PROVIDER MANUAL (Provider Handbook)

Medicare Products 2025

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Central Health Plan of California (CHPC) and Central Health Plan (CHMP). “CHPC” or “CHMP” have the same meaning as “Health Plan” or “Plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at CentralHealthPlan.com.

Important Notice: Please be aware that if you are a California resident, you have new privacy rights with respect to the business contact information that you share with the Plan as a Provider. For more details, please see the “Business Contact Information” section on page 109.

Last Updated: 01/2025

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1. Introduction

Central Health Plan of California (CHPC) and Central Health Medicare Plan (CHMP) (individually and collectively the Plan or Plan) are committed to providing cost-effective, high-quality health care services to our Medicare Members. The Plan is positioned as a niche player in a well-developed, rapidly growing market aimed at addressing the specific needs of our Members and is firmly committed to its Members who put their trust in the Plan to provide high-quality, cost-effective and culturally sensitive health care services.

As a full-service health maintenance organization (HMO) licensed by the State of California and the Federal government, the Plan provides coverage to individual Medicare beneficiaries. The Plan markets competitive Covered Services options to Medicare beneficiaries and provides comprehensive Inpatient and Outpatient medical and Behavioral Health Services. The Plan has a wide range of Contracted Providers throughout its Service Area, including facilities and practitioners that traditionally serve the Plan's target population. Contracted Providers share our vision and mission to furnish appropriate and accessible care, establish and maintain the health of our Members, and provide high-quality services, which satisfy the reasonable expectations of consumers and purchasers.

About the Provider Manual

Providers agree to comply with the standards and procedures set forth in this Provider Manual.

This Provider Manual is intended to evolve and change and to reflect the dynamic nature of HMOs, state and federal regulations and other managed care operating policies and procedures. The Plan may change or add to its provisions. Accordingly, the Plan will communicate changes to Providers for review when such changes are expected to have a material impact on Providers. If applicable, the Plan will provide Providers with copies of all contract amendments and other supporting documentation.

Should Providers have suggestions or comments regarding this Provider Manual, please contact the Plan's Contracting or Provider Relations Department. The Plan intends for the administration of the Provider Agreement with the Plan and the Provider Manual to be a tool in the consistently evolving process for both the Plan and Providers.

Please refer to the Provider Agreement with the Plan for specific terms, conditions and exceptions. In the event of any discrepancy between the Provider Agreement with the Plan and this Provider Manual, the Provider Agreement with the Plan or state and federal regulations shall prevail.

Statement of confidentiality

The Plan secures and confidentially maintains information requested as a part of any visit, audit or report. All submitted information and documents will be viewed exclusively

by the Plan in compliance with the regulatory requirements of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and California Civil Code § 56, and all relevant state and federal law.

Providers shall maintain the confidentiality of all the Plan Members' medical records and treatment information in accordance with state and federal law.

2. Medicare products overview

Central Health Plan of California (CHPC) and Central Health Medicare Plan (CHMP)

2025 Plan Name	County
Central Health Medicare Plan (HMO)	Los Angeles; Orange; Riverside; San Bernardino
Central Health Medi-Medi Plan I (HMO D-SNP)	Los Angeles; Riverside; Sacramento; San Bernardino; San Diego
Central Health Focus Plan (HMO C-SNP)	Alameda; Contra Costa; Fresno; Los Angeles; Orange; San Bernardino; San Joaquin; Santa Clara
Central Health Ventura Medicare Plan (HMO)	Ventura
Central Health Medi-Medi Plan II (HMO D-SNP)	Ventura
Central Health San Mateo Medicare Plan (HMO)	San Mateo
Central Health Savings Plan (HMO)	Los Angeles; Orange; Riverside; San Bernardino
Central Health Premier Plan I (HMO)	Alameda; Contra Costa; Fresno; San Francisco; San Joaquin; Santa Clara; Solano
Central Health Jade Plan (HMO)	Los Angeles
Central Health Dual Access Plan (HMO D-SNP)	Alameda; Contra Costa; Fresno; Imperial; Kern; Kings; Madera; Orange; Placer; San Francisco; San Joaquin; San Mateo; Santa Clara; Solano; Stanislaus; Tulare; Yolo
Central Health Embrace Care Plan (HMO C-SNP)	Alameda; Contra Costa; Fresno; Imperial; Kern; Kings; Madera; Placer; Sacramento; San Francisco; San Joaquin; San Mateo; Santa Clara; Solano; Stanislaus; Tulare; Yolo
Central Health Embrace Care Plan (HMO C-SNP)	Los Angeles; Orange; Riverside; San Bernardino; San Diego
Central Health Embrace Choice Plan (HMO C-SNP)	Alameda; Contra Costa; Fresno; Imperial; Kern; Kings; Madera; Placer; Sacramento; San Francisco; San Joaquin; San Mateo; Santa Clara; Solano; Stanislaus; Tulare; Yolo
Central Health Embrace Choice Plan (HMO C-SNP)	Los Angeles; Orange; Riverside; San Bernardino; San Diego
Central Health Classic Care Plan II (HMO)	Alameda; Contra Costa; Fresno; Imperial; Kern; Kings; Madera; Placer; Sacramento; San Francisco; San Joaquin; San Mateo; Santa Clara; Solano; Stanislaus; Tulare; Yolo

2025 Plan Name	County
Central Health Valor Care Plan (HMO)	Fresno; Imperial; Kern; Kings; Los Angeles; Madera; Orange; Riverside; Sacramento; San Bernardino; San Diego; San Francisco; San Joaquin; San Mateo; Santa Clara; Tulare
Central Health Part B Savings Plan (HMO)	Los Angeles; Orange; Riverside; San Bernardino; San Diego
Central Health Classic Care Plan I (HMO)	Los Angeles; Orange; Riverside; San Bernardino; San Diego

3. Contact information

Central Health Medicare Plan
200 Oceangate, Suite 100
Long Beach, CA 90802

Provider services

The Plan's Provider Contact Center handles telephone inquiries from Providers regarding Claims, appeals, authorizations, eligibility and general concerns. Provider Contact Center representatives are available Monday to Friday, 8:30 a.m. to 5:30 p.m., local time, excluding state and federal holidays.

Provider Contact Center Telephone: (866) 403-8296

The Plan strongly encourages participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials (Availity) portal whenever possible.

- EDI Payer ID number: CHCPI

To verify the status of your Claims please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity Essentials (Availity) portal.

Providers may verify a Member's Medi-Cal eligibility directly through the Department of Health Care Services (DHCS) via the Automated Eligibility Verification System (AEVS) at (800) 800-456-2387. AEVS is available from 7 a.m. to 8 p.m., 7 days a week. Providers will need their Medi-Cal Provider Identification Number (PIN). For additional information, please refer to DHCS's website at mcweb.apps.prd.cammis.medi-cal.ca.gov/contact.

Providers may verify a Member's Medicare eligibility directly through the Centers for Medicare & Medicaid Services (CMS) website at cms.gov/MAC-info. Providers will need to select their state to access state-specific information.

Provider relations

The Provider relations department manages Provider calls regarding issue resolution, Provider education and training.

The Plan has local Provider relations representatives who serve all of the Plan's Provider network.

Provider demographic changes, including additions, terminations and updates should be emailed to the following county email addresses:

PRCalifornia@molinahealthcare.com

Member services

The Member Contact Center handles all telephone and written inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), Member complaints, assists Members with obtaining Medicaid-covered services and resolving grievances, including requesting authorization of Medicaid services, and navigating Medicaid appeals and grievances regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan. Member Contact Center representatives are available:

- October 15 – March 31: 7 days a week, 8 a.m. to 8 p.m., local time, excluding state and federal holidays
- April 1 – October 14: Monday to Friday, 8 a.m. to 8 p.m., local time, excluding state and federal holidays

Our automated phone system may answer calls on weekends and holidays.

Member Contact Center Telephone: (866) 314-2427
Hearing Impaired: (TTY/TDD) 711
Email: memberservices@centralhealthplan.com

Claims

The Plan strongly encourages participating Providers to submit Claims electronically (via a clearinghouse or the Availity portal) whenever possible.

- EDI Payer ID number CHCPI

To verify the status of your Claims, please use the Availity portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal. For additional information please refer to the **Claims and Compensation** section of this Provider Manual.

Provider Contact Center Telephone: (866) 403-8296

Claims recovery

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Mailing address for refunds:

Central Health Medicare Plan
PO Box 30567
Los Angeles CA 90030-0567

Cost Recovery Disputes address:

Central Health Medicare Plan
PO Box 2470
Spokane, WA 99210-2470

Telephone: (866) 403-8296
Fax: (888) 396-1163

Compliance/anti-fraud hotline

Suspected cases of fraud, waste or abuse must be reported to the Plan. You may do so by contacting the Plan's Alertline or submit an electronic complaint using the website listed below. For additional information on fraud, waste and abuse please refer to the **Compliance** section of this Provider Manual.

Telephone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Address:
Confidential
Compliance Official
Central Health Medicare Plan
200 Oceangate, Suite 100
Long Beach, CA 90802

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on the Plan's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Plan's network. For additional information please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Provider Contact Center Telephone: (866) 403-8296

24-hour Nurse Advice Line

This telephone-based Nurse Advice Line is available to the Plan's Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week to assess symptoms and help make good health care decisions.

Telephone: (888) 920-8809
Hearing Impaired (TTY/TDD): 711

Health care services

The Health Care Services (HCS) department conducts concurrent review on inpatient

cases and processes Prior Authorizations/Service Requests. The HCS department also performs care management for Members who will benefit from care management services. Participating Providers are required to interact with the HCS department electronically whenever possible. Prior Authorization/Service Requests and status checks can be easily managed electronically. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access to 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs associated with fax and telephonic interactions

The Plan offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly via the Availity portal.
- Submit requests via 278 transactions. See the EDI transaction section of the Plan's website for guidance.

Prior Authorization Fax:

- Advanced imaging: (877) 731-7218
- Outpatient requests (MAPD/DSNP/CSNP): (844) 251-1450
- Outpatient requests (MMP/EAE): (844) 251-1451
- Hospital inpatient and concurrent review requests: (844) 834-2152
- Medicare transplants: (877) 813-1206
- Post-acute admission (SNF, LTACH and AIR): (833) 912-4454

Health management

The Plan provides health management programs designed to assist Members and their families in better understanding their chronic health condition(s) and adopting healthy lifestyle behaviors. The Plan's health management programs will be incorporated into the Member's treatment plan to address the Member's health care needs. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Telephone: (833) 269-7830
Fax: (800) 642-3691

Behavioral health

The Plan manages all components of covered services for behavioral health. For Member behavioral health needs, please contact us directly at (866) 314-2427. The

Plan has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Member ID card. For additional information please refer to the **Behavioral Health** section of this Provider Manual.

Pharmacy

The prescription drug benefit is administered through CVS Health. A list of in-network pharmacies is available on the CentralHealthPlan.com website, or by contacting the Plan. For additional information please refer to the **Medicare Part D** section of this Provider Manual.

Telephone: (800) 665-3086
Hearing Impaired (TTY/TDD): 711
Part D fax: (866) 290-1309
J Code fax: (800) 391-6437

Quality

The Plan maintains a Quality department to work with Members and Providers in administering the Plan's Quality programs. For additional information please refer to the **Quality** section of this Provider Manual.

Provider Contact Center Telephone: (866) 403-8296

4. Provider responsibilities

Non-discrimination in health care service delivery

Providers must comply with the non-discrimination in health care service delivery requirements as outlined in the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Additionally, the Plan requires Providers to deliver services to the Plan's Members without regard to the source of payment. Specifically, Providers may not refuse to serve the Plan's Members because they receive assistance with cost-sharing from a government-funded program.

Section 1557 investigations

Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to the Plan's Civil Rights Coordinator.

Central Health Medicare Plan
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Telephone: (866) 606-3889
Hearing Impaired (TTY/TDD): 711
Online: MolinaHealthcare.Alertline.com
Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Department Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel and administrative services

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider data accuracy and validation

It is important for Providers to ensure the Plan has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA)-required

element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with the Plan at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement with the Plan, Providers must notify the Plan of any changes as soon as possible, but at a minimum of 30 calendar days in advance of changes in any Provider information on file with the Plan. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Change in specialty
- Any other information that may impact Member access to care

For Provider terminations (within an existing clinic/practice), Providers must notify the Plan in writing in accordance with the terms expressed in the Provider Agreement with the Plan.

Please visit our Provider Online Directory at https://ca-chp.sapphirethreesixtyfive.com//?ci=ca-chp-medicare to validate your information. Providers can make updates through the CAQH portal or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Relations representatives for assistance.

Note: Some changes may impact credentialing. Providers are required to notify the Plan of changes to credentialing information in accordance with the requirements outlined in the **Credentialing and Recredentialing** section of this Provider Manual.

The Plan is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods such as letters, phone campaigns, face-to-face contact, fax, and fax-back verification, etc. The Plan also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All Plan Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the California Department

of Health Care Services at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/ and meet the Medicaid Provider enrollment requirements as set forth in the https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/provider-enrollment for fee-for-service Providers of the appropriate provider type.

National Plan and Provider Enumeration System (NPPES) data verification

In addition to the above verification requirements, Center for Medicare & Medicaid (CMS) recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

The Plan supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the frequently asked questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Electronic solutions requirements

The Plan requires Providers to utilize electronic solutions and tools whenever possible.

The Plan requires all contracted Providers to participate in and comply with the Plan's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal, and registration for and use of the Availity portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity portal.

Any Provider entering the network as a Contracted Provider will be required to comply with the Plan's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity portal within 30 days of entering the Plan's network.

The Plan is committed to complying with all HIPAA Transactions, Code Sets and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with the Plan. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to the Plan. Providers may obtain additional information by visiting the Plan's HIPAA Resource Center located on our website at CentralHealthPlan.com.

Electronic solutions/tools available to Providers

Electronic Tools/Solutions available to the Plan's Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Availity portal

Electronic Claims submission requirement

The Plan strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time enabling Claims to reach the Plan faster

The Plan offers the following electronic Claims submission options:

- Submit Claims directly to the Plan via the Availity portal.
- Submit Claims to the Plan through your EDI clearinghouse using Payer ID CHCPI, refer to our website at CentralHealthPlan.com for additional information.

While both options are embraced by the Plan, submitting Claims via the Availity portal (available to all Providers at no cost) offers a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity portal Claim submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claim status
- Receive timely notification of a change in status for a particular Claim
- Ability to save incomplete/un-submitted Claims
- Create/manage Claim templates

For more information on EDI Claims submission please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic payment requirement

Participating Providers are required to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA

access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. The Plan uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

The Plan has partnered with ECHO Health, Inc. (ECHO) for payment delivery and 835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by the Plan or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com and request that the Plan's Tax ID be opted out of Virtual Cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Plan's Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal at providerpayments.com.

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Customer Services team at (888) 834-3511.

As a reminder, the Plan's Payer ID is CHCPI.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-(2) year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on the Plan's website at CentralHealthPlan.com.

Availity portal

Providers and third-party billers can use the no-cost Availity portal to perform many functions online without the need to call or fax the Plan. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
  - Correct/void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View ERA and EOP
  - Create and manage Claim templates
  - Create and submit a Claim appeal with attached files
- Prior authorization/service request
  - Create and submit prior authorization/service request
  - Check status of prior authorization/service request
- Download forms and documents
- Send/receive secure messages to/from the Plan

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

Balance billing

Pursuant to law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts. Providers are responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of the Plan to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable co-payment, co-insurance and deductible amounts. Providers agree to comply with their Provider Agreement with the Plan which requires a contracted Medicare Providers to comply with Welfare and Institutions Code section 14019.4.

Member rights and responsibilities

Providers are required to comply with the Member rights and responsibilities as outlined in the Plan's Member materials (such as Member Handbooks).

For additional information please refer to the **Member Rights and Responsibilities** section of this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to the Plan's Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by the Plan prior to use.

Please contact your Provider Relations representative for information and review of proposed materials.

Member eligibility verification

Possession of the Plan's Member ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of the Plan's Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and the Plan places the responsibility for eligibility verification on the Provider of services.

Providers who contract with the Plan may verify a Member's eligibility by checking the following:

- Availity portal
- Provider Contact Center automated IVR system at (866) 403-8296

Providers may verify a Member's Medi-Cal eligibility directly through the Department of Health Care Services (DHCS) via the Automated Eligibility Verification System (AEVS) at(800) 800-456-2387. AEVS is available from 7 a.m. to 8 p.m., 7 days a week. Providers will need their Medi-Cal Provider Identification Number (PIN). For additional information, please refer to DHCS's website at mcweb.apps.prd.cammis.medi-cal.ca.gov/contact.

For additional information please refer to the **Eligibility and Enrollment in Medicare Advantage Plans** section of this Provider Manual.

Member cost share

Providers should verify the Member's cost share status prior to requiring the Member to pay co-pay, co-insurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health care services (utilization management and care management)

Providers are required to participate in and comply with the Plan's utilization management and care management programs, including all policies and procedures regarding the Plan's facility admission, prior authorization, medical necessity review determination, and interdisciplinary care team (ICT) procedures. Providers will also cooperate with the Plan in audits to identify, confirm, and/or assess utilization levels of covered services.

Providers are required to participate in and comply with the CMS Model of Care (MOC) training requirements as applicable. This includes completing the Plan's initial and annual MOC training and submitting attestation documentation upon completion. The

Plan's MOC Provider training and attestation documents are found on the Plan's website at CentralHealthPlan.com.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

In-office laboratory tests

The Plan's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an in-network laboratory provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing, and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Plan's website at CentralHealthPlan.com.

Additional information regarding in-network laboratory providers and in-network laboratory provider patient service centers is found on the laboratory providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with the Provider Agreement with the Plan and applicable state and federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on the Plan's list of allowed in-office laboratory tests will be denied.

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct the Plan's Members to health professionals, hospitals, laboratories and other facilities and Providers which are contracted and credentialed (if applicable) with the Plan. In the case of urgent and emergency services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and hospital emergency room (ER). There may be circumstances in which referrals may require an out-of-network provider. Prior authorization will be required from the Plan except in the case of emergency services.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to the Plan.

Treatment alternatives and communication with Members

The Plan endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow-up care. The Plan promotes open discussion between Providers and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Maternal mental health screening

AB 2193 Maternal Mental Health requires a licensed health care Practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health care Provider must use a validated tool to assess the Member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS). The Plan requires health care Providers to document the mental health screening for pregnant or postpartum Members using the Current Procedural Technology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Claim codes. The Plan's Maternal Mental Health Program guidelines and criteria are available upon request by contacting the Provider Contact Center at (866) 403-8296.

Pharmacy program

Providers are required to adhere to the Plan's drug formularies and prescription policies. For additional information please refer to the **Medicare Part D** section of this Provider Manual.

Participation in quality programs

Providers are expected to participate in the Plan's Quality programs and collaborate with the Plan in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to care standards
- Site and medical record-keeping practice reviews as applicable
- Delivery of patient care information

For additional information please refer to the **Quality** section of this Provider Manual.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of the Plan's Members.

Confidentiality of Member health information and HIPAA transactions

The Plan requires that Providers respect the privacy of the Plan's Members (including the Plan's Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member protected health information. For additional information please refer to the **Compliance** section of this Provider Manual.

Participation in grievance and appeals programs

Providers are required to participate in the Plan's grievance program and cooperate with the Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the **Medicare Member Grievances and Appeals** section of this Provider Manual.

Participation in credentialing

Providers are required to participate in the Plan's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by the Plan and applicable accreditation, state and federal requirements. This includes providing prompt responses to the Plan's requests for information related to the credentialing or re-credentialing process.

For additional information on the Plan's credentialing program, including policies and procedures please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in the Plan's Delegated Services Addendum. For additional information on the Plan's delegation requirements and delegation oversight, please refer to the **Delegation** section of this Provider Manual.

Primary care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with the Plan
- Triage appropriately
- Notify the Plan of Members who may benefit from care management
- Participate in the development of care management treatment plans
- Complete annual SNP MOC training
- Participate with all MOC required activities including coordination of care during transitions

5. Cultural competency and linguistic services

Background

The Plan works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. The Plan complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, national origin, sex, age and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). The Plan complies with applicable portions of the Americans with Disabilities act of 1990. The Plan also complies with all implementing regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech or visual impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all colors, national origins, creeds, ancestry, health status, marital status, sex, gender identities, sexual orientations, ages and religions, as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at CentralHealthPlan.com from your local Provider Relations representative and by calling the Provider Contact Center toll-free at (866) 403-8296.

Non-discrimination in health care service delivery

The Plan complies with Section 1557 of the ACA. As a Provider participating in the Plan's provider network, you and your staff must also comply with the non-discrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR) state law and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found on the Member pages of the Plan's website at CentralHealthPlan.com.

3. You **MUST** post in a conspicuous location in your office a Tagline Document, which explains how to access non-English language services. A sample of the Tagline Document that you will post can be found on the Member pages of the Plan's website at CentralHealthPlan.com.

4. If a Plan Member needs language assistance services while at your office, and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html and hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

5. If a Plan Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Plan's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Central Health Medicare Plan 200 Oceangate, Suite 100 Long Beach, CA 90802 Telephone: (866) 606-3889 TTY/TDD, 711 Email: civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Plan Member needs additional help or more information, call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural competency

The Plan is committed to reducing healthcare disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. The Plan integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances how people think about our members, service delivery, and program development so that cultural competency becomes a part of everyday thinking.

Provider and community training

The Plan offers educational opportunities in cultural competency concepts for Providers, their staff and community-based organizations. The Plan conducts Provider training

during Provider orientation, with annual reinforcement training offered through Provider Relations and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials
2. On-site and webinar cultural competency training
3. Online cultural competency Provider training modules and videos. These can be found on the Plan's website at CentralHealthPlan.com.
4. Integration of cultural competency concepts and non-discrimination of service delivery into Provider communications

Integrated quality improvement

The Plan ensures Members access to language services such as oral interpretation, American Sign Language (ASL) and written translation. The Plan also ensures access to programs, aids and services congruent with cultural norms. The Plan supports Members with disabilities and assists Members with LEP to provide meaningful access to interpretation services when needed. Based on the needs of the Member, the Plan may deliver interpretation in person, via video remote interpretation (VRI) or over the phone.

The Plan develops Member materials according to plain language guidelines. Members or Providers may request written Member materials in alternate languages and formats (i.e., Braille, audio, large print), leading to better communication, understanding, and Member satisfaction. Online materials found on CentralHealthPlan.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including Appeal and Grievance forms, are also available on the Plan's Member website in its threshold languages.

Access to interpreter services

Providers may request interpreters for Members whose primary language is other than English by calling the Plan's Member Contact Center toll-free at (866) 314-2427. The Member Contact Center representatives will immediately connect you and the Member to a qualified language service Provider.

The Plan's Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a dual headset. Access to telephonic interpreter services is available 24 hours a day for Members with LEP at no cost. Providers may offer the Plan's Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend, or minor to interpret or to rely on an interpreter who is not qualified.

All eligible Members who are LEP are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP,

limited reading proficiency (LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are the Plan's Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. The Plan is available to assist Providers with locating these services if needed.

An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

The Plan's Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964
- Be given access to care managers trained to work with individuals with cognitive impairments
- Be notified by the medical Provider that interpreter services are available at no cost
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation
- Be assured of confidentiality, as follows:
  - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records
  - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf
  - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the Plan.

Interpreters include qualified people who can speak the Member's native language, assist with a disability, or help the Member understand the information.

When the Plan's Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available
- The Plan is available to assist Providers with locating these services if needed:
  - Providers needing assistance finding onsite interpreter services
  - Providers needing assistance finding translation services
  - Providers with Members who cannot hear or have limited hearing ability may use TTY/TDD at 711
  - Providers with Members with limited vision may contact the Plan for documents in large print, Braille or audio version

- Providers with Members with LRP: the Plan's Member Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

The Plan offers Video Remote Interpretation (VRI) if a telephonic interpreter does not provide meaningful access for an appointment. VRI is available for more complicated appointments or when the Member needs access to a sign language interpreter. The service can be accessed with a webcam through any standard smartphone, tablet or laptop. No specific software is needed, and the platform is HIPAA-compliant and can be used for telehealth visits as well as in-person appointments. VRI appointments can be requested by calling the Plan's Member Contact Center. Requests should be made 48 hours before an appointment.

The Plan offers qualified onsite interpreter services to Providers and Members at medical appointments based on complex medical cases. Providers and Members may call the Plan's Member Contact Center to submit a request. Requests should be made at least three (3) business days before an appointment.

Documentation

As a contracted Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by the Plan.
- Document all Member requests for interpreter services
- Document who provided the interpreter service. This includes the name of the Plan's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend or minor as an interpreter or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members who are deaf or hard of hearing

TTY/TDD connection is accessible by dialing 711. This connection provides access to Member and Provider Contact Center, Quality, Health Care Services, and all other Plan functions.

The Plan strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

The Plan will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing, either via VRI or an on-site interpreter. Requests should be

made at least three (3) business days before an appointment to ensure the service's availability. In most cases, Members will have made this request via the Plan's Member Contact Center at (866) 314-2427.

24-hour Nurse Advice Line

The Plan provides nurse advice services for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call the Plan's 24-hour Nurse Advice Line directly at (888) 920-8809, or TTY/TDD 711. The 24-hour Nurse Advice Line telephone numbers are also printed on the Plan's membership cards.

Program and policy review guidelines

The Plan conducts assessments at regular intervals of the following information to ensure its programs are effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data form:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report)
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

6. Member rights and responsibilities

Providers must comply with the rights and responsibilities of the Plan's Members as outlined in the Plan's Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current EOC can be found on the Member pages of the Plan's website at CentralHealthPlan.com.

State and federal law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact the Plan:

- October 1 – March 31: 7 days a week, from 8 a.m. to 8 p.m., local time
- April 1 – September 30: Monday – Friday, from 8 a.m. to 8 p.m., local time

Our automated phone system may answer calls on weekends and holidays.

Member Contact Center Telephone: (866) 314-2427
Hearing Impaired: (TTY/TDD) 711

Second opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call Members Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

7. Eligibility and enrollment in Medicare Advantage products

Enrollment Information

Members who wish to enroll in the Plan's Medicare Advantage plans must meet the eligibility criteria as outlined in the Plan's Evidence of Coverage (EOC). The most current EOC can be found on the Member pages of our website at CentralHealthPlan.com.

Furthermore, the Plan does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Members Toll-Free Telephone Numbers

Members may call our Member Contact Center toll-free at:

- October 1 – March 31: 7 days a week, from 8 a.m. to 8 p.m., local time
- April 1 – September 30: Monday – Friday, from 8 a.m. to 8 p.m., local time

Our automated phone system may answer calls on weekends and holidays.

Member Contact Center Telephone: (866) 314-2427
Hearing Impaired: (TTY/TDD) 711

Effective Date of Coverage

The Plan will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed and received, following the Member's enrollment election period.

Disenrollment

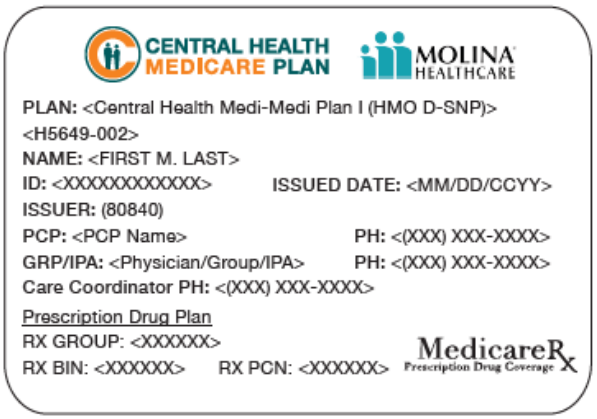
The Plan's staff may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll except as outlined in the Plan's EOC. The most current EOC can be found on the Member pages our website at CentralHealthPlan.com.

In all circumstances except death, the Plan will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Member Identification Card Example – Medical Services

HMO D-SNP; HMO C-SNP (EAE)


CENTRAL HEALTH MEDICARE PLAN
MOLINA HEALTHCARE
PLAN: <Central Health Medi-Medi Plan I (HMO D-SNP)>
<H5649-002>
NAME: <FIRST M. LAST>
ID: <XXXXXXXXXXXX> ISSUED DATE: <MM/DD/CCYY>
ISSUER: (80840)
PCP: <PCP Name> PH: <(XXX) XXX-XXXX>
GRP/IPA: <Physician/Group/IPA> PH: <(XXX) XXX-XXXX>
Care Coordinator PH: <(XXX) XXX-XXXX>
Prescription Drug Plan
RX GROUP: <XXXXXX>
RX BIN: <XXXXXX> RX PCN: <XXXXXX>
MedicareRx Prescription Drug Coverage

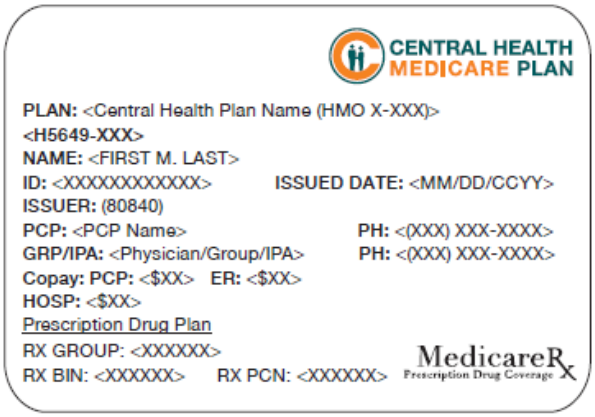

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICES. Contact Central Health Medicare Plan to confirm eligibility. All care must be arranged through your assigned contracted Primary Care Physician or Specialist.
NON-PLAN PROVIDERS / HOSPITAL EMERGENCY ROOM – Except in emergencies, members must obtain a prior authorization for physician and hospital services including post-stabilization.

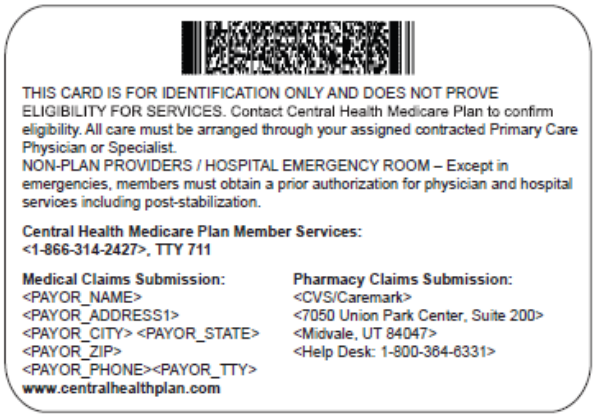
Central Health Medicare Plan Member Services:
<1-866-314-2427>, TTY 711

Medical Claims Submission:
<PAYOR_NAME>
<PAYOR_ADDRESS1>
<PAYOR_CITY> <PAYOR_STATE>
<PAYOR_ZIP>
<PAYOR_PHONE><PAYOR_TTY>
www.centralhealthplan.com

Pharmacy Claims Submission:
<CVS/Caremark>
<7050 Union Park Center, Suite 200>
<Midvale, UT 84047>
<Help Desk: 1-800-364-6331>

HMO (Non-EAE)


CENTRAL HEALTH MEDICARE PLAN
PLAN: <Central Health Plan Name (HMO X-XXX)>
<H5649-XXX>
NAME: <FIRST M. LAST>
ID: <XXXXXXXXXXXX> ISSUED DATE: <MM/DD/CCYY>
ISSUER: (80840)
PCP: <PCP Name> PH: <(XXX) XXX-XXXX>
GRP/IPA: <Physician/Group/IPA> PH: <(XXX) XXX-XXXX>
Copay: PCP: <$XX> ER: <$XX>
HOSP: <$XX>
Prescription Drug Plan
RX GROUP: <XXXXXX>
RX BIN: <XXXXXX> RX PCN: <XXXXXX>
MedicareRx Prescription Drug Coverage

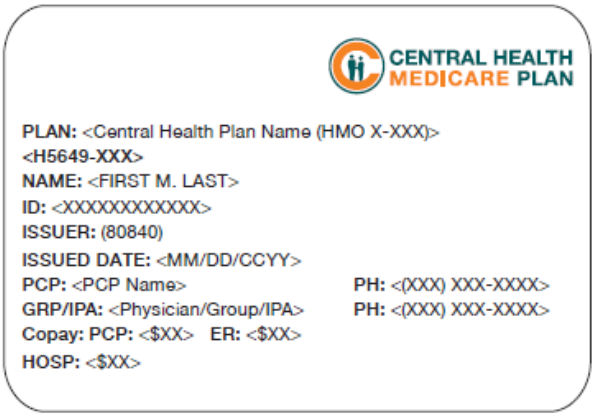

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICES. Contact Central Health Medicare Plan to confirm eligibility. All care must be arranged through your assigned contracted Primary Care Physician or Specialist.
NON-PLAN PROVIDERS / HOSPITAL EMERGENCY ROOM – Except in emergencies, members must obtain a prior authorization for physician and hospital services including post-stabilization.

Central Health Medicare Plan Member Services:
<1-866-314-2427>, TTY 711

Medical Claims Submission:
<PAYOR_NAME>
<PAYOR_ADDRESS1>
<PAYOR_CITY> <PAYOR_STATE>
<PAYOR_ZIP>
<PAYOR_PHONE><PAYOR_TTY>
www.centralhealthplan.com

Pharmacy Claims Submission:
<CVS/Caremark>
<7050 Union Park Center, Suite 200>
<Midvale, UT 84047>
<Help Desk: 1-800-364-6331>

Central Health Valor Care Plan (HMO) (Non-EAE No Part D)


CENTRAL HEALTH MEDICARE PLAN
PLAN: <Central Health Plan Name (HMO X-XXX)>
<H5649-XXX>
NAME: <FIRST M. LAST>
ID: <XXXXXXXXXXXX>
ISSUER: (80840)
ISSUED DATE: <MM/DD/CCYY>
PCP: <PCP Name> PH: <(XXX) XXX-XXXX>
GRP/IPA: <Physician/Group/IPA> PH: <(XXX) XXX-XXXX>
Copay: PCP: <$XX> ER: <$XX>
HOSP: <$XX>


THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICES. Contact Central Health Medicare Plan to confirm eligibility. All care must be arranged through your assigned contracted Primary Care Physician or Specialist.
NON-PLAN PROVIDERS / HOSPITAL EMERGENCY ROOM – Except in emergencies, members must obtain a prior authorization for physician and hospital services including post-stabilization.

Central Health Medicare Plan Member Services:
<1-866-314-2427>, TTY 711

Medical Claims Submission:
<PAYOR_NAME>
<PAYOR_ADDRESS1>
<PAYOR_CITY> <PAYOR_STATE>
<PAYOR_ZIP>
<PAYOR_PHONE><PAYOR_TTY>
www.centralhealthplan.com

Verifying Eligibility

To ensure payment, the Plan strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of

the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Providers who contract with the Plan may verify a Member's eligibility by checking the following:

- Availity portal: availity.com/molinahealthcare
- The Plan's Provider Contact Center automated IVR system: (866) 403-8296

Providers may verify a Member's Medi-Cal eligibility directly through the Department of Health Care Services (DHCS) via the Automated Eligibility Verification System (AEVS) at(800) 800-456-2387. AEVS is available from 7 a.m. to 8 p.m., 7 days a week. Providers will need their Medi-Cal Provider Identification Number (PIN). For additional information, please refer to DHCS's website at mcweb.apps.prd.cammis.medi-cal.ca.gov/contact.

D-SNP Members and Cost-Share

The Plan allows Members to enroll with various levels of Medicaid assistance (based on plan and/or CMS/state agreements). The Plan's State Medicaid Agency Contract (SMAC) determines the Medicaid aid categories that are allowed to enroll in the D-SNP.

Providers can find cost-share information on an individual Plan Member through the Availity portal or by visiting CentralHealthPlan.com.

8. Benefit overview

Questions about the Plan's Medicare Advantage benefits

If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools on the Plan's website at CentralHealthPlan.com and the Availity portal. You may also contact the Plan's Provider Contact Center toll-free at (866) 403-8296, 7 days a week, from 8 a.m. to 8 p.m., local time, or TTY/TDD 711, for persons with hearing impairments.

Links to the Plan's benefit materials

Member benefit materials including the Summary of Benefits and the EOC documents can be found on the Plan's website at CentralHealthPlan.com.

Detailed information about benefits and services can be found in the EOC booklets provided to each Plan Member.

Please note: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

Obtaining access to certain covered services

Telehealth and telemedicine services

Plan Members may obtain physical and behavioral health covered services by participating Providers, through the use of telehealth and telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating Provider
- Members have the option of receiving services from their PCP through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are a method of accessing covered services, and not a separate benefit
- Services are not permitted when the Member and participating Provider are in the same physical location
- Member cost sharing may apply based on the applicable Schedule of Benefits
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines
- Rendering Providers must comply with applicable federal and state guidelines for telehealth service delivery
- A licensed physician and/or surgeon in another state would be authorized to deliver health care via telehealth to eligible Members whom, among other requirements, has an immediately life-threatening disease or condition, in accordance to the David Hall Act Assembly Bill 1369.

For additional information on telehealth and telemedicine Claims and billing, please refer to the **Claims and Compensation** section of this Provider Manual.

Supplemental services

The Plan offers supplemental benefits for all Plan Members. Supplemental Benefits can be either mandatory meaning all Members on the plan are eligible for that supplemental benefit, or considered Special Supplemental Benefits for the Chronically Ill, referred to as SSBCI. As per CMS, SSBCIs are only available to Members who meet specific criteria by having certain chronic conditions that qualify them for a specific benefit and who have a current completed Health Risk Assessment (HRA).

A request for a SSBCI can be sent directly to the Plan's care management department who will verify the HRA is current, complete and validate the Member has the qualifying diagnosis. Verification of qualifying criteria may require confirmation directly with our Providers in which a member of our care management team will reach out to your office. Additionally, you can assist by helping with HRA completion. We appreciate your assistance with this process and your support to ensure that all SSBCIs are provided as CMS had intended. Depending on the plan, SSBCI benefits may include:

- Food and produce

A referral from the Member's PCP is not required for mandatory supplemental benefits.

Please refer to the Member EOC for more information – a link is available above under "Links to the Plan's Benefit Materials."

The Plan partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory on the Plan's website at https://ca-chp.sapphirethreesixtyfive.com//?ci=ca-chp-medicare.

Provider education on covered benefits and Member access to care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify Medicare and Medicaid covered benefits by accessing the appropriate plan or state agency materials (see hyperlinks below)
- How to access Medicaid-covered services including waiver services such as Long Term Support Services (LTSS), In-home Support Services (IHSS), or behavioral services

Medicaid-covered benefits

Medicaid covered services not covered by the Plan's D-SNP can be found on the state's Medicaid website at dhcs.ca.gov/services/medi-cal/Pages/Benefits_services.aspx#top.

9. Health care services

Health Care Services is comprised of utilization management (UM) and care management (CM) departments that work together to achieve an integrated approach to coordinating care. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. The Plan provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

Utilization management (UM)

The Plan's UM program provides pre-service authorization, inpatient authorization management and concurrent review of inpatient and continuing services. The Plan aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the medical necessity and appropriateness of health care services across the continuum of care
- Applying appropriate criteria based on CMS guidelines, third-party guidelines, and, when applicable, state requirements
- Providing pre-admission, admission, and inpatient hospital and skilled nursing facility review
- Ensuring services are available in a timely manner in appropriate settings
- Ensuring qualified health care professionals are engaged in the UM decision-making process when appropriate
- Ensuring the appropriate application of Member benefit coverage and coverage criteria
- For dual eligible Members:
    - The Plan will coordinate benefits for dual eligible Members, where applicable, in circumstances where the requested services are not covered by Medicare but are covered by their Medicaid benefit.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to the Plan's UM Policies. Their programs, policies and supporting documentation are reviewed by the Plan at least annually.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

The Plan has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity portal. With MCG Cite for Guideline Transparency, the Plan can share clinical indications with Providers. The tool operates as a secure extension of the Plan's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency — Delivers medical determination transparency
- Access — Clinical evidence that payers use to support Member care decisions

- Security — Ensures easy and flexible access via secure web access

MCG Cite for Guideline Transparency does not affect the process for notifying the Plan of admissions or for seeking prior authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

The Plan has also partnered with MCG Health to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization requests.

Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the PA will be reviewed by the Plan. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization request and sending it directly to the Plan, health care Providers receive an expedited, often immediate response. Through a customized rules engine, Cite AutoAuth compares the Plan's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include but are not limited to MRIs, CTs, PET scans. To see the full list of imaging codes that require prior authorization, refer to the Prior Authorization Code Look-Up Tool at CentralHealthPlan.com.

Medical necessity review

The Plan only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. Medical necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct medical necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations), state guidelines (when applicable) and use nationally recognized evidence-based guidelines, third-party guidelines, guidelines from recognized professional societies and peer-reviewed medical literature when appropriate. Providers may request to review the criteria used to make the final decision.

Where applicable, the Plan's clinical policies can be found on the public website at CentralHealthPlan.com. Please note that the Plan follows federal/state-specific criteria if available before applying the Plan's specific criteria.

Requesting prior authorization

Contracted Providers are responsible for requesting prior authorization of services when required by the Plan's policy, which may change from time to time. Failure to obtain prior authorization before rendering a service may result in a denial with Provider liability and/or denial of the Claim. The Member cannot be billed when a contracted Provider fails to follow the utilization management requirements for the Plan, including failure to obtain prior authorization before the Member receives the item or service. Obtaining authorization does not guarantee payment. The Plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service (DOS), correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care.

The Plan requires prior authorization for specified services. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS code. The prior authorization list is customarily updated quarterly but may be updated more frequently and is posted on the Plan's website at CentralHealthPlan.com. The Prior Auth Lookup Tool is also available in the Availity portal.

Providers are encouraged to use the Plan's prior authorization form provided on the Plan's website at CentralHealthPlan.com. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, the Plan Member ID number, health plan)
- Provider demographic information (ordering provider, servicing Provider, and referring Provider (when appropriate)
- Relevant Member diagnoses and ICD-10 codes
- Requested items and/or services, including all appropriate CPT and HCPCS codes
- Location where services will be performed (when relevant)
- Supporting clinical information demonstrating medical necessity under Medicare guidelines (and/or state guidelines when applicable)

Members and their authorized representatives may also request prior authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with the Plan's UM processes and guidelines, including submission of sufficient clinical information to support the medical necessity, level of care, and/or site of service of the items and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If the Plan determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement with the Plan or the Provider Manual, a denial may be issued with Provider liability. Members cannot be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement with the Plan or this Provider Manual. For information on the contracted

Provider Claims appeals process see the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Requests for prior authorization may be sent via the Availity portal (preferred method) or fax.

Availity portal: Contracted Providers are encouraged to use the Availity portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity portal. The benefits of submitting your prior authorization request through the Availity portal are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests
- Attach all supporting medical documentation

Fax: The Prior Authorization Request Form can be faxed to the appropriate Utilization Management department at the number provided below:

Advanced Imaging	(877) 731-7218
Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Part D: (866) 290-1309 Part B (J-Codes): (800) 391-6437
Hospital Inpatient Admission and Concurrent Review (physical health)	(844) 834-2152
Outpatient prior authorization: MAPD/DNSP/CSNP (physical health and behavioral health)	(844) 251-1450
Outpatient prior authorization: MMP/EAE (physical health and behavioral health)	(844) 251-1451
Medicare Transplants	(877) 813-1206
Post Acute Admission (SNF, LTACH and AIR)	(833) 912-4454

The Plan's 24-hour Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (888) 920-8809.

Notwithstanding any provision in the Provider Agreement with the Plan that requires the Provider to obtain a prior authorization directly from the Plan, the Plan may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the prior authorization tools located on the CentralHealthPlan.com website:

- Prior Authorization Code Look-up Tool

- Prior Authorization Code Matrix

Affirmative statement about incentives

Health care professionals involved in the UM decision-making process base their decisions on the appropriateness of care and services and the existence of coverage. The Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or care and does not provide financial incentives or other types of compensation to encourage decisions that result in under-utilization or barriers to care.

Time frames

Prior authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Medicare organization and coverage determination timeframes for pre-service requests are:

Expedited (non-Part B, non-Part D drug)	**72 hours – Medicare guidance allows written notice to follow within 3 calendar days after verbal notice to the member
Expedited Part B drug	24 hours
Expedited Part D drug :	24 hours
Standard (non-Part B, non-Part D drug)	**14 calendar days
Standard Part B drug	72 hours
Standard Part D drug	72 hours

***Timeframes for fully integrated plans such as a FIDE SNP may vary with regulatory and contractual requirements.*

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A Provider may request that a UM decision be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition. Vendors are not allowed to expedite without a physician order stating it needs expedited timeframe.

Communication of pre-service determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax.

When a pre-authorization request is denied with Member liability, the Member is issued a denial notice informing them of the decision and their appeal rights with a copy to the Provider. The Member's appeal rights are discussed further in the **Member Grievances and Appeals** section of this Provider Manual.

When a pre-authorization request is denied with Provider liability, the Provider is issued a denial notice by fax informing them of the decision. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Peer-to-peer discussions and re-openings

Contracted Providers may request a peer-to-peer conversation with a Plan Medical Director. Once a final adverse decision is made, however, the decision may not be reversed if Member liability is assigned (i.e., the Member is issued a denial notice with Medicare appeal rights) unless the CMS requirements for a reopening are met. CMS allows Medicare Advantage plans to use the reopening process only sparingly. Requirements for a reopening include clear clerical error, the procurement of new and material evidence that was not available or known at the time of the decision that may result in a different conclusion, or evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision (i.e., the decision was clearly incorrect based on all the evidence presented). Providers may not use the reopening process for the routine submission of additional information. Re-openings are not allowed once an appeal is filed by the Provider or the Member (or their authorized representative). The Plan's Medical Directors are available prior to the time of the decision to discuss any unique circumstances to be considered in the case.

Adverse decisions for which only Provider liability is assigned and that do not involve an adverse determination or liability for the Member may be subject to a peer-to-peer conversation. A peer-to-peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information. The Plan will not allow contracted Providers to use the peer-to-peer process as a vehicle for routine failure to provide sufficient information in the UM process or to avoid the contracted Provider Claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required timeframes.

For additional information on the contracted Provider Claims appeals process see the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Open communication about treatment

The Plan prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. The Plan requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

The Plan and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a

Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

UM functions performed exclusively by the Plan

The following UM functions are conducted by the Plan and are **never delegated**:

1. **Transplant –** The Plan does not delegate management of transplant cases to the medical group once a member has been listed for transplant. Providers are required to notify the Plan's UM department (or delegated medical group) when the need for a transplant evaluation is identified. Contracted Providers must obtain prior authorization from the Plan (or delegated medical group) for transplant evaluations. Upon notification, the Plan conducts medical necessity review. The Plan selects the facility to be accessed for the evaluation and possible transplant.

2. **Clinical Trials –** The Plan does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and Investigational Reviews –** The Plan does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Clinical Trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD) as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial;
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and,
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service and in particular, for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the noncovered item or service itself will not.

Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.

If the member participates in an unapproved study, the member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and member liability for Medicare cost-sharing amounts in their EOC or Member Handbook.

Delegated UM functions

The Plan may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions in compliance with all current Plan policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the **Delegation** section of this Provider Manual.

Emergency services, urgent care, and post-stabilization services

The Plan covers emergency services as well as urgently needed services and post-stabilization care for Members in accordance with applicable federal and state law.

Medicare defines emergency services as covered services provided to evaluate or treat an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgently needed services are covered services that:

1. Are not emergency services, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
2. Are provided when (a) the Member is temporarily absent from the Plan's service area and therefore, the Member cannot obtain the needed service from a network Provider; or (b) when the Member is in the Plan's service area, but the network is temporarily unavailable or inaccessible; and

3. Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from their regular Plan provider after returning to the service area or the network becomes available.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Providers requesting an in-patient admission as a post-stabilization service must request this type of service by calling the Plan at (866) 403-8296.

Inpatient admission requests (not including post-stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual timeframes.

Emergency services and urgently needed services do not require pre-authorization, although contracted Provider notification requirements may apply. For additional information, please refer to the Emergent Inpatient Admissions subsection below.

Members over-utilizing the emergency department may be contacted by the Plan's case managers to provide assistance whenever possible and determine the reason for using emergency services.

Emergency Department Support Unit (EDSU)

The Plan highly encourages that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. While the Member is in the ER call (844) 966-5462.

Additionally, clinical records for authorization of post-stabilization care can be faxed to the dedicated EDSU fax number: (877) 665-4625. This fax number is used exclusively for Members currently in the ER, to help expedite requests and assist with discharge planning.

The Plan's EDSU will collaborate with the ER to provide assistance to ensure Members receive the care they need when they need it.

The EDSU is a dedicated team, available 24 hours a day, 7 days a week to provide support by:

- Assisting in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations for post-stabilization care, transportation, or home health
- Involving a hospitalist or on-call medical director for any peer-to-peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated

- Coordinating placement into case management with the Plan when appropriate
- Beginning the process of discharge planning and next day follow-up with a primary care provider if indicated

Notification requirements

When a Member receives stabilization services in the hospital ER, the Plan requires timely notification to the EDSU for any post stabilization services, i.e., inpatient admission.

The Plan strongly recommends that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. Contact with the EDSU will be considered a formal request that requires a determination for post stabilization services and will be responded to within 30 minutes.

- For EDSU please call: (844) 966-5462
- Fax clinical documentation to: (877) 665-4625

If there is insufficient clinical information to render an approval during the post stabilization timeframe, the EDSU nurse will contact the Plan's physician on call for consultation. If the physician determines that clinical information does not support medical necessity, a denial will be issued. Denials may be overturned if additional clinical information is provided to support medical necessity for the admission.

For post stabilization services that are denied, the hospital may submit Claims for observation level of care for payment consideration.

Notifications received from hospitals, where a post-stabilization admission determination is **NOT** expected by the hospital within 30 minutes, will follow the Plan's standard UM process.

After hours, weekends and holidays, please call (844) 966-5462.

Observation status

Observation stays up to 72 hours do not require prior authorization and can be billed directly to the Plan along with any related charges. Those scenarios where an observation stay needs to be converted to an inpatient stay should follow the emergency services, urgent care and post-stabilization services subsection above.

Inpatient admission notification and management

Elective inpatient admissions

The Plan requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, SNFs and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACHs) and acute

inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify the Plan of the admission within 24 hours or by the following business day or as otherwise specified in the relevant Provider Agreement with the Plan. Inpatient notifications may be submitted by fax. Contact telephone numbers and fax numbers are provided in the Requesting Prior Authorization section of this Provider Manual.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or to support the level of care may result in denial with Provider liability. Members cannot be held liable for the failure of a contracted Provider to follow the terms of the relevant Provider Agreement with the Plan and this Provider Manual.

For additional information on the contracted Provider Claims appeal process, please refer to the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Emergent inpatient admissions

The Plan requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day or as otherwise specified in the relevant Provider Agreement with the Plan. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Notification must include Member demographic information, facility information, date of admission and clinical information supporting the level of care. Notifications may be submitted by fax. Contact telephone numbers and fax numbers are noted in the Requesting Prior Authorization subsection of this Provider Manual.

Prior authorization is not required for an observation level of care. Once the Member is stabilized and a request for inpatient admission is made or the observation period expires, contracted Providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with Provider liability. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement with the Plan and this Provider Manual.

For additional information on the contracted Provider Claims appeal process, please refer to the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Inpatient at time of termination of coverage

Members hospitalized on the day that a Member in the Plan terminates are usually covered through discharge. Specific Plan rules and Provider Agreement with the Plan provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that they are an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that their services are covered under Part B and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect their eligibility for a SNF level of care and that Part B does not cover self-administered drugs.

Inpatient concurrent review

The Plan performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment, and development of appropriate discharge plans. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF, and other inpatient setting), although the cadence and extent of concurrent review may vary depending on the setting and the member's circumstances. Performing these functions requires timely clinical. The Plan will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission with Provider liability dependent on the circumstances and the terms of the relevant Provider Agreement with the Plan. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement with the Plan or this Provider Manual.

The Plan will authorize hospital care as an inpatient when the clinical record supports the medical necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide the Plan with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Discharge planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work communicate with hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is important to ensure that the Plan's Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within one (1) calendar day of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out-of-network Providers and services

The Plan maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. The Plan requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include emergency services and medically necessary dialysis services obtained by the Member when they are outside the service area. For additional information, please refer to the subsection on Emergency Services, Urgent Care, and Post-stabilization Services above. When no exception applies, The Plan will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

Termination of ongoing services

Termination of inpatient hospital services

Hospitals are required by CMS regulations to deliver the Important Message from Medicare (IM, Form CMS-10065), to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within two (2) calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two (2) calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or their representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay and the hospital has not initiated discharge planning, the Plan may require that the hospital issue a follow-up copy of the IM and notify the Member of their discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care (aside from

any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the IM and if the Member exercises their appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of a determination adverse to the Member.

When the Member exercises their appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon following the day of the QIO's notification to the hospital of the appeal. The hospital is required to provide all information that the QIO requires to make its determination. At the Member's request, the hospital must provide the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than the close of business the first day the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF, and HHA services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with their appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two (2) calendar days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When the Plan makes a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF and CORF) for delivery with a designation of the last covered day. Contracted Providers are responsible for delivering the NOMNC on behalf of the Plan to the Member or Member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide the Plan with a copy of the signed NOMNC. The failure of the contracted Provider not issuing the letter to the Member could potentially result in denial of payment for those days not issued If the Member appeals the discharge to the Quality Improvement Organization (QIO), the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located in the NOMNC and if the Member exercises their appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable until a proper NOMNC is issued, and the Member is given their appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS

guidelines or to provide information timely to the QIO may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider Agreement with the Plan or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a Member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the Member moves to a higher level of care (e.g., from home health to SNF);
- When the Member exhausts their Medicare benefit;
- When the Member terminates services on their own initiative;
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services but has a dangerous animal on the premises).

Coordination of care and services

The Plan's HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for the Plan's integrated care management (ICM) program via assessment, or referral such as self-referral, Provider referral, etc. In addition, the coordination of care process assists the Plan's Members, as necessary, in transitioning to other care when benefits end.

The Plan's staff provide an integrated approach to care needs by assisting Members with identification of resources available such as community programs, national support groups, appropriate specialists, and facilities, identifying best practice or new and innovative approaches to care. Care coordination by the Plan's staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies
- Education about alternative care
- How to obtain care as appropriate

Continuity of care and transition of Members

It is the Plan's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time

and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member for 90 days or for as long as the treatment plan requires. The Member will be safely transferred to another Provider by the Plan or its delegated Medical Group/IPA.
- Pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members please contact the Plan at (866) 403-8296.

Continuity and coordination of Provider communication

The Plan stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is or receiving or may be in need of receiving community care services by reason of mental or other disability, age, or illness; and who is or may be unable to take care of themself, or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or childcare givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Los Angeles County
(800) 540-4000 – Within CA
(213) 639-4500 – Outside CA
(800) 272-6699 – TTY/TDD

Online Reporting: reportChildAbuseLA.org

San Diego County
(858) 560-2191
(800) 344-6000

Imperial County
(760) 337-7750

Riverside County
(800) 442-4918
(877) 922-4453

San Bernardino County
(909) 384-9233
(800) 827-8724

Sacramento County
(916) 875-5437

Adult Abuse

Los Angeles County
Community & Senior Services
3333 Wilshire Blvd. Suite 400
Los Angeles, CA 90010

24-Hour Abuse Hotline: (877) 477-3646
APS Mandated Reporter Hotline: (888) 202-4248
M-F, 8 a.m. – 5 p.m.

Sacramento County
Department of Health & Human Services
PO Box 269131
Sacramento, CA 95826

24 Hour Abuse Hotline
Telephone: (916) 874-9377
Fax: (916) 854-9341

San Diego County
Aging & Independence Services
PO Box 23217
San Diego, CA 92193-3217

24 Hour Abuse Hotline
(800) 339-4661 or (800) 510-2020
Fax: (858) 495-5247

Imperial County
Department of Social Services
2999 South 4th Street
El Centro, CA 92243

24 Hour Abuse Hotline
Telephone: (760) 337-7878
Fax: (760) 336-8593

Riverside County
Department of Public Social Services - Adult Services Division
4060 County Circle Drive
Riverside, CA 92501

24 Hour Abuse Hotline
Telephone: (800) 491-7123
Fax: (951) 358-3969

San Bernardino County
Department of Aging and Adult Services
686 East Mill Street
San Bernardino, CA 92415

24 Hour Abuse Hotline
Telephone: (877) 565-2020
Fax: (909) 388-6718

Health & Human Services
1111 San Felipe Rd, Ste 206
Hollister, CA 95023

The Plan's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

The Plan will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. The plan will track, analyze, and report aggregate information regarding abuse reporting to the Healthcare Services Committee and the proper state agency.

Primary care providers

The Plan provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by the Plan. The Plan's Members are required to see a PCP who is part of the Plan's network. The Plan's Members may select or change their PCP by contacting the Plan's Member Contact Center at (866) 314-2427.

Specialty providers

The Plan maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, prior authorization may be required depending on delegation. Members are allowed to directly access women health specialists within the network for routine and preventive health without a referral for services.

Referrals to specialty care outside the network require prior authorization from the Plan. The Plan will assist in ensuring access for second opinions from in-network and out of network providers as applicable.

Care management (CM)

The integrated care management (ICM) program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. CM focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs Members who would benefit from more intensive support and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

1. **The role of the case manager includes:**

    - Coordination of quality and cost-effective services
    - Appropriate application of benefits
    - Promotion of early, intensive interventions in the least restrictive setting of the Member's choice
    - Assistance with transitions between care settings and/or Providers
    - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans
    - Creation of individualized care plan (ICP), updated as the Member's conditions, needs and/or health status change.
    - Facilitation of interdisciplinary care team (ICT) meetings as needed

- Promote utilization of multidisciplinary clinical, behavioral, and rehabilitative services
- Referral to, assessment of, and coordination of appropriate resources and support services, including but not limited to Long-Term Services and Supports (LTSS)
- Attention to Member preference and satisfaction
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality
- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence
- Protection of Member rights
- Promotion of Member responsibility and self-management

2. **Referral to CM may also be made by the following entities:**

- Member or Member's designated representative(s)
- Member's primary care provider
- Specialists
- Hospital staff
- Home health staff
- The Plan's staff

Special Needs Plan (SNP) Model of Care (MOC)

The MOC is the framework for the Plan's care management processes and systems that enable coordinated care for our Members in our Special Needs Plans. As defined by CMS, our Model of Care includes the following areas: description of SNP population (including health conditions), care coordination, Provider network, quality measurement and performance improvement. We value the partnerships we have with our Providers and want to work with you to coordinate care and help our Members obtain the best possible outcomes and improve the health and well-being of our aging, vulnerable, and chronically ill Members. Our MOC program addresses the following areas:

1. **Targeted population** – We operate Medicare Dual Eligible Special Needs Plans (D-SNP) in multiple markets for Members who are eligible for both Medicare and Medicaid. Our population may include full benefit duals that have access to Medicaid benefits and Members who are only eligible to receive assistance with some or all the Medicare premiums and cost sharing. Our MOC describes our population and includes a description of the medical conditions, co-morbidities, cognitive issues, social and environmental factors our Members experience. We identify the most vulnerable Members as those who may have experienced a change in health status, transition of care setting, a diagnosis that requires extensive use of resources or those who need help navigating the health care system due to social determinants of health.

2. **Care coordination:** This section of the MOC defines our clinical program and includes multiple sections as described below:

A. **Staff structure:** Our staff structure has both administrative and clinical teams that directly or indirectly affect the care coordination of our Member and is designed to manage the needs of the SNP enrollees. Our clinical team interact directly with the Member or care givers and/or with the Providers caring for this complex population.

B. **HRA, ICP, ICT, face-to-face encounter, and care transitions:**

Our program has multiple care coordination strategies including the following:

- Completion of an initial and annual health risk assessment targeted to assess physical, behavioral, cognitive, psychosocial, and functional areas. We outreach to our Members in multiple ways to complete the initial assessment within 90 days of the effective date and at a minimum annually thereafter. We also reassess the Member if a significant status change or if a targeted transition in care occurs. Our team may reach out to your office to obtain additional contact information on our unable to reach Members who do not respond to our multiple outreach attempts.
- Each Member has an ICP created using the results of the HRA and other data available from multiple areas such as claims, authorizations or other assessments. Feedback from the Member, care givers or Providers may also be included in the ICP. The ICP is a living document updated as needs change and is available to members of the care team.
- ICT: Each Member has an ICT developed based on the Member's preferences, complexity and needs as identified during the assessment and care planning process. The Member and/or care giver are encouraged to participate. Our Providers, especially the primary care provider (PCP), are key members of the ICT and our team may reach out to you to provide feedback or participate in the care planning process or address needs identified by our care team. The ICP will be made available for the ICT members to review. Communication with the ICT is coordinated based on the Member's needs and may be a formal or informal discussion or sharing of information using multiple communication strategies.
- Face-to-face encounter: All SNP Members must have a face-to-face encounter annually for the delivery of health care, care management or care coordination services. The encounter must be with a Member of the Member's ICT, the plan's case management and coordination staff, or contracted plan health care Providers and may be in person or through visual, real-time, interactive telehealth encounters.
- Care transition protocols: Coordination of care and managing transitions is an important part of our SNP program. This population has a substantial risk of experiencing fragmented and unsafe care during transitions. The best way to help Members navigate through the complexities of transitions is a team approach with both our team

and Providers caring for the Member working together to coordinate care. To effectively manage the care of a Member that experiences an applicable transition we expect our Providers to notify the care management staff in advance of Member planned transitions requiring an authorization as soon as possible, but no later than three (3) business days for unplanned transitions. Our Providers are essential to successful coordination of care during transitions and should be actively involved in the process. Managing transitions include processes such as assisting with logistical arrangements, providing education on post transition care and self-management, coordination of care, transferring data to the receiving Provider during a transition, and making sure the Member has access to their personal health information. Our care team is available to assist during complex transitions in care. Additional details are provided in the previous sections of this Provider Manual on coordination and transition of Members.

- Point of contacts during transitions may be the PCP chosen by the Member to coordinate care or the Provider of care during the transitions.
- Our case manager supports the Member and the Provider during a transition.
- Our Members also have access to our customer service team at the number listed on the Plan's Member identification card.

3. **Provider network:**

- We have a contracted Provider network that includes Providers and facilities relevant and necessary to address the unique and/or specialized health care needs of our membership. Our credentialing process validates the licensure and credentials of our network. In most situations the Member's PCP is responsible for determining what medical services a Member needs, however, if treatment is primarily through a specialist physician, the specialist may be primarily responsible for determining needed services. Our care team is available to assist our Providers or Members with care coordination. For Members undergoing transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services.
- Clinical practice guidelines (CPG): We use nationally recognized, evidence based clinical practice guidelines relevant to the SNP population. These clinical practice guidelines will be communicated using the Provider newsletter and the Plan's website. The Plan will annually measure Provider compliance with important aspects of the clinical practice guidelines and report results to Providers.
- MOC Training: All Providers are encouraged to complete annual MOC training and provide an attestation confirming completion. Providers will have access to the training via the Plan's website or through web-based or in-person training sessions. Providers will receive notice to participate in the

training with instructions on how to complete the attestation. Providers are encouraged to leverage Dementia Care Aware resources for any primary care visit to detect cognitive impairment. When detected a full diagnostic workup should be conducted. Providers can leverage tools presented in the California Alzheimer's Disease Center's Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease and/or Medicare related tool

4. **Quality performance improvement plan:** We have a comprehensive and multi-functional Quality program and conduct a wide range of quality improvement activities focusing on the health care and services our Members receive across the health care continuum. Our program includes quality measurement and performance improvement which is a collaborative process for improving our ability to deliver high-quality health care services and benefits to our Members.

   - Our program includes multiple goals based on our program design and population that focus on structure, process, and outcomes. We have a specific set of goals to measure the effectiveness of our program focusing on all aspects of care and health outcomes including but not limited to the following:
     - Improved access to essential health services
     - Improved access to affordable care
     - Improved coordination of care/case management
     - Improved access to preventive health services and management of chronic conditions
     - Appropriate utilization of services for preventive health and chronic conditions
     - Improved beneficiary health outcomes
     - Improved access to behavioral health services
   - We use multiple data sources to monitor, analyze, and evaluate performance outcomes, according to our work plan activities and MOC objectives. Based on our results we will take corrective actions if needed to improve our performance.
   - Our program is evaluated, and results communicated to multiple stakeholders.

   We want to be your partner and assist in helping manage and coordinate the complex needs experienced by our Members. To better assist you, we ask the following of all our Providers involved in the care of our SNP Members:

   - Complete the annual MOC Provider training
   - Review the HRA results, the ICP and other data we may provide to you. If asked sign and return the ICP.
   - Respond to communications you may receive from our team concerning needs identified during our interactions with the Members or requesting assistance in developing the ICP
   - Participate in ICT by providing feedback to communications or inquiries sent by members of the ICT

- Assist in managing transitions in care, completing post discharge follow up activities, sharing Member information with other Providers, and closing care gaps
- Assist with coordination of care including coordinating with Medicaid on our Dual Members
- Communicate and collaborate with our care team, the ICT, Members, and caregivers. Reach out to our team if you have complex Members, we can assist you with coordinating needed care.
- Encourage the Member to work with your office, the care team, keeping all appointments, completing the HRA and complying with all treatment plans.

10. Behavioral health

Overview

The Plan provides a Behavioral Health benefit for Members. The Plan takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health and other specialty Providers to ensure whole person care. The Plan complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization management and prior authorization

Behavioral health inpatient and residential services can be requested by submitting a Prior Authorization Request Form or contacting the Plan's prior authorization team at (866) 403-8296. Providers requesting after-hours authorization for these services should utilize the Availity portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for behavioral health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. The Plan utilizes standard, generally accepted medical necessity criteria for prior authorization reviews. Please see the Prior Authorization subsection found in the **Health Care Services** section of this Provider Manual for additional information.

Access to behavioral health Providers and PCPs

Members may be linked to an in-network behavioral health Provider via referral from a PCP, medical specialist or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice. A formal referral form or prior authorization is not needed for a Member to access their assigned PCP, specialist or an in-network behavioral health Provider. However, individual services provided by non-network behavioral health Providers will require Prior Authorization.

Behavioral health Providers may refer a Member to their assigned in-network PCP or a Member may self-refer. Members may be referred to PCP and specialty care Providers to manage their health care needs. behavioral health Providers may identify other health concerns, including physical health concerns, which should be addressed by referring the Member to their PCP.

Care coordination and continuity of care

Discharge planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral

health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of the discharge date.

Interdisciplinary care coordination

In order to provide care for the whole person, the Plan emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral health, primary care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. The Plan's care management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care management

The Plan's CM team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a behavioral health professional or primary care Provider to the ICM program.

Referrals to the ICM program may be made by contacting the Plan at:

Phone: (866) 403-8296
Email: medicare_cm_team@molinahealthcare.com

Additional information on the CM program can be found in the Care Management subsection found in the **Health Care Services** section of this Provider Manual.

Responsibilities of behavioral health Providers

The Plan promotes collaboration with Providers and integration of both physical and behavioral health services in an effort to provide quality care coordination to Members. Behavioral health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to the Plan's Members. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. The Plan provides oversight of Providers to ensure Members can obtain needed health services within acceptable appointment timeframes. Please refer to the **Quality** section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a

behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

The Plan has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Plan's Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (888) 920-8809.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support or anyone with concerns about someone else, can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

The Plan has developed an online Behavioral Health Tool Kit to provide support with screening, assessment and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, training opportunities for Providers and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab on the CentralHealthPlan.com Provider website.

11. Quality

Maintaining quality improvement processes and programs

The Plan works with Members and Providers to maintain a comprehensive Quality Improvement and Health Equity Transformation program. You can contact the Plan's Quality department at (866) 403-8296.

The address for mail requests is:

Quality Improvement Department
200 Oceangate, Suite 100
Long Beach, CA 90802

This Provider Manual contains excerpts from the Plan's Quality Improvement and Health Equity Transformation program. For a complete copy of the Plan's Quality Improvement and Health Equity Transformation program, please contact your Provider Relations representative or call the telephone number above.

The Plan has established a Quality Improvement and Health Equity Transformation program that complies with regulatory requirements and accreditation standards. The Quality Improvement and Health Equity Transformation program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our quality improvement and health equity transformation program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

The Plan does not delegate quality improvement and health equity transformation activities to Medical Groups/IPAs. However, the Plan requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. The Plan's Medical Groups/IPAs must:

- Have a quality improvement and health equity transformation program in place
- Comply with and participate in the Plan's Quality Improvement and Health Equity Transformation program including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations
- Cooperate with the Plan's quality improvement and health equity transformation activities that are designed to improve quality of care and services and Member experience
- Allow the Plan to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability
- Allow access to the Plan's Quality personnel for site and medical record review processes.

Patient Safety program

The Plan's Patient Safety program identifies appropriate safety projects and error avoidance for the Plan's Members in collaboration with their PCPs. The Plan continues to support safe health practices for our Members through our safety program, pharmaceutical management and care management/health management programs and education. The Plan monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and CMS processes to identify events and deny payment.

Quality of care

The Plan has established a systematic process to identify, investigate, review and report any quality of care, adverse event/never event, critical incident (as applicable) and/or service issues affecting Member care. The Plan will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

The Plan is not required to pay for inpatient care related to "never events."

Medical records

The Plan requires that medical records be maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components that include, but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records
- Medical record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- Process for archiving medical records and implementing improvement activities

Medical record-keeping practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's medical records:

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available during each visit and archived records are available within 24 hours
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for Quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation, and gender identity
- Storage maintenance for the determined timeline and disposal per record management processes
- Process is in place for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

Providers must remain consistent in their practices with the Plan's medical record documentation guidelines. Medical records are maintained and should include, but not limited to the following information. All medical records should contain:

- The patient's name or ID number on each page in the record
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact
- Legible signatures and credentials of the Provider and other staff members within a paper chart
- Electronic Medical Records (EMR) must be electronically signed with credentials noted
- A list of all Providers who participate in the Member's care
- Information about services that are delivered by these Providers
- An active problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Documentation that shows advance directives, power of attorney and living will have been discussed with Member, and a copy of advance directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors

- Treatment plans that are consistent with diagnosis
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Lab and other diagnostic tests that are ordered as appropriate by the Provider
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls or visits that include the specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants as applicable
- Up-to-date immunization records and documentation of appropriate history
- All staff and Provider notes are signed physically or electronically with the Provider's full signature with credentials noted; for other quick areas of a note initials can be used
- All entries are dated
- All abnormal lab/imaging results show explicit follow-up plan(s)
- All ancillary services reports
- Documentation of all emergency care provided in any setting
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals and operative reports.
- Labor and Delivery Record for any child seen since birth
- A signed document stating with whom protected health information may be shared

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file
- Chart sections are easily recognized for retrieval of information
- A release document for each Member authorizing the Plan to release medical information for facilitation of medical care

Retrieval

- The medical record is available to the Provider at each encounter
- The medical record is available to the Plan for purposes of quality improvement
- The medical record is available to applicable state and/or federal agencies and the External Quality Review Organization upon request
- The medical record is available to the Member upon their request
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years.

- An established and functional data recovery procedure in the event of data loss

Confidentiality

Plan Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include and is not limited to the following:

- Ensure that medical information is released only in accordance with applicable federal or state law or pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information
- Medical records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected

Additional information on medical records is available from the Plan's local Quality department. For additional information regarding HIPAA, please refer to the **Compliance** section of this Provider Manual.

Advance directives (Patient Self-Determination Act)

The Plan complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are three (3) types of Advance Directives:

- **Durable power of attorney for health care**: allows an agent to be appointed to carry out health care decisions.
- **Living will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **5 wishes:** records an end-of-life care plan for future care in case someone is unable to make decisions for themselves at that time.

When there is no advance directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform the Plan's adult Members 18 years old and up, of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

Members who would like more information are instructed to contact the Plan's Member Contact Center at (866) 314-2427 or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Plan's website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

The Plan's network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. The Plan will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations give Members the right to file a complaint with the Plan or the state survey and certification agency if the Member is dissatisfied with the Plan's handling of advance directives and/or if a Provider fails to comply with advance directives instructions.

The Plan will notify the Provider of an individual Member's advance directive identified through care management, care coordination or case management. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Auditors will also look for copies of the advance directive form. Advance directive forms are state-specific to meet state regulations.

The Plan expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to care

The Plan maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine and pediatric), OB/GYN (high-volume specialists), Hematology/Oncologist (high impact specialists) and behavioral health practitioners. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Plan Members within the noted time frames. The Plan will implement corrective action plan (CAP) for access to health care Providers that do not meet the performance standards.

Medical appointment

Type of care and service	Standard
Urgently needed services or emergency	Immediately
PCP Office Wait Time	Within < 30 minutes from the appointment time
PCP-Urgent Care without prior authorization	Within < 48 hours of the request
PCP-Urgent Care with prior authorization	Within < 96 hours of the request
Primary Care: Services that are not emergency or urgently needed but require medical attention	Within < 7 business days of the request
PCP Well Child Preventive Care	Within < 7 business days of the request
Primary Care: Routine and Preventive Care	Within < 20 business days of the request
Specialist Routine or Non-Urgent Care	Within < 15 business days of the request
Specialist Urgent Care without prior authorization	Within < 48 hours of the request
Specialist Urgent Care with prior authorization	Within < 96 hours of the request
Routine or Non-Urgent Care Appointment for Ancillary Services	Within ≤ 15 working days of the request
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ≤ 7 working days of the request
After Hours Care	24 hours/day; 7 day/week availability
Maternity Care Appointments for First Prenatal Care	Within ≤ 2 weeks of the request
Office Telephone Answer Time (during office hours	Within ≤ 30 seconds of call
Office Response Time for Returning Member Calls (during office hours)	Within same working day of call
Appropriate after-hour Instruction for Life Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life threatening emergency, hang up and dial 911"
Timely Physician Response to After-Hour Phone Message, Calls and/or Pages	Within < 30 minutes of call, message. and/or page. A clear instruction on how to contact the physician or the designee (on-

Type of care and service	Standard
	call physician) must be provided for Members

Behavioral health appointment

Appointment type	Standard
Life-Threatening Emergency: Urgently needed services or emergency	Immediately
Non-life Threatening Emergency	Within 6 hours
Urgent Care with a Behavioral Health Provider without prior authorization	Within ≤ 48 hours of the request
Urgent Care requiring prior authorization with a Behavioral Health Provider	Within ≤ 96 hours of the request
Behavioral Health Initial Routine Care Visit: Services that are not emergency or urgently needed but require medical attention	Within ≤ 7 business days
Behavioral Health Life-threatening emergency: Urgently needed services or emergency	Immediately
Behavioral Health Non-life-threatening emergency	Within ≤ 6 hours of the request
Routine Follow Up with Prescribers (i.e., Psychiatrist)	Within ≤ 30 business days from the initial appointment for a specific condition
Routine Follow Up with Non-Prescribers	Within ≤ 10 business days from the initial appointment with Non-Prescribers (i.e., nonphysician mental health care or substance use disorder provider) for a specific condition
Routine or Non-Urgent Care Appointment with a Non-Physician Mental Health Provider or substance use disorder providers	Within ≤ 10 working days of the request

Additional information on appointment access standards is available from the Plan's local Quality department.

Office wait time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. The Plan requires Providers to maintain a 24-hour telephone

service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with a life-threatening emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

After-hour answering service or recorded message must provide a clear instruction on how to reach the physician or the designee (on-call physician) after business hours. The physician or the designee must respond to urgent after-hours phone calls, messages, and/or pages within 30 minutes.

Appointment scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Plan's Provider Contact Center at (866) 403-8296.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes but is not limited to wheelchair-bound Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to, immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member based on age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental, or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close their panel to new Members, the Plan must receive 30 calendar days advance written notice from the Provider.

Women's health access

The Plan allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by the Plan as providing obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from the Plan's local Quality department.

Monitoring access for compliance with standards

Access to care standards is reviewed, revised as necessary and approved by the Quality Improvement and Healthy Equity Transformation Committee on an annual basis.

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access
2. Member complaint data – assessment of Member complaints related to access and availability of care
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement and Healthy Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Healthy Equity Transformation Committee.

Quality of Provider office sites

Plan Providers are to maintain office-site and medical record keeping practices standards. The Plan continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. The Plan assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance

- Adequacy of waiting and examining room space

Physical accessibility

The Plan evaluates office sites, as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of waiting and examining room space

During the site visit as required, the Plan assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and confidentiality of facilities

Facilities contracted with the Plan must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, blood-borne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.

- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- When the appropriate lab work is run in the office, a Clinical Laboratory Improvement Amendments (CLIA) waiver is displayed.
- Prescription pads are not kept in exam rooms
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily

Monitoring for compliance with standards

The Plan monitors compliance with the established performance standards as outlined above at least annually. Performance below the Plan's standards may result in a CAP with a request the Provider submit a written CAP to the Plan within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement and Health Equity Transformation activities and programs

The Plan maintains an active Quality Improvement and Health Equity Transformation program. The Quality Improvement and Health Equity Transformation program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The Plan focuses on reducing health care disparities through the QI Program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health management and care management

The Plan's health management and care management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases or other case management needs.

For additional information please refer to the Health Management and Care Management subsections in the **Health Care Services** section of this Provider Manual.

Clinical practice guidelines

The Plan adopts and disseminates clinical practice guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

The Plan's CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPGs are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis CPGs are distributed to Providers at CentralHealthPlan.com (or when changes are made during the year) and the Provider Manual. Notification of the availability of the CPGs is published in the Plan's Provider Newsletter.

Preventive health guidelines

The Plan provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC) in accordance with CMS guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on the Plan's website)
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on the Plan's website)
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on the Plan's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on the Plan's website.

All preventive health guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, Preventive Health Guidelines are distributed to Providers via CentralHealthPlan.com and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the Plan's Provider Newsletter.

Cultural and linguistic appropriate services

The Plan works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about the Plan's program and services please refer to the **Cultural Competency and Linguistic Services** section of this Provider Manual.

Measurement of clinical and service quality

The Plan monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- HEDIS®
- CAHPS®
- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of quality improvement initiatives

The Plan evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/Plan level.

Contracted Providers and facilities must allow the Plan to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include but is not limited to the following: (1) development of Quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

The Plan's most recent results can be obtained from the Plan's local Quality department or by visiting our website at CentralHealthPlan.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

The Plan utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by the Plan to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of the Plan's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Medicare Health Outcomes Survey (HOS)

The HOS measures Medicare Members' physical and mental health status over a two (2)-year period and categorizes the two (2)-year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

Provider Satisfaction survey

Recognizing that HEDIS® and CAHPS® both focus on the Plan's Member's experience with health care Providers and health plans. The Plan conducts a Provider Satisfaction survey annually. The results from this survey are very important to the Plan, as this is one of the primary methods used to identify improvement areas pertaining to the Plan's Provider network. The survey results have helped establish improvement activities relating to the Plan's specialty network, inter-Provider communications and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of quality improvement initiatives

The Plan monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The Plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, the Plan also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

Medicare Star Ratings – The Affordable Care Act

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare Members. This system is based on nationally recognized quality goals which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through the collection and reporting of specific measure results.

Preventive Health:

- Annual wellness/physical exams
- Mammograms
- Osteoporosis testing and management
- Influenza and pneumonia immunizations
- Colonoscopies

Chronic care management:

- Diabetes management screenings
- Cardiovascular and hypertension management screenings
- Medication adherence for chronic conditions

Member Satisfaction survey questions:

- "…rate your satisfaction with your personal doctor."

- "…rate your satisfaction with getting needed appointments."

What can Providers do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.
- Check that staff are properly coding all services provided.
- Be sure patients understand what *they* need to do.

The Plan has additional resources to assist Providers and their patients. For access to tools that can assist please visit the Availity portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® Star Ratings measures, contact the Plan's local Quality department.

Merit-based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program MIPS. This is a quality payment program that eligible Providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for MIPS, unless it is specifically in the agreement you have with the Plan. Please contact your Provider Relations representatives for other quality programs the Plan offers.

12. Risk adjustment management program

What is risk adjustment?

CMS defines risk adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to the Plan's Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions. Risk adjustment accounts for the medical differences in each Member to ensure the health plan receives the correct funds to support their medical needs.

Why is risk adjustment important?

The Plan relies on our Provider network to care for our Members based on their health care needs. Risk adjustment relies on complete and accurate diagnostic documentation and reporting of our Members full burden of illness. c Clinical data elements of a Member's health profile are utilized to determine care gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions
- Identify Members for Care Management referral
- Ensure adequate resources for the acuity levels of the Plan's Members
- Have the resources to deliver the highest quality of care to the Plan's Members

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for the Plan's Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Epic Payer Platform, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for the Plan's Members to the interoperability vendor designated by the Plan.

The Provider will participate in the Plan's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the HIPAA-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having Provider's Digital Contact Information added in NPPES.
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with the Plan's established interoperability partner to get an account established.

Your role as a provider

As a Provider, your complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to utilize the annual visit (for all new and existing patients) to perform a comprehensive assessment of Members' chronic conditions and current health status. We encourage Providers to record all diagnoses to the highest specificity. This will ensure the Plan receives adequate resources to provide quality programs to Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., a diabetic patient needs an eye exam or assessment of multiple comorbid conditions) provided by the Plan and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes for conditions assessed/addressed or affecting the Member as confirmed by the Provider during the visit. The visit may be face-to-face or telehealth, depending on CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.
- Providers must supply copy of the medical record to the Plan, if requested.

Risk Adjustment Data Validation (RADV) audits

As part of the regulatory process, federal agencies may conduct RADV audits to ensure that the diagnosis data submitted by the Plan for risk adjustment is complete and accurate. All Claims/Encounters submitted to the Plan are subject to state and/or federal and internal health plan auditing. If the Plan is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact information

For questions about the Plan's risk adjustment programs, please contact the Plan's Provider Relations representatives.

13. Compliance

Fraud, waste and abuse

Introduction

The Plan is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste and abuse. As such, the Plan's Compliance department maintains a comprehensive plan, which addresses how the Plan will uphold and follow state and federal statutes and regulations pertaining to fraud, waste and abuse. The plan also addresses fraud, waste and abuse prevention, detection and correction along with the education of appropriate employees, vendors, Providers and associates doing business with the Plan.

The Plan's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect and correct fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission statement

Our mission is to pay claims correctly the first time and that mission begins with the understanding that we need to proactively detect fraud, waste and abuse, correct it and prevent it from reoccurring. Since not all fraud, waste or abuse can be prevented, the Plan employs processes that retrospectively address fraud, waste or abuse that may have already occurred. The Plan strives to detect, prevent, investigate and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally-funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double **billing** for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with the Plan, Providers and their staff have the same obligation to report any actual or suspected violation or fraud, waste or abuse. Entities must have written policies that inform employees, contractors and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false Claims
- How Providers will detect and prevent fraud, waste and abuse
- Employee protection rights as whistleblowers
- Administrative remedies for false claims and statements

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two (2) times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer’s inappropriate actions

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. The Plan will take steps to monitor the Plan’s contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which the Plan has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed “Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032” to the Plan.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs

(e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration - as well as the recipients of kickbacks-those who solicit or receive remuneration.

The Plan conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under the Plan's policies, Providers may not offer, solicit an offer, provide or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal.

Under the Plan's policies, Marketing means any communication, to a beneficiary who is not enrolled with the Plan which can reasonably be interpreted as intended to influence the beneficiary to enroll with the Plan's Medicaid, Marketplace or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state to state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both

ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR § 455.2).

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to the state and federal health care programs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the state and federal health care programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the state and federal health care programs (42 CFR § 455.2).

Examples of fraud, waste and abuse by a Provider

The types of questionable Provider schemes investigated by the Plan include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement
- Balance billing a Plan Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider’s usual and customary fees.
- Billing and providing for services to Members that are not medically necessary
- Billing for services, procedures and/or supplies that have not been rendered

- Billing under an invalid place of service in order to receive or maximize reimbursement
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider
- Concealing a Member's misuse of the Plan's Member identification card
- Failing to report a Member's forgery or alteration of a prescription or other medical document
- False coding in order to receive or maximize reimbursement
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients
- Not following incident to billing guidelines in order to receive or maximize reimbursement
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more
- Using the adjustment payment process to generate fraudulent payments

Examples of fraud, waste and abuse by a Member

The types of questionable Member schemes investigated by the Plan include but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits
- Conspiracy to defraud state and federal health care programs
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services
- Falsifying documentation in order to get services approved
- Forgery related to health care
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else

Review of Provider Claims and Claims system

The Plan's Claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste and abuse. If the Claims examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

The Plan performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment fraud, waste and abuse detection activities

Through implementation of Claims edits, the Plan's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

The Plan has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid guidelines, federal CMS guidelines, AMA and published specialty-specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, the Plan may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with the Plan, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to the Plan under the Provider Agreement with the Plan or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with the Plan, the parties agree that the Plan shall

in its sole discretion exercise the terms that are expressed in the Provider Agreement with the Plan, the terms that are expressed here, its rights under law and equity, or some combination thereof.

The Provider will provide the Plan, governmental agencies and their representatives or agents, access to examine, audit and copy any and all records deemed by the Plan, in the Plan's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with the Plan, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any Plan Members. Auditable documents and records include but are not limited to medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by the Plan and without charge to the Plan. In the event the Plan identifies fraud, waste or abuse, the Provider agrees to repay funds or the Plan may seek recoupment.

If a Plan auditor is denied access to Provider's records, all of the Claims for which the Provider received payment from the Plan is immediately due and owing. If the Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. The Plan may offset such amounts against any amounts owed by the Plan to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by the Plan) and without charge to the Plan. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from the Plan, the Provider is required to allow the Plan to conduct audits of its pertinent records to verify the services performed and the payment Claimed, and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Claim auditing

The Plan shall use established industry Claims adjudication and/or clinical practices, state and federal guidelines and/or the Plan's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges the Plan's right to conduct pre- and post-payment billing audits. Provider shall cooperate with the Plan's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with this Provider Manual, to submit all supporting medical

records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, the Plan reserves the right and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proporttion of Claims that the Plan paid in error. The estimated proportion, or error rate, may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. The Plan asks that you provide the Plan, or the Plan's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If the Plan's Special Investigations Unit suspects that there is fraudulent or abusive activity, the Plan may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, the Plan reserves the right to recover the full amount paid or due to you.

Provider education

When the Plan identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, the Plan may determine that a Provider education visit is appropriate.

The Plan will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to the Plan addressing the issues identified and how it will cure these issues moving forward.

Reporting fraud, waste and abuse

Suspected cases of fraud, waste or abuse must be reported by contacting the Plan's Alertline. The Plan's Alertline is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. The Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call the Alertline, a trained professional at NAVEX Global will note your concerns and provide them to the Plan's Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to the Alertline can be made from anywhere within the United States with telephone or internet access.

The Plan's Alertline can be reached toll-free at (866) 606-3889 or you may use the service's website to make a report at any time at secure.ethicspoint.com/domain/media/en/gui/75190.

You may also report cases of fraud, waste, or abuse to the Plan's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Central Health Medicare Plan
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, the Plan's Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to CMS:

- CMS Toll-free Phone: 1-800-MEDICARE (1-800-633-4227)
- Office of Inspector General
  Attn: OIG Hotline Operations
  PO Box 23489
  Washington, DC 20026

  Toll-free Phone: (800) 447-8477
  TTY/TDD: (800) 377-4950
  Fax (10-page max): (800) 223-8164
  Online at the Health and Human Services Office of the Inspector General website at oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP.

HIPAA requirements and information

The Plan's commitment to patient privacy

Protecting the privacy of Members' personal health information is a core responsibility that the Plan takes very seriously. The Plan is committed to complying with all federal and state laws regarding the privacy and security of Members' protected health information (PHI).

Provider responsibilities

The Plan expects that its contracted Providers will respect the privacy of the Plan's Members (including the Plan's Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. The Plan provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how the Plan uses and discloses their PHI and includes a summary of how the Plan safeguards their PHI.

Telehealth/telemedicine Providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Applicable laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information including, without limitation, the following:

1. **Federal laws and regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid laws
   - The Affordable Care Act

2. **State medical privacy laws and regulations** – Providers should be aware that HIPAA provides a floor for patient privacy, but that state laws, including the California Confidentiality of Medical Information Act (California Civil Code, Division 1, Part 2.6), should be followed in certain situations, especially if the state law is more stringent than HIPAA and if permitted by such federal law. Providers should consult with their own legal counsel to address their specific situation. The California Confidentiality of Medical Information Act includes a requirement that permits the Plan's Members to request confidential communications. Providers should ensure that they comply with the applicable requirements of the California Confidentiality of Medical Information Act.

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Plan Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Plan Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Plan Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by the Plan, the Provider further agrees to (i) allow the Plan to audit Providers' AI use, as requested by the Plan from time to time, and (ii) to cooperate with the Plan with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Plan Members.

If you have additional questions, please contact your Plan Contract Manager.

Uses and disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality improvement
    - Disease management
    - Case management and care coordination
    - Training programs
    - Accreditation, licensing and credentialing

Importantly, this allows Providers to share PHI with the Plan for our health care operations activities, such as HEDIS® and Quality improvement.

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Confidentiality of Substance Use Disorder Patient Records

Federal confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2. (*Please note that the HHS Office for Civil Rights, in coordination with the Substance Abuse and Mental Health Services (SAMHSA) is expected to issue a rule that would implement Section 3221 of the CARES Act and better harmonize the 42 CFR Part 2 confidentiality requirements with HIPAA*).

Inadvertent disclosures of PHI

The Plan may on occasion inadvertently misdirect or disclose PHI pertaining to the Plan's Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Plan's Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of the Plan.

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient rights

Patients are afforded various rights under HIPAA. The Plan's Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of privacy practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests from the patient.

4. **Requests for Patient Access to PHI**
Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**
Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6)-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of the Plan's Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to the Plan.

HIPAA transactions and code sets

The Plan strongly supports the use of electronic transactions to streamline health care administrative activities. The Plan's Providers are encouraged to submit Claims and other transactions to the Plan using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses

- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

The Plan is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with the Plan should refer to the Plan's website at CentralHealthPlan.com for additional information.

1. Click on the area titled "Health Care Professionals"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to the Plan and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to the Plan within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and encounters submitted to the Plan.

Additional requirements for delegated Providers

Providers that are delegated for Claims and UM activities are considered the Plan's "business associates." Under HIPAA, the Plan must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for copies of PHI

The Plan does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex medical care management services
- Claims review
- Resolution of an appeal and grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits

- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by the Plan to perform a health plan function(s), and in connection with such delegated functions.

1. Definitions:

   (a) "Plan Information" means any information: (i) provided by the Plan to Provider; (ii) accessed by Provider or available to Provider on the Plan's Information Systems; or (iii) any information with respect to the Plan or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Plan Nonpublic Information.

   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Plan Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Plan Information, or sustained interruption of service obligations to the Plan.

   (c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

   (d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

   (e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

      i. HIPAA and HITECH

ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database, and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission, or reception) and other apparatus used to create, store, transmit, exchange, or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:
i. The Plan's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Plan Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and

cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which the Plan shall be permitted to audit via written request, and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Plan Information accessible to or held by the Provider.

ii. Encryption. Use of encryption to protect Plan Information, in transit and at rest, accessible to or held by the Provider.

iii. Security. Safeguarding the security of the Information Systems and Plan Information accessible to or held by the Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three [3]or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If the Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, the Provider shall adopt a “zero-trust architecture” satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. The Provider agrees that any and all Plan Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Plan Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium unless that device or storage medium is in use as part of the Provider’s designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. The Provider agrees to store all Plan Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. The Provider further agrees that any and all Plan

Information stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. The Provider agrees that any and all electronic transmission or exchange of system and application data with the Plan and/or any other parties expressly designated by the Plan shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Plan Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of the Provider. The Provider further agrees that no Plan Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties except on a case-by-case basis as specifically agreed to in advance and in writing by the Plan.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). The Provider shall have documented procedures in place to ensure the continuity of the Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt the Provider's delivery of services to the Plan.

(a) Resilience Questionnaire. The Provider shall complete a questionnaire provided by the Plan to establish Provider's resilience capabilities.

(b) BC/DR Plan.

(i) The Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and the Plan. The BC/DR Plan shall include the following:

a) Notification, escalation, and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services provided to the Plan.
d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third parties or any combination thereof providing services to the Plan.
e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.

f) Detailed list of resources to recover services to the Plan including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.

g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.

h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to the Plan. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

(ii) To the extent that Plan Information is held by Provider, Provider shall maintain backups of such Plan Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

(iii) The Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. The Provider shall notify the Plan's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. The Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to the Plan or that detrimentally affects the Provider's Information Systems or the Plan's Information.

ii. Provider's activation of business continuity plans. The Provider shall provide the Plan with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue until normal services have been resumed.

(d) BC and DR Testing. For services provided to the Plan, the Provider shall exercise its BC/DR Plan at least once each calendar year. The Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, the Provider shall provide the Plan a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on the results of the exercise(s).

4. Cybersecurity Events.

(a) The Provider agrees to comply with all applicable data protection and privacy laws and regulations. The Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects the Plan's Information Systems (in connection with the Provider having access to such Information Systems); the Provider's Information Systems; or Plan Information accessible to or held by the Provider, the Provider shall notify the Plan's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from the Provider's discovery of the Cybersecurity Event.

i. In the event that the Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Plan Information, the Provider shall notify the Plan's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Plan Information, the Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to the Plan's Chief Information Security Officer shall be provided to:

Central Health Medicare Plan
Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

Central Health Medicare Plan
Chief Information Security Officer
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, the Provider will at the Plan's request (i) fully cooperate with any investigation concerning the Cybersecurity Event by the Plan, (ii) fully cooperate with the Plan to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will the Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Plan Information without the prior written consent of the Plan.

(e) Following notification of a Cybersecurity Event, the Provider must promptly provide the Plan any documentation requested by the Plan to complete an investigation, or, upon request by the Plan, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify the Plan's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Plan Information.

(f) The Provider must provide the Plan the following required information regarding a Cybersecurity Event in electronic form. The Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to the Plan concerning the Cybersecurity Event. The information provided to the Plan must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen, or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether the Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each State affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of the Provider's privacy policy and a statement outlining the steps the Provider will take to investigate and if requested by the

Plan, the steps that the Provider will take to notify consumers affected by the Cybersecurity Event; and

xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of the Provider.

(g) The Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon the Plan's request.

5. Right to Conduct Assessments; Provider Warranty. The Provider agrees to fully cooperate with any security risk assessments performed by the Plan and/or any designated representative or vendor of the Plan. The Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If the Plan performs a due diligence/security risk assessment of the Provider, the Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in the Provider's response to the Plan's due diligence/security risk assessment questionnaire; (ii) agrees to inform the Plan promptly of any material variation in operations from what was provided in the Provider's response to the Plan's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to the Plan's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Other Provisions. The Provider acknowledges that there may be other information security and data protection requirements applicable to the Provider in the performance of services which may be addressed in an agreement between the Plan and Provider but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between the Plan and the Provider, the stricter of the conflicting provisions will control.

Business contact information

If you are a California resident, you may have certain rights with respect to the business contact personal information that you provide to the Plan as a Provider, pursuant to the California Privacy Rights Act (CPRA), which amends the California Consumer Privacy Act (CCPA). For more information about those rights and how they may be exercised, please see the "California Residents" section of the Plan's Website Privacy Policy, available at CentralHealthPlan.com.

14. Claims and compensation

Payer ID	**CHCPI**
Availity portal	**availity.com/molinahealthcare**
Clean Claim timely filing	**One (1) calendar year after the discharge for inpatient services or the Date of Service (DOS) for outpatient services**

Electronic Claims submission

The Plan strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach the Plan faster

The Plan offers the following electronic Claims submission options:

- Submit Claims directly to the Plan via the Availity portal
- Submit Claims to the Plan via your regular EDI clearinghouse using Payer ID number CHCPI

Availity portal

The Availity portal is a no-cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
- Correct/void Claims
- Add attachments to previously submitted Claims
- Check Claim status
- View ERA and EOP
- Create and manage Claim templates
- Create and submit a Claim appeal with attached files

Clearinghouse

The Plan uses the SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, the Plan offers additional electronic Claim submission options as shown by logging on to the Availity portal.

The Plan accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse
- You should refer to the Plan's Companion Guide for information on the response format and messages
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claim submission issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Relations representative for additional support.

Timely Claim filing

The Provider shall promptly submit Claims to the Plan for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by the Plan and shall include all medical records pertaining to the Claim if requested by the Plan or otherwise required by the Plan's policies and procedures. Claims must be submitted by the Provider to the Plan within one (1) calendar year after the discharge date for inpatient services or the DOS for outpatient services. If the Plan is not the primary payer under the coordination of benefits or third-party liability, the Provider must submit Claims to the Plan within one (1) calendar year after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any Claims that are not submitted to the Plan within these timelines shall not be eligible for payment and the Provider hereby waives any right to payment.

Claim submission

Participating Providers are required to submit Claims to the Plan with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse or the Availity portal whenever possible and use current HIPAA-compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number CHCPI. For Members assigned to a delegated medical group/IPA that processes its

own Claims, please verify the Claim Submission instructions on the Plan's Member ID card.

Providers must bill the Plan for services with the most current CMS-approved diagnostic and procedural coding available as of the DOS was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to the Plan as soon as possible, not to exceed 30 calendar days from the change. The Plan supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. The Plan may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and the Plan's Companion Guide for format and code set information when submitting or receiving files directly with the Plan. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Plan's website at CentralHealthPlan.com under EDI>Companion Guides for regularly updated information regarding the Plan's companion guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Plan's Companion Guide, it is also necessary to use the state-specific companion guides, which are also available on the Plan's website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1-5.

The following information must be included on every Claim:

- Member name, date of birth and the Plan's Member ID number, whether electronic or paper
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code

- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Units of Measure and Days or Units for medical injectables
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

EDI (Clearinghouse) submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for compliance with SNIP levels 1-5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

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

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	The Plan will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	The Plan will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 ERA.

Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Central Health Medicare Plan
Claims Department
PO Box 14246
Orange, CA 92863

Please keep the following in mind when submitting paper Claims:

- Paper Claim submissions are not considered to be “accepted” until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink. Link to paper Claims submission guidance from CMS: CMS.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

Corrected Claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

The Plan strongly encourages participating Providers to submit Corrected Claims electronically via EDI or Availity portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 Claim forms or the Uniform Billing (UB) Editor for CMS-1450 Claim forms.

Corrected Claims must be sent within 365 calendar days of the most recent adjudicated date of the Claim.

Corrected Claims submission options:

- Submit Corrected Claims directly to the Plan via the Availity portal.
- Submit corrected Claims to the Plan via your regular EDI clearinghouse.

Coordination of Benefits (COB) and Third-Party Liability (TPL)

COB – The Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If the Plan is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit Claims for the same items or services to the Plan for reimbursement. The Plan will adjudicate the Claim based upon the primary EOB submitted and pay for covered services up to the secondary liability based upon COB payment guidelines. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Medicaid Coverage for the Plan's Medicare Members

There are certain benefits that will not be covered by the Plan's Medicare program but may be covered by fee-for-service Medicaid. In this case, the Provider should bill Medicaid with a copy of the Plan's Medicare remittance advice and the associated state agency will process the Claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit Claims to the Plan's Medicare program. A copy of the remittance advice from the primary payer must accompany the Claim or the Claim will be denied. If the primary insurance paid more than the Plan's contracted allowable rate the Claim is considered paid in full, and zero dollars will be applied to Claim.

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) program

The Deficit Reduction Act of 2005 mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Diabetic Ketoacidosis
    b. Nonketotic Hyperosmolar Coma
    c. Hypoglycemic Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
10. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    a. Laparoscopic Gastric Bypass
    b. Gastroenterostomy
    c. Laparoscopic Gastric Restrictive Surgery
11. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
12. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement
14. Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers:

- Acute Inpatient Prospective Payment System (IPPS) hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information at CMS.hhs.gov/HospitalAcqCond/.

The Plan's Coding Policies and Payment Policies

Frequently requested information on the Plan's Coding Policies and Payment Policies is available on the CentralHealthPlan.com website under the Policies tab. Questions can be directed to your Provider Relations representative.

Reimbursement guidance and payment guidelines

Providers are responsible for submission of accurate Claims. The Plan requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes).
  - Inpatient hospital Claims require the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes.

Furthermore, the Plan requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

The Plan utilizes a Claims adjudication system that encompasses edits and audits that follow federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - NCCI edits, including procedure-to-procedure (PTP) bundling edits and MUE. If a professional organization has a more stringent/restrictive standard than a federal MUE, the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCD)
  - Medicare Local Coverage Determinations (LCD)
  - CMS Physician Fee Schedule RVU indicators
- CPT guidance published by the AMA
- ICD-10 guidance published by the National Center for Health Statistics
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than federal guidelines.
- The Plan's policies based on the appropriateness of health care and medical necessity
- Payment policies published by the Plan

Telehealth Claims and billing

- Providers must follow CMS guidelines as well as state-level requirements.
- All telehealth Claims for Plan Members must be submitted to the Plan with the correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the resources located at telehealth.hhs.gov/providers.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. The Plan uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes MUE which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same DOS. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General coding requirements

Correct coding is required to properly process Claims. The Plan requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the DOS for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component

- Service or procedure was performed by more than one (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

The Plan utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny Claims that do not meet the Plan's ICD-10 Claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the DOS for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of service (POS) codes

POS codes are two (2)-digit codes placed on health care professional Claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

The Plan processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Plan-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The NDC number must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2-digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA)-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (3) types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – Healthcare Common Procedural Coding System; a CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification; maintained by the National Center for Health Statistics, CDC within the Department of Health and Human Services (HHS).

ICD-10-PCS – International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim auditing

The Plan shall use established industry Claims adjudication and/or clinical practices, state, federal guidelines and/or the Plan's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges the Plan's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with the Plan's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, the Plan reserves the right and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims the Plan paid in error. The estimated proportion, or error rate, may be extrapolated across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. The Plan asks that you provide the Plan, or the Plan's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If the Plan's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, the Plan reserves the right to recover the full amount paid or due to you.

Timely Claim processing

A complete Claim is a Claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" above, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with the Plan. Unless the Provider and the Plan or contracted medical group/IPA have agreed in writing to an alternate schedule, the Plan will process the Claim for service as follows:

- 95% of the monthly volume of non-contracted "clean" Claims are to be adjudicated within 30 calendar days of receipt.
- 95% of the monthly volume of contracted Claims are to be adjudicated within 60 calendar days of receipt.
- 95% of the monthly volume of non-clean non-contracted Claims shall be paid or denied within 60 calendar days of receipt.

The receipt date of a Claim is the date the Plan receives notice of the Claim.

Electronic Claim payment

Participating Providers are required to enroll for EFT and ERA. Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. The Plan uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at CentralHealthPlan.com or by contacting the Provider Relations department.

Overpayments and incorrect payments refund requests

In accordance with 42 CFR 438.608, the Plan requires network Providers to report to the Plan when they have received an overpayment and to return the overpayment to the Plan within 60 calendar days after the date on which the overpayment was identified and notify the Plan in writing of the reason for the overpayment.

If, as a result of retroactive review of Claim payment, the Plan determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment or check status. This is the Plan's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are the Plan's standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date and subscriber information. For Members with Commercial COB, the Plan will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. The Plan will adjudicate the Claim and pay or deny the Claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by the Plan which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid

amount within the time frame allowed the Plan may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the Plan, or the date that the Provider receives a payment from the Plan that reduces or deducts the overpayment.

Contracted provider dispute/appeal/payment inquiry reconsideration process

Provider Claim Dispute: A Claim dispute is a reconsideration review of a Claim previously adjudicated related to a denial of payment/partial payment (example: timely filing, duplicate, code edit, NCCI Edit, non-covered service, benefit exhaustion, rate of payment/contracted rate issue) with documentation to support your dispute, such as coding requirements (AAPC/Novartis), contracts, state and/or federal regulations, and payment policies. The Claim dispute reconsideration must be requested within the contractual timeframes outlined in your Provider Agreement with Molina. This will be directed to the Appeals department for review of the dispute. The dispute will be investigated, addressed and the Provider will be notified of the outcome in writing within 60 calendar days from the date the dispute is received by Molina.

Provider Claim Appeal: Provider Claim Appeal is a written request for medical necessity review of a Claim denial or partial denial. All requests must include the necessary documentation, such as labs, hospital history and physical (H&P), discharge summaries, progress notes, radiology images/information for the date of service pertaining to the Claim in question for the appeal review to be completed. The appeal must be requested within the contractual timeframes outlined in your Provider Agreement with Molina. The appeal will be investigated, addressed and the Provider will be notified of the outcome in writing, within 60 calendar days from the date the appeal is received by Molina.

- The denial or limited authorization of a requested service, including the type or level of service.
  - The authorization did not meet medical necessity.
  - Partial Denials.
- The reduction, suspension or termination of a previously authorized service.
- The denial of whole payment for services rendered.
  - Timely submission of authorization.

Note: Please include the authorization number on all Claims submitted to Molina for services rendered that require authorization per the “Authorization Lookup tool.” Please make sure that you are authorizing services prior to rendering, 24 hours after inpatient admission or sooner and prior to any outpatient on in-patient planned (admission) service or other service that requires authorization. Link: provider.molinahealthcare.com/Provider/AvailityCPTCodeLookUp

Provider Claim Payment Inquiries/Reconsiderations (Availity portal): Previously known as a reconsideration. A review of a Claim that you believe was paid or denied incorrectly. You suspect a minor error that can easily be remediated. Examples include retro-eligibility issues, coordination of benefit updates, Claims denied as a duplicate in error and Claims denied for no authorization when authorization is not required or when an approved authorization is on file. You cannot submit supporting documentation with a Claim payment inquiry. A payment inquiry may result in a Claims adjustment or the outcome may direct you to submit a Corrected Claim or initiate the Claim Payment Dispute/Appeal process.

Providers can submit appeals and or disputes to the below:

- Availity portal (Preferred Method) link: provider.molinahealthcare.com/provider/login
- Fax: (562) 499-0610
- Mail:
  Molina Healthcare
  Attn: Provider Appeals
  PO Box 22816
  Long Beach, CA 90801-9977

Claims that are denied for itemized bill: All Claim/Claim lines that deny for itemized bill on the Explanation of Provider Payment (EPP) remit, must be sent with a corrected Claim to the address below. The corrected Claim and the itemized bill must match for the reconsideration to be completed.

Mailing address:
Molina Healthcare
PO Box 22630
Long Beach, CA 90801

Electronic Data Interchange (EDI) Number: 61799

NDC Denials: If your Claim denies for “missing /invalid NDC National Drug code” please review the NDC billed on your Claim prior to submitting the dispute to make sure it is a correct/valid NDC for the HCPCS code you are submitting which is included on the Claim.

Recommendations when submitting disputes/appeals for multiple Claims for different Members or multiple Claims for the same Member:

- Each Member must have a separate dispute/appeal submitted - do not consolidate multiple Members into one request.
- Molina will accept multiple Claims for one Member on one appeal/dispute request, but please list all applicable Claim numbers you want addressed.
- Please include all supporting documentation with the original submission for the service in question. If we receive partial documentation, we will review based on the documentation received.

- If no documentation is received and you are requesting a medical necessity review, we will send a letter, unable to process due to lack of information.

Please review your authorization prior to submitting Claims to make sure the authorization is matching services billed (date of service/service provided).

Provider reconsideration of delegated Claims – contracted providers

Providers requesting a reconsideration, correction or reprocessing of a Claim previously adjudicated by an entity that is delegated for Claims payment must submit their request to the delegated entity responsible for payment of the original Claim.

Balance billing

Pursuant to Law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of the Plan to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable co-payment, co-insurance and deductible amounts. Providers also agree to comply with their Provider Agreement with the Plan which requires a contracted Medicare Providers to comply with Welfare and Institutions Code section 14019.4.

Fraud, waste and abuse

Failure to report instances of suspected fraud, waste and abuse is a violation of the law and subject to the penalties provided by law. For additional information, please refer to the **Compliance** section of this Provider Manual for more information.

Encounter data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit Encounter data to the Plan for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month and within 60 days from the DOS in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA-compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

The Plan has a comprehensive automated and integrated Encounter data system capable of supporting of supporting all 837 file formats.

Providers must correct and resubmit any Encounters which are rejected (non-HIPAA compliant) or denied by the Plan. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

The Plan has created 837P, 837I and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, the Plan will provide a 999 acknowledgement of the transmission
- Second, the Plan will provide a 277CA response file for each transaction

15. Medicare Member grievances and appeals

Distinguishing between appeals involving Provider liability and appeals involving Member liability

All Medicare and MMP Member liability denials are subject to the Member Appeals terms of this Provider Manual described below. The Member will receive the appropriate denial notice with appeal rights (e.g., Integrated Denial Notice, Notice of Denial of Medicare Prescription Drug Coverage, Important Message from Medicare (IM), Notice of Medicare Non-Coverage (NOMNC) or Explanation of Benefits (EOB)) indicating there is Member responsibility assigned to a Claim processed). When Member liability is assigned the Member Appeals process must be followed.

Disputes between Molina and a contracted Provider that do not result in an adverse determination or liability for the Member are subject to the Claims Appeals provisions of this Provider Manual. Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider Agreement with the Plan. When Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement with the Plan or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services unless Molina assigned Member liability and issued the appropriate notice with Member appeal rights. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection located in the **Claims and Compensation** section of this Provider Manual.

Definition of key terms used in the Medicare Member grievances and appeals process

Appeal: Medicare defines an appeal as the procedures that deal with the review of adverse initial determinations made by the Plan on health care services or benefits under Part C or D that the Member believes they are entitled to receive, including a delay in providing, arranging for or approving the health care services or drug coverage (when a delay would adversely affect the Member's health) or on any amounts the Member must pay for a service or drug. These appeal procedures include a Plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council) and judicial review.

For plans providing integrated Medicare and Medicaid benefits, an Appeal includes procedures that deal with the review of adverse initial determinations made by the Plan

on the health care services or benefits under the Member's Medicaid coverage under the Plan. For FIDE SNPs and certain HIDE SNPs, Appeals are called Integrated Appeals because they incorporate Medicare and Medicaid processes. Integrated Appeals follow a Unified Appeals process. Appeals involving Medicaid-covered services or Medicare-Medicaid overlap services for an MMP may follow procedures that vary from standard Medicare rules.

Applicable Integrated Plan (AIP): A type of D-SNP in which state policy limits the D-SNP's membership to enrollees whose Medicaid benefits are covered under a Medicaid managed care organization contract between the state and the D-SNP's Medicare Advantage organization (or another entity related to the D-SNP's Medicare Advantage organization as specified in federal rules) (also known as "exclusive alignment"). AIPs are subject to federal rules providing a unified, integrated process for Appeals and Grievances for the enrollee's Medicare and Medicaid benefits.

Authorized representative: An individual appointed by the Member or authorized under state law to act on behalf of the Member in filing a Grievance or Appeal. An authorized representative has all of the rights and responsibilities of the Member. For Medicare, an individual may be appointed using the CMS Appointment of Representative Form found at CMS.gov/cmsforms/downloads/cms1696.pdf. For Plans providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP or MMP), Medicaid rules may apply for appointing a Member representative for those services covered under Medicaid.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO or QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and the beneficiary.

Coverage Determination: Any determination made by a Part D plan sponsor, or its delegated entity, with respect to:

- A decision about whether to provide or pay for a drug that a Member believes may be covered by the Plan sponsor, including a decision related to a Part D drug that is: not on the Plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded by law if applied to Medicare Part D.
- A decision on the amount of cost sharing for a drug;

- Failure to provide a Coverage Determination in a timely manner when a delay would adversely affect the Member's health;
- Whether a Member has (or has not) satisfied a prior authorization or other Utilization Management requirement;
- A decision about a tiering exception; or
- A decision about a formulary exception request.

Dual Eligible Special Needs Plan (D-SNP): A Medicare Advantage Prescription Drug (MAPD) plan that enrolls individuals who are entitled to both Medicare and Medicaid. D-SNPs coordinate the delivery of the Member's Medicare and Medicaid benefits.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare Advantage Plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include and is distinct from, an appeal. Examples of a grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the coverage decision or Appeals process, the Plan formulary, or the availability of contracted Providers.

Organization Determination: Any determination (an approval or denial) made by a Medicare Advantage Plan, or its delegated entity, with respect to:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services (for more information on these services see the Emergency Services, Urgent Care, and Post-Stabilization Services section of this Provider Manual);
- Payment for any other health services furnished by a Provider that the Member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare Advantage plan;
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by the Medicare Advantage plan;
- Reduction or premature discontinuation of a previously ongoing course of treatment; or
- Failure of the Medicare Advantage plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

Medicare Member liability appeals: how to file an appeal

For expedited appeals: Call the Plan's Member Contact Center at (866) 314-2427

For standard appeals (non-Part D): Mail or fax a written appeal to:

Central Health Medicare Plan
Attn: Grievance and Appeals
PO Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

For additional information on Part D appeals/redeterminations, please refer to the **Medicare Part D** section in this Provider Manual.

Providers assisting their Members with Expedited Appeal requests should call the Plan's Provider Contact Center at (866) 403-8296.

Members and their authorized representatives (and treating providers acting on their behalf) have 60 days from the date of the denial to file an appeal. This timeframe may be extended for good cause.

What to include with the appeal

Members should include their name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation or other information that explains why Molina should provide or pay for the item or service.

Medicare Member liability appeals: participating provider responsibilities in the Medicare Member appeals process

Appeals should include the Member's name, contact information, Member ID number, health plan name, the reason for appealing, and any evidence to support the request

Providers can request Appeals on behalf of Members; however, if the appeal is not requested by a treating physician, an Appointment of Representative (AOR) form may be required. The AOR form can be found online and downloaded at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

Please provide all medical records and/or supporting documentation with the appeal request. Please note that if additional information must be requested, processing of the Appeal may be delayed.

Expedited appeals should only be requested if waiting the time frame for a standard appeal could jeopardize the Member's life, health or ability to regain maximum function.

Medicare Member liability appeals: time frames

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Expedited Pre-Service (non-Part B, non-Part D drug)	*72 hours
Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service (non-Part B, non-Part D drug)	*30 calendar days
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service (Part C)	*60 calendar days
Standard Post-Service Part D drug	14 calendar days

**Timeframes for fully integrated plans may vary with regulatory and contractual requirements.*

Extensions may be allowed under specific conditions (except requests involving a Part B or Part D drug).

A Provider may request that a pre-service appeal be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that an Appeal be expedited only when this standard is supported by the Member's condition.

Medicare Member liability appeals: continuation of benefits (aka "Aid Continuing")

Members enrolled in a Plan providing integrated Medicare and Medicaid benefits may be entitled to continue benefits pending appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medicaid-covered services such as personal care services, but can be applicable to other Medicare or Medicaid services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within ten (10) calendar days of the date of the notice of suspension, termination, or reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides with the member. When Providers are allowed to request continuation of benefits under applicable federal and state regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by the Plan, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing.

Federal and state rules applicable to the specific Plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Medicare Member appeals: further appeal rights

If the Plan upholds the initial adverse determination, in whole or in part, for a Part C item or service (including a Part B drug), the appeal will be forwarded to an independent review entity (IRE). (For Part D upholds, the Member must request a review by the IRE.) The IRE is a CMS contractor independent of the Plan. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of appeal with an administrative law judge (ALJ) or attorney adjudicator. Additional levels of appeal are available to the Member if the amount in controversy requirements is met, including an appeal to the Medicare Appeals Council (MAC) and Federal court.

The Member may have additional appeal rights if they are enrolled in a Plan providing integrated Medicare and Medicaid benefits. In these plans, when the item or service is or could be covered by Medicaid or by both Medicare and Medicaid (overlap), the Member will be provided with their State Fair Hearing (SFH) rights and any other state appeal rights to which they are entitled. (For example, the Member may be entitled to additional appeal rights for Medicaid-covered services under the state HMO law.) Additional levels of appeal follow the applicable state rules and requirements.

Member liability appeals: hospital discharge appeals

Hospital discharges are subject to an expedited Member appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate appeal to the QIO for the service area (Livanta or Acentra Health). The Member must appeal to the QIO as soon as possible and no later than the planned discharge date and before the Member leaves the hospital. The QIO will typically respond within one day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care beginning at noon of the calendar day following the day the QIO provides notice of its decision to the Member. The Member may request a reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an ALJ or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the hospital, the Member (or their authorized representative) may request an expedited pre-service appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service appeal and may be financially

liable for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

Member liability appeals: SNF, CORF and HHA termination of services appeals

Discharges from care provided by a SNF (including a swing bed in a hospital providing Part A and Part B services), CORF, or HHA are subject to an expedited (fast track) Member appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services continue, an Integrated Denial Notice (IDN) with Member appeal rights is issued to the Member. Members receive their discharge appeal rights through the delivery of the NOMNC by the SNF, CORF or HHA. For additional information on delivery of the NOMNC, see the Termination of SNF, CORF and HHA Services section of this Provider Manual.

Members disputing their discharge decision may request an expedited (fast-track) appeal to the QIO for the service area (Livanta or Acentra Health). The Member must appeal to the QIO by noon of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration from the QIO if they remain in the SNF or continue to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to an ALJ or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the NOMNC. The Member will then have an opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the SNF or continuing to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their authorized representative) may request an appeal with the QIO. In this case, the Member does not have financial protection during the course of the Appeal and may be financially liable for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Member liability appeals: obtaining additional information about the Member appeal process

For additional information about Member appeal rights, call the Plan's Provider Contact Center toll-free at (866) 403-8296 or (TTY/TDD) 711 for persons with hearing impairments. A detailed explanation of the appeal process is also included in the Member's EOC (or Member Handbook), which is available on the Plan's website. If Members have additional questions, please refer them to the Plan's Member Contact Center at (866) 314-2427.

Medicare Member grievances

A Member may file a grievance verbally or in writing within 60 days of the event precipitating the grievance. (Members enrolled in HMO D-SNP may file a grievance at any time, except a Part D grievance. Part D grievances must be filed within 60 days of the event precipitating the grievance).

Grievances are typically responded to by the Plan within 30 days. The Plan may also be allowed to take an extension under certain circumstances.

Medicare allows an expedited grievance only if the Plan diverts an expedited request for a coverage decision or appeal to the standard time frame or if the Plan takes an extension in making a coverage decision or deciding an appeal (when allowed). These expedited grievances are decided within 24 hours.

Members may file a grievance by calling the Plan's Member Contact Center at (866) 314-2427 or by writing to:

Central Health Medicare Plan
Attn: Grievance and Appeals
PO Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

16. Credentialing and recredentialing

The purpose of the Credentialing Program is to assure that the Plan's network consists of quality Providers who meet clearly defined criteria and standards. It is the Plan's objective to provide superior health care to the community.

Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Provider Relations representative. Provider Relations representative area assigned to each Provider's office. For a list of Provider Relations representatives please refer to the "Contact Information" section of this Provider Manual.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the NCQA. In accordance with those standards, Members will not be referred and/or assigned until the credentialing process has been completed and added to the health plan systems. The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-discriminatory credentialing and recredentialing

The Plan does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude the Plan from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of practitioners credentialed and recredentialed

Practitioners and groups of Practitioners with whom the Plan contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified, or registered by the state to practice independently.
- Chiropractors
- Clinical Social Workers
- Dentists

- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

HIV/AIDS specialist

The Plan requires Practitioners to submit a complete, signed and dated HIV/AIDS specialist form to identify appropriately qualified specialists who meet the definition of an HIV/AIDS specialist under California Code of Regulations Section 1374.16 of the Act. This form will be collected annually. If a Practitioner does not respond to requests for annual confirmation, they will be removed from the list of HIV/AIDS Specialists.

Criteria for participation in the Plan network

The Plan has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Plan network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Plan network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by the Plan.

The Plan reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. The Plan may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of the Plan and the community it serves. The refusal of the Plan to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Providers shall not be eligible to see Members as Participating Providers until notified of their effective date from the Plan.

Additionally, Providers shall not be eligible to treat Members as a Participating Provider at a location until both notified of credentialing completion and added to the health plan systems. The Provider will receive a welcome notice from the Plan with the effective date of participation, along with a copy of the fully executed agreement for new contract execution (if applicable).

Practitioners must meet the following criteria to be eligible to participate in the Plan network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Plan network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or administrative termination from the Plan network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to the Plan a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** – Practitioners must hold a current and valid license, certification or registration to practice in their specialty in every state in which they will provide care and/or render services for Plan Members. Telemedicine practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Administration (DEA) Certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to Plan Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) Certificate** – Practitioners working from Nevada practice locations must meet CDS requirements in that state.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Plan Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training** – Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. The Plan only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and

Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board-certified, the podiatrist must have five (5) years of work history practicing podiatry.

- **Fellowship training** – Fellowship training is verified when a Practitioner will be advertised in the directory in their fellowship specialty. The Plan only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board-certified will be considered for participation if they have satisfactorily completed residency training from an accredited training program in the specialty in which they are practicing. The Plan recognizes certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board-certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Plan network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. The Plan will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a primary care physician (PCP), or as an urgent care or wound care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners and Physician Assistants** – In certain circumstances, the Plan may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with the Plan.
- **Work history** – Practitioners must supply the most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The Plan will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice history** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.

Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **State sanctions, restrictions on licensure or limitations on scope of practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.
- **Medicare, Medicaid and other sanctions and exclusions** – Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any state or federally-funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Plan network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Plan network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet the Plan's criteria. This coverage shall extend to Plan Members and Practitioner activities on the Plan's

[3]If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.

- **Inability to perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of present illegal drug use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal convictions** – Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions, including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
  - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or limitations of clinical privileges** – At initial credentialing, the Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have an NPI issued by CMS.

Notification of discrepancies in credentialing information & Practitioner's right to correct erroneous information

The Plan will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history,

board certification actions, sanctions, or exclusions. The Plan is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the Plan's website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from the Plan.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Central Health Medicare Plan
  Attention: Credentialing Director
  PO Box 2470
  Spokane, WA 99210

Upon receipt of notification from the Practitioner, the Plan will document receipt of the information in the Practitioner's credentials file. The Plan will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within ten (10) calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's right to review information submitted to support their credentialing application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Plan's website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A medical director and a director responsible for credentialing or the quality improvement director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to the Plan (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's right to be informed of application status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner rights are published on the Plan's website and included in this Provider Manual. The Plan will respond to the request within two (2) working days. The Plan will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Professional Review Committee (PRC)

The Plan designates a PRC to make recommendations regarding credentialing decisions using a peer review process. The Plan works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Members. The PRC reports to the Quality Improvement Committee (QIC). The Plan utilizes information such as, but not limited to credentialing verifications, QOCs and Member complaints to determine continued participation in the Plan's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, Providers should request a fair hearing as outlined below and in the Plan's policy. Please contact your Provider Relations representative for additional information about fair hearings.

Notification of credentialing decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Plan medical director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals is not required.

Recredentialing

The Plan recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, the Plan and its subcontractors may not subcontract with an Excluded Provider/person. The Plan and its subcontractors shall terminate subcontracts immediately when the Plan and its subcontractors become aware of such excluded Provider/person or when the Plan and its subcontractors receive notice. The Plan and its subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. Where the Plan and its subcontractors are unable to certify any of the statements in this certification, the Plan and its subcontractors shall attach a written explanation.

Ongoing monitoring of sanctions and exclusions

The Plan monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a Plan Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health and Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk List** – Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)** – The Plan enrolls all credentialed Practitioners with the NPDB continuous query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

The Plan also monitors the following for all Practitioner types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt-Out
- Social Security Administration Death Master File

Provider appeal rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

17. Delegation

This section contains information specific to the Plan's delegation criteria. The Plan may delegate certain administrative responsibilities upon meeting all of the Plan's delegation criteria. The Plan is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. The Plan's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions please contact the Plan's contract manager.

Delegation is a process that gives another entity the ability to perform specific functions on behalf of the Plan. The Plan may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Sanction monitoring for employees and contracted staff at all levels
4. Claims and Provider dispute resolution
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

When the Plan delegates any clinical or administrative functions, the Plan remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be compliant with the Plan's established delegation criteria and standards. To remain a delegate, the Provider/ACO/vendor must maintain compliance with the Plan's standards and best practices.

Delegation reporting requirements

Delegated entities contracted with the Plan must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by the Plan's delegation oversight staff for compliance with performance expectations within the timeline indicated by the Plan. Revised reporting expectations including template changes and cadence are subject to change to accommodate the health plans operational standards. Changes are non-negotiable and take precedence over prior reporting terms.

Note: Member notification responsibilities depend on the functions delegated and the services provided. Not all subcontractors are responsible for this piece, and in some cases, are required to send the appropriate information to the Plan in a timely manner so that the Plan can notify impacted Members. If there are questions about subcontractor responsibilities related to Member notification of precluded Providers, please contact the Plan's delegation oversight staff.

Corrective action plans and revocation of delegated activities

If it is determined that the delegate is out of compliance with the Plan's guidelines or regulatory requirements, the Plan may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. The Plan may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if the Plan determines that is the best course of action. We reserve the right to impose consequences regardless of any prior contractual language stipulating mutual agreement on reporting changes.

If you have additional questions related to delegated functions please contact the Plan's contract manager.

Delegation criteria

Sanction monitoring

All of the Plan's sub-contractors are required to show proof of processes to screen staff and employees at all levels against federal exclusions lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter. The Plan will include a sanction monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction monitoring functions may be delegated to entities that meet the Plan's criteria. To be delegated for sanction monitoring functions Providers must:

- Pass the Plan's sanction monitoring pre-assessment which is based on CMS standards
- Demonstrate that employees and staff are screened against OIG and SAM sanction lists prior to hire dates and monthly thereafter
- Correct deficiencies within the Plan's approved time frames when issues of non-compliance are self-reported by a delegated entity or identified by the Plan
- Agree to the Plan's contract terms and conditions for sanction monitoring delegates
- Submit timely and complete sanction monitoring delegation reports as detailed in the Delegated Services Addendum or as communicated by the Plan to the applicable Plan contact
- Comply with all applicable federal and state laws
- When staff or employees are identified as having a positive sanction, provide the Plan with notification according to contractual agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to the Plan's Members
- Provide a 90-day advance notification to the Plan of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in the Plan, legal and regulatory inquiries and audits.

Credentialing

Credentialing functions may be delegated to entities which meet NCQA criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass the Plan's credentialing pre-assessment and annual audits, which are based on NCQA credentialing standards and applicable state and federal regulations
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of Practitioners included in delegation
- Have an ongoing monitoring process in place that screens all Practitioners included in delegation against OIG and SAM exclusion lists a minimum of every 30 days
- Correct deficiencies within time frames approved by the Plan when issues of non-compliance are identified by the Plan
- Agree to the Plan's contract terms and conditions and applicable accreditation standards for credentialing delegates
- Submit timely and complete credentialing delegation reports as detailed in the Delegated Services Addendum or as communicated by the Plan to the applicable Plan contact
- Comply with all applicable federal and state laws
- When key specialists, as defined by the Plan, contracted with IPA or group terminate, provide the Plan with a letter of termination according to contractual agreements and the information necessary to notify affected Members.
- Provide a 90-day advance notification to the Plan of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Plan, legal and regulatory inquiries and audits

Note: At its discretion, the Plan may conduct a modified pre-assessment audit if the Provider is an NCQA-certified or accredited organization. Modifications to the audit depend on the type of certification or accreditation the Medical Group, IPA, or vendor has, but will always include evaluation of applicable state requirements and Plan business needs.

If the Provider sub-delegates credentialing functions, the sub-delegate must be NCQA-accredited or certified in credentialing functions and demonstrate an ability to meet all Plan, NCQA and state and federal requirements identified above. A written request must be made to the Plan prior to execution of a contract and a pre-assessment must be completed on the potential sub-delegate, and annually thereafter. Evaluation should include review of credentialing policies and procedures, credentialing and recredentialing files, Credentialing Committee minutes, ongoing monitoring document and a process to implement corrective action if issues of non-compliance are identified.

An entity may request credentialing delegation from the Plan through the Plan's Delegation Oversight department or through their contract manager. The Plan will ask the potential delegate to submit a credentialing pre-delegation survey, policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review and approval. The Plan retains the right to make the final decision to delegate credentialing responsibilities

and all decisions are based on the entity's ability to meet Plan, state and federal requirements for delegation.

CMS Preclusion List

All subcontractors delegated for credentialing and/or Claims administration must review their Practitioner network against the CMS Preclusion List. The CMS Preclusion List will be provided to the subcontractor on a monthly basis by the Plan. Within five (5) business days of receipt, the subcontractor must review the list and identify any Practitioners with a new preclusion since the last publication date. Within 15 calendar days of receipt of the list, the subcontractor must notify the Plan of any identified Practitioner(s), including a report of all the Plan's Claims paid to the Provider in the previous 12 months. Depending on delegated expectations, subcontractors may also be responsible for sending the necessary Member notification at least 60 calendar days prior to the preclusion effective date, informing the Member of the need to select a new Practitioner.

Utilization management (UM)

UM functions may be delegated to entities that meet NCQA criteria, regulatory and Plan established standards for UM functions and processes.

To be delegated for UM functions, the potential delegates must at minimum:

- Pass the Plan's UM pre-assessment and annual audits, which are based on regulatory, NCQA UM and the Plan's established standards and state and federal regulatory requirements
- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions
- Have a full time medical director responsible for the UM program who holds an unrestricted license to practice medicine in California
- Have internal controls and quality monitoring of work performed by the UM staff
- Correct deficiencies within the Plan's established time frames when issues of non-compliance are self-identified, identified by the Plan or a state or federal regulatory agency.
- Agree to and cooperate with the Plan's contract terms and conditions for UM delegates
- Submit timely and complete UM delegation reports in a format and frequency determined by the Plan
- Comply with all applicable accreditation and regulatory standards and applicable federal and state laws
- Provide a 90-day advance notification to the Plan of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Plan, legal and regulatory inquiries and audits
- Comply with contractual, regulatory and legal requirements for Member and Provider

notification of UM decisions
- Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law

Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Plan requirements for Claims functions.

To be delegated for Claims functions, the potential delegates must at minimum:

- Pass the Plan's Claims pre-assessment and annual audits, which are based on state and federal laws, regulatory and the Plan's established standards
- Have internal controls and quality monitoring of work performed by Claims staff
- Correct deficiencies within the Plan's established time frames when issues of non-compliance are identified by the Plan or a state or federal regulatory agency
- Agree to the Plan's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum or as communicated by the Plan to the applicable Plan contact
- Comply with all regulatory standards and applicable federal and state laws for Claims administration
- Have systems enabled to accurately and timely adjudicate professional and facility Claims, including but not limited to the appropriate application of interest penalties, Claims appropriate edits, audit trail, fee schedule, Provider contracting status, denial codes, payment codes, pend codes and accumulators
- Provide a 90-day advance notification to the Plan of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Plan, legal and regulatory inquiries and audits

Oversight monitoring of delegated functions

Prior to approval of delegation, and at least annually thereafter, the Plan conducts an onsite/virtual review of potential delegates requesting delegation. The Plan uses delegation standards and practices in compliance with NCQA, state and federal requirements. A member or designee of the Delegation Oversight team assigned to evaluate and oversee the delegate's activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate committee may approve specific delegation of functions. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between the Plan and the delegated entity. For delegation of UM, a "Delineation of Utilization Management Responsibilities" grid is included with the "Acknowledgement and Acceptance of Delegation" outlining the delegated activities; the Plan's responsibilities; the delegated entity's responsibilities; the frequency of reporting; the Plan's process for evaluating performance and corrective actions if the IPA/Medical Group fails to meet its responsibilities. Ad-hoc audits may be conducted at the Plan's discretion.

The Plan reserves the right to request corrective action plans, impose administrative or financial sanctions and/or revoke the delegation of these responsibilities when the delegated entity demonstrates non-compliance to NCQA, contractual, state and federal requirements.

Complex case management services are not delegated. The Plan's medical case management department retains sole responsibility for authorization and implementation of these services.

Delegated entities are required to refer known or potential cases to the Plan's case management department. The referral may be made by telephone or facsimile. This information can also be found in the Medical Management section and in the Public Health Coordination and Case Management.

PCP termination and Member reassignment policy

Directly contracted PCPs

Scenario	Action
Terming PCP practices under a group contract	Members will remain with the group
Terming PCP practices under a solo contract	Member will be assigned within the Network

IPAs/Medical Groups

Scenario	Action
Terming PCP practices in a Federally Qualified Health Center (FQHC)	Member will remain with the FQHC
Federally Qualified Health Center (FQHC) is moving from one IPA to another	Member will remain with the FQHC
Terming PCP is a solo practitioner and is affiliated with multiple IPA	Member will remain with the PCP and be transitioned to the still contracting IPA to ensure the Member's continuity of care
If PCP is being admiratively terminated by the Plan or the IPA for such reasons as malpractice insurance, suspension of license, or failure to pass Facility Site Review	Member will remain with the IPA
If an IPA wishes to have Members reassigned to PCPs within the IPA at time of Provider termination, the IPA must make those assignments know at the time of notice	The Plan will make every effort to accommodate the request subject the Members right to choose their PCP

18. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative, or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative, or Provider are the only parties who may request that the Plan expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

Appeals/redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or other authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 60 days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven (7) days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers, or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the Independent Review Entity (IRE) within 60 days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify the Plan and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE changes the Plan's decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

Payment appeals must be paid within 30 days from the date the plan receives notice of the reversal.

If the IRE upholds the Plan's denial, they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors the Plan's compliance with determinations to decisions that fully or partially reverse an original Plan denial. The IRE is currently C2C Innovative Solutions, Inc. (C2C).

Part D prescription drug exception policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

The Plan is committed to providing access to medically necessary prescription drugs to the Plan's Members. If a drug is prescribed that is not on the Plan's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the Plan level (on-site) and are not delegated to another entity. Please see below for contact information by Plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax, or e-mail the Plan's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call the Plan toll-free at (800) 665-3086 or fax (866) 290-1309.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception/prior authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary** – A formulary is a list of medications selected by the Plan in consultation with a team of health care Providers which represents the prescription therapies believed to be a necessary part of a quality treatment program. The Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA-approved or compendia supported for the diagnosis for which it is being used), and other Plan rules are followed.

   Formularies may be different depending on the plan and will change over time. Current formularies for all products may be downloaded from our website at CentralHealthPlan.com.

2. **Co-payments for Part D** – The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.

   - Most Part D services have a co-payment;
   - Co-payments cannot be waived by the Plan per CMS; and,
   - Co-payments may differ by state and plan.

3. **Restrictions on the Plan's Medicare Drug Coverage**

   Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

   - **Prior authorization:** The Plan requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, the Plan may not cover the drug.
   - **Quantity limits:** For certain drugs, the Plan limits the amount of the drug that it will cover.
   - **Step therapy:** In some cases, the Plan requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if drug A and drug B both treat a medical condition, the Plan may not cover drug B unless drug A is tried first.
   - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA-approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Plan's Pharmacy and Therapeutics Committee

4. **Non-covered Medicare Part D Drugs:**

   - Agents when used for anorexia, weight loss or weight gain (no mention of medically necessary)
   - Agents when used to promote fertility
   - Agents used for cosmetic purposes or hair growth
   - Agents used for symptomatic relief of cough or colds
   - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations
   - Non-prescription drugs, except those medications listed as part of the Plan's Medicare over-the-counter (OTC) monthly benefit as applicable and depending on the plan
   - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
   - The Plan's Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to the Plan's Medicaid program

- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System)

5. **There may be differences between the Medicare and Medicaid formularies.** The Plan's Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. **Requesting a Plan Medicare formulary exception –** The Plan's Medicare product drug prior authorizations are called exceptions, which are required when your patient needs a drug that is not on the formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an exception. (The process for filing an exception is predominantly a fax-based system.) The form for exception requests is available on the Plan's website.

7. **Requesting a Plan Medicare formulary redetermination (appeal) –** The appeal process involves an adverse determination regarding the Plan issuing a denial for a requested drug or Claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, they may request a redetermination (appeal) from the Plan by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help the Plan with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to the Plan in writing. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven (7) calendar days from the date the request for re-determination is received.
   - An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, the Plan will honor this request.
   - If a Member submits an appeal without Provider support, the Plan will review the request to determine if it meets Medicare's criteria for expedited processing. If the Plan determines that the request meets the expedited criteria, the Plan will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, the Plan will render a coverage decision within the standard redetermination time frame of seven (7) calendar days.

- To submit a verbal request, please call toll-free (800) 665-3086. Written appeals must be mailed or faxed toll-free (866) 290-1309.

8. **Initiating a Part D coverage determination request –** The Plan will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the Plan's standardized Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/3 calendar days after the Plan receives the completed request.

   The Plan will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by 1) the Plan's pharmacy technician under the supervision of a pharmacist; 2) the Plan's Pharmacist; or, 3) the Plan's Chief Medical Officer (CMO). Review criteria will be made available at the request of the Member or their prescribing Provider. The Plan will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information
      - DRUGDEX Information System

   b. Requests for off-label use of medications will need to be accompanied with excerpts from one (1) of the two (2) CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

   c. Depending upon the prescribed medication, the Plan may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

      Denial decisions are only given to the Member or Member's representative by the Plan's Pharmacist or CMO. The written denial notices to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member's right to, and conditions for, obtaining an expedited appeals process.

      If the Plan denies coverage of the prescribed medication, the Plan will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified time frame, the Plan will start the next level of appeal by sending the coverage determination request to the IRE within 24 hours.

If a coverage determination is expedited, the Plan will notify the Member of the coverage determination decision within the 24-hour time frame by telephone and mail the Member a written Expedited Coverage Determination within three (3) calendar days of the oral notification. If the Plan does not give the Member a written notification within the specified time frame, the Plan will start the next level of appeal by sending the Coverage Determination request to IRE within 24 hours.

9. **Initiating a Part D appeal –** If the Plan's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a standard appeal the Plan has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request the Plan to expedite a redetermination if the standard appeal time frame of seven (7) days may seriously jeopardize the Member's life, health or ability to regain maximum function. The Plan has up to 72 hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for re-determination. If additional information is needed for the Plan to make a re-determination, the Plan will request the necessary information within 24 hours of the initial request for an expedited re-determination. The Plan will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

10. **The Part D independent review entity (IRE) –** If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D qualified independent contractor is currently C2C, a CMS contractor that provides second level appeals.

    - **Standard appeal:** The IRE has up to seven (7) days to make the decision
    - **Expedited appeal:** The IRE has up to 72 hours to make the decision
    - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory time frame is not applicable on this level of appeal.
    - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory time frame is not applicable on this level of appeal
    - **Federal District Court (FDC):** If the MAC's decision is unfavorable, the Member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory time frame is not applicable on this level of appeal.

Pain Safety Initiative (PSI) resources

Safe and appropriate opioid prescribing, and utilization is a priority for all of us in health care. The Plan requires Providers to adhere to the Plan's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

The Plan is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Plan's Provider website. Providers may access additional opioid-safety and substance use disorder resources at CentralHealthPlan.com under the Health Resource tab. Please consult with your Provider Relations representative or reference the medication formulary for more information on the Plan's pain safety initiatives.

Central Health Medicare Plan
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 403-8296