MANAGED LONG TERM HEALTH CARE PLAN

Ad

PROVIDER MANUAL

PRIME HEALTH CHOICE, LLC

PRIME HEALTH CHOICE, LLC

PROVIDER MANUAL

Prime Health Choice, LLC

Dear Provider:

I would like to welcome you to the PRIME HEALTH CHOICE, LLC Provider Network. As you are aware PRIME HEALTH CHOICE, LLC is a Partially Capitated Managed Long-Term Care Program established to coordinate health care services for your clients and our Members.

Together we will be providing needed services to the elderly/disabled population. This manual is designed to inform you of our process and your rights and responsibilities as a PRIME HEALTH CHOICE, LLC Provider.

Sincerely,

Administration
Prime Health Choice
Managed Long-Term Care Plan

TABLE OF CONTENTS

PRIME HEALTH CHOICE, LLC

PROVIDER MANUAL

PRIME HEALTH CHOICE OVERVIEW

PRIME HEALTH CHOICE, LLC is a partially capitated Managed Long Term Care Program (MLTCP) established to coordinate healthcare services for chronically ill adults wishing to remain in their own home and communities as long as possible.

Member's healthcare needs, both covered and non-covered, are coordinated by an assigned Care Manager in collaboration with Member's primary care physician and Prime Health Choice Participating Providers.

The benefits provided to individuals enrolled in Prime Health Choice are considered to be Medicaid benefits.

PRIME HEALTH CHOICE, LLC provides access to care 24 hours a day, 7 days a week. You can access services by calling Member Services at 1 (855) 777-4630 or TTY/TDD: 1 (855) 777-4613. At other times, you can call this number and answering service will refer your call to the Care Manager On-Call and we will return your call as soon as possible.

PRIME HEALTH CHOICE CONTACT NUMBERS

President:
1-718-513-7373

Care Management and Patient Care Services:
1-855-777-4630

Quality Assurance:
1-855-777-4638

Intake and Enrollment:
1-855-777-4633

Provider Relations:
1-855-777-4632

EXPECTED EMPLOYMENT STANDARDS FOR PRIME HEALTH CHOICE PARTICIPATING PROVIDERS

PRIME HEALTH CHOICE, LLC is committed to providing the highest quality of health care to its members.

To provide the best possible care, it is essential that PRIME HEALTH CHOICE, LLC Participating Providers attract and retain the highest quality of staff to perform these services. While mindful that providing services must be accomplished within available funding levels, we believe that morally and ethically, we have an obligation to encourage our business partners to treat their employees fairly.

The five items below enumerate the terms and conditions of employment that we consider to be minimum standards for all Prime Health Choice Participating Providers.

Providers that meet or exceed these minimum standards will be considered “preferred” in consideration of future business.

1. Provide the highest level of care
2. Provide fair and reasonable wages
3. Provide fringe benefits including, but not limited to, adequate health care, retirement and paid leave
4. Provide safe and healthy working conditions
5. Treat employees with dignity and respect

ELIGIBILITY CRITERIA

To be enrolled in Prime Health Choice members must meet the following eligibility criteria:

1) Age 21 or older.
2) Reside in the plan's service area of Dutchess County.
3) Have a chronic illness or disability that makes you eligible for enrollment.
4) Be able to stay safely at home at the time of enrollment to the plan.
5) Require care management and are expected to need one or more of the following services for more than 120 days from the time of enrollment:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day health care
    - Private Duty Nursing
    - Consumer Directed Personal Assistance Services (CDPAS)
6) Have Medicaid or be eligible for Medicaid.

COVERED SERVICES/BENEFITS

Covered services must be deemed medically necessary for the member to access the benefit.

Prime Health Choice Plan's Definition of Medical Necessity is as follows: Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a Healthcare Provider, exercising prudent clinical judgment, would provide to a member for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and/or necessary to enable the member to remain safely in the community and that are:

a) a service or product covered by the Heath Plan (covered benefit);
b) in accordance with the generally accepted standards of medical practice;
c) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, or well being; and
d) not primarily for the convenience of the patient or Healthcare Provider, a Physician or any other Healthcare Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community,
- Physician and Healthcare Provider Specialty Society recommendations,
- The views of Physicians and Healthcare Providers practicing in relevant clinical areas and
- Any other relevant factors.

When in dispute, determination of medical necessity shall be made by the Health Plan's Medical Director.

As a Managed Medicaid program, Prime Health Choice Plan is always the payer of last resort. Prime Health Choice is the thus the secondary payer to Medicare and/or third party payers. If Medicare covers any of the above services, then Medicare shall be billed first. If the Member has any additional insurance (other than Medicare or Medicaid) that covers any of the above services, then the additional insurer shall be billed after Medicare.

Prime Health Choice Plan Benefits are community based and include the following:

- Adult Day Health Care
- Adult Social Day Care
- Skilled Nursing Facility Care
- Licensed Home Health Care (nursing, HHA, PCA, PT, OT, ST)
- Audiology
- Dentistry
- Optometry
- Podiatry
- Meals (Home and Congregate)
- Outpatient and in-home Physical Therapy, Occupational Therapy, Speech Therapy
- Respiratory Therapy
- Nutritional Counseling
- Durable Medical Equipment (including oxygen)
- Medical and Surgical Supplies
- Prosthetics and Orthotics
- Social and Environmental Supports
- Non-Emergency Transportation (assessable by calling the member's Nurse Care Manager)
- Personal Emergency Response Systems (PERS)
- Medical Social Services
- Personal Care
- Care Management
- Enteral and Parenteral Supplements-as per Medicaid guidelines
- Private Duty Nursing

There is no cost sharing expenses for Members, including deductibles or co-pays, as they are covered by Prime Health Choice Plan.

NON-COVERED SERVICES

Prime Health Choice Plan does not cover the following services:

- Inpatient and Outpatient Hospital Care
- Physician Services
- Laboratory and Diagnostic Tests
- Radiology and RadioIsotope Services
- Hospital Emergency Room Care
- Renal Dialysis
- Mental Health Services including:
    - Methadone maintenance
    - Psychiatric rehabilitation treatment programs
    - Day treatment
    - Continuing day treatment
    - Case management for the seriously and persistently mentally ill
    - Partial Hospitalizations
    - Assertive Community Treatment (ACT)
    - Personal recovery oriented services (PROS)
- Alcohol and Substance Abuse
- Prescription and Non-Prescription Medications
- Services provided by the Office of People with Developmental Disabilities
- Emergency Transportation
- Family Planning
- Assisted Living Program
- Hospice
- AIDS Adult Day Health Care.

The above services may be covered by fee-for-service Medicare, Medicaid or third party insurance.

ACCESS TO CARE AND SPECIALTY PROVIDERS

Pursuant to 10 NYCRR 98.1.13, PRIME HEALTH CHOICE LLC Managed Long Term Care Plan endeavors to assure care for its members. As such, all covered services must be directly provided or arranged for within the Health Plan's approved provider network pursuant to written contracts developed and maintained in a form and manner prescribed by the commissioner. When services are unavailable within our provider network, such service shall be arranged for outside of the approved provider network.

Services provided by specialist, specialty care center, and/or out-of-network providers must be approved by the Director of Quality Assurance or the Director of Care Management. Providers must submit timely reports concerning services rendered as outlined herein. To initiate a referral for specialty care contact the member's Care Management Team. The limitation in the above paragraph and other limitations imposed on accessing the entire approved network is clearly transmitted to enrollees via an addendum to the member handbook.

If there is a need for a standing referral, contact the member's Care Management Team to discuss. When services are provided by a specialist and/or an out-of-network provider, said provider is bound to the terms and conditions of this Provider Manual including **but not limited to:**

- Provider responsibilities
- Member rights
- Access to care
- Claim submission
- Service authorization
- Balance billing
- Cost of non-covered services

TRANSITIONAL CARE, OBTAINING SERVICES OUT OF AREA AND USING OUT-OF-NETWORK RPOVIDERS

Transitional Care (New Member): Upon entering the program, new members being treated by out-of-network providers shall be transitioned to in-network providers within 90-days from the date of enrollment. Prime Health Choice Plan will ensure that the transition will be seamless. New members who are being treated by an out of network dentist will be allowed to continue seeing that dentist until their current treatment regimen is completed and then will be transitioned to an in-network provider.

Using an Out-of-Network Provider: When the Health Plan's Network does not include an available provider with the appropriate training and experience to meet the member's needs, the Nurse Care Manager will provide a referral to an out-of-network provider pursuant to a treatment plan approved by the MLTCP members of the Interdisciplinary Care Team and non-participating provider. The enrollee may not elect to use a non-participating specialist provider unless there is no specialist provider in the network.

Transitional Care (Provider leaves network): Subject to the provider agreement, a plan shall permit an enrollee to continue an on-going course of treatment for a transition period of up to 90 days.

THE ROLE OF PRIME HEALTH CHOICE CARE MANAGEMENT

Care Manager/Interdisciplinary Team
Each Member is assigned to a Care Manager/Interdisciplinary Team that will include health care professionals (nurses, social workers, psychologists or therapists, as appropriate) who have ongoing responsibility for coordinating, managing and authorizing all aspects of the delivery of care and services to members.
As the primary coordinator of care, the Care Manager's responsibilities include:

- Authorization and implementation of covered services outlined in the Member's service plan,
- Monitoring of all services for quality and effectiveness,
- Integration of feedback, observations, and recommendations of other professionals involved in managing the care to the Member, including network
- Providers, PCP's, Specialists, and Providers of uncovered services,
- Coordination of discharge planning from hospital or nursing home stays.

Member Service Representative/Member Service Assistant
Member service staff serves as liaison between the Member and Care Manager and assist the care management team by providing information about Prime Health Choice policies, available services, and network Providers to Members; making and confirming service arrangements, issuing authorizations as directed by the Care Manager, and by answering questions and resolving problems presented by Members and Providers, as appropriate.

COORDINATION OF CARE

PRIME HEALTH CHOICE LLC is a New York State Managed Long Term Care program, responsible for providing long-term care and health services to its members. Because intensive care coordination and management is critical to the health and well-being of its membership, PRIME HEALTH CHOICE LLC participating providers agree, through the PRIME HEALTH CHOICE LLC Participating Provider Agreement to fully cooperate with PRIME HEALTH CHOICE LLC care management, even if the episode of care does not result in any payment by PRIME HEALTH CHOICE LLC to the participating provider because the provider's fee is covered entirely by a primary payer, such as Medicare.

Specifically, it is not unusual for a Prime Health Choice member to also be Medicare-eligible. In these cases, because Medicaid is always the payer of last resort and Medicare is the primary payer, under the PRIME HEALTH CHOICE, LLC coordination of benefits procedure PRIME HEALTH CHOICE, LLC may owe no secondary payments to the participating provider. This payment circumstance does not alter the responsibility of participating providers to cooperate with Prime Health Choice care management.

PARTICIPATING PROVIDER RESPONSIBILITIES

All Network Providers must:

- Effectively communicate with the Nurse Care Manager and Member Services staff to ensure efficient scheduling of services, prevention of duplication, improved access to care, increased continuity of care, and progress toward goal achievement regardless of primary payer
- Offer the covered services for which they are contracted to PRIME HEALTH CHOICE LLC's members within the scope of their licensure, expertise, and range of services
- Comply with all applicable laws and program requirements
- Be in compliance with employee licensure, certification, and/or registration as required by applicable law, provider agreement, agency requirements, and standards of practice
- Comply with all regulatory and professional standards of practice
- Obtain physician orders when required. The Nurse Care Manager may assist during times when a Provider is having difficulty obtaining physician orders
- Timely report verbally and in writing the nature of services provided and the Member's progress toward goal achievement
- Obtain and maintain accreditation where required and notify PRIME HEALTH CHOICE LLC Health Plan, within two (2) business days, of any notice of restrictions or suspension or loss of accreditation.
- Determine Member eligibility prior to providing services, except in the case of an emergency medical condition
- Participate and cooperate in the Health Plan's system of coordination of healthcare services through Care Management
- Provide clinical encounter data to PRIME HEALTH CHOICE LLC when requested
- Provide access to clinical data by PRIME HEALTH CHOICE LLC staff for review of medical records, concurrent review, audits, and site visits for credentialing
- Comply and cooperate with all agency requirements for credentialing, utilization management, quality improvement projects, grievance, appeals, audits and coordination of benefits with other payers
- Maintain professional liability, general liability, and workers' compensation insurance and promptly provide copies of insurance certificates when requested
- Report fraud, abuse, malfeasance, and misconduct under law or Provider contract
- Agree not to bill PRIME HEALTH CHOICE LLC Members for covered services, either in whole, or in part
- Treat all PRIME HEALTH CHOICE LLC Members and Health Plan employees with dignity and respect
- Cooperate with any and all investigations that PRIME HEALTH CHOICE LLC may conduct into Provider practices, both clinical and billing.

PROVIDER RESPONSIBILITIES BY TYPE

Note: ***All PRIME HEALTH CHOICE LLC services MUST be Authorized by the Health Plan***

HOME CARE PROVIDERS

- Verify primary payor coverage and eligibility prior to providing services
- Obtain physician orders for all services (RN, PT, OT, ST, RT, MSW, DME, Aides)
- Provide Home Health Aide and Personal Care Aide services within 24 hours of request
- Develop the Aide care plan for services
- Timely notify members, in advance, of the names of assigned staff
- Timely notify members, in advance, of the need for replacements and the name of replacement staff
- Timely provision of replacement aides for members who are without services
- Timely notification of PRIME HEALTH CHOICE, LLC when aide services were not present
- Make efforts to implement an electronic attendance program to assure Aide daily attendance
- In the absence of an electronic attendance program, conduct random manual verification of Aide attendance
- Assure that no aides are assigned to care for their own family.

HOME THERAPIES (PT, OT, ST)

- Verify payor coverage and eligibility prior to providing services (may be Medicare billable)
- Obtain physician orders
- Services must be provided within 5 days of request
- Progress notes and updates must be provided to the Nurse Care Manager within 48 hrs
- Services must be authorized by PRIME HEALTH CHOICE, LLC.

TRANSPORTATION PROVIDERS

- Arrive within 20 minutes of requested pickup time
- Make every effort to consistently deliver members to their appointments on time.
- Ensure that all transports are to medical appointments unless otherwise directed by the Nurse Care Manager or Member Services Coordinator
- Notify PRIME HEALTH CHOICE, LLC when a Member requests transport to a non-medical destination or to a destination that does not appear on the authorization

- Notify PRIME HEALTH CHOICE, LLC when a Member cancels or does not show for a pickup
- Ensure that all drivers are licensed to transport Members in the State of New York and that all insurances are up to date
- Ensure that all Members (and accompanying aides) are secured by seatbelt and shoulder belts during transport
- Ensure that all vehicles meet New York State Department of Motor Vehicles and Taxi and Limousine standards
- Treat all Health Plan members and Health Plan staff with dignity and respect
- Timely call Members and the Health plan when a vehicle will be late, whether during initial pickup or during return trip pick up
- Use 4 Tie-Down Straps for each Wheelchair position, and ensure that Wheelchairs are consistently tied down during trips.

DME and MEDICAL SUPPLIERS

- Verify primary payor coverage and eligibility prior to delivery of equipment and/or supplies
- Exhaust all other payor sources prior to billing PRIME HEALTH CHOICE LLC
- Delivery must occur within 72 hrs (unless order is customized)
- Notify the Health Plan when equipment is delivered
- Provide delivery confirmation (delivery receipt)
- Ensure that all products delivered are in working order
- Timely completion of requested repairs

RESIDENTIAL PROVIDERS

Short Term Rehabilitation (up to 6 months)

- Verify payor coverage and eligibility prior to the SNF admission
- Obtain authorization for SNF stay and any covered services from the Nurse Care Manager (NCM)
- Assist in the recertification process
- Provide progress notes to the NCM bi-weekly
- Notify the NCM when a Member is being transferred from and to the facility i.e., hospitalized
- Notify the Health Plan regarding any change in payor i.e., Medicare episode
- Obtain authorization for transportation services from the NCM
- Notify the Health Plan when an incident occurs involving Plan Members.

Long Term Permanent Placement

- Verify payor coverage and eligibility prior to the permanent placement
- Assist with conversion applications for Members placed for long term are and identify the admission as a Managed Long Term Care admission
- Notify NCM when a Member is being transferred from and to the facility i.e., hospitalized
- Notify the Health Plan regarding any change in payor i.e., Medicare episode

- Collect the NAMI which will be deducted from payments
- Submit monthly summaries to PRIME HEALTH CHOICE LLC NCM
- Obtain authorization for facility stay on a monthly basis
- Notify the Health plan when an incident occurs involving our Members
- Assist in Medicaid Recertification process.

ADULT and SOCIAL DAY CARE PROVIDERS

- Placement must occur within 14 days of request
- Provide monthly progress notes to the NCM
- Services must be authorized by the PRIME HEALTH CHOICE LLC plan.

NUTRITIONAL COUNSELING

- Services must be provided within 14 days of request
- Progress notes and updates must be provided to the NCM within 48hrs
- Services must be authorized by PRIME HEALTH CHOICE LLC plan.

THERAPIES (Facility Based)

- Obtain physician orders
- Verify payor source and eligibility prior to providing services (may be Medicare billable)
- Services must be provided within 7 days of request
- Progress notes and updates must be provided to the NCM within 48 hrs of the initial visit and then every two weeks
- Progress notes and updates must be provided prior to reauthorization for service continuation
- Services must be authorized by PRIME HEALTH CHOICE LLC plan.
- Maximum 20 visits per year per discipline.

RESPIRATORY THERAPY

- Verify payor source and eligibility prior to providing services
- Services must be provided within 24 hrs of request
- Progress notes and updates must be submitted within 48 hrs
- Services must be authorized.

PODIATRY

- Verify payor source and eligibility prior to providing services (Podiatry exam may be Medicare billable
- Services must be provided within 7 days of request
- Progress notes and updates must be submitted within 48 hrs
- Services must be authorized.

SERVICE STANDARDS FOR PROVIDERS

Providers participating in the Prime Health Choice Provider Network shall provide service to Members in accordance with the standards set by Prime Health Choice except when a longer timeframe is required by the Member. These standards are outlined below:

Service:	**Standard (relative to requested start date):**
Adult Day Health Care	Placement must occur within 14 days
Audiology	Standard: within 7 days Emergency: within 48 business hours
Dentistry	Standard: within 28 days Emergency: within 24 business hours
DME/Supplies	Delivery must occur within 72 hours, unless custom order
Home Health Care	Initial visit must occur within 24 hours
Meals (Home/Congregate)	Date and time specified by Prime Health Choice
Skilled Nursing Facility	Placement must occur as quickly as possible
Nutritional Counseling	Service must be provided within 14 days.
Optometry	Standard: within 7 days Emergency: within 24 business hours
Personal Care	Initial visit must occur on the date and time specified by Prime Health Choice
Physical, Occupational & Speech Therapy (not in home)	Initial visit within 7 days
Physical, Occupational &Speech Therapy (in home)	Initial visit must occur within 72 hours

Podiatry	Standard: within 7 days Emergency: within 24 business hours
Private Duty Nursing	Date and time specified by Prime Health Choice
Prosthetics/Orthotics	Measurement within 14 days.
Respiratory Therapy	Initial visit must occur within 24 hours
Social Day Care	Placement must occur within 14 days
Social and Environmental Supports	Delivery within 14 days unless custom ordered
Social Work Services	Service must be provided within 14 days.
Transportation	Pick up within 20 minutes of scheduled time

Clinical notes should be submitted within 48 hours of assessment visit. Progress notes/summaries should be submitted every two (2) weeks thereafter unless otherwise requested or there is a decrease in member health status.

AUTHORIZATION REQUIREMENTS

MLTCP Authorization Requirements

Prime Health Choice requires prior written authorization, except for in network Optometry, Podiatry and Dentistry. Those services may be self-selected and self-scheduled by the member from the Provider Network for routine visits. Limitations of services are in accordance with MMIS guidelines.

The table on the following pages outlines the authorization requirements for Prime Health Choice.

For Prime Health Choice authorizations and prior approvals are obtained from the Prime Health Choice Case Manager 1-855-777-4630.

Covered Service	Authorization/Prior Approval requirement
	Prime Health Choice MLTCP
Adult Day Health	Yes Prime Health Choice Care Manager
Ambulance - Emergency	Not Covered
Ambulance - Non-emergent	Yes Prime Health Choice Care Manager
Diabetes Monitoring - Diabetes self-monitoring, management training and supplies including glucose monitors, test strips and lancets.	Yes Prime Health Choice Care Manager
Durable Medical Equipment (DME)	Yes Prime Health Choice Care Manager
Medical and Surgical Supplies - non Part B	Yes Prime Health Choice Care Manager
Medical and Surgical Supplies - Part B	Yes Prime Health Choice Care Manager
Parenteral/enteral feeds	Yes Prime Health Choice Care Manager
Hearing Exams/ Hearing Aids	Yes Prime Health Choice Care Manager
Home Health Care (CHHA)	Yes Prime Health Choice Care Manager
Hospice Care Fee for service Medicare/Medicaid	Not Covered
Meals (Home/Congregate)	Yes Prime Health Choice Care Manager

Nutrition Therapy	Yes Prime Health Choice Care Manager
Occupational Therapy/ Services	Yes Prime Health Choice Care Manager
Optometry - Eye Exams, Eye Glasses, Contact Lenses; Low Vision Services	No Prime Health Choice Care Manager
Orthotics/Prosthetics Orthopedic Footwear	Yes Prime Health Choice Care Manager
Ostomy Supplies	Yes Prime Health Choice Care Manager
Oxygen Therapy	Yes Prime Health Choice Care Manager
PERS	Yes Prime Health Choice Care Manager
Physical Therapy/Occupational Therapy/ Speech-Language Pathology (PT/OT/ST)(other than in-home)	Yes Prime Health Choice Care Manager
Podiatry/Foot Care	No Prime Health Choice Care Manager will approve routine foot care 4 times per year. Care Manager will consider routine foot care beyond 4 visits per year and for medically necessary treatment of injuries or diseases of the foot.
Private Duty Nursing	Yes Prime Health Choice Care Manager
Respite Care	Yes Prime Health Choice Care Manager
Skilled Nursing Facility (SNF) Care	Yes Prime Health Choice Care Manager
Social and Environmental Modifications	Yes Prime Health Choice Care Manager
Social Day Care	Yes Prime Health Choice Care Manager
Social Work Services	Yes Prime Health Choice Care Manager
Transportation - Non Emergent	Yes Prime Health Choice Care Manager
Consumer Directed Personal Care	Yes Prime Health Choice Care Manager

CLAIMS SUBMISSION

Billing and claims procedures

- **<u>Validate Enrollee membership</u>**
- Providers shall not bill enrollee for services covered by PRIME HEALTH CHOICE LLC
- Provider must advise enrollee, prior to initiation of service, that the service is uncovered and the cost of the service.

Claims Submission Timeframes
All claims must be submitted to PRIME HEALTH CHOICE LLC Plan's Claims Processing Center as per contractual agreement within timeframe. Claims that are not submitted as per contractual agreement will be rejected for untimely filing. Please note that the foregoing is in effect on pursuant to INS § 3224 (a).

Late Claims
Claims that are denied for untimely filing may be appealed under special circumstances or for compelling reasons i.e., where the provider can demonstrate that the late claim resulted from an unusual occurrence and the provider has a pattern of timely claims submissions. However, the Health Plan may reduce the reimbursement of claim by up to 25 percent of the amount that would have been paid if the claim had been submitted 365 days after the service and in such cases the Health Plan will deny the claim(s) in full. Please see the section on appealing a denial of payment.

Claims Processing Timeframes
All payable paper and facsimile claims shall be paid within forty-five (45) days. Claims submitted electronically shall be paid within thirty (30) days. Claims submission timeframes applicable to coordination of benefits are not affected by this change.

Coordination of Benefits
The Health plan cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the Health plan has a "reasonable basis" to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if the Health Plan request information from the member regarding other coverage, and does not receive the information within forty-five (45) days the Health Plan must adjudicate the claim. However, the claim cannot be denied on the basis of non-receipt of information about other coverage. The Health plan must update their claims processing and systems to prevent denial of claims based in coordination of benefits in the above instances.

Overpayment Recovery
The process for overpayment recoveries was amended to apply to all health care professionals licensed, registered, or certified under Title 8 of the State Education law, and providers licensed or certified pursuant to PHL Articles 28,

36 or 40 or Mental Hygiene Law Articles, 19, 31 and 32. The statute requires that Health Plans provide the health care professional or provider with an opportunity to challenge the overpayment recovery.

How does this affect your relationship with PRIME HEALTH CHOICE LLC?
Any provider identified above may challenge an overpayment recovery. Providers wishing to do so should contact the PRIME HEALTH CHOICE LLC at 1-855-777-4630 or QI Department at 1-855-777-4638. Also see the "Claim Appeal" section.

Where to Send Your Claims
Claims should be submitted to our Claims Processing Center. The Claims Processing Center will check the system for authorization, match claims to the network provider, and submit the claim to PRIME HEALTH CHOICE LLC Finance Department for payment. Please submit claims directly to PRIME HEALTH CHOICE LLC to:

Prime Health Choice LLC
Attn: Claims Department
3125 Emmons Avenue
Brooklyn, NY 11235

Encounter Data:
Encounter data enables us to track utilization, analyze patient care patterns, adhere to state and federal HMO reporting requirements, and provide a source of data for quality assurance studies. Submit member encounter data claims to PRIME HEALTH CHOICE, LLC using an approved Encounter Form (CMS-1500 Claim Form).

Encounter Forms
Submit the approved form to PRIME HEALTH CHOICE LLC at least monthly and complete the following information:

- Member name, birth date, sex, address and member number found on the member's ID card
- Provider's name and number and tax ID number
- Date of service (within the authorization dates)
- Diagnosis and the appropriate CPT/HCPCS procedure codes as establishes by the federal government, and type of visit.

Charged amount must be consistent with contracted rates and may not exceed the units appearing on the authorization. All coordination of benefits claims must include a copy of the primary insurer's Explanation of Payment (EOP). Claims data (paid/denied) is transmitted to the NYSDOH monthly.

CLAIM INQUIRY

All claim inquiries and appeals must be submitted within 45 days of the claim determination.

To inquire about a claim for which no payment has been received, or for a denial, contact the PRIME HEALTH CHOICE LLC Claims Processing Department at 718-513-7375. If you are dissatisfied with the outcome, contact Provider Relations.

Before making an inquiry

Compare the claim to the authorization and determine if they match. Remember only authorized services will be paid. If the service was requested and/or provided on the weekend or outside of normal business hours, the authorization must be requested by calling the Health plan's office and requesting authorization from the on-call Nursing Care Manager (NCM). Please note the following concerning denials:

- If there is an error on the authorization, call Provider Relations at 1-855-777-4632
- If a service is provided other than the service/dates requested, call the Member's NCM to discuss. Please note that the Prime Health Choice Care Management Team is not required to change an authorization however; reasonable requests will be considered
- If you are dissatisfied with the Care Management decision, you may call Provider Relations
- If your claim is incorrect, resubmit the corrected claim and clearly note "Corrected Claim"
- The best way to ensure prompt payment is to make certain that the claim matches the authorization
- Make sure that your claim included the following:
    - Member's name
    - Claim Number
    - Member's ID
    - Date of Service
    - Service Code Billed
    - Units Billed
    - Dollar Amount Billed
    - Diagnosis (if required) for the claim.

CLAIM APPEALS

COMMON REASONS FOR DENIAL OF PAYMENT

- No Authorization/ Service Not Authorized
- Untimely Claim Submission
- Duplicate Claim or Paid Authorized Units
- Units Not Authorized
- Service Not In Fee Schedule
- Reimbursement Limited to Prevailing Medicaid or Contractual Amount.

Resubmit all claims that are associated with a corrected authorization and note *"Corrected Claim."*

TO APPEAL DENIED CLAIMS
All claim appeals and inquiries must be submitted within 45 days of receipt of the claim determination.

When appealing a claim denial, your appeal must include:

- Claim Number
- Authorization Number
- Member's Name
- Member's ID Number
- Date of Service
- Service Code
- Units Billed
- Amount Billed
- REASON FOR THE APPEAL.

Appeals should be sent to:
Prime Health Choice LLC Plan
Attn: Claims Department
3125 Emmons Avenue
Brooklyn, NY 11235

Claim Inquiry Contacts: 718-513-7375

Provider External Appeal Rights
Public Health Law § 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. Payment for an external appeal at PHL § 4914 was amended to include a health care provider filing an external appeal of a concurrent adverse determination. A provider will be responsible for the full cost of an appeal for concurrent adverse determination upheld in favor of the Health Plan; the Health plan is responsible for the full cost of an appeal that is overturned, and the provider and Health Plan must evenly divide the cost of a concurrent adverse determination that is overturned in-part. The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the Health Plan. For the provider to

claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application and the designation. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provisions described above. If the provider is unresponsive, the appeal will be rejected.

Hold Harmless
If the provider requests an external appeal of a concurrent adverse determination, either in its own right or as an enrollee's designee, the provider shall hold the enrollee harmless and shall be prohibited from seeking payment from the enrollee for services determined not to be medically necessary by the external appeal agent, except for applicable co-payments – PHL § 4917.

Alternate Dispute Resolution
If the provider is a facility licensed under Article 28 of the PHL, the parties may agree to alternative dispute resolution ("ADR") in lieu of an external appeal, the cost of which must be agreed upon, in advance, by the parties. However such agreement to ADR shall not adversely affect an enrollee's right to an external appeal or the enrollee's right to designate the provider as his/her designee. If the enrollee files an external appeal, the external appeal determination process shall take precedence over the ADR-PHL § 4906.

Reimbursement and Rate Changes
Public Health Law § 4406 was amended effective January 1, 2010 as follows; Health care professionals are to receive written notice from the Health Plan at least 90 days prior to an adverse reimbursement change to their contract. If the health care professional objects to the change that is the subject of the notice by the Health Plan, the health care professional may, within thirty days of the date of the notice, give written notice to the Health plan to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional."

MEDICAID SPEND-DOWN AND THIRD PARTY INSURANCE

PRIME HEALTH CHOICE LLC is responsible for billing Medicaid Spend-down amounts for Health Plan Members who have been determined by Medicaid Spend-down amounts for Health Plan Members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Providers shall not bill or collect such amounts from Members.

Members who are permanently placed in nursing home will have their surplus amounts collected by the Residential Health Care Facility. A nursing home or skilled nursing facility (SNF) stay is considered short-term for a maximum of six (6) months.

As always, providers are required to bill Medicare or any third party insurance first, with PRIME HEALTH CHOICE LLC the payer of last resort.

Medicare and other Primary Payor Sources

Prime Health Choice Members continue to access their services that are fully or partially covered by fee-for-service Medicare or another Medicare product in which the Member may be enrolled. Providers may bill PRIME HEALTH CHOICE for any secondary payments. PRIME HEALTH CHOICE LLC Members are not responsible for any deductibles or co-payments for covered services.

If PRIME HEALTH CHOICE LLC requests a needed service that is fully or partially covered by Medicare or another primary payor, PRIME HEALTH CHOICE LLC will send a request for services in the form of a zeroed-out authorization. The forgoing is not an authorization to bill PRIME HEALTH CHOICE LLC, but rather, a request for services hence the unit number will appear as “0”.

If a service is provided that is fully or partially covered by Medicare or another primary payor and PRIME HEALTH CHOICE, LLC did not request the service, send a copy of the Explanation of Payment (EOP) to PRIME HEALTH CHOICE, LLC along with your claim for “back-end” processing.

Except in the case of Skilled Nursing Facilities, co-insurance claims do not require prior authorization. Simply attach a copy of the primary and secondary insurers EOP to the claim and PRIME HEALTH CHOICE, LLC will enter the authorization and have the claim processed.

In the event that the provider does not agree that the service is fully or partially covered by Medicare, kindly contact the PRIME HEALTH CHOICE LLC Nurse Care Manager to discuss the issue and provide the rationale. If the Provider and Care Manager cannot reach an agreement, the Care Manager Supervisor should be contacted.

Co-payment for all services except SNF services should be sent directly to the Health Plan at the 3125 Emmons Avenue address to the attention of the Claims Supervisor.

MEMBER CONFIDENTIALITY

Network providers shall protect the Member's right to privacy and confidentiality by maintaining all member information and medical records in accordance with NYS Public Health Law, NYS Social Services Law, and HIPAA (Health Insurance Portability and Accountability Act). Information may be released if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to prevent fraud or abuse.

Network Providers are not to release health information to any person or entity not directly providing a Member's care or paying for a Member's care. Written permission from the Member or the Member's designee is required to release information. For members who are HIV positive, all applicable New York State Laws that govern the disclosure of HIV related information must be followed.

Providers shall train their employees on compliance with applicable State and Federal confidentiality and disclosure laws, including HIPAA.

Member authorization for release of information is not required for disclosure to:

- Medicare
- NYS Department of Health
- Accreditation organizations
- Government agencies authorized to conduct investigations
- PRIME HEALTH CHOICE, LLC Plan.

MEMBER RIGHTS

Providers will uphold the Member's rights and responsibilities as outlined below.

As a Member of Prime Health Choice, the Member has the right to:

- Receive medically necessary care;
- Privacy about the Member's medical record and treatment;
- Timely access to care and services;
- Receive information on available treatment options and alternatives presented in a manner and language understood by Member;
- Receive information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Receive a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to receive the services they need from Prime Health Choice, including how they can receive covered benefits from out-of-network Providers if they are not available in the plan network;
- Complain to Prime Health Choice, the New York State Department of Health, the right to use the New York State Fair Hearing System or in some instances request a NYS External Appeal;
- Appoint someone to speak for them about their care and treatment; and
- Make advance directives and plans about their care.

MEMBER RESPONSIBILITIES

As a Prime Health Choice Member, the Member is responsible to:

- Use Network Providers who work with Prime Health Choice for Eligible Covered Services;
- Receive approval from their physician, Care Manager or care management team before receiving a covered service requiring such approval;
- Tell Prime Health Choice about their care needs and concerns and work with their Care Manager in addressing them;
- Notify Prime Health Choice when they go away or are out of town;
- Make all required payments to Prime Health Choice; and
- Cooperate with any requests for documentation related to maintaining Medicaid eligibility.

CHOOSING AMONG PROVIDERS

The following criteria are considered for Provider Selection:

- Member choice - a member requests a specific Network Provider
- Special needs – language, access
- Provider location
- Provider's past performance
    - Number of complaints from Members
    - Number of complaints from Health Plan personnel
    - Level of Provider quality
    - Level of customer service

MEMBER GRIEVANCES

A grievance is any communication from a Member to PRIME HEALTH CHOICE, LLC that expresses dissatisfaction with the care and treatment received from Network Providers or Health Plan staff. To be considered a grievance, the expression of dissatisfaction must not be associated with a change in scope, amount, and/or duration of services or other *actionable* reasons. Members, or Providers on behalf of a Member, may file a grievance verbally or in writing which shall be treated confidentially. Confidentiality is assured by allowing the complainant the option of remaining anonymous when registering a grievance and using an identification number on documents associated with a Member. Each person who receives a grievance from a Member is to collect details and report it to the PRIME HEALTH CHOICE LLC Quality Improvement (QI) Department by the next business day. Grievances may also be addressed directly to the PRIME HEALTH CHOICE LLC'S QI department by calling 1-855-777-4638 and requesting the QI Department.

The QI Department staff will collect all relevant information, initiate an investigation, and will adhere to the procedural steps of the Health Plan's Grievance and Appeal process. Grievances that are resolved the same day do not require an acknowledgement letter from the Quality Improvement Department; however the grievance will be logged in the Grievance Log which is maintained by the QI Department for trending and reporting purposes. All grievances shall be resolved without disruption to the Member's Plan of Care. In addition, Member shall be free from coercion, discrimination, or reprisal in response to filing a grievance.

In the event of a substantiated grievance against a Network Provider, the QI Department will involve the Network Provider in the development and implementation of a Corrective Action Plan. Providers will be requested to conduct their own investigation, as required by their respective licensing or regulatory body, and report the results of that investigation to the QI staff. The complainant is informed of the outcome of the investigation in writing within required time limits. The QI Department will monitor the effectiveness of the Corrective Action Plan. If the grievance is not resolved to the Member's satisfaction, it may be elevated to the appeals process.

There are two types of grievances – standard and expedited. Standard grievances are acknowledged within 15 business days of receipt or less. A standard determination is made as fast as the Member's condition allows but within 45 calendar days from receipt of all necessary information but no more than 60 calendar days from receipt of the grievance. The determination will be communicated by telephone and in writing within 3 business days of the decision. If in the Member's best interest, the determination may be extended additional 14-days. The member, the Provider on the Member's behalf, or the Health Plan may request the extension. If extended by the Health Plan, a notice will be sent to the Member or the Provider that will explain the reason for the extension and how the decision is in the best interest of the Member.

If the standard grievance procedure would seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, then the Health Plan will expedite the grievance. The Member or Provider on the Member's behalf may request an expedited grievance. If the Health Plan agrees, then the determination will be made within 48 hrs of receipt of all necessary information but no more than 7 calendar days from receipt of the grievance. As in the case with standard grievances, the expedited grievance decision notification will be by telephone and by mail within 3 business days of the determination.

If the expedited grievance decision is made prior to sending the written acknowledgement, the acknowledgement and the expedited grievance determination will be combined. If the Member or Provider on the Member's behalf requests that a grievance be expedited and PRIME HEALTH CHOICE LLC disagrees, then the Health Plan will notify both parties verbally within 2 days and in writing within 15 days that the grievance was not expedited and that it will be handled as a standard grievance.

Grievance data and the analysis of such data are used by the Health Plan to identify opportunities for improvement, both on the Health Plan level and on the Provider level. Senior management reviews the grievance data to identify Provider type, specific Providers, and PRIME HEALTH CHOICE LLC staff identified as responsible parties in the grievance. Grievance outcomes and tracking and trending all go far in determining courses of action associated with substantiated grievances. The QI department reports grievance data to internal management, internal stakeholders such as the Care Management team, and external stakeholders such as the NYS Department of Health.

MEMBER APPEAL OF GRIEVANCES

Members or the Provider on behalf of a Member have the right to appeal an adverse determination by the Health Plan. A grievance appeal is a written communication from a Member, or Provider on behalf of a Member, that concerns disagreement with the Health Plan's decision. If the Member or Provider on behalf of a Member wishes to appeal a decision, the Member or Provider must notify PRIME HEALTH CHOICE, LLC in writing of the request for an Appeal.

The Member has the right to present their case for the grievance appeal both in person and in writing during the appeal process. The Member has the right to examine all records that are a part of the grievance appeal process. The Member has a right to representation during the appeal process as well.

There are two types of appeals. The first is an appeal of a grievance and the second is an appeal of a notice of action (NOA). Both appeal types have standard and expedited categories.

APPEAL OF A GRIEVANCE

The Health Plan must send written acknowledgement of grievance appeal within 15 days of receipt of the request.

- Standard: Must be decided as fast as the Member's condition requires but no more than 30 business days from the date of receipt of necessary information. At PRIME HEALTH CHOICE LLC Plan, appeals may be requested verbally or in writing.
- Expedited: Must be decided as fast as the Member's condition requires but no more than 2 business days from the date of receipt of necessary information. At PRIME HEALTH CHOICE LLC Plan, appeals may be requested verbally or in writing.

NOTICE OF ACTION/DENIALS

ACTIONS BY THE HEALTH PLAN

Actions fall under the following categories:

- Denial of a covered benefit
- Denial of a request for a referral
- Decision that a requested service is not a covered benefit
- Reduction, suspension, or termination of services previously authorized
- Denial of payment for services
- Failure to provide timely services
- Failure to render grievance or appeal determinations within the required timeframes.

An action is subject to appeal (See Appeal of an Action section below).

NOTICE OF ACTION

The **Notice of Action** is a notice that explains the action that PRIME HEALTH CHOICE LLC Plan intends to take; the reasons for the action; the right of the Member or Provider on the Member's behalf to file an Appeal with the Health Plan; how to file an Appeal and the circumstances under which the Member can request an Expedited review of the Appeal. If the Health Plan is reducing, suspending or terminating an authorized service, the notice will also inform the Member of their right to have Aide services continued while the Appeal is decided; how to request Aide services be continued; and the circumstances under which the Member may have to pay for the service if they are continued while the Appeal is being reviewed.

APPEAL OF AN ACTION (NOA)

An appeal is requested for a review of an action taken by the Health Plan such as, reduction or termination of home health aide hours. The Health Plan must send written acknowledgement of the appeal within 15 days of receipt. The appeal must be requested within 45 days of the postmark date of the Notice of Action if there is no request for continued Aide services, or within 10 days of the notice's postmark date.

- Standard: Must be decided as fast as the Member's condition requires but no more than 60 calendar days from the date of receipt of necessary information. Verbal and written notification shall occur within 2 business days of making the decision. Written notification will be sent to the member, member's designee and as appropriate, the provider. Notice shall include the reasons for the decision, and if the appeal is upheld, include the clinical rationale. Notice shall also include additional appeal rights such as NYS Fair Hearing and External Appeal.

- Expedited: Must be decided as fast as the Member's condition requires but no more than 2 business days from the date of receipt of necessary information. At PRIME HEALTH CHOICE LLC, appeals may be requested verbally or in writing and may be filed by enrollee or enrollee's designee. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process.

Circumstances in which an expedited appeal may occur:

- Continued or extended health care services, procedures or treatments;
- Additional services for enrollee undergoing a course of continued treatment;
- When health care provider believes an immediate appeal is warranted.

PROVIDER CREDENTIALING

Please Note: Any provider who has been sanctioned by Medicare or Medicaid and has been prohibited from serving Medicaid beneficiaries or receiving Medicaid payment is excluded from participating in the PRIME HEALTH CHOICE, LLC Network.

PRIME HEALTH CHOICE LLC's Provider Relations Department maintains credentialing files for each Provider and ensures timely re-credentialing. Providers must submit information and documentation required to validate qualifications to provide services to Health Plan Members.

Providers must be able to serve one or more approved counties within the Prime Health Choice approved service area and provide the following:

- A completed and signed Network Provider application
- License verification form
- All regulatory licenses and certifications

Evidence of Insurances:

- General Liability (with PRIME HEALTH CHOICE LLC as certificate holder and additional insured)
- Professional Liability
- Worker's Compensation
- Automobile Insurance (where applicable)

Renewed licenses and insurances must be submitted to PRIME HEALTH CHOICE, LLC within 7 business days of receipt. The Health Plan will inform the Provider of any deficiencies or missing documents. The Network Provider must provide updated documents when requested for re-credentialing failure to provide said documents, i.e., insurance renewals, will result in non-renewal of the Provider Agreement and termination from the Provider Network.

PRIME HEALTH CHOICE, LLC may conduct a site survey of the Provider's premises when services are to be rendered on-site. Site surveys are at the discretion of the Director of Managed Care. PRIME HEALTH CHOICE, LLC considers the results of site surveys in determining whether to contract with or renew an agreement with a Provider.

Upon request, the application procedures and minimum qualifications requirements must be made available to healthcare professionals.

Public Health Law § 4406-d: Credentialing Effective October 1, 2009

This statute amends the application process for credentialing newly licensed health care professions (HCP) or HCPs relocating from another state, who are joining a group practice of in-network providers. A HCP joining a group practice can be considered provisionally credentialed on the ninety first day after submitting a complete application to an MCO if the MCO does not approve or decline the application within 90 days. This status will continue until the MCO either credentials the provider or declines the application. The HCP is considered in network for covered services during this time but cannot act as the primary care provider. As a part of this statute the group practice must agree to refund any payments made by the MCO for in-network services delivered by the provisionally credentialed HCP that exceed any out of network benefit. The group practice must also agree to hold the member harmless from payment for any services denied during this period except for collection of co-payments that would be payable had the member received services from an in-network provider.

QUALITY IMPROVEMENT

Mission and Overview:
To provide a formal approach to the analysis of service quality and a systematic platform that continuously improves clinical; and administrative performance. To ensure that enrollees have equitable access to all covered services to which they are entitled and which are medically necessary and/or essential for them to remain safely in the community.

Quality Management is central to all aspects of clinical and administrative activity in Prime Health Choice. As a corporation established to demonstrate the capacity of an innovative program, Prime Health Choice combines adherence to regulatory, accrediting and contractual standards with exploration of best practices in long term care services, customer care, and administrative services. The program utilizes clinical and service indicators, implement, monitor and improve the organization's commitment to improve quality, maximize safe clinical practices and enhance service delivery to our members. To assure that the program fulfills its mission, it is vital that governance, staff, providers and consumers participate in monitoring and improving policy and practice.

Key Objectives:

- To establish and maintain a Quality management Program that demonstrates a commitment from the Governance of Prime Health Choice to every employee of the organization, and to provide the highest possible quality in clinical care and service delivery to our members.
- To share with its participating providers, clinical and service performance indicators by which care and member satisfaction are measured and hold those accountable in the implementation of actions designed to improve performance.
- To establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes.
- To demonstrate a quality process that ensures compliance with all rules and regulations set forth by local and federal regulatory agencies that affect all aspects of the organization's business, service and clinical operations.
- To implement and monitor education materials and programs designed to empower members to practice and maintain good health.

Responsibility and Accountability:
President of Prime Health Choice-Implements the Quality Management Program and Work Plan in conjunction with the Director of Quality, and directs the activities of all staff and contracted professionals engaged in quality management and quality improvement planning, intervention and reporting. The President reports to Governance.

Medical Director-Provides medical/clinical support and guidance in all Quality Assurance activities as a part of corporate wide oversight for medical activities within Prime Health Choice; Chair of the Quality Improvement Committee.

Director of Quality-Directs and oversees the Quality Improvement Program in collaboration with the Governance, the Medical Director, and senior management staff; ensures that the Quality Improvement Program recognizes opportunities for improvement, is data driven, and relies heavily on Governance, member and staff input; ensures the Quality Improvement Program is in compliance with regulatory agencies requirements including report submission; oversee the Appeals and Grievance processes and serves as Appeals and Grievance Coordinator; coordinates internal processes for developing and maintaining clinical policies and procedures.

Responsibility and Accountability:

- Developing and approving the Quality Improvement Plan
- Establishing measurable objectives based upon priorities identified through the use of establishes criteria for improving the quality of services
- Compiling data and preparing reports for presentation and utilization
- Meeting quarterly and as necessary to discuss the monitoring of the quality metrics and trends including analysis of quality care measures and reporting the same to the Governance
- Developing indicators of quality on a priority basis
- Discussing external quality reviews as necessary
- Periodically assessing information based on key indicators, taking action, as evidenced through quality improvement initiatives, to solve problems and pursue opportunities to improve quality
- Addressing Quality Management and monitoring to help ensure members are receiving high quality care

UTILIZATION REVIEW

The purpose of Utilization Review is to ensure that health care provided to Prime Health Choice members are coordinated, appropriate, effective and efficient and meets federal and state regulations and the benefit guidelines for the enrollee. The utilization review program is consistent with all applicable Sections of Public Law Section 4901.

All staff involved in utilization control and review activities are trained in the principles and procedures of intake screening and data collection and are monitored by the Quality Assurance Coordinator and Medical Director.

Program activities are designed to review utilization with a particular focus on detecting under and over utilization of services through a variety of control and oversight mechanisms. These mechanisms include, but may not be limited to, establishing a referral process that ensures appropriateness while preserving access; pre-authorizing services; conducting reviews; promoting and evaluating the appropriate use of services; and for providing for continuity of care through discharge planning, case management and disease management activities.

Prime Health Choice will communicate the member's progress with the member's primary care physician. Review of requests for authorization and services will be performed as often as needed. Each provider in the Prime Health Choice network will be expected to participate in the process. Each provider will update the Care Manager regarding the accomplishment of goals or any problems with interventions and/or desired goals. The Care Manager will coordinate with network provider agencies and report issues, concerns and changes. Providers in the network are expected to make problems known to the Care Manager, including any identified lack of follow-up or ineffectiveness of the plan of care.

Retrospectively, claims are matched to service authorizations to identify ordered services are occurring as required and authorized. Monthly utilization reviews by supervisors and medical records staff alerts the Care Manager to any inconsistencies in actual care provided compared to the individual plan of care. Trends may be identified during the Quality Assurance process and system issues will be identified and plans created to correct the same.

MEDICAL RECORD GUIDELINES

Each Network Provider must:

- Keep a separate medical record for each enrollee
- Ensure that the medical record verifies that the Nurse Care Manager coordinates care
- Assure access to medical records by Health Plan, NYSDOH and CMS
- Retain medical records for 6 years following the member's date of service.

PROVIDER AUDITS

PRIME HEALTH CHOICE LLC will perform periodic reviews of provider records documenting evidence of service delivery to determine accuracy, patterns of error, and to guard against malfeasance.

Documents collected may include but are not limited to:

- Medical record notes
- Attendance sheets
- Activity records
- Time slips
- Sign in logs
- DME delivery tickets
- Trip verifications
- Progress notes
- Care plans

Audits will be based on a sampling of claims for a specific period. Provider selection will be based on utilization.

Methodology

- With 30 days notice, Providers will make available requested documents based on invoice number, Member names, and dates of service
- Providers will make available service documents for review by Health Plan staff
- The Health Plan will develop a report of findings, including errors if found
- Providers showing a trend of errors in excess of 5% will be notified and a Corrective Action Plan will be requested. Providers under an Action Plan will be reviewed more frequently
- Failure to take corrective action will result in termination from the Health Plan's Network with notification to the NYS Department of Health, Medicaid, and CMS
- Cases of suspected fraud, abuse, and malfeasance will be referred to the Medicaid Fraud Bureau and/or the Office of the Medicaid Inspector General for investigation.

PROVIDER TERMINATION

A Network Provider may be terminated for a variety of reasons with written notice. Reasons for Provider Network termination include but are not limited to:

1. Inability to consistently provide appointments for Members within reasonable timeframes.
2. Consistent delays in providing services to Members.
3. No longer able to service the contracted county.
4. Failure to respond in an appropriate manner or timeframe to Member or Health Plan complaints regarding services.
5. Loss of license or certification.
6. Failure to provide proper insurance documents.
7. False application.
8. Disqualification from Medicaid and/or Medicare.
9. Failure to provide a Corrective Action Plan.
10. Consistent billing errors in excess of 5%.

A written explanation of the reason for termination with an opportunity for a review or hearing will be offered to the Provider. The hearing at the Providers discretion will be before a panel appointed by PRIME HEALTH CHOICE, LLC and will be conducted not less than thirty (30) days from receipt of the request. The hearing panel will consist of 3 persons appointed by PRIME HEALTH CHOICE, LLC Plan. At least one person shall be a clinical peer in the same discipline and the same or similar specialty as the person or entity under review. The panel may consist of more than 3 persons, provided that the number of clinical peers on the panel equals 1/3 or more of the total panel membership.

The hearing panel shall render a decision in a timely manner. Decisions shall include reinstatement, provisional reinstatement with conditions set forth by PRIME HEALTH CHOICE, LLC Plan or termination. Decisions shall be provided to the Provider in writing. A Provider may not be terminated or be refused renewal of a contract solely for the following reasons:

1. Acting as an advocate on behalf of a Member.
2. Filing a grievance against PRIME HEALTH CHOICE, LLC.
3. Appealing a decision of PRIME HEALTH CHOICE, LLC.
4. Providing information or filing a report to PHL Section 4406-c regarding prohibitions of PRIME HEALTH CHOICE, LLC.
5. Requesting a hearing or review.

Decisions of termination shall be effective not less than 30 days following receipt of the hearing panel's decision by the healthcare professional; provided that Section 4403(6) (e) of the New York Public Health Law, concerning Members rights to continue an ongoing course of care shall apply to such termination. The MLTCP is legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrences appearing below. In no event shall a determination be effective earlier than 60 days from receipt of the notice of termination. A Provider who is terminated due to the following is not eligible for a hearing or review:

- Termination of health care Provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of Member safety or welfare.
- The voluntary/involuntary termination of contract/employment or other affiliation with such organization to avoid the imposition of disciplinary actions.
- The termination of a health care Provider contract in the case of a determination of fraud or in a case of imminent harm to a Member's health.

PRIME HEALTH CHOICE, LLC is legally obligated to report to the appropriate professional disciplinary agency within 60 days of obtaining knowledge of any information that reasonably appears to show that a health care professional is guilty of professional misconduct as defined in Education Law (4405-b (1)(b)).

PRIME HEALTH CHOICE, LLC is legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrence of the following:

- Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare.
- The voluntary/involuntary termination of contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures.
- The termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

Non-Renewal of Contract: Either party may exercise a right of non-renewal at the expiration of the contract period, or for a contract with a specific expiration date on each January first occurring after the contract has been in effect at least one year. In either case, 60 days notice is required. Non-renewal of a contract does not constitute termination.

MLTC/PCS BILLING TIPS

Once Prime Health Choice is set up in your billing system to receive electronic claims, you will need an ID number for your client. This information is provided on every Authorization that Prime Health Choice sends to you. If you would like to upload ID numbers in your system in advance, please request a text file or print out and it will be provided.

The workflow:

Once you receive an Authorization for the services, you will be required to provide the Authorization Number as part of the electronic claim. This number should be entered in the "Prior Authorization" field of your billing system.

For your reference, below are the proper 837 fields and loops to populate:

- **Payer: Loop ID-2010BB**
  Mediture's Payer ID: 20039
- **Group Number: Loop ID-2000B-SBR03**
  Prime Health Choice LLC Group/Policy Number: PRIME
- **Participant Number: Loop ID-2000B-NM109**
- **Prior Authorization Number: Loop ID-2300-REF02**

If you have any questions please call Claims Department at 718-513-7375

Partial list of clearinghouses with Mediture LLC pre-established as a Payer:

- Capario
- Emdeon
- Netwerkes

If you use RelayHealth as a clearinghouse then we are unable to receive electronic claims from you at this time. Emdeon and RelayHealth do not have a forwarding agreement.

****NOTE: We use a third-party, Mediture LLC, to update our system with incoming claims. Therefore, in order to send electronic claims to Prime Health Choice, you must establish Mediture LLC as a Payer with your clearinghouse. Mediture uses Emdeon as its clearinghouse and its Payer ID is 20039.**

Additional Billing Tips……

- Prior approval is required for all services.
- Electronic billing is preferred. Turnaround time for processing and issuance of payment is generally faster when claims are submitted via EDI (Electronic Data Interchange).
- CMS - 1500 is the correct type of claim form.
- It is very important to complete the CMS-1500 accurately and completely in order to ensure timely processing of your claims.
- Submit paper claims on red "drop out" forms and forms should be typed, not handwritten.
- Complete only required fields. Entry in fields that are not required may result in your claim being denied.
- Be sure that the billed services match those that were previously approved or authorized. If the billed service was not previously approved or authorized, the claim will be denied.
- Services performed on the same date of service and/or same hour should be billed on the same CMS-1500 claim form.
- Be sure to bill the units as appropriate for each type of service
- Review your Agreement to verify the types of services you have contracted and the amount you should expect to be reimbursed per the contractual agreement.
- Long Term Support Services (LTSS) providers are required by New York State Department of Health to verify member eligibility and managed care enrollment status of all patients twice per month. LTSS services include private duty nursing, home health care, personal care services, consumer directed personal assistant service (CDPAS), adult health care (ADHC) and nursing home stays.

MANAGED LONG-TERM HEALTH CARE PLAN

PRIME HEALTH CHOICE, LLC

3125 EMMONS AVENUE
BROOKLYN, NY 11235

TEL.: 855-777-4630

OR TTY/TDD
TEL.: 855-777-4613

WWW.PRIMEHEALTHCHOICE.COM