:

- The original entry must remain visible.
- Corrections should be clearly identified.
- The correction must be dated and authenticated by the individual making the correction.
- Electronic records should maintain audit trail functionality when available.

## Telephone and Verbal Communications

Documentation of clinically relevant telephone calls, consultations, and verbal communications should be maintained in the member's medical record when such information affects treatment decisions or care management activities.

## Confidentiality and Record Security

Providers are responsible for protecting the privacy, confidentiality, and security of member health information.

**All medical records must be maintained in compliance with:**

- HIPAA Privacy Rules
- HIPAA Security Rules
- Federal Medicare regulations
- Applicable state privacy laws
- Other applicable regulatory requirements

Providers should implement appropriate administrative, physical, and technical safeguards to protect health information from unauthorized access, use, disclosure, alteration, or destruction.

## Medical Record Reviews and Audits

eternalHealth reserves the right to review medical records for purposes including:

- |                              |                          |                                    |
|------------------------------|--------------------------|------------------------------------|
| • Quality of care evaluation | • Care coordination      | • Claims payment verification      |
| • HEDIS® reporting           | • Utilization management | • Regulatory compliance review     |
| • Risk adjustment validation | • Coding accuracy review | • Payment integrity investigations |

Providers are expected to cooperate fully with record review requests and provide documentation within requested timeframes.

Medical record audits may be conducted by eternalHealth, regulatory agencies, accreditation organizations, delegated entities, or authorized vendors acting on behalf of eternalHealth.

Medical records must be stored in secure locations and only accessible to authorized personnel.

## Electronic Medical Record (EMR) Integration

eternalHealth supports secure Electronic Medical Record (EMR) integration capabilities designed to streamline medical record exchange and improve care coordination.

Through approved integration vendors and secure HIPAA-compliant connections, participating providers may electronically transmit medical record information for authorized eternalHealth members.

**Benefits of EMR integration may include:**

- Reduced administrative burden
- Enhanced care coordination
- Faster medical record retrieval
- Improved quality reporting
- Improved risk adjustment reporting
- Reduced paper record requests
- Enhanced population health analytics

EMR integrations do not provide eternalHealth access to information for individuals who are not eternalHealth members. Access remains limited to authorized healthcare operations and regulatory purposes.

Providers who do not participate in EMR integrations may continue to submit records using approved alternative methods.

## Risk Adjustment and HEDIS Documentation Support

Accurate and complete documentation supports risk adjustment, quality measurement, care management, and regulatory reporting activities.

Providers play an important role in documenting all evaluated and managed conditions during each member encounter. Documentation should clearly describe:

- Active medical conditions
- Disease severity
- Clinical status
- Treatment plans
- Monitoring activities
- Member response to treatment

Documentation should support the diagnoses reported on claims and accurately reflect the member's health status during the encounter.

## HEDIS® Support

Providers may receive requests for medical records to support Healthcare Effectiveness Data and Information Set (HEDIS®) reporting and other quality measurement activities.

### **Providers are encouraged to:**

- Document preventive screenings.
- Document chronic disease management activities.
- Record immunizations.
- Maintain complete medication histories.
- Document follow-up care and treatment plans.
- Respond promptly to medical record requests.

Accurate documentation contributes to improved quality performance, enhanced care coordination, and better health outcomes for eternalHealth members.



## SECTION 06

# Claims and Billing

### IN THIS SECTION

- › Overview
- › Claims Submission
- › Electronic Claims Submission
- › Paper Claims Submission
- › Clean Claim Requirements
- › Timely Filing Requirements
- › Corrected Claims
- › Claims Processing
- › Claims Status Inquiries
- › Claims Payment
- › Medicare Sequestration
- › Claim Denials and Additional Information Requests
- › Provider Responsibilities

## Overview

eternalHealth is committed to accurate and timely claims adjudication in accordance with Centers for Medicare & Medicaid Services (CMS) requirements, applicable regulatory standards, and provider contractual agreements. Participating providers are responsible for submitting complete, accurate, and timely claims that comply with industry-standard coding and billing requirements.

This section outlines claims submission procedures, billing requirements, payment processes, and provider responsibilities related to claims administration.

## Claims Submission

Providers are encouraged to submit claims electronically whenever possible to support faster processing, improved accuracy, and enhanced security of protected health information.

Claims must be submitted using the appropriate coding standards, billing guidelines, and claim forms required by CMS and eternalHealth. Providers are responsible for ensuring all submitted claims accurately reflect the services rendered.

## Electronic Claims Submission

eternalHealth supports electronic claims submission through Change Healthcare using HIPAA-compliant transaction standards. Electronic submission is the preferred method of claim submission and may reduce processing delays.

Electronic Claims Information

| Description   | Information       |
|---------------|-------------------|
| Clearinghouse | Change Healthcare |
| Payer ID      | RP037             |

### Providers should submit:

- Professional claims using the 837P transaction format.
- Institutional claims using the 837I transaction format.

Electronic claims must comply with CMS electronic claims standards and applicable HIPAA requirements.

## Paper Claims Submission

Although electronic submission is strongly encouraged, eternalHealth accepts paper claims submitted on approved CMS claim forms.

### Accepted Claim Forms

- CMS-1500 (Professional Claims)
- UB-04 / CMS-1450 (Institutional Claims)

Mailing Address

eternalHealth Billing Department

PO Box 1263

Westborough, MA 01581

Attn: eternalHealth Medicare

Providers should ensure all paper claims are legible and contain complete and accurate information.

## Clean Claim Requirements

A clean claim is a claim that can be processed without obtaining additional information from the provider, member, or another party.

**To be considered a clean claim, a submission must include:**

- Member identification number
- Provider National Provider Identifier (NPI)
- Date(s) of service
- Appropriate diagnosis codes
- Appropriate procedure codes
- Place of service information
- Required modifiers
- Authorization information, when applicable
- Any supporting documentation necessary to adjudicate the claim

Claims that are incomplete, inaccurate, improperly coded, or missing required information may be denied, rejected, pending for review, or returned for correction.

## Timely Filing Requirements

Providers must submit claims within the filing deadlines specified in their Provider Agreement. Unless otherwise stated in the Provider Agreement, the standard timely filing requirement for participating providers is ninety (90) calendar days from the date of service.

Claims submitted beyond the applicable filing deadline may be denied.

Providers may not bill members for covered services denied solely due to provider failure to comply with timely filing requirements.

## Corrected Claims

A corrected claim may be submitted when changes are needed to a previously submitted claim due to missing information, coding corrections, billing errors, or other claim inaccuracies.

### Corrected claims should:

- Reference the original claim when applicable.
- Clearly identify the submission as a corrected claim.
- Include all corrected information.
- Be submitted within applicable filing deadlines.

Failure to properly identify a corrected claim may result in delays or duplicate claim denials.

## Claims Processing

### Claims are processed in accordance with:

- CMS Medicare Advantage requirements
- National coding standards
- National Correct Coding Initiative (NCCI) edits
- Medicare payment methodologies
- eternalHealth claims policies and procedures

### Claims may be subject to:

- Coding edits
- Medical necessity review
- Authorization verification
- Payment integrity review
- Coordination of Benefits review
- Documentation requests

Additional information or medical records may be requested when necessary to determine coverage, coding accuracy, or payment eligibility.

## Claims Status Inquiries

Providers may monitor claim activity and review claim status through the eternalHealth Provider Portal.

### Provider Portal:

[provider.eternalhealth.com](https://provider.eternalhealth.com)

### The Provider Portal provides access to:

- Claim status information
- Claim payment information
- Claim history
- Corrected claim status
- Authorization status
- Member eligibility and benefit information
- Remittance advice information
- Payment history
- Denied and pended claim information

Providers are encouraged to utilize the Provider Portal as the primary source for claim status inquiries and payment information.

For additional assistance, providers may contact Provider Services at 1-800-680-9255.

## Claims Payment

Participating providers are reimbursed according to the reimbursement terms and methodologies outlined in their Provider Agreement.

### Payment methodologies may include:

- Medicare-based fee schedules
- Diagnosis Related Group (DRG) methodologies
- Resource-Based Relative Value Scale (RBRVS) methodologies
- Contracted rates
- Other payment arrangements specified in the Provider Agreement

Providers should review remittance advices carefully and reconcile all payments received.

## Medicare Sequestration

eternalHealth applies Medicare sequestration adjustments in accordance with applicable CMS requirements. Unless otherwise specified in the Provider Agreement, reimbursement for covered services may be subject to federally mandated sequestration reductions.

### When applicable:

- A sequestration adjustment of two percent (2%) may be applied.
- Sequestration reductions are applied consistent with CMS guidance.
- The adjustment will be identified on the provider remittance advice as “Sequestration.”

Providers should review remittance advice statements for details regarding any sequestration-related adjustment.

## Claim Denials and Additional Information Requests

### A claim may be denied, rejected, or pended when:

- Required information is missing.
- Coding is inaccurate or incomplete.
- Eligibility cannot be verified.
- Prior authorization requirements were not met.
- Medical necessity requirements are not supported.
- Timely filing requirements were not satisfied.

Providers should review denial information carefully and submit corrected claims, additional documentation, or payment disputes as appropriate.

## Provider Responsibilities

### Participating providers are responsible for:

- Submitting complete and accurate claims.
- Complying with coding and billing guidelines.
- Maintaining documentation supporting billed services.
- Responding promptly to requests for records or additional information.

- Monitoring claim status and payment activity.
- Identifying and reporting overpayments when discovered.
- Complying with all applicable contractual, CMS, and regulatory billing requirements.

Failure to comply with claims submission requirements may result in processing delays, denials, payment adjustments, or other actions permitted under the Provider Agreement and applicable regulations.



## SECTION 07

# Payment Integrity and Provider Disputes

### IN THIS SECTION

- › Overview
- › Program Integrity
- › Payment Accuracy Reviews
- › Overpayment Recovery
- › Reopening and Revision of Claims Determinations
- › Provider Refunds
- › Payment Disputes
- › Payment Dispute Appeals
- › Dispute Resolution Timeframes
- › Provider Responsibilities

## Overview

eternalHealth is committed to ensuring accurate claims payment and maintaining compliance with Centers for Medicare & Medicaid Services (CMS) requirements, applicable federal and state regulations, and provider contractual obligations. Payment Integrity activities are designed to identify billing inaccuracies, prevent improper payments, support regulatory compliance, and promote responsible stewardship of healthcare resources.

Participating providers are expected to cooperate with payment integrity reviews, overpayment investigations, audit activities, and dispute resolution processes.

## Program Integrity

To support accurate claims adjudication and regulatory compliance, eternalHealth maintains a comprehensive Payment Integrity Program that includes both pre-payment and post-payment reviews.

### Program Integrity activities may include:

- Claims reviews
- Coding validation
- Medical necessity reviews
- Documentation audits
- Coordination of Benefits verification
- Fraud, Waste, and Abuse investigations
- Retrospective payment reviews
- Overpayment identification and recovery activities

eternalHealth may utilize internal resources and contracted vendors to conduct these activities. Providers are expected to respond promptly to requests for medical records, billing documentation, and other information necessary to support review activities.

## Payment Accuracy Reviews

### Claims may be reviewed before or after payment to determine:

- Accuracy of coding and billing
- Medical necessity of services provided
- Compliance with Medicare coverage requirements
- Accuracy of reimbursement
- Compliance with provider contract provisions
- Appropriate use of modifiers and coding methodologies

### As part of these reviews, providers may be asked to furnish:

- Medical records
- Treatment notes
- Operative reports
- Diagnostic testing results
- Authorization documentation
- Other supporting records relevant to the claim under review

Failure to provide requested documentation may result in payment adjustments, claim denials, or recovery actions, as permitted by applicable regulations and provider agreements.

## Overpayment Recovery

eternalHealth complies with CMS requirements regarding identification, notification, and recovery of overpayments.

**An overpayment may occur as a result of:**

- Duplicate payments
- Incorrect coding
- Eligibility errors
- Coordination of Benefits updates
- Data entry errors
- Medical necessity determinations
- Audit findings
- Fraud, Waste, or Abuse investigations

**When an overpayment is identified, eternalHealth may:**

- Notify the provider in writing.
- Request repayment.
- Offset the amount against future claim payments.
- Initiate recovery activities through authorized vendors.
- Assess applicable interest when permitted by law.

## Reopening and Revision of Claims Determinations

eternalHealth may reopen and revise a claim determination in accordance with CMS regulations and applicable Medicare reopening guidelines. Claims may be reopened:

- Within one (1) year of the original determination for any reason.
- Within four (4) years for good cause.
- At any time when fraud or similar fault is identified.

## Provider Refunds

If a provider independently identifies an overpayment, the provider should promptly notify eternalHealth and return the overpaid amount.

### Refund submissions should include:

- Member name
- Member ID number
- Date(s) of service
- Claim number
- Amount being refunded
- Explanation of the reason for the refund
- Applicable remittance advice or correspondence related to the claim

Timely reporting of overpayments supports compliance with federal Medicare program requirements and applicable provider contractual obligations.

## Payment Disputes

Participating providers who disagree with a claim payment determination may submit a Payment Dispute for review.

Payment disputes must be submitted within one hundred eighty (180) calendar days from the provider's receipt of the applicable remittance advice.

A payment dispute should contain sufficient information to support review, including:

- |                             |                                |                                                        |
|-----------------------------|--------------------------------|--------------------------------------------------------|
| • Provider name             | • Service Date(s)              | • Relevant medical records or supporting documentation |
| • Member name and member ID | • Explanation of the dispute   | • Provider contact information and return address      |
| • Claim number              | • Applicable remittance advice |                                                        |

Additional information may be requested if necessary to complete the review.

Payment Dispute Submission Address

eternalHealth

Attn: Claims

PO Box 1263

Westborough, MA 01581

Payment Dispute Fax

Fax: 1-888-692-7270

## Payment Dispute Appeals

If a provider disagrees with the outcome of an initial Payment Dispute determination, the provider may submit an appeal for secondary review.

### Appeal requests should include:

- Payment dispute case number
- Original claim information
- Explanation of the basis for appeal
- Any additional supporting documentation
- Provider return address and contact information

Appeals should be submitted to the same mailing address or fax number used for payment disputes.

eternalHealth will review the appeal and issue a written determination consistent with applicable regulatory requirements and provider agreement provisions.

## Dispute Resolution Timeframes

Upon receipt of a complete dispute submission, eternalHealth will review the dispute and provide a written determination.

### First-Level Payment Disputes

- Resolution issued within sixty-five (65) calendar days of receipt.

### Second-Level Payment Dispute Appeals

- Resolution issued within sixty-five (65) calendar days of receipt of the appeal request.

Providers should allow the full review period to expire before submitting duplicate requests regarding the same claim dispute.

Favorable Determinations

If a dispute or appeal is resolved in the provider's favor, eternalHealth will issue any additional payment, interest, or penalties required by law within applicable regulatory timeframes.

## Provider Responsibilities

### Participating providers are responsible for:

- Maintaining documentation supporting billed services.
- Cooperating with audit and payment integrity review requests.
- Responding timely to requests for records or information.
- Reporting identified overpayments.
- Retaining records necessary to support reimbursement.
- Submitting payment disputes within required timeframes.
- Complying with CMS, regulatory, and contractual requirements related to claims payment and reimbursement.

Failure to cooperate with payment integrity activities may result in delayed payments, audit findings, overpayment recoveries, corrective action plans, or other actions permitted under applicable regulations and provider agreements.



## SECTION 08

# Compliance, Fraud, Waste, and Abuse

### IN THIS SECTION

- › Overview
- › Compliance with Federal and State Laws
- › Fraud, Waste, and Abuse (FWA)
- › Fraud
- › Waste
- › Abuse
- › Reporting Fraud, Waste, and Abuse
- › Compliance and FWA Training Requirements
- › Nondiscrimination Requirements
- › Treatment of Immediate Relatives and Household Members
- › Balance Billing and Prohibited Billing Practices
- › Provider Responsibilities

## Overview

As a Medicare Advantage organization, eternalHealth is required to maintain a comprehensive compliance program that promotes adherence to federal and state laws, Centers for Medicare & Medicaid Services (CMS) regulations, contractual obligations, and ethical business practices. Participating providers are important partners in helping ensure compliance with these requirements and maintaining the integrity of the Medicare program.

Providers are expected to conduct business in an ethical manner, comply with applicable laws and regulations, report suspected misconduct, and cooperate with compliance-related activities conducted by eternalHealth, CMS, or other regulatory agencies.

## Compliance with Federal and State Laws

Participating providers must comply with all applicable federal, state, and local laws and regulations governing the delivery of healthcare services and participation in the Medicare Advantage program. This includes requirements established by CMS, the U.S. Department of Health and Human Services (HHS), state regulatory agencies, and other governmental authorities.

Providers are responsible for ensuring that services rendered to eternalHealth members are delivered in accordance with:

- Medicare Advantage regulations
- Medicare coverage policies
- State licensing requirements
- Provider contract requirements
- Privacy and security laws
- Anti-fraud and abuse requirements
- Nondiscrimination requirements

eternalHealth may monitor provider compliance through audits, reviews, education programs, credentialing activities, and regulatory oversight processes.

## Fraud, Waste, and Abuse (FWA)

Fraud, Waste, and Abuse can negatively impact the Medicare program, healthcare costs, and member access to care. Participating providers are expected to remain vigilant in identifying and preventing activities that may constitute Fraud, Waste, or Abuse.

### Fraud

Fraud is the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in an unauthorized benefit. Examples may include:

- Billing for services not rendered
- Falsifying medical records
- Misrepresenting diagnoses or procedures
- Submitting false claims for reimbursement

## Waste

Waste includes the overutilization or misuse of healthcare resources that directly or indirectly results in unnecessary costs to the Medicare program. Examples may include:

- Excessive testing
- Unnecessary services
- Inefficient healthcare practices

## Abuse

Abuse includes actions that are inconsistent with sound medical, business, or fiscal practices and result in unnecessary costs or improper reimbursement. Examples may include:

- Improper billing practices
- Inappropriate coding
- Failure to maintain adequate documentation
- Services that do not meet accepted standards of medical necessity

## Reporting Fraud, Waste, and Abuse

Providers have an obligation to report suspected Fraud, Waste, or Abuse involving providers, facilities, members, vendors, employees, or other individuals associated with Medicare benefits or healthcare services.

Suspected Fraud, Waste, and Abuse may be reported through the following channels:

Office of Inspector General (OIG)

Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

Website: [oig.hhs.gov/fraud/report-fraud](https://oig.hhs.gov/fraud/report-fraud)

eternalHealth Compliance Hotline

Phone: 1-857-557-6007

Email: [compliance@eternalhealth.com](mailto:compliance@eternalhealth.com)

Providers are encouraged to report concerns promptly. Reports may be made without fear of retaliation for good-faith reporting of suspected misconduct.

## Compliance and FWA Training Requirements

CMS requires Medicare Advantage organizations to provide education regarding compliance and Fraud, Waste, and Abuse requirements. Participating providers are strongly encouraged to ensure that employees, contractors, and applicable workforce members receive appropriate compliance, FWA, and HIPAA training.

### Training topics may include:

- General compliance requirements
- Medicare Advantage regulations
- Fraud, Waste, and Abuse prevention
- HIPAA Privacy and Security requirements
- Code of conduct expectations
- Reporting obligations

Providers may utilize compliance training resources available through the CMS Medicare Learning Network® and other approved compliance education programs.

## Nondiscrimination Requirements

eternalHealth prohibits discrimination in the delivery of healthcare services and administration of health plan benefits. Participating providers must comply with all federal and state nondiscrimination laws and regulations.

Providers may not discriminate against any individual on the basis of:

- |                   |                     |                                                        |
|-------------------|---------------------|--------------------------------------------------------|
| • Race            | • Gender            | • Genetic information                                  |
| • Color           | • Age               | • Veteran status                                       |
| • National origin | • Disability        | • Geographic location                                  |
| • Religion        | • Health status     | • Plan membership                                      |
| • Sex             | • Source of payment | • Any other characteristic protected by applicable law |

Providers must ensure members receive equitable access to services and are treated with dignity and respect regardless of protected status.

Providers must also comply with Section 1557 of the Affordable Care Act, the Americans with Disabilities Act (ADA), the Civil Rights Act of 1964, and other applicable civil rights laws.

## Treatment of Immediate Relatives and Household Members

eternalHealth follows Medicare guidance regarding reimbursement for services provided to immediate relatives and members of the provider's household. Certain services may not be eligible for reimbursement when provided to individuals who meet Medicare's definition of immediate relatives or household members.

### Examples of immediate relatives include:

- Spouse
- Parent
- Child
- Sibling
- Grandparent
- Grandchild
- Stepparent
- Stepchild
- In-law relationships recognized under Medicare guidance

Providers should refer to applicable Medicare guidance for additional details regarding these restrictions.

## Balance Billing and Prohibited Billing Practices

Participating providers may not balance bill members for covered services except for applicable member cost-sharing amounts specifically authorized under the member's benefit plan.

### Examples of prohibited billing practices include:

- Billing members for the difference between billed charges and contracted reimbursement amounts
- Billing members for claims denied due to provider timely filing failures
- Billing members for covered services denied because required documentation was not submitted
- Billing members for covered services when authorization requirements were not followed by the provider

- Billing members for payment reductions resulting from claims editing or reimbursement methodologies permitted under the Provider Agreement

Providers who engage in prohibited billing practices may be subject to corrective action, regulatory reporting, recovery actions, credentialing review, or network termination.

## Provider Responsibilities

### Participating providers are responsible for:

- Complying with all applicable laws, regulations, and contractual obligations.
- Maintaining an effective compliance culture within their organization.
- Reporting suspected Fraud, Waste, and Abuse.
- Cooperating with compliance investigations and audits.
- Ensuring workforce members receive appropriate compliance education.
- Protecting member privacy and confidentiality.
- Adhering to nondiscrimination requirements.
- Avoiding prohibited billing practices and balance billing.

Failure to comply with compliance requirements may result in corrective action, repayment obligations, sanctions, credentialing review, termination from the network, or referral to appropriate regulatory authorities.



## SECTION 09

# Quality Improvement and Risk Adjustment

### IN THIS SECTION

- › Overview
- › Quality Improvement Program
- › Provider Participation in Quality Activities
- › HEDIS® and Performance Measurement
- › Risk Adjustment Program
- › Clinical Documentation and Coding Accuracy
- › Medical Record Retrieval and Audit Support
- › Population Health and Care Gap Closure
- › Health Equity and Cultural Competency
- › Provider Responsibilities

## Overview

eternalHealth is committed to improving the health outcomes, safety, and healthcare experience of its members through a comprehensive Quality Improvement (QI) Program and Risk Adjustment Program. These programs support the delivery of high-quality, coordinated, and evidence-based healthcare while ensuring compliance with Centers for Medicare & Medicaid Services (CMS) requirements and industry best practices.

Participating providers are essential partners in achieving quality improvement goals, closing gaps in care, improving clinical outcomes, and ensuring accurate reporting of member health status.

## Quality Improvement Program

The eternalHealth Quality Improvement Program is designed to continuously monitor, evaluate, and improve the quality, safety, accessibility, and effectiveness of healthcare services provided to

members. The program supports regulatory compliance, member satisfaction, and improved health outcomes through ongoing performance measurement and improvement activities.

### The Quality Improvement Program focuses on:

- Improving clinical quality outcomes
- Enhancing member safety
- Promoting preventive care services
- Improving access to healthcare services
- Reducing health disparities
- Improving care coordination
- Supporting member and provider satisfaction
- Advancing population health initiatives

Quality improvement activities may be conducted through provider outreach, performance reviews, educational initiatives, audits, and collaborative improvement efforts.

Providers may be invited to participate in quality improvement committees, advisory groups, provider councils, or educational initiatives designed to improve member outcomes, enhance care quality, and support performance improvement activities across the provider network.

## Provider Participation in Quality Activities

Participating providers are expected to cooperate with quality improvement initiatives and support efforts to improve healthcare outcomes for eternalHealth members. Providers may be asked to participate in activities including:

- Quality improvement projects
- Provider education programs
- Medical record reviews
- Performance measurement initiatives
- Member experience improvement activities
- Care gap closure programs
- Health equity initiatives
- Population health programs

Providers may receive periodic reports regarding quality performance measures and opportunities for improvement.

## HEDIS® and Performance Measurement

Healthcare Effectiveness Data and Information Set (HEDIS®) measures are used to evaluate healthcare quality and performance across multiple clinical and preventive care categories.

eternalHealth utilizes HEDIS and other performance measures to assess the quality of care provided to members and identify opportunities for improvement. Providers may be asked to submit medical records or supporting documentation to validate performance measures and quality outcomes.

**Examples of areas commonly measured include:**

- Preventive screenings
- Immunizations
- Chronic disease management
- Medication management
- Follow-up care after hospitalization
- Behavioral health services
- Annual wellness visits

Providers are encouraged to document all services thoroughly and respond promptly to requests for quality-related documentation.

## Risk Adjustment Program

Risk adjustment is a CMS methodology used to accurately reflect the health status and expected healthcare needs of Medicare Advantage members. The Risk Adjustment Program relies on diagnosis coding and clinical documentation to ensure appropriate reporting of member conditions.

**Accurate and complete documentation allows eternalHealth to:**

- Support appropriate care management
- Identify high-risk members
- Coordinate member services
- Improve population health strategies
- Meet CMS reporting requirements
- Ensure accurate representation of member health status

Providers play a critical role in documenting and reporting all conditions evaluated, monitored, assessed, or treated during a member encounter.

## Clinical Documentation and Coding Accuracy

Medical record documentation must support all diagnoses submitted on claims and reported for risk adjustment purposes. Diagnoses should be documented based on the member's condition during the encounter and supported by clinical evidence in the medical record.

### Documentation should clearly reflect:

- Current medical conditions
- Assessment findings
- Follow-up recommendations
- Disease severity
- Treatment plans
- Clinical status
- Monitoring activities

### Providers should ensure diagnosis coding is:

- Accurate
- Complete
- Supported by documentation
- Consistent with CMS coding requirements
- Submitted annually, as applicable for risk-adjusted conditions

Accurate coding and documentation improve care coordination and help ensure appropriate reporting of member health status.

## Medical Record Retrieval and Audit Support

To support quality measurement, risk adjustment validation, and regulatory reporting requirements, eternalHealth may request medical records and supporting documentation from participating providers.

### Medical records may be requested for:

- HEDIS® reviews
- Risk adjustment validation
- CMS audits
- Quality improvement activities
- Medical necessity reviews

- Population health initiatives

#### **Providers are expected to:**

- Respond promptly to record requests.
- Submit complete and legible documentation.
- Meet requested submission deadlines.
- Cooperate with authorized vendors acting on behalf of eternalHealth.

## **Population Health and Care Gap Closure**

eternalHealth utilizes population health programs to identify preventive care opportunities, manage chronic conditions, and improve overall health outcomes.

Participating providers are encouraged to support care gap closure initiatives by:

- Performing recommended preventive screenings.
- Conducting Annual Wellness Visits.
- Managing chronic conditions according to evidence-based guidelines.
- Promoting immunizations.
- Following up on abnormal test results.
- Coordinating care transitions.
- Addressing social and behavioral factors that may affect health outcomes.

Providers may receive member-specific outreach reports identifying open care gaps, preventive care opportunities, or quality improvement initiatives.

## **Health Equity and Cultural Competency**

eternalHealth is committed to advancing health equity and reducing disparities in healthcare access and outcomes.

#### **Participating providers are encouraged to:**

- Deliver culturally competent care.

- Respect member preferences, beliefs, and values.
- Utilize interpreter services when appropriate.
- Address barriers to care.
- Promote equitable access to healthcare services.
- Support members with disabilities and special healthcare needs.

Health equity initiatives help ensure all members receive high-quality care regardless of demographic, geographic, socioeconomic, or cultural factors.

## Provider Responsibilities

### **Participating providers are responsible for:**

- Cooperating with Quality Improvement Program activities.
- Supporting HEDIS® and quality reporting initiatives.
- Maintaining accurate clinical documentation.
- Submitting complete and accurate diagnosis coding.
- Responding to medical record requests.
- Participating in care gap closure activities.
- Supporting population health and preventative care initiatives.
- Promoting culturally competent and equitable healthcare services.

Through partnership and collaboration, providers help improve member outcomes, strengthen care quality, and support the long-term success of the Medicare Advantage program.



## SECTION 10

# Credentialing and Provider Rights

### IN THIS SECTION

- › Overview
- › Credentialing Program
- › Credentialing Standards
- › Provider Rights During Credentialing
- › Right to Be Informed of Credentialing Application Status
- › Right to Review Credentialing Information
- › Right to Correct Erroneous Information
- › Notification of Credentialing Decisions
- › Credentialing Confidentiality
- › Credentialing Nondiscrimination Policy
- › Review of Information on File
- › Provider Responsibilities

## Overview

eternalHealth maintains a comprehensive credentialing and recredentialing program designed to ensure participating providers meet applicable professional, regulatory, accreditation, and quality standards. The credentialing process supports member safety, quality of care, network adequacy, and compliance with Centers for Medicare & Medicaid Services (CMS) and accreditation requirements.

Credentialing activities are conducted in a fair, objective, and nondiscriminatory manner and are intended to verify the qualifications, professional competence, and eligibility of providers participating in the eternalHealth network.

## Credentialing Program

The eternalHealth Credentialing Program evaluates providers before participation in the network and periodically thereafter through the recredentialing process. Credentialing reviews may include verification of:

- Professional licensure
- Board certification, when applicable
- Education and training
- Work history
- Professional liability coverage
- Medicare and Medicaid sanctions
- Office and practice information
- Hospital privileges, when applicable
- Malpractice history
- Regulatory compliance status

Credentialing and recredentialing activities are conducted in accordance with applicable CMS requirements, state regulations, accreditation standards, and eternalHealth policies and procedures.

## Credentialing Standards

Providers participating in the eternalHealth network must maintain all qualifications necessary to practice within their specialty and scope of service.

### Participating providers are expected to:

- Maintain an active and unrestricted professional license.
- Maintain all required certifications and registrations.
- Maintain professional liability insurance consistent with contractual requirements.
- Comply with Medicare participation requirements.
- Maintain all required hospital privileges or approved coverage arrangements, when applicable.
- Remain free from exclusions, sanctions, or debarment from participation in federal healthcare programs.

Providers are responsible for notifying eternalHealth of any material change that may affect credentialing status or network participation.

## Provider Rights During Credentialing

Applicants and participating providers have specific rights throughout the credentialing and recredentialing process.

These rights are intended to promote fairness, transparency, and due process during credentialing reviews. Notification of these rights is provided during the credentialing process and through this Provider Manual.

## Right to Be Informed of Credentialing Application Status

Providers have the right to request information regarding the status of a credentialing or recredentialing application.

Upon receipt of a written request, eternalHealth will provide information regarding the status of the application, including any outstanding items necessary to complete the credentialing review process.

### Status information may include:

- Outstanding verification requirements
- Missing documentation
- Delays in obtaining verification information
- Discrepancies identified during review

## Right to Review Credentialing Information

Applicants have the right to review information submitted in support of their credentialing application and information obtained from primary source verification activities.

### This may include information obtained from:

- State licensing boards
- Certification organizations
- Professional liability carriers
- Educational institutions
- Other credentialing verification sources

Peer review materials, protected quality review information, and other confidential information that is protected by law are not available for review.

## Right to Correct Erroneous Information

If the credentialing process identifies information that differs substantially from information submitted by the provider, eternalHealth will notify the provider of the discrepancy.

### The provider may:

- Submit corrected information.
- Provide additional supporting documentation.
- Submit a written explanation regarding the discrepancy.

### The notification will include:

- A description of the discrepancy.
- Instructions for submitting corrections.
- Required documentation, if applicable.
- Applicable submission deadlines.
- Contact information for credentialing staff.

Providers are responsible for submitting corrections within the timeframe specified by eternalHealth.

## Notification of Credentialing Decisions

Providers will receive notification regarding credentialing and recredentialing decisions within applicable regulatory and accreditation timeframes.

### Notification may include:

- Approval decisions
- Denial decisions
- Requests for additional information
- Corrective action requirements, when applicable

All credentialing determinations are based on established credentialing criteria and applicable policies.

## Credentialing Confidentiality

eternalHealth is committed to maintaining the confidentiality of information collected and maintained during the credentialing and recredentialing process.

Credentialing files are maintained in a secure manner and accessed only by individuals with a legitimate business need related to credentialing activities.

Information obtained through peer review processes and quality evaluation activities may be protected under applicable federal and state laws and may not be disclosed except as permitted by law.

## Credentialing Nondiscrimination Policy

eternalHealth does not discriminate against providers during credentialing, recredentialing, network participation, or other provider-related activities.

### Credentialing decisions are not based on:

- Race
- Color
- National origin
- Religion
- Age
- Disability
- Sex
- Sexual orientation
- Marital status
- Protected veteran status
- Any other status protected by applicable law

Credentialing decisions are also not based upon the types of procedures performed by a provider or the populations served by a provider. All decisions are based on objective credentialing criteria and qualification standards.

## Review of Information on File

With the exception of information protected by peer review confidentiality or applicable law, providers may request access to information maintained by eternalHealth in support of credentialing evaluations.

### Providers have the right to:

- Request review of credentialing file information.
- Submit corrections to inaccurate information.
- Provide clarification regarding discrepancies.

- Request updates to provider data maintained by eternalHealth.

Requests should be submitted in writing to the Credentialing Department or Provider Relations Department.

## Provider Responsibilities

### **Participating providers are responsible for:**

- Maintaining current licensure and certifications.
- Maintaining an active CAQH profile.
- Providing complete and accurate credentialing information.
- Cooperating with credentialing and recredentialing activities.
- Reporting material changes affecting credentialing status.
- Maintaining professional liability insurance as required.
- Responding timely to requests for documentation or verification.

Failure to comply with credentialing requirements may result in delays in participation, corrective actions, suspension, termination, or other actions consistent with the Provider Agreement and applicable regulatory requirements.



## SECTION 11

# Provider Termination and Continuity of Care

### IN THIS SECTION

- › Overview
- › Termination of Participation
- › Immediate Termination Events
- › Termination for Cause
- › Termination Without Cause
- › Provider Appeal Hearing Process
- › Nonrenewal of Provider Agreement
- › Continuity of Care Requirements
- › Provider Responsibilities Following Termination
- › Conclusion

## Overview

eternalHealth is committed to maintaining a high-quality provider network that supports the healthcare needs of its Medicare Advantage members. While the goal is to maintain productive and collaborative provider relationships, circumstances may arise that require termination or nonrenewal of a provider's participation in the network.

This section outlines the circumstances under which participation may be terminated, available appeal rights, continuity of care requirements, and provider obligations during the transition process.

## Termination of Participation

A provider's participation in the eternalHealth network may be terminated in accordance with the terms and conditions of the Provider Agreement, applicable state and federal laws, CMS requirements, and credentialing policies.

### Termination may occur:

- For cause.
- Without cause.
- Due to nonrenewal of a Provider Agreement.
- Due to immediate termination events.
- As otherwise permitted under applicable law or contractual agreements.

Providers should refer to their Provider Agreement for specific contractual notice requirements and termination provisions.

## Immediate Termination Events

eternalHealth reserves the right to immediately terminate a provider's participation when circumstances present a risk to members, the Medicare program, or the integrity of the provider network.

Immediate termination may occur for reasons including, but not limited to:

- Suspension, revocation, expiration, or restriction of a professional license.
- Suspension, exclusion, or debarment from participation in Medicare, Medicaid, or other federal healthcare programs.
- Fraud, abuse, or other unlawful conduct.
- Failure to maintain required professional liability insurance.
- Criminal indictment, conviction, or other serious legal actions affecting provider eligibility.
- State sanctions or disciplinary actions.
- Circumstances that, in the reasonable judgment of eternalHealth, pose a threat to member health, safety, or welfare.

Immediate termination may become effective upon notice as permitted by applicable law and contractual requirements.

## Termination for Cause

Termination for cause may occur when a provider fails to comply with contractual, professional, operational, credentialing, quality, or regulatory requirements.

### Examples may include:

- Repeated failure to comply with Provider Agreement requirements.
- Failure to maintain credentialing standards.
- Repeated quality of care concerns.
- Failure to comply with CMS requirements.
- Failure to cooperate with credentialing, compliance, quality, or audit activities.
- Material breach of contract terms.

When appropriate, eternalHealth may implement corrective action plans or remediation efforts prior to termination. However, corrective action is not required in all circumstances.

## Termination Without Cause

Either the provider or eternalHealth may terminate participation without cause in accordance with the notice provisions outlined in the Provider Agreement.

Termination without cause typically requires advance written notice and allows time for member notification, continuity of care planning, and provider directory updates. Providers should review their Provider Agreement for specific notice requirements and effective dates.

## Provider Appeal Hearing Process

Providers who receive notice of a termination action may have appeal rights depending on the circumstances of the termination and applicable regulatory requirements.

When an appeal is permitted, eternalHealth may convene a hearing panel or committee to review the termination decision.

### Hearing Committee Requirements

#### The hearing committee:

- Will consist of at least three (3) members.
- May include peers or healthcare professionals with appropriate expertise.
- Will not include individuals who participated in the investigation that led to the termination recommendation.

### Hearing Procedures

### **The hearing process may include:**

- Presentation of information by eternalHealth.
- Presentation of information by the provider.
- Review of supporting documentation.
- Discussion by the hearing committee.
- Deliberation and voting by committee members.

A designated hearing officer may oversee the hearing process, maintain order, and ensure all parties have an opportunity to present information. The hearing officer may not participate in committee voting.

### **Final Determination**

### **Following review, the committee may:**

- Affirm the proposed action.
- Modify the proposed action.
- Reverse the proposed action.

Providers will receive written notification of the committee's final determination and the basis for the decision.

## **Nonrenewal of Provider Agreement**

Unless otherwise specified in the Provider Agreement, provider participation agreements may renew automatically at the end of the contract period. A decision not to renew a Provider Agreement may result in termination of network participation upon expiration of the agreement.

Nonrenewal decisions will be managed in accordance with applicable contractual obligations, regulatory requirements, and provider notification requirements.

## **Continuity of Care Requirements**

eternalHealth is committed to minimizing disruptions in care when provider participation changes occur. Both providers and eternalHealth share responsibility for ensuring members continue to receive medically necessary services during transition periods.

Providers may be required to continue furnishing covered services for a period of time following termination when necessary to support continuity of care for members receiving active treatment.

**Continuity of care considerations may apply to members who are:**

- Undergoing active treatment for serious medical conditions.
- Receiving inpatient care.
- Receiving post-acute care services.
- Pregnant and receiving ongoing prenatal care.
- Receiving ongoing specialty treatment.
- Transitioning between providers or healthcare settings.

Providers must cooperate with continuity of care activities, including communication with receiving providers and transfer of medical records when appropriate and permitted by law.

## Provider Responsibilities Following Termination

**Following notice of termination, providers are expected to:**

- Continue providing services when required under continuity of care provisions.
- Cooperate with member transition activities.
- Transfer medical records in accordance with applicable laws and regulations.
- Continue to protect the confidentiality of member information.
- Submit claims for covered services in accordance with contractual requirements.
- Update practice materials to remove references to network participation after the effective termination date.
- Comply with all post-termination obligations identified in the Provider Agreement.

Failure to comply with post-termination obligations may result in additional contractual or legal remedies available to eternalHealth.

## Conclusion

eternalHealth values its provider partnerships and recognizes the important role providers play in delivering high-quality healthcare to members. Through cooperation, professionalism, and

compliance with applicable requirements, providers help ensure members receive coordinated, accessible, and effective care throughout their healthcare journey.



## APPENDIX A

# Acronyms and Definitions

The following acronyms and definitions are provided for reference throughout this Provider Manual.

| Acronym | Definition                                          |
|---------|-----------------------------------------------------|
| ADA     | Americans with Disabilities Act                     |
| CAQH    | Council for Affordable Quality Healthcare           |
| CMS     | Centers for Medicare & Medicaid Services            |
| COB     | Coordination of Benefits                            |
| CPT®    | Current Procedural Terminology                      |
| DRG     | Diagnosis-Related Group                             |
| EFT     | Electronic Funds Transfer                           |
| EHR     | Electronic Health Record                            |
| EMR     | Electronic Medical Record                           |
| EOC     | Evidence of Coverage                                |
| FWA     | Fraud, Waste, and Abuse                             |
| HEDIS®  | Healthcare Effectiveness Data and Information Set   |
| HIPAA   | Health Insurance Portability and Accountability Act |

| Acronym | Definition                                    |
|---------|-----------------------------------------------|
| HMO     | Health Maintenance Organization               |
| NCCI    | National Correct Coding Initiative            |
| NCQA    | National Committee for Quality Assurance      |
| NPI     | National Provider Identifier                  |
| OIG     | Office of Inspector General                   |
| PA      | Prior Authorization                           |
| PCP     | Primary Care Provider                         |
| PHI     | Protected Health Information                  |
| PPO     | Preferred Provider Organization               |
| TIN     | Tax Identification Number                     |
| UB-04   | Uniform Billing Form for Institutional Claims |
| UM      | Utilization Management                        |



## APPENDIX B

# Provider Resources and Contact Information

### IN THIS SECTION

- › Provider Contact Directory
- › Online Resources
- › Claim Submission Information
- › Electronic Claims
- › Paper Claims
- › Provider Relations
- › Compliance Reporting
- › Office of Inspector General (OIG)

## Provider Contact Directory

| Department                       | Phone          | Fax            |
|----------------------------------|----------------|----------------|
| Provider Services                | 1-800-680-9255 | 1-866-347-8130 |
| Care Management                  | 1-800-787-5076 | 1-855-708-2735 |
| Authorization Requests (UM)      | 1-800-680-9255 | 1-866-337-8686 |
| Expedited Authorization Requests | 1-800-680-9255 | 1-866-215-4297 |
| Pharmacy Services (OptumRx®)     | 1-800-891-6989 | 1-800-527-0531 |
| Appeals & Grievances             | 1-800-651-9613 | 1-888-692-7270 |

| Department      | Phone          | Fax            |
|-----------------|----------------|----------------|
| Member Services | 1-800-680-4568 | 1-888-347-8130 |

## Online Resources

| Resource                                         | Website                                                                                                                                                                  |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provider Portal                                  | <a href="http://provider.eternalhealth.com">provider.eternalhealth.com</a>                                                                                               |
| Corporate Website                                | <a href="http://www.eternalhealth.com">www.eternalhealth.com</a>                                                                                                         |
| Find a Provider or Pharmacy                      | <a href="http://www.eternalhealth.com/for-members/find-a-provider-or-pharmacy">www.eternalhealth.com/for-members/find-a-provider-or-pharmacy</a>                         |
| Provider Forms and Documents                     | <a href="http://www.eternalhealth.com/for-providers/forms-and-documents">www.eternalhealth.com/for-providers/forms-and-documents</a>                                     |
| Part D Prior Authorization Information           | <a href="http://www.eternalhealth.com/for-members/prescription-drugs/#Prior-Authorization">www.eternalhealth.com/for-members/prescription-drugs/#Prior-Authorization</a> |
| Electronic Part D Prior Authorization Submission | <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a>                                                                                               |
| EFT Enrollment                                   | <a href="http://www.zelis.com">www.zelis.com</a>                                                                                                                         |

## Claim Submission Information

### Electronic Claims

| Description   | Information       |
|---------------|-------------------|
| Clearinghouse | Change Healthcare |
| Payer ID      | RP037             |

## Paper Claims

eternalHealth Billing Department

PO Box 1263

Westborough, MA 01581

Attn: eternalHealth Medicare

## Provider Relations

Provider roster submissions, provider demographic updates, practice changes, and other network administration requests should be submitted to:

Provider Relations

[providerrelations@eternalhealth.com](mailto:providerrelations@eternalhealth.com)

## Compliance Reporting

Compliance and Ethics Hotline

Phone: 1-857-557-6007

Email: [compliance@eternalhealth.com](mailto:compliance@eternalhealth.com)

## Office of Inspector General (OIG)

Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

Website: [oig.hhs.gov/fraud/report-fraud](https://oig.hhs.gov/fraud/report-fraud)



## APPENDIX C

# Provider Manual Revision History

This manual is reviewed periodically and may be updated to reflect changes in CMS requirements, state regulations, operational processes, network requirements, and organizational policies.

| Version | Effective Date   | Description of Change                                     |
|---------|------------------|-----------------------------------------------------------|
| 2.0     | January 1, 2027  | Complete Provider Manual Reorganization and Modernization |
| 1.0     | Previous Version | Original Provider Manual Publication                      |

Providers are responsible for reviewing updated versions of the Provider Manual and complying with all current requirements and policies.



## APPENDIX D

# Regulatory and Contractual Disclaimer

This Provider Manual is intended as a reference tool for participating providers and their staff. The information contained in this manual is subject to change based on regulatory requirements, Centers for Medicare & Medicaid Services (CMS) guidance, state law, accreditation standards, and operational updates.

This manual does not replace, amend, or supersede the Provider Agreement. In the event of a conflict between this manual and the Provider Agreement, the terms of the Provider Agreement shall control.

Nothing contained within this manual should be interpreted as a guarantee of coverage, authorization, payment, credentialing approval, or continued participation in the eternalHealth network.

Benefits, coverage determinations, and reimbursement decisions are subject to applicable CMS guidance, member eligibility, benefit plan provisions, medical necessity requirements, and contractual obligations.



## APPENDIX E

# Provider Standards at a Glance

| Topic                      | Requirement                  |
|----------------------------|------------------------------|
| Urgent Appointment         | Within 24 hours              |
| Routine Appointment        | Within 7 days                |
| Wellness Appointment       | Within 30 days               |
| Provider Data Updates      | Prompt notification required |
| Claims Filing              | 90 days                      |
| Payment Disputes           | 180 days                     |
| New Patient Closure Notice | 60 days                      |
| Hospital Privilege Changes | 10 business days             |



## ABOUT THIS MANUAL

# Provider Manual Administration

This Provider Manual is maintained by the eternalHealth Provider Operations and Provider Network Management departments and may be updated periodically to reflect changes in CMS requirements, state regulations, operational policies, and provider resources.

Providers are encouraged to reference the most current version of this manual available through the Provider Portal and provider communications.

Questions regarding this manual may be directed to Provider Services at 1-800-680-9255 or through the Provider Portal at [provider.eternalhealth.com](https://provider.eternalhealth.com).



## THANK YOU

# Thank You for Partnering with eternalHealth

Thank you for your commitment to providing high-quality, coordinated, and member-centered healthcare services to eternalHealth Medicare Advantage members.

Your partnership is essential to advancing our mission of improving health outcomes, enhancing the member experience, and promoting accessible, affordable healthcare within the communities we serve.

For questions regarding this Provider Manual or provider participation, please contact:

### Provider Services

Phone: 1-800-680-9255

### Provider Portal

[provider.eternalhealth.com](https://provider.eternalhealth.com)

### Website

[www.eternalhealth.com](https://www.eternalhealth.com)

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