

2016



Elderplan Provider Manual

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INTRODUCTION

Welcome to Elderplan's growing network of providers in the five boroughs of New York City, Nassau, Suffolk, Westchester, and Monroe counties. Elderplan currently services members in their Medicare Advantage, Medicaid Advantage Plus, Medicaid Advantage, Special Needs, and Chronic Special Needs Plans. You have joined a growing network of over 52,000 provider locations committed to caring for the healthy and frail elderly population Elderplan has been serving since 1985.

As part of our ongoing commitment to individuals covered by Medicare, Elderplan has been awarded a Special Needs Plan designation as of January 2006. In 2010 Elderplan added Medicaid Advantage Plus and Medicaid Advantage to our plan offerings. In 2015, Elderplan proudly introduced 3 new plans: Elderplan FIDA Total Care (Medicare-Medicaid Plan), Elderplan Diabetes Care, and Elderplan Healthy Balance.

The Medicare improvement for Patients and Providers Act (MIPPA) of 2008 requires all Special Need Plans (SNP) to have a structure by which they deliver healthcare services and benefits to Special needs individuals. Elderplan has created Model of Care training materials that outline coordination of care delivered by our network of providers who have clinical expertise to meet the targeted population's specialized needs. Coordination of care is an integral component of the partnership between providers and Elderplan toward improving our members' health and wellness. Elderplan's

Model of Care training is made available to all of our providers for an overview of Elderplan's Model of Care please visit our website at www.Elderplan.org

All of our participating Medicare Providers are required to review the Model of care training slides and complete the attestation form to confirm your yearly compliance with CMS-SNP guidelines.

For FIDA Model of care Training, Please access the FIDA training material online at: https://www.resourcesforintegratedcare.com/FIDA_Downloadable_Provider_Training

The organization's trainer(s) will need to submit documentation (participant list) attesting to those individuals who completed the training.

1. Access the PDF versions of the FIDA training modules;
2. The organizations leadership conducts and completes the training
3. Email: HYPERLINK
 - Noting FIDA Provider Training in the subject line
 - Submitting the participant listing in excel format

Please note that by submitting an email with the participant list of who took the training, you and/or your organization are attesting that the training was completed. It's also recommended that you maintain documentation of the training for future review if requested by the contracted Elderplan, NY State, or CMS.

For Individual Provider Training

Access the FIDA Training Portal online at: <https://fida.resourcesforintegratedcare.com>

- Log in to the FIDA Training Portal,
- Click the "Training Modules" Link and select the courses you need to complete.
- After completing the modules you'll be tested on your knowledge to receive credits for the training. You must pass with a score of 80% or higher.

For our DSNP, ISNP, and FIDA please click [here](#).

Our Provider Manual is designed to assist you and your office staff in member care management and Elderplan operations. This manual is an extension of your Elderplan provider contract and adds to the understanding of member benefits as outlined in the member's certificate of coverage (Evidence of Coverage).

We encourage you to keep this provider manual in a convenient and accessible location. Since changes in Medicare and Medicaid policies and Elderplan operations are inevitable over time, changes to policies herein are subject to updates and modifications. Elderplan will provide ongoing updates through provider mailings, provider newsletter, and/or the Elderplan web site.

If you and your staff have any questions about the information, policies, and procedures outlined in this Provider Manual, please feel free to contact the Elderplan Customer Service Department at (718) 921-7979, or EPPProviderServices@mjhs.org.

Thank you for joining our dedicated team of providers committed to bringing optimal health to our members.

YOUR MOST IMPORTANT RESOURCE

Medicare Advantage Membership Card

You and your staff should familiarize yourself with Elderplan's member ID cards. The member ID card provides you with information on co-pay requirements, care management authorization requirements, drug benefit information, product identification, and other high level information to help you collect any advance payments from the member and ensure you pre-authorize services.

Important information:

Member Name: identifies the name of the member covered by the plan

Member Number: number assigned by Elderplan unique to the member named on the card.

Effective Date of Coverage: the date the member's coverage under Elderplan became effective. Ongoing eligibility must be verified at point of service.

PCP Name: the name of the primary care provider the member has selected at time of enrollment or following a PCP change. A primary care physician is selected from a list of participating physicians in Internal Medicine, Family or General Practice, and Pediatrics. The PCP renders general medical care to the member and coordinates specialty care as needed.

PCP Telephone Number: the member's selected PCP's office telephone as reflected in Elderplan's provider files.

Prescription Drug Co-payments: the fixed dollar amount assigned to a specific drug tier (generic, brand, all non-formulary brand) the member must pay the pharmacy at retail or the mail-order pharmacy at point of sale.

Specialist Co-payments: the fixed dollar amount, which the specialist provider may collect from the member when covered services are rendered.

Elderplan Pre-authorization telephone number: the telephone number the participating provider's office must contact in order to receive Elderplan approval for the procedure and/or admission as outlined in the member's Evidence of Coverage and/or provider manual and provider updates. All non-participating provider visits and services must receive prior- authorization. Emergency care does not require prior-authorization. Emergency admissions require notification within 24 hours of admission.



VERIFYING ELIGIBILITY

Verifying eligibility and product participation is extremely important in the care and payment process. Eligibility and product participation determines ones coverage status with Elderplan. Failure to establish these elements may result in non-reimbursement for services rendered.

All Primary Care and Specialty Care Physicians must verify a member's eligibility and product participation at the time of service. To verify membership eligibility, call Elderplan Customer Service at (718) 921-7979 or use the Elderplan web portal. To sign up for the Provider Portal, simply go to: <http://elderplan.org/for-providers/> and choose the option "CLICK HERE to register for the Physician Web Portal today." To verify product participation, please refer to the lower left hand corner of the member ID card or call Elderplan Customer Service at (718) 921-7979.

It is the provider's responsibility to request the member's membership card at the time of service. Elderplan does not retrieve membership cards from members when they disenroll or lose coverage; therefore presentation of a membership card is NOT a guarantee of eligibility.

Though capitated Primary Care Physicians can consult their membership roster of the present month to ensure the member appears on their list, verification of eligibility through Elderplan Customer Service or web is always recommended. If the member is on the capitation list, the provider has received the monthly capitation payment for that member and can thus provide services during that month.

PROVIDER NETWORK OPERATIONS AND SERVICES

Important Definitions

Network Operations and Planning: the department designation given to the group of Elderplan staff dedicated to complete provider recruitment and contracting, field service, and managing provider files.

Provider Services Representative: field individuals employed by Elderplan to service providers.

Provider Contract: a legal agreement between Elderplan and participating professionals, facilities, hospitals, agencies that binds the participants to provide covered services to Elderplan members at a mutually agreed upon rate.

Network: the collective group of physicians, facilities, hospitals, agencies, and ancillary providers contracted with Elderplan.

Participating Provider: a licensed healthcare professional, facility, hospital, or agency who or which has entered into a contractual agreement either directly or indirectly with Elderplan to provide services to Elderplan members. Some non-participating provider services may be provided to members in cases of Elderplan prior-authorization.

Non-Participating Provider: a licensed healthcare professional, facility, hospital, or agency who or which has NOT entered into a contractual agreement either directly or indirectly with Elderplan to provide services to Elderplan members.

Primary Care Physician (PCP): a primary care physician is a participating provider contracted with Elderplan the member selects from a list of participating physicians in Internal Medicine, Family or General Practice, and Pediatrics. The PCP renders general medical care to the member and coordinates specialty care as needed.

Specialty Care Provider (SCP): a physician specialist who is board eligible or board certified in the specialty he/she has declared on the Elderplan participation application.

Service Area: the counties of New York under which Elderplan has received NYS approval to enroll members, recruit a provider network, and provide coverage.

Provider Service

Elderplan Web Site

Providers and their office staff are encouraged to visit our web site at www.elderplan.org. On this site, providers can find participating providers and ancillary providers, using the Provider directory. The website also includes new policies and procedures enacted by Elderplan, as well as other provider reference materials.

We have also introduced the provider web portal. For Elderplan's participating providers, some of the most common inquiries—including member eligibility, claims details, and authorization status—now can be done with the click of a mouse 24 hours a day, 7 days a week. While the Web portal uses sophisticated technology, it is easy to use.

Elderplan has paid close attention to feedback from providers. In addition to eligibility and claims details, the portal offers important resources such as:

- Formulary
- Participating providers
- Steps for filing an appeal
- Summary of benefits for each member plan

To learn more about the Web portal, contact Elderplan Customer service at (718) 921-7979. To sign up for the Provider Portal, simply go to: <http://elderplan.org/for-providers/> and choose the option “CLICK HERE to register for the Physician Web Portal today.”

Please input your information and finalize the request by pressing the “Confirm and Submit” button. Elderplan will approve your request as promptly as possible by validating your information. You will need to keep your login information on hand in order to access the valuable data housed in the portal 24 hours a day, 7 days a week.

Customer Service

If you have question about a claim, pre-authorization, or other questions, please call (718) 921-7979.

Avoid busy call volume times by using Elderplan's web site – www.elderplan.org

Field Representatives

Elderplan assigns Field Representatives by region. Each new participating provider will be visited by an Elderplan Provider Services Representative for an orientation on our plan, products, and procedures. Your Provider Services Representative will then visit your office periodically in order to ensure the service Elderplan is providing you is efficient and the services you provide to Elderplan members conforms with the contractual agreement and policies and procedures outlined herein.

You should become familiar with your Field Representative as they can provide assistance in making your Elderplan network participation a very positive experience.

ROLES AND RESPONSIBILITIES

PCP and Specialist Roles and Responsibilities

All Elderplan participating professionals, hospitals, facilities, agencies, and ancillary providers agree to:

Contractual Requirements: provider must comply with all contractual, administrative, medical management, quality management, appeals & grievances, and reimbursement policies as outlined in the Elderplan provider contract, Provider Manual, and circulated updates. Failure to adhere or comply with all contractual/regulatory requirements may result in termination of your contract.

The provider is expected to coordinate referrals for Elderplan members who require care outside the scope of the provider's practice to appropriate in-network specialists, participating ancillary providers, or facilities for medical care or services. A full list of participating providers can be found on the Elderplan Web site at www.elderplan.org/find-a-provider/. Note: An Elderplan PCP who has training in a sub-specialty may be credentialed in that specialty and also participate as a specialist in Elderplans network. Such providers are called “Dual Providers”. Out-of-network referrals require prior authorization.

A referral should be made only when, in your professional opinion, you believe it is medically appropriate and necessary. If you have never seen the patient before, you have the right to ask the patient to come in for an examination and diagnosis before issuing a referral. If you do not examine the patient on the day you issue a referral, you may not charge for any evaluation and management service at that time. For complete details log on to Elderplan.org

At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat Elderplan members.

Non-Discrimination, ADA Compliance and Accessibility:

- Provider must not differentiate or discriminate in accepting and treating patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- Elderplan and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds. Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Further, Section 504 of the Rehabilitation Act of 1973 requires providers (e.g., facilities, clinics, individual providers) who receive payments, directly or indirectly, from Medicaid or Medicare ensure individuals with disabilities have an equal opportunity to receive services by way of accessible health care services. Under the ADA, Title III, public entities, such as private doctors' offices, hospitals and clinics are required to make reasonable accommodations for individuals with disabilities irrespective of the receipt of federal funds.
- Accessibility of doctors' offices, clinics and other health care providers is essential in providing medical care to people with disabilities. Medical care providers are required to make their services available in an accessible manner. This standard includes physical access, non-discrimination in policies and procedures and communication. Accessibility needs should be noted in the member's chart so the provider is prepared to accommodate the member on future visits.
- Physical accessibility is not limited to entry to a provider site (including accessibility along public transportation routes and/or availability of parking with adequate number of accessible parking spaces and path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs), but also means access to services within a site, such as:
 - accessible exam tables,**
 - accessible stretcher or gurney, or a patient lift,**
 - trained staff available to assist the member with transfers,**
 - accessible medical equipment.**

Provider site physical accessibility is verified during Elderplan credentialing process. When a member is unable to sufficiently access a provider location, alternative treatment locations will be made available. For more information on important accessibility requirements click [here](#).

- **Communications Access:** Communications with individuals with disabilities are required to be as effective as communication with others, including members with hearing, vision, or speech impairment. Providers are encouraged to utilize the TTY (teletypewriter lines) at 711. Member materials are made available in an alternate format such as Braille, larger print, or audio. Elderplan Member Service should be contacted at (718) 921-7979 for additional information.

Cultural Competency

Elderplan takes pride in serving an incredibly culturally diverse member population. Rooted in the long tradition of caring for New York elderly and disabled of various ethnic and cultural backgrounds, Elderplan strives to meet the individual needs of the population it serves through recognizing the diversity and providing appropriate support to the members with unique linguistic and communication needs as well as to the provider community treating this population.

The required Elderplan Cultural Competency training helps medical, behavioral, community-based and facility-based LTSS providers to appreciate the cultural diversity and make appropriate accommodations when providing services to the culturally diverse population.

Elderplan emphasizes the importance of utilizing additional resources when caring for a diverse population, which includes but is not limited to the following:

- Tele-Interpreters (24-Hour Telephone Language Services that helps bridge communication barriers resulting from languages and cultural differences)
- TTY (teletypewriter lines) can be accessed at 711.
- Recruiting and training bilingual/multilingual staff interacting with the member population and serving as a support to the provider community as necessary.
- Making Member materials available in an alternate format such as Braille, larger print, or audio. Elderplan Member Service should be contacted at (718) 921-7979 for additional information.
- Bridging the Providers and the Members to the appropriate community-based organizations optimizing the access to the resources available for the diverse population.

Elderplan Provider Cultural Competency training helps the providers to identify the cultural and/or linguistic barriers in member population and offers a relevant tutorial designed to build on to the providers' cultural sensitivity as well as decrease potential health care disparities experienced by the diverse population. The required training tutorial Cultural competency can be accessed through:

- Elderplan Provider Web Portal (to register for the Provider Web Portal please [Click Here](#))
- One-on-one in-service training sessions facilitated by Provider Services Representative onsite.

Elderplan Provider Services Department will maintain a record of provider participation in the Cultural Competency training. The provider is required to attest to taking the Cultural Competency Course and offering it to the practice/facility staff by filling out an Attestation form available via the provider portal. Provider may either utilize Cultural Competency tutorial available on Elderplan web portal or attest to taking the equivalent course as training requirements may be met by demonstrating completion of Cultural Competency certificate program or another New York State FIDA Plans equivalent Cultural Competency training program. Examples of proof of training completion may include copies of course certifications, pre/post test, and knowledge check results and are subject to random audits by Elderplan Provider Services team.

Collection of Co-payments

Specialist offices should collect member co-payments at the time of service. The co-payment, in conjunction with an office visit, represents your reimbursement in full for services rendered. Member co-payment information is outlined on the member's membership card. Failure to collect co-pay from the member does not make Elderplan responsible for the co-payment. Providers may only bill members for co-pays that were not collected at time of service.

Ethical and Evidence-Based Medical Practice:

Provider agrees to provide services within the scope of the provider's license and/or specialty. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.

Provider agrees to relate to Elderplan any reports or sanctions against them for failure to provide quality care, negligence determinations, or licensing terminations imposed upon them.

Evidence-based practice (EBP) is an approach to the delivery of health care whereby health professionals and health care services providers use the best evidence available to identify and select proven and effective medical and therapeutic interventions, educational models, and pharmaceutical therapies, and to make clinical decisions for individual Members that has been demonstrated through research, evaluation, and successful clinical trials to be most successful in addressing a specific Member's health needs and conditions.

EBP values, enhances, and builds on clinical expertise, knowledge of disease mechanisms, research and evaluation of clinical and therapeutic practices and educational models, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on Member characteristics, situations, and preferences. It recognizes that health care is individualized, person-centered, and dynamic as the health industry finds innovative and proven methodologies for effective interventions to diagnose and treat Member conditions that support the achievement of lasting improvements and enhanced Member health outcomes.

Elderplan supports the implementation of EBP and requires Providers to identify and utilize these proven and effective models and interventions in the services they provide to Elderplan Members.

Credentialing and Recredentialing

Provider Termination and Disciplinary Action

Discipline of Providers

The Credentialing Subcommittee has responsibility for recommending suspension or termination of a participating provider for substandard performance or failure to comply with the requirements outlined in the ELDERPLAN Provider Agreement.

In the event that the Credentialing Subcommittee recommends suspension or termination of a participating provider, written notification is sent to the provider. The provider may then request a hearing in accordance with applicable law and regulations.

Appeal of Disciplinary Action

The provider may appeal any formal disciplinary action, except that providers participating only in ELDERPLAN Managed Long Term Care Plans may not appeal a formal disciplinary action taken based on Immediate Action Events. Requests for appeal must be submitted in writing and sent by certified mail, return receipt requested to the Credentialing Subcommittee within 30 days after the provider receives notice from the Subcommittee of its proposed action.

- Elderplan credentials providers upon acceptance of application and signed participation contract.
- Elderplan recredentials all participating providers on a three (3) year cycle from date of initial credentialing.
- Provider must notify Elderplan within two business days if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification in two business days is also required when any reportable action is taken by a City, State, or Federal agency.
- Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur as a result of item above, the provider must notify Elderplan immediately.
- Directly contracted groups must contact the Provider Services Department, IPA's must contact the Business Development as soon as a new associate joins the group or IPA. Elderplan will provide you the necessary materials to begin the credentialing process for the new providers in the group or IPA. You may also request application materials through the Elderplan IVR.
- Any change, addition or deletion of office hours, associate or billing address should be sent in writing within 60 days to ensure accuracy of Elderplan directories and databases.

Billing Requirements

- a. Provider may NOT balance bill members for authorized and/or covered services.
- b. Provider may bill member for co-pays not collected at time of service.
- c. Provider agrees that co-pays and Elderplan reimbursement for services constitute payment in full.
- d. Provider agrees to follow CMS and Elderplan billing guidelines.
- e. A provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member and that Elderplan does not cover the service.
- f. FIDA plan members shall not be balanced billed for any covered services, any coinsurance, deductible, financial penalties, or any other amount in full or in part

Medical Records and On-site Auditing

Elderplan participating physicians' offices must maintain medical records in accordance with good professional medical documentation standards. The provider and office staff must provide Elderplan staff with member medical records upon request. Elderplan staff must also have access to member medical records for on-site chart reviews. The physician's office responsibilities are as follows:

- Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
- Maintaining medical records in a safe and secure manner that ensures member confidentiality and medical record confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
- Making the medical record available when requested by the Plan and regulatory agencies. Providers are required to allow medical information to be accessed by Elderplan, the New York State Department of Health, and the Centers for Medicare and Medicaid Services.
- Keeping medical records for ten years after the death or disenrollment of a member from Elderplan. The record shall be kept in a place and form that is acceptable to the Department of Health and in accordance with New York State Article 44.

- New York Education Law 6530(32) requires that all New York practicing physicians and other healthcare professionals maintain detailed records for each patient. Maintaining proper medical records is a professional responsibility of a New York doctor or another practitioner.

Medical Record Documentation Criteria:

The medical record must be written in ink or computer generated and contain at minimum:

- a. Each page of the medical record contains identifying information for the member.
- b. All entries must contain author identification and professional title.
- c. All entries must be dated.
- d. All entries must be in ink or computer generated.
- e. Identification of all providers participating in care and information on services furnished are found in the record.
- f. An up-to-date problem list, including significant illnesses and medical/psychological conditions, is present in the record.
- g. Each note describes presenting complaints, diagnoses, and treatment plan.
- h. A medication list containing prescribed medications, including dosages and dates of initial or refill prescriptions, are present in the record.
- i. Information on allergies and adverse reactions (or notation that patient has no known allergies or adverse reactions) is contained in the record.
- j. The record contains documentation of past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to a particular treatment.
- k. Information on Advance Directives (or notation of discussion whereby member does not have or wish to have an Advance Directive)

The record is legible to other than the writer.

Confidentiality: provider and staff must maintain complete confidentiality of all medical records and patient visits/admissions. Medical record release, other than to the plan or noted government agencies, may only occur with the patient's written consent or if required by law.

Conflict of Interest

No practitioner in Medical Management may review any case in which he or she is professionally involved.

Elderplan does not reward practitioners or other individual professional consultants performing utilization review for issuing denials of coverage or service.

Reporting Elder Abuse: if a provider suspects Elder Abuse, the provider should immediately initiate the proper notifications to any agency or authority that are required by the law in effect at the time. In addition, for Elderplan Special Needs Plans, please advise the Care Management Team of your concern and action by calling (718) 921-7979.

Transition of Care: provider agrees to provide transition of care to new members and members transitioning from a provider leaving the Elderplan network according to the guidelines below:

New Member: when a new member is currently undergoing a course of treatment for a life-threatening or debilitating condition, with a non-participating provider upon or prior to enrollment with Elderplan, the member will have the option of continuing care for up to 60 days of their enrollment date to allow for consultations, medical record transfer, and stabilization of their medical condition. After the 60-day period, the transition must be complete and care must be received from participating providers. The Medical Management Department will assist with and coordinate the transition of care plan.

Participating Provider Leaves the Plan: when a provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, Elderplan will authorize the member to continue an ongoing course of treatment for a life-threatening or debilitating condition, for a period of up to 90 days. The request for continuation of care will be authorized provided that the request is agreed to or made by the member, and the provider agrees to accept Elderplan's reimbursement rates as payment

in full. The provider must also agree to adhere to Elderplan's quality assurance requirements, abide by Elderplan's policies and procedures, and supply Elderplan with all necessary medical information and encounter data related to the member's care. The Medical Management Department will assist with and coordinate the transition of care plan.

Specialist Communication with PCP: specialists must work closely with a member's PCP to foster continuity of care and promptly provide consultation and progress reports to the PCP.

Medicaid Advantage and Medicaid Advantage Plus Participating Providers Additional Contract Terms are noted below:

SUMMARY OF HCA (For Medicaid Providers)

Provider Agreement Requirements

This summary of Medicaid managed care provider agreement requirements is intended as an aid to Contractors, to ensure that these agreements are consistent with the requirements imposed upon the Contractor under the New York City Medicaid Managed Care Model Contract ("Model Contract"). Provider agreements must be reviewed and approved by CDOH, acting through the Division of Health Care Access, and SDOH. For your convenience, section references to the Model Contract will be cited, as appropriate.

Please be advised that although this summary can give the Contractor guidance, it is ultimately the Contractor's obligation to assure that its subcontracts are in compliance with its obligations under the Model Contract. The Model Contract states as follows:

The Contractor shall impose obligations and duties on its subcontractors, including its Participating Providers, that are consistent with this Agreement, and that do not impair any rights accorded to CDOH, SDOH or DHHS. (§ 22.5(a))

No subcontract, including any Provider Agreement shall limit or terminate the Contractor's duties and obligations under this Agreement. (§ 22.5(b))

A. Alternative Methods of Achieving Provider Agreement Compliance

There are several acceptable methods of imposing the necessary Medicaid managed care requirements upon participating providers:

1. Insert a paragraph or execute an addendum to provider agreements, which incorporate

The CDOH contract by reference, such as the following statement:

“Participating provider (or providing physician or providing hospital as appropriate) agrees to be bound by the provisions contained in the Agreement between the City of New York, acting through the Division of Health Care Access and (Name of Plan), attached hereto and incorporated herein as Appendix A. In the event that the provisions of this agreement are inconsistent with the provisions in the CDOH Agreement, the provisions of the CDOH Agreement shall govern.”

2. Include specific provisions in provider agreements which will impose all relevant obligations and duties on the participating providers, specifically including the terms and conditions described in this summary. If a common provider agreement is utilized for both commercial and the Medicaid managed care program, the agreement may state that it is applicable only for services provided to Medicaid enrollees.

3. Execute an amendment or addendum to existing provider agreements which incorporate any items described in this Summary, which are not already contained in the provider agreements.

B. Contract Formalities

All provider agreements must be dated and signed by both parties.

If the Contractor executes contracts prior to approval by SDOH and HCA, the Contract must state that it requires the approval of SDOH and HCA to become effective.

If the Contractor’s provider agreements provide for amendment by the Contractor upon notice to the participating provider, the Contractor may utilize this method in achieving the terms and conditions described in this summary, and submit to HCA verification of the date of the transmission to its providers.

Public Health Law § 4406-c was amended to add a new subdivision 5-c with the previous subdivision 5-c being re-lettered to subdivision 5-d. Health care professionals are to receive written notice from the MCO at least 90 days prior to an adverse reimbursement change to the provider’s contract. If the health care professional objects to the change that is the subject of the notice by the MCO, the health care professional may, within thirty days of the date of the notice, give written notice to the MCO 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.” A health care professional under this section is one who is licensed, registered, or certified under Title 8 of the New York State Education Law.

C. Required General Provisions

1. Required Statements.

Each provider agreement must contain the following statements:

- “The obligations and duties performed by participating providers shall be consistent with the Agreement between the Contractor and CDOH.” (§ 22.5(a))
- “Nothing contained in this Agreement shall impair the rights of CDOH, SDOH, or DHHS.” (§ 22.5(a))
- “Nothing contained in this Agreement shall limit or terminate the Contractor’s duties and obligations under the Agreement.” (§ 22.5(b))
- “Nothing contained in this Agreement shall create any contractual relationship between the subcontractor and New York City or CDOH.” (§ 22.5(c))

2. Required General Terms

Each provider agreement shall contain the following provisions:

In the event the Contractor becomes insolvent or fails to pay the provider, the provider will not seek payment from New York City, the enrollees or their eligible dependents. (§ 22.5(e))

The provider must agree that payment received from the Contractor for services included in the benefit package is payment in full for services provided to Enrollees.

- The language of § 33 of the Model Contract regarding the prohibition on the use of Federal funds for lobbying must be included in every provider agreement. (§ 33)
- The provider shall agree that the Contractor's Enrollees are not subject to Medicaid Utilization thresholds (MUTS), limitations on, or co-payments for services included in the Benefit package. Enrollees may be subject to MUTS for outpatient pharmacy services which are billed Medicaid fee-for-services. (§ 10.15) The Contractor shall ensure that all Provider Agreements entered into with Providers require acceptance of a woman's enrollment in the MCO as sufficient to provide services to her newborn, unless the newborn is excluded from participating in Medicaid Managed Care. (§ 22.5(g))

3. Dispute Resolution

All provider agreements shall contain a mechanism for the prompt resolution of disputes between the Contractor and its providers. (§ 22.5(f))

4. Service Delivery Requirements

Where applicable, provider agreements should incorporate, either directly or by reference (for example, by reference to a provider manual which includes these requirements), Model Contract requirements related to the following:

- general duties of a PCP (§ 10.4 and § 21.9) [PCP agreements only] informed consent for hysterectomy and sterilization (§ 10.11) C/THP services and EPSTD Requirements (§ 10.5)

- free access for family planning and reproductive services (§ 10.11) HIV counseling and testing (§ 10.11) 24-hour access (§ 15.2) {note: this provision is not required if the MCO has elected to provide this service directly rather than through its PCP's} appointment availability guidelines (§15.1) welfare reform documentation (§ 10.8)

5. Requirements for Primary Care Providers.

Each primary care provider must agree to practice at least 16 hours at each of his/her "primary care" sites and should agree to notify the Contractor if there is any change in his/her office hours or location, so that the Contractor may accurately submit its quarterly HPN submission. The timeframe for notifying the Contractor should be sufficient for the Contractor to notify its Enrollees within three (3) business days of the change. (§ 21. (8)(a))

The primary care provider shall agree not to exceed the member to provider ratios, and to notify the Contractor when the number of its Medicaid enrollees begins to approach this limit. (§ 21.10)

Where applicable, the Agreement shall include requirements from the Medicaid contract concerning the use of PCP teams, including:

- Limited to no more than four physicians/nurse practitioners
- One practitioner must be designated as "lead provider" for each enrollee
- Requirements contained in Appendix I, concerning use of medical residents.
- This requirement may be satisfied by a specific reference to a provider manual.

6. Records Maintenance and Audit Rights.

The model contract contains a number of provisions related to records maintenance and audit rights. (See in particular, § 19). Provider agreement provisions regarding records and governmental access for audits must be consistent with these provisions of the Model Contract. Key provisions of the agreements that should be reviewed for consistency are as follows:

The definition of "Medical Record," if any must be consistent with that in the model contract. Model Contract § 1, page 1-3.

The parties who have access to records must include CDOH, SDOH, the Comptroller General of the State of New York, DHHS, the Comptroller General of the United States, and their authorized representatives. (§ 19.3)

The access rights should be broadly stated and not limited to certain types of records. (§ 19)

The records maintenance requirements must be consistent with those in the Model Contract including six year retention (§ 19.4; Appendix A § 5.7)

7. Confidentiality

Provisions regarding confidentiality must be consistent with the Model Contract. (§ 20 and Appendix A; 5.5)

8. Insurance

Provider agreements should specify the amount of malpractice insurance that each Provider must carry, which should not be less than \$1,000,000 per occurrence (§37; Appendix A) (Part II, §2.1)

9. Equality of Access

Language regarding equality of access must be consistent with Model Contract. (§ 6.2; 34.1)

10. Non Discrimination

Non-discrimination provisions must be consistent with those in the Model Contract. (§ 34.2 and § 34.3, respectively)

11. Patient Rosters

Primary care provider agreements should provide a mechanism for providing primary care providers with a patient roster, on a regular basis, identifying Enrollees for whom the physician is serving as the primary care provider.

12. Physician Incentive Plan Requirements

Participating providers shall agree to provide physician incentive plan information in an accurate timely manner to the Contractor, in the format requested by SDOH.

If the Contractor elects to operate a Physician Incentive Plan, Contractor agrees that no specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. (§ 22.12)

In the event that incentive arrangements place the physician or physician group at a risk for services beyond those provided directly by the physician or physician group for an amount beyond the risk threshold of 25% of potential payments for covered services (substantial financial risk), the contract must ensure compliance with requirements listed in regulation, including but not limited to adequate stop-loss protection for the physicians and physician groups at substantial financial risk (§ 22.12)

13. Termination of Provider Agreements.

The Contractor must notify SDOH and HCA in advance of material changes or renewals of its provider agreements. (§ 22.4 (d))

Provider agreements shall include immediate termination of a provider in the Contractor's Medicaid program if SDOH excludes or terminates such provider from its Medicaid program. (§ 21.3)

The agreement shall provide that either party may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty (60) days notice to the other party; provided, however, that any non-renewal shall not constitute a "termination." (§ 22.11)

Prohibited Provisions

Provider agreements may not contain provisions restricting provider disclosure, as described in § 22.7 of the Medicaid contract.

Provider agreements may not contain any clause purporting to transfer to the health care provider, other than a medical group, by indemnification or otherwise, any liability relating to activities, actions, or omissions of the Contractor as opposed to those of the health care provider.

Recommendations

- Health plans should determine whether they have adequate mechanisms to ensure submission of encounter/ claims data by providers and other quality data, or whether provider agreements should be appropriately modified.

Elderplan's Role and Responsibilities

Provider Participation: Elderplan does not discriminate, in terms of participation, reimbursement or indemnification, or those who serve high risk populations or specialize in the treatment of costly conditions, against any health care professional that is acting within the scope of his or her license or certification under state law. Elderplan reserves the right to deny any provider participation in the Elderplan network if:

- The network of providers in that provider's specialty exceeds the number necessary to service Elderplan's membership volume.
- Quality of care issues have been recorded against the provider in the past.

Reimbursement: Elderplan agrees to reimburse provider according to the Elderplan provider participation agreement signed by both parties. Elderplan processes claims according to the claims processing rules outlined in this provider manual and CMS processing rules and guidelines.

Policy and Procedure Communication: Elderplan agrees to advise providers of any administrative, procedural, and policy changes in a timely manner through periodic mailings, the Elderplan Provider Quarterly, telephonically, or via web site at www.elderplan.org. Health care professionals will receive written notice from Elderplan 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 Elderplan, the health care professional may, within thirty days of the date of the notice, give written notice to Elderplan 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." A health care professional under this section is one who is licensed, registered, or certified under Title 8 of the New York State Education Law.

Member Eligibility: Elderplan agrees to provide current member eligibility through its customer service line. Member eligibility accuracy of a dual eligible may be

influenced by enrollment status in Medicaid at the time of services rendered.

Provider Directories: Elderplan agrees to provide members and providers with updated provider directories as outlined by CMS requirements. Provider directories may be available in paper and/or electronic formats. Our electronic directory can be accessed on the Elderplan website, www.elderplan.org.

MEMBER'S RIGHTS AND RESPONSIBILITIES

Elderplan members have the right to:

- Receive considerate, courteous, and respectful care.
- Refuse to participate in or be a patient for research purposes.
- Change physicians in accordance with the provisions of the member's Evidence of Coverage.
- Be assured that only persons having the qualifications established by Medicare and Elderplan will provide medical services.
- Obtain from the member's physicians, at reasonable times, comprehensive information about the physicians' diagnosis, treatment, and prognosis in terms that the member can reasonably be expected to understand. When it is not medically advisable to provide such information to the member, the information should be made available to an appropriate person on the member's behalf.
- Receive from the member's physician information necessary to enable the member to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of the action.
- Be informed, upon request, as to all medication given the member, the reasons for prescribing the medication, and the expected effects of the medication.
- Be treated in clean facilities, and with clean equipment and materials.
- Request a second opinion.
- Be assured privacy related to the member's medical care program is respected and secured. This shall mean at minimum that a person not directly involved in the member's care may not be present without the member's permission during any portion of the member's case discussion, consultation, examination, or treatment.

- Expect all communication, records, and other information pertaining to the member's care or otherwise regarding the member's personal condition will be kept confidential except if disclosure is required by law or permitted by the member.
- Request that unaltered copies of a member's complete medical records be forwarded to the physician or hospital of the member's choice, the cost of duplication and forwarding to be paid by the member.
- Written request, to have made available to the member copies of the member's medical records; Reasonable fees may be charged for such copies. However, information may be withheld from a member if, in the reasonable exercise of a physician's professional judgment, it is believed that release of such information would adversely affect the member's health.

Elderplan members have the responsibility to:

- To know and confirm their benefits before receiving treatment
- To contact an appropriate health care professional when they have a medical need or concern
- To show their ID card before receiving health care services
- To pay any necessary co-payment at the time services are rendered
- Use emergency room services only for injury or illness that in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- To keep scheduled appointments
- To provide information needed for care and treatment
- To follow agreed-upon instructions and guidelines of doctors and health care professionals
- To participate in understanding their health problems and developing a mutually agreed-upon treatment goals.
- To access our Web site or call Customer Care to verify that the selected provider or health care professional participates in the Elderplan network before receiving services

Second Opinions

Elderplan Members, their Authorized Representatives, and their health care providers acting on behalf of the Elderplan Members have a right to request the second opinion for a recommended surgical procedures or

medical treatment plan at no cost to the member (relevant co-pays may apply depending on the plan.)*

No referral or prior authorization is required to receive the second opinion from the Elderplan participating providers. Prior authorization must be requested in the event the second opinion is sought from an out-of-network provider.

When issuing the prior authorization, the following factors are being considered:

1. Lack of availability of an in-network provider with the scope of practice and clinical background including training and expertise, related to the particular illness or condition associated with the request for a second opinion and within reasonable time and distance standards.
2. The member questions that of recommended surgical procedures or medical treatment plan is medically necessary or clinically appropriate.
3. The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
4. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
5. The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or treatment plan.

All requests for prior authorization must be called in to the Medical Management Department and a Certifax form must be completed and faxed to (718) 921-8813/ (718) 759-4038. Certifax form can be found in the Provider Orientation Package or requested through Provider Services Call Center by calling (718)-921-7979. Prior authorization may be requested by either the PCP or by a specialist.

Member's Right to File a Grievance

Members have the right to file a complaint or grievance without fear of penalty when they feel they have received inappropriate treatment by the Plan or a Plan provider. Examples of grievances are: quality of care, office waiting times, and appointment waiting times.

Please consult the Appeal and Grievances section of this manual for further details.

*No cost applies to FIDA members.

Provider Panels

Closing Panels

Providers may not close panels to Elderplan members without explicit notification to Elderplan. The notification must be submitted in writing within 60 days prior to the date on which they intend to close the panel. Panels may only be closed if it applies to all patients regardless of insurance coverage. Providers may not discriminate by closing their patient panel to Elderplan members only or by Elderplan product line.

Credentialing Standards

Elderplan follows state and federal regulations, as well as the accreditation guidelines of the National Committee for Quality Assurance (NCQA). Following receipt and acceptance of a completed provider application and signed participating provider contract, Elderplan credentials physicians and allied health providers.

Elderplan's credentials verification process includes but is not limited to:

- Primary source verification of the provider's credentials; NYS license, sanctions/exclusion / Medicare Opt Out lists, Board Certification. (Non-board certified providers are accepted but must submit additional documentation), National Practitioner Data Bank,
- Non-board certified providers require verification of training and may require additional documentation.
- Demographic information: SSN, DOB, provider specialty, languages spoken, Medicaid number, Medicare number, NPI
- Office information: tax ID, office address, telephone and fax numbers, handicap accessibility, staff language skills,
- Site visits are performed on all PCP and OBGYN provider offices.

Elderplan recredentials providers on a three (3) year cycle from date of initial credentialing.

Medicaid only Providers: The application process for credentialing newly licensed Medicaid health care professionals (HCP) or HCPs relocating from another state, who are joining a group practice of in-network providers is as follows:

- A HCP joining a group practice can be considered a "provisionally" credentialed provider on the ninety first day after submitting a complete application to EP, if EP does not approve or decline the application within 90 days. This status will continue until EP either credentials the provider or declines the application. During this provisional period the HCP is considered an in-network provider for the provision of covered services to members, but may not act as a primary care provider (PCP).
- If the application is ultimately denied, the HCP will revert back to non-participating status. The group practice wishing to include the newly licensed or relocated HCP must agree to refund any payments made by EP for in-network services delivered by the provisionally credentialed HCP that exceed any out-of-network benefit... In addition, the provider group must agree to hold the member harmless from payment of any services denied during the provisional period except for collection of co-payments that would have been payable had the member received services from an in-network provider.

Social Adult Day Care Certification:

This new Certification has been implemented in order to ensure those entities involved in the delivery of SADC services are in compliance with relevant rules and regulations.

The goal is to ensure eligible individuals have access to safe SADC service settings.

Completion of the Certification will attest to a SADCs compliance with Title 9 NYCRR section 6654.20, as required under Article VII, section C of the Managed Long Term Care model contract.

- The Certification must be completed electronically, via OMIG's website: <https://www.omig.ny.gov/sadc-certification>

The SADC must print and retain a copy of the confirmation as proof of completion. The SADC must also provide a copy of this confirmation to the MLTC plan. (Upon completion, the confirmation will be automatically sent to the email address provided on the electronic Certification form).

Any SADC seeking to enter into a new contract with Elderplan would need to successfully complete the Certification first, and provide a copy of the confirmation page to Elderplan as proof of completion.

Vendor Oversight Program

Vendors in managed care organizations (MCOs) provide a number of ancillary services to a MCO's membership. Ancillary service vendors are often delegated a variety of MCO operations such as customer service, utilization management, quality management, network management, and reporting on their specialty area. Vendors manage such specialties as laboratory, radiology, podiatry, physical and occupational therapy, audiology, vision services, pharmacy through a Pharmacy Benefits Manager (PBM), and disease specific and population management activities.

Regardless of what services and delegated operations are being managed by a vendor, oversight is critical to ensure the vendor is managing member care effectively and efficiently. In addition, the vendors must be responsive to the plan needs and manage to contract. Monthly reporting from the vendor and a quarterly review by the plan of the vendor(s) ensures optimal performance from the vendor.

Elderplan's Delegated Vendor Oversight Subcommittee meets regularly to review monthly metric reports. Performance standards on each metric are outlined to the vendor and must be met. Vendors who are repeatedly unsuccessful in meeting the standards for any metric will be flagged by the committee for review. Vendors may be required to submit Corrective Action Plans (CAP). Failure to meet the expectations of a CAP could result in the replacement of a vendor.

Provider Satisfaction Survey

As an Elderplan Participating Provider, we encourage you to participate in our annual Provider Satisfaction Survey that is mailed in September. This survey is your opportunity to express your needs, expectations, and opinions about doing business with Elderplan.

Benefits Summary

Important Definitions:

Medicare: a national publicly financed health insurance program that pays for a set of covered services for individuals 65 years old and older who qualify for Social Security retirement benefits or individuals who are 64 years old or younger who qualify for Social Security disability benefits.

Medicaid: a government based program co-sponsored by the federal and state government that covers health insurance for the indigent and disabled.

Dual Eligible: a member that meets requirements for coverage by both Medicaid and Medicare.

Medicare Advantage and Special Needs Plan

Final regulations on the Medicare+Choice program were promulgated in June 2000, which created the Medicare Advantage program, or Medicare Part C of Title XVIII of the Social Security Act. The primary goal of the Medicare Advantage program is to provide Medicare beneficiaries with a wide range of health plan options to complement the Original Medicare option.

Under the Medicare Advantage plan, Elderplan receives a monthly premium from CMS for each Medicare beneficiary electing to enroll in Elderplan's Medicare Advantage program. Elderplan provides enhanced benefits to its members for the premium received from CMS.

In 2006, Elderplan was awarded a Special Needs Plan (SNP) designation in our service area. Our SNP designation will expand our services to Medicare eligible disabled individuals of all ages. Elderplan also provides service to dual eligible members covered by Medicare and Medicaid.

Elderplan's Medicare Advantage Plans

Elderplan Medicare for Nursing Home Residents (HMO) is available to anyone who requires nursing home level care and who resides in or agrees to reside in one of Elderplan's contracted Special Needs Plan network nursing facilities.

Elderplan Medicare for Medicaid Beneficiaries (HMO): A plan designed for people with Medicare and full Medicaid or those who are enrolled in the Medicare Savings Program such as Qualified Medicaid Beneficiaries (QMB). This also changed

Elderplan Medicare Plus Managed Long Term Care (HMO): A plan for Medicare beneficiaries with full Medicaid who have chronic health care needs and are eligible to live in a nursing home, but would prefer and are able to live at home.

Elderplan Extra Help (HMO): A Medicare Advantage Prescription Drug Plan that works with the Low Income Subsidy (LIS) to lower the cost sharing associated with the Defined Part D Standard

Elderplan Diabetes Care (HMO SNP): Elderplan Diabetes Care (HMO SNP) is the only diabetes plan in New York State. It is specifically designed to offer diabetics the care and support they need in order to maintain or improve their health condition

Elderplan Healthy Balance (POS): Elderplan Healthy Balance (POS) is a high quality, affordable plan designed exclusively for Medicare beneficiaries living Westchester, Nassau, and Suffolk

Elderplan FIDA Total Care (Medicare-Medicaid Plan): delivers more than Medicare and Medicaid benefits alone. There's a larger pool of doctors to choose from. Dental benefits are expanded to cover dentures, fixed bridges, root canals and more. Plus, a dedicated Care Manager manages the people and services needed to remain safely at home. These services and people may include doctors, hospitals, pharmacies, long-term care providers, and others health and medical professionals.

Ancillary Benefits

Elderplan members have access to a broad range of ancillary services. Ancillary services may be provided directly through the Elderplan network or through a vendor network. Vendor networks abide by the same Elderplan policies and procedures as physicians and other medical professionals. Certain ancillary services require prior-authorization. Please call Medical Management at (718) 921-7979 to verify if authorization is required.

Pharmacy Benefits

Elderplan also provides Prescription Drug coverage and has a Formulary (a list of preferred prescription drugs). The searchable formulary may be viewed by accessing Elderplan's website at www.elderplan.org. Certain drugs need authorization from Elderplan prior to dispensing at the pharmacy. The Prior Authorization Approval List link can also be found on the Elderplan website, www.elderplan.org.

If you have any questions regarding prior authorizations, call our pharmacy benefit manager at 1-800-361-4542 or Customer service at (718) 921-7979, or the TTY number for the hearing impaired, 711, seven days a week between the hours of 8:00 a.m. and 8:00 p.m.

Transportation

Elderplan is contracted with LogistiCare for Non-Emergency Routine Transportation.

To Make a Reservation: 1-877-659-6141

Transportation Help Line: 1-877-659-6142

Hearing-Impaired TTY: 1-866-288-3133

MEDICAL MANAGEMENT

Important Definitions

Inpatient Care: refers to any care a member receives in a hospital bed where an overnight stay occurs. In addition to an assessment and diagnosis the patient/member receives room and board and care or treatment for the illness or injury sustained.

Outpatient Care: refers to any care the member receives in an ambulatory surgical center or professional office where assessment and diagnosis result in care or treatment for the illness or injury sustained. No overnight stay or room and board applies.

Medical Management: the process of evaluating medical necessity of care in accordance with guidelines and standards established and accepted by professional organizations and healthcare professionals.

Prior Authorization: the process of seeking prospective Plan approval for specific procedures and services such as elective hospital admissions, admission to Skilled Nursing Facility, certain ambulatory surgical and/or office-based procedures or treatments as outlined in the benefits section of this manual and the member's document known as the Evidence of Coverage (EOC). In instances where the provider of care is unsure of the need for prior authorization, a call should be placed to Elderplan's Medical Management Department prior to service. Prior Authorization is not required for Emergency Care.

Medically Necessary: services planned or provided to a member that, based on sufficient medical evidence such as; peer reviewed medical literature, publications, reports and/or governmental regulations, and/or medical standards of care and/or established medical criteria, are determined necessary for the diagnosis and treatment of an illness or injury. Certain services though medically necessary may require prior authorization by Elderplan to ensure the services are covered services under the member's EOC.

Emergency: 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:

- 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;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Standard Initial (organization) Determination: a plan decision to provide, authorize, deny, or discontinue a service as expeditiously as the member's health condition requires, but no later than 14 calendar days, unless a delay to obtain additional information would benefit the member.

Expedited Initial (organization) Determination: a plan decision to provide, authorize, deny, or discontinue a service as expeditiously as the member's health condition requires, but no later than 72 hours, unless a delay to obtain additional information would benefit the member.

Member's Designee: a representative acting on the member's behalf. The assigned designee may be a physician, or other provider of care, or a family member.

Medical Management Program

The purpose of the Medical Management Program is to maximize quality of care while providing services in the most efficient and cost effective manner. The Program includes ongoing planning and coordination of services provided to Elderplan members. The Program incorporates prospective, concurrent and retrospective review to meet program objectives.

Medical Management begins with the prior authorization of services. Services covered under the member's EOC requiring prior authorization are evaluated against the plan's criteria to establish medical necessity.

The program also identifies and evaluates high-risk members who may be eligible to participate in our Chronic Care Improvement Program (CCIP). These programs are designed to maximize the member's health and wellness and manage health crises more effectively.

Emergency Care

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:

- 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;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services include inpatient and outpatient services that are furnished by a provider qualified to render services to evaluate or stabilize an emergent medical condition.

Elderplan will cover services furnished by a participating or non-participating provider when an emergency medical condition exists, or a Plan provider instructs the member to seek emergency services within or outside the Plan.

Prior authorization for treatment of emergency medical conditions and out-of-area urgently needed care is not required. In the event of an emergency medical condition, the member is encouraged to go to the closest emergency room or the nearest hospital, or call 911 for assistance. Elderplan offers worldwide emergency coverage on some products. Members are requested to contact Elderplan and/or their Primary Care Physician within 24 hours of the emergency, or as soon as reasonably possible as instructed on their membership identification card and in their Evidence of Coverage booklet.

Should the emergency situation result in a medically necessary hospital admission, Elderplan will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely discharged or transferred to a next level of care.

Post-Stabilization Care

Post Stabilization Care Services are provided after emergency care is received, and additional services or post stabilization care is medically necessary to ensure that the member remains stabilized from the time that the treating hospital requests authorization from Elderplan or until:

- The member is discharged
- A Plan physician arrives and assumes responsibility for the member's care
- The treating physician and Elderplan agree to another arrangement

Potential Transfer of Members

If an emergency medical condition is treated at a non-contracted facility and requires a level of care and/or treatment that the facility cannot provide, the patient may be evaluated for transfer to a contracted facility. The hospital attending physician must collaborate with the primary care physician and/or receiving hospital attending physician once medical stabilization is achieved. The transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records, and uses qualified personnel and transportation equipment for the transfer. The receiving facility must have an available bed and qualified personnel to accept the transfer and provide appropriate medical treatment. The Elderplan Utilization Management Coordinator is available to assist the collaborating physicians during this process.

MEDICAL REVIEW PROCESS

Criteria

The medical review process utilizes the most current version of InterQual's Care Enhance Guidelines for inpatient and outpatient care. Elderplan follows Medicare Coverage guidelines for outpatient therapies such as Physical Therapy, Occupational Therapy, Speech Therapy, Durable Medical Equipment, and Mental Health and Substance Abuse care. Additional criteria may be used as deemed appropriate or necessary. All criteria are used in conjunction with the application of professional medical judgment and/or guidance from the Elderplan Medical Director.

Criteria used in the medical review process are available to all providers upon written request.

Standard Initial (organization) Determinations

A standard initial (organization) determination is a plan decision to pay for, provide, authorize, deny, or discontinue a service requested. Providers and members are notified in writing within 14 days of the plan decision. In cases of denials, please review letter content under the Service Denial/Adverse Determination section below.

Expedited Initial (organization) Determination Process

Members or providers may request an expedited initial determination when the provider or member believes an immediate determination is warranted, as delay in treatment would negatively impact the member's health.

Expedited initial determinations may be requested for a continuation or extension of health care services, additional procedures/treatments/services for members undergoing a course of continued treatment. Such requests may apply to inpatient and outpatient services.

Expedited initial determinations are preferred in writing via fax, but may be submitted in person or via telephone. Requests are tracked and determinations must be made within 72 hours of initial request providing sufficient information is made available. Requests that are approved are communicated verbally upon decision and followed with written confirmation. A request that is denied is communicated verbally and a written notice is generated within three (3) calendar days. Members are given grievance rights in writing should they disagree with the determination. To request an expedited initial determination, please contact the Customer Service Department immediately at (718) 921-7979.

The timeframe for standard or expedited initial (organization) determinations may be extended by up to 14 calendar days if the member or member's designee requests the extension or if the organization justifies a need for additional information in favor of the member.

LEVELS OF REVIEW

Prior-Authorization/Prospective Review

Prior authorization requests received through the Medical Management Intake receive a first level review. The professional staff conducting first level reviews includes; licensed registered nurses, physician assistants, or paraprofessionals such as licensed practical nurses, social workers, and health information professionals.

The first level review is a screening process against approved criteria to establish medical necessity and appropriateness of the level of care.

A second level review may be necessary to render a determination of medical necessity. Second level reviewers, or physician advisor reviewers, hold an unrestricted license and are board certified physicians. When appropriate, second level reviewers consult with physician specialists in reviewing the services rendered by a like specialist. Only a clinical peer may render adverse determinations for medical necessity.

Prior Authorization is the prospective review or first level review of medical services before the services are rendered. Certain services as outlined in the benefits section and member's EOC require prior authorization. Elderplan's Medical Management program evaluates a request for prior authorization against established medical criteria to:

- Establish medical necessity,
- Determine appropriateness of level of care,
- Establish coverage under the member's benefits,
- Coordinate a plan of care,
- Assign of initial length of stay,
- Coordinate a discharge plan.

In the event the provider is uncertain whether a service requires prior authorization or not they should call Medical Management for confirmation prior to providing service. Prior authorization does not guarantee payment if the member has disenrolled and eligibility was not verified prior to the service.

All requests for prior authorization must be called in to the Customer Service Department (718) 921-7979.

Payment to both the facility and attending physician will be denied if:

- Services requiring prior authorization are rendered by participating providers without authorization
- The requested clinical information is not provided or is insufficient.
- If length of stay or dates of service exceed the authorized length of stay or period of time and approval for extension is not obtained from Elderplan.
- The member was disenrolled on the date of admission or procedure and failed to notify his/her provider

In the event that prior authorization for a service is needed urgently during non-business hours, the provider should arrange for or provide the necessary services and contact the Medical Management Department for authorization the next business day.

Service Denials (Adverse Determinations)

Service Denials (Adverse Determinations), which limit or reduce or deny services based on medical necessity are only made by Elderplan physician advisor reviewers and are peer-based decisions. Elderplan will provide the member and requesting provider a written notice within three (3) days of the determination with clinical rationale for the denial included in the letter. The process for appealing the decision will also be included in the letter.

Medicaid Services —A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

Public Health Law 4914 was amended to extend external appeal rights to providers in connection with the 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 a concurrent adverse determination upheld in favor of Elderplan;

Elderplan is responsible for the full cost of an appeal that is overturned; and the provider and Elderplan 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 Elderplan. 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 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 provision described above. If the provider is unresponsive, the appeal will be rejected.

PhL Article 49 was amended to include rare disease treatment. The definition of rare disease treatment is found at PHL 4900(7-g): and the established external appeal right for a final adverse determination involving a rare disease treatment was added to Section 4910

Subdivision 3 of PHL 4903 was amended to change the timeframe for utilization review determinations of home health care (HHC) services following an inpatient hospital admission. Elderplan will provide notice of its determination within one business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or holiday, within 72 hours of receipt of necessary information. If a request for home health care services and all necessary information is provided to Elderplan prior to a member's inpatient hospital discharge, Elderplan will not deny the home care coverage request on the basis of lack of medical necessity or lack of prior authorization while the UR determination is pending. There may however, be other reasons for denying the service such as an exhaustion of a benefit.

An appeal of a denial for home health services following a discharge from a hospital admission must be treated as an expedited appeal under PHL 4904(2). For the purpose of this section, the term inpatient hospital admission is limited to services provided to a member in a general hospital that provided inpatient care. This may include inpatient services in an Article 28 rehabilitation facility.

Practitioner Denials

Elderplan educates enrollees and practitioners that when there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive from the health plan a detailed written notice regarding the practitioner's decision.

Should the member contact Elderplan, the Medical Management Department will contact you to receive details of the service denial. The plan will then issue a Notice of Denial of Medical Coverage to the member/member's representative, explaining the reason for the denial and notifying the member of appeal rights.

Concurrent Review

Concurrent review focuses on the continued care review for medical necessity and appropriateness of level of care.

PCP offices or staff at the admitting facility are required to notify Elderplan within 24 hours of any emergency admission.

Notification may come from the member or representative of that member, from staff at the admitting facility, or from the PCP's office.

Inpatient concurrent review consists of:

Admission Review – Conducted to determine the appropriateness of emergent admissions, based on clinical information during the first 24 hours of admission. When Elderplan notification requirements are met, emergency admissions that occur when Elderplan is closed will be paid until the admission review is completed.

Continued Stay Review – Conducted to ensure that inpatient care continues to be appropriate. Continued stay reviews are conducted prior to the expiration of the initially assigned length of stay.

Discharge Planning – Begins prior to admission, except with emergency admissions, where it is initiated upon receipt of the first review of the case. Discharge planning facilitates moving a member efficiently through the health care system.

Discharge Review – Is conducted to ensure the member's stability and discharge readiness to the most appropriate and safe setting.

Part of our discharge review includes follow-up telephone calls to assess members' transition from one level of care to the next. Safe transition should include a follow-up visit with the primary care physician within the first seven days of discharge. Elderplan Care Managers will often advocate with the provider office to facilitate that visit.

Inpatient Denials

The Important Message notice is delivered to the member by the hospital within two days of admission. The member or member's representative must sign the notice. The signed copy is re-issued to the member/member's representative within two days of planned discharge. A member may request an independent Peer Review Organization (IPRO) review up until the date of discharge on the notice. If the member/member's representative requests an IPRO review, the plan will issue a Detailed Notice to the member with a copy to the IPRO, explaining the reason for discharge. The IPRO reviews the request and makes a determination within one business day of receipt of the request and the hospital records, and notifies the member of its decision. If the IPRO upholds the adverse determination made by Elderplan, the member will become liable for hospital costs commencing at noon of the day following receipt of the IPRO determination.

Outpatient concurrent review is conducted prior to the expiration of the authorization period for all outpatient services requiring continued authorization. Examples may include home health services, physical therapy, and DME rentals. Providers/vendors are responsible for obtaining authorization for continued services prior to expiration of existing authorization.

Retrospective Review

Retrospective medical record review may be required for health care services that were provided without formal prior authorization and medical necessity screening. A retrospective review can be triggered by claims/encounter data where services are denied for failure to obtain prior authorization or pre-defined focused reviews such as DRG validation, short stay, and/or readmission reviews.

A retrospective review does not guarantee full payment for all services or inpatient days if services were determined to be either not medically necessary, and/or the length of stay/services exceeds established medical criteria and/or the level of care was inappropriate.

Physician Review

Elderplan prides itself on providing its members with the very best network of quality care providers to meet all their medical needs. As such, when our Medical Management staff requires assistance in making a medical necessity or level of care determination, Elderplan has established a group of physician advisor reviewers. Once a physician advisor reviewer has made a determination, Elderplan recognizes this as a final determination from an expert peer in the field.

When the physician advisor reviewer believes the requested service is unnecessary, the treating physician is notified immediately and afforded the opportunity to discuss the case with the physician reviewer. If additional information is requested but not provided or is insufficient to justify the requested service, the physician reviewer will utilize available information to make a determination. When the treating physician does not agree with an adverse determination, the physician advisor reviewer informs the treating physician that a denial, including appeal rights, will be issued to all appropriate parties.

DETERMINATIONS

A determination is an Elderplan decision to pay for, provide, authorize, deny, or discontinue service.

Notice of Determination

Providers and members are notified of standard and adverse determinations in writing. Adverse determinations are communicated telephonically and in writing. When an adverse determination is issued the provider and member are advised of their right to appeal the determination. The written notice will include:

- Reason for the denial
- Notification format and language pre-approved by DOH and CMS
- Right to a standard or expedited reconsideration
- Information the provider may act as the member's designee
- Explains the appeals process and time frames for service denials, payment denials and or expedited appeals.

Types of Determinations	Timeframe for making a Determination	Timeframe for Extension	Examples
Standard Organization Determination	Elderplan must make a determination within fourteen (14) days	Extensions may be authorized for an extra fourteen (14) days if requested by the member or additional information requested by Elderplan	Additional information requested by the plan in favor of member and in anticipation of preventing an adverse determination
Expedited Organization Determination	Elderplan must make a determination within seventy-two (72) hours	Extensions may be authorized for an extra fourteen (14) days if requested by the member or additional information requested by Elderplan	Additional medical information requested to validate extension of physical therapy services and prevent contractures
Notification of Adverse Organization Determination	Elderplan notifies the member and provider telephonically at the time of decision followed by written mail and/or fax	N/A	Elderplan must notify provider of following appeal time frames: <ul style="list-style-type: none"> • within 30 days for service denials (clinical) • within 60 days for payment denials • within 72 hours of a request for an expedited appeal

COORDINATED CARE MANAGEMENT

Coordinated Care Management is available to all of our members in our Special Needs Products (Access, MAP, MAMA, and Advantage) and to our Homefirst members as well. Medical Management prides itself on the coordination of medical and social interventions to maximize our member's health, independence, and wellness keeping them physically, socially, and mentally functional for as long as possible. The integration of the various medical and social interventions is critical to keeping our members active and well in their community until such time as it becomes necessary to assist them in alternate living arrangements.

The interventions of the Elderplan Coordinated Care Model provide support to our members and physicians through a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the individual member's health care needs. The model focuses on members identified as at risk for adverse health events and may benefit from interventions and services available. Members in those products are identified during the initial enrollment process, risk stratification tools, clinical algorithms, authorization process, concurrent review, or in response to a referral generated by a provider, member or informal caregiver, as well as data from specific targeted reports.

The Model is designed to provide:

- Improved member care
- Identification of options in health care delivery
- Identification and coordination of appropriate plan benefits
- Identification of possible community resources
- Collaborative care planning through the creation, review and update of a care plan with the member and the Primary Care Physician
- Monitoring of quality and appropriateness of care and timeliness of services delivered
- Improved communication among members, their caregiver(s), health care providers, the community, and Elderplan

- Increased physician and member/caregiver knowledge, skill, and comfort in the care for all members confronting end of life illness
- Empowerment of members to articulate preferences about desired care as well as the kinds of treatment they do not want
- Member education regarding health prevention, management, and disease process to members and their families

Transitional care team members are also available to assist our members in Special Needs Products when they experience a change in their normal level of care (for example, an inpatient hospitalization). They are available to assist the member, representatives, and care teams to safely and efficiently transition the member to the next appropriate level of care.

Clinical Case Management and Other Programs

If you have a member that is not in one of Elderplan's Special Needs Products or Home first, they can still be eligible for Clinical Case Management, based on their needs. An interdisciplinary team is available to evaluate and coordinate care for those members who have chronic conditions or needs temporary assistance during an acute episode.

Chronic Care Improvement Program – All members that meet the requirements for Elderplan's Chronic Care Improvement Program will also have access to an interdisciplinary team to assist the member in the education and self-management of their chronic condition. This program is offered to all Elderplan members that meet the program's requirements, regardless of product.

Medication Therapy Management (MTM) for Part D Pharmacy Management – All members that meet the requirements for Elderplan's MTM program will have access to a comprehensive review of their current medications, completed by a pharmacist. All information is communicated to the member, member's representative, prescribing physicians, and primary care physicians.

If you would like to refer a member for Clinical Case Management or reach Customer Service call (718) 921-7979.

CLAIMS/REIMBURSEMENT

Introduction

The Claims Department is essential to provider and facility reimbursement. The department receives and processes claims for medical and hospital services rendered to Elderplan members by both participating and non-participating providers. Claims received from provider and facility billing areas are accepted by the department in paper and electronic format. Reimbursement may be on a fee-for-service basis or capitated arrangement.

The accuracy of claims submitted and processed are key to Elderplan's encounter data collection and internal and regulatory reporting requirements. In addition, Elderplan utilizes Code Review and CMS' CCI (Correct Coding Initiative) in the claims editing process. These are both common editing programs utilized by Medicare and/or health insurance carriers.

Checks, EOPs and EOBs are sent to providers and members on a weekly basis.

ICD-10 coding will be required on claims beginning October 1, 2015. To learn more about how Elderplan can help with your ICD-10 readiness, please visit www.elderplan.org/for-providers/icd-10/

Important Definitions

CMS HCFA 1500 Form: standard form most commonly utilized to submit office-based services, free standing ambulatory surgery centers and ancillary services UB-04/CMS 1450 Form: standard form most commonly used to submit hospital-based services both inpatient or outpatient and Skilled Nursing Facility services.

Capitation: a contractually agreed upon monthly pre-payment reimbursement a participating provider receives for defined health services provided to the member.

Fee for Service (FFS): a contractually agreed upon fee schedule the provider receives for services rendered to the member and covered by the plan.

Co-payment: a fixed dollar amount the member is responsible to pay the provider of service at the time services are rendered.

Coinsurance: a pre-determined fixed percentage of the maximum allowable charge, which a member is responsible for some, covered services.

Clean Claim: a claim received from a provider for services rendered that contain all of the required information for processing.

Coordination of Benefits (COB): a claims processing mechanism designed to prevent or eliminate duplicate payment for services when a member has coverage from two or more insurance agencies.

CPT-4 codes: (Current Procedural Terminology) a set of five digit codes that represent medical services. Commonly used for billing purposes.

HCPCS: (CMS Common Procedural Coding System) a set of Medicare codes commonly used for procedures and services. Most commonly used for services in DME, ambulance, and drugs.

APC pricing: a CMS pricing methodology for outpatient services that group the outpatient services to one of the APC groups and prices according to the price set for that group.

ASC pricing: a CMS pricing methodology for ambulatory surgical services that group the ambulatory surgical services to one of nine ASC groups and prices according to the price set for that group.

ICD-10-CM: (International Classification of Diseases, 10th Revision, and Clinical Modification) a standard classification system of disease by diagnosis set on a six-digit coding model. Decimal point specificity is important to clear diagnosis identification and reimbursement.

EOP: (Explanation of Payment) is a remittance notice to the provider explaining the reimbursement amount received. **EOB:** (Explanation of Benefits) is a remittance notice to the provider of coverage information. May or may not accompany an EOP.

Modifier: an indicator used by the reporting physician to indicate a service or procedure has been modified or enhanced by some circumstance but has not changed the type of procedure or service or its code.

NPI: (National Provider Identifier) 10-digit identifier used to identify health care providers in all standard transactions that does not have an expiration date. Will never expire.

Submit EDI Claims to:

Emdeon
 Elderplan Payer ID – 31625
 Elderplan is accepting electronic claims submitted in the HIPAA compliant format only.

Submit Paper Claims to:

Elderplan Claims Department
 P.O. Box 73111
 Newnan, GA 30271-3111

Electronic Fund Transfer (EFT)

Elderplan has partnered with Emdeon to offer you the option to select EFT to deposit funds directly into your bank account. To receive your payments electronically please sign up for EFT at www.emdeon.com/epayment and select the Enroll Now button.

CMS 1500 CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

Claim completion requirements apply to providers under fee for service and capitated arrangements. To ensure timely claims adjudication, the following information must be included on the claim form:

- Member’s last and first name, the eleven digit Elderplan ID member number, date of birth
- Provider’s name, Elderplan’s Provider ID number, CMS 2-digit location code, tax ID number, address
- Date and place of service
- Current procedure code (CPT-4 or HCPCS) with 2 digit CMS place of service code
- Charge amount
- Number of units
- ICD-10-CM diagnosis code(s) coded to the highest specificity
- Complete Box 33 with office location and Elderplan provider ID number
- Complete Box’s 17a/b if applicable; 24J; 32A; 32B; 33A; 33B with Elderplan Provider ID number and Provider NPI number

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
1 Type of Insurance	Enter an “X” to indicate “other” type of insurance
1a Insured’s ID Number	Enter the member’s eleven digit Elderplan ID number
2 Patient’s Name	Enter the patient’s last name followed by the first name and middle initial
3 Patient’s Birth Date	Enter in 2-digit numbers, month, day and year of patient’s date of birth
4 Insured’s Name	Leave this field blank if the patient and the insured are the same I
5 Patient’s Address/Telephone Number	Enter the patient’s complete address. Number and street, city, state, zip code, area code and telephone number
6 Patient’s Relationship to Insured	Check the appropriate box.
7 Insured’s Address	Leave this field blank if the patient and the insured are the same
8 Patient Status	Check the appropriate box.
9 Other Insured’s Name	Leave this field blank unless you enter yes in field 11d

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
12 Patient's or Authorized Person's Signature/Date	Entering "signature on file" is acceptable provided physician or supplier actually has patient's or authorized person's signature on file.
13 Insured's or Authorized Person's Signature	Entering "signature on file" is acceptable provided physician or supplier actually has patient's or authorized person's signature on file.
14 Date of Current Illness	Enter 2-digit numbers for month, day and year
15 If Patient Has Had Same or Similar Illness Give First Date	If patient has had same or similar illness, indicate first date
16 Dates Patient Unable to Work in Current Occupation	Leave field blank
17 Name of Referring Physician or Other Source	For a physician referral service enter the referring physician's first and last name.
17a ID Number of Referring Physician 17b NPI ID Number	Enter the appropriate qualifier and the Elderplan provider number. Enter the NPI ID number of the referring physician.
18 Hospitalization dates related to current services	Enter the dates that apply to current services. If code 21 is entered in field 24b, then completion of fields 18 and 32 are required
19 Reserved for Local Use	Leave this field blank
20 Outside Lab Charges	Leave this field blank

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
21 Diagnosis or Nature of Illness or Injury	<p>Using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding system, enter the appropriate code coded to the highest specificity (up to 5 digits), which best describes the main condition or symptom of the patient. Relate Items 1, 2, 3 and 4 to Item 24E by line.</p> <p><i>Diagnosis codes with subcategories must be entered with the subcategories indicated after the decimal point. A 3-digit diagnosis code (no entry following the decimal point) will only be accepted when the diagnosis code has no subcategories.</i></p> <p>Example: 786 Symptoms involving respiratory system and other chest symptoms. 786.51 Precordial Pain</p> <p>Enter 786.51 instead of 786</p> <p>Please list all appropriate diagnoses.</p> <p>Diagnoses that are not coded to the highest specificity will be denied. Should this happen, you may resubmit the claim with the corrected information for consideration of payment provided the correction is submitted within the timely filing timeframe.</p>
22 Medicaid Resubmission/Original Reference Number	Leave this field blank
23 Prior Authorization Number	If the provider is billing for a service, which required prior approval, enter the approval number specified by Elderplan.
24a Date of Service	Indicate in 2-digit numbers the month, day and year on which a service was rendered. Be sure to enter a date of service for each procedure code listed. Dates should include the “from and to” dates in which the service was performed including same day services.

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
24b Place of Service	<p>This code indicates the type of location where each service was rendered. Enter the appropriate CMS 2-digit codes Note: these are the most commonly used codes. Additional codes can be found in the Medicare Claims Processing Manual- Chapter 26, Section 10.5.</p> <p>CMS 1500</p> <p>Office</p> <p>Home</p> <p>21 Inpatient Hospital</p> <p>22 Outpatient Hospital</p> <p>23 Emergency Room-Hospital</p> <p>24 Ambulatory Surgical Center</p> <p>25 Birthing Center</p> <p>26 Military Treatment Facility, Skilled Nursing Facility or Nursing Home</p> <p>Nursing Facility</p> <p>41 Ambulance</p> <p>00-09 Other</p> <p>62 Comprehensive Outpatient Rehab Facility</p> <p>65 Independent Kidney Disease Treatment Center</p> <p>81 Independent Lab</p> <p>89 Ambulate</p> <p>Note: If Code 21, 22, 23, 24 or 00-09 is entered in field 24b for any claim line, the name and address where procedure was performed must be entered in field 32.</p>
24c EMG	Complete if appropriate.

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
24d Procedures, Services, or Supplies	<p>CPT/HCPCS</p> <ul style="list-style-type: none"> • This code identifies the service, which was rendered to the patient. Enter the appropriate 5-digit number using the current CPT-4 codes corresponding to the service date. • All anesthesia claims must be submitted with anesthesia CPT-4 codes followed by the “AA” modifier, and not surgical codes. Time must be in hours and minutes and include the start and completed time of anesthesia. <p>Modifier</p> <p>The 5-digit CPT-4 code identifying a specific procedure may be expanded by two additional characters called a modifier to further define the nature of the procedure.</p> <p>Anesthesia services (service code 00100-01999) must be reported with an “AA” modifier. See above notation for anesthesia coding specificity.</p>
24e Diagnosis Pointer	For each line enter the appropriate number that corresponds to the code which best describes the main condition or symptom of the patient for which the procedure was performed. At all times coding to the highest specificity is required.
24f Charges	Enter amount billed for the procedure, even if the service is capitated and is being submitted for encounter reporting purposes.
24g Days or Units	Procedures performed more than once on the same date of service should be entered with the correct number of times it was performed. When a procedure is only performed once it should be noted as “1” in the space provided.
24h EPSDT	Leave this field blank
24i ID Qual	Enter the appropriate ID Qualifier
24j Rendering Provider ID. # Rendering Provider NPI ID. #	<p>Enter the rendering Elderplan provider number in the box directly below the section title.</p> <p>Enter the rendering provider NPI number in the box below the Elderplan provider number.</p>
25 Federal Tax ID number	Enter the Employer Federal Tax ID number or the Social Security Number of the payee and check the appropriate box.
26 Patient’s Account number	Enter your patient account number. This Will appear on the explanation of payment.
27 Accept Assignment	Leave this field blank

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
28 Total Charges	Insert Total Billed Amount
29 Amount Paid	If payment from other medical insurance is received, attach the Explanation of Benefits/Payment form to the claim from that insurer.
30 Balance Due	Leave blank
31 Certification (Signature of Physician or Supplier including Degrees or Credentials) Date	The physician must sign the claim form or a signature stamp may be used. Please note that the certification statement is on the back of the claim form.
32 Service Facility Location Information 32a Provider NPI # 32b E.P. Provider ID #	If you entered Code 21, 22, 23, 24, 31,32,33 or 00-09 in field 24b, enter the name and address where the service was rendered Enter the NPI # of the service facility. Enter the Elderplan provider number of the facility.
33 Billing Provider Info & Ph. # 33a Provider NPI # 33b E.P. Provider ID #	Enter the providers billing name, address, zip code and phone number. Enter the NPI # of the billing provider or group. Enter the Elderplan provider number assigned to the billing provider or group.

Elderplan requires that **all claims must be submitted within 180 days of the date of service to ensure payment.**

Providers that do not have an Elderplan provider ID number should call Elderplan Customer service Department for assistance at (718) 921-7979 to obtain an Elderplan provider number or receive assistance in meeting claims completion criteria.

CMS 1500 (Version 02/12) CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

If your organization uses the CMS 1500 form, ICD-10 requires the use of version 02/12 which supersedes version 08/05.

Claim completion requirements apply to providers under fee for service and capitated arrangements. To ensure timely claims adjudication, the following information must be included on the claim form:

- Member's last and first name, the eleven digit Elderplan ID member number, date of birth
- Provider's name, Elderplan's Provider ID number, CMS 2-digit location code, tax ID number, address
- Date and place of service
- Current procedure code (CPT-4 or HCPCS) with 2 digit CMS place of service code
- Charge amount
- Number of units
- ICD-10-CM diagnosis code(s) coded to the highest specificity
- Complete Box 33 with office location and Elderplan provider ID number of the billing group
- Complete Box's 17b if applicable; 24J; 32A; 33A; 33B with Elderplan Provider ID number and Provider NPI number.

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
1 Type of Insurance	Enter an "X" to indicate "other" type of insurance
1a Insured's ID Number	Enter the member's eleven digit Elderplan ID number
2 Patient's Name	Enter the patient's last name followed by the first name and middle initial as shown on patient's Medicare card
3 Patient's Birth Date and Sex	Enter in 2-digit numbers, month, day and year of patient's date of birth and sex
4 Insured's Name	Leave this field blank if the patient and the insured are the same I
5 Patient's Mailing Address/Telephone Number	Enter the patient's complete address. Number and street, city, state, zip code, area code and telephone number
6 Patient's Relationship to Insured	Check the appropriate box.
7 Insured's Address	Leave this field blank if the patient and the insured are the same
8 Patient Status	Leave this field blank
9 Other Insured's Name	Leave this field blank unless you enter yes in field 11d
9a Other Insured's Policy or Group Number	Leave this field blank unless there is other Health Benefit Plan (see field 11d)
9b Other Insured's Date of Birth/Sex	Leave this field blank

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
9c Employer's Name or School	Leave this field blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer.
9d Insurance Plan Name or Program Name	Leave this field blank unless there is other Health Benefit Plan (see field 11d) If the condition being treated is not related to Patient Employment, Auto Accident and/or other Accident, leave these boxes blank
10 Is Patient's Condition Related To: • 10a Employment (current or previous) • 10b Auto Accident • 10c Other Accident	<ul style="list-style-type: none"> • Enter an "X" to indicate illness/injury related to Motor Vehicle Accident. Indicate (State) accident occurred, no fault. Leave this box blank if condition is related to an auto accident other than no fault or if no fault benefits are exhausted. • Enter an "X" to indicate illness/injury related to Motor Vehicle Accident. Indicate (State) accident occurred, no fault. Leave this box blank if condition is related to an auto accident other than no fault or if no fault benefits are exhausted • Enter an "X" to indicate that the condition was related to an accident other than described in 10a or 10b above.
11 Insured's Policy Group or FECA Number	Leave this field blank
11a Insured's Date of Birth	Leave this field blank
11b Employer's Name or School Name	Leave this field blank
11c Insurance Plan Name or Program Name	Insert – Elderplan
11d Is there Another Health Benefit Plan	Indicate if patient has other medical insurance. If yes, return to and complete items 9a through 9d. If other medical insurance is involved either through payment or denial of a claim, the explanation of benefits from the other insurance carrier must accompany the claim form
12 Patient's or Authorized Person's Signature/Date	Entering "signature on file" is acceptable provided physician or supplier actually has patient's or authorized person's signature on file.
13 Insured's or Authorized Person's Signature	Entering "signature on file" is acceptable provided physician or supplier actually has patient's or authorized person's signature on file.
14 Date of Current Illness	Enter 2-digit numbers for month, day and year
15 If Patient Has Had Same or Similar Illness Give First Date	If patient has had same or similar illness, indicate first date
16 Dates Patient Unable to Work in Current Occupation	Leave this field blank

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
17a ID Number of Referring Physician 17b NPI ID Number	For a physician referral service enter the referring physician's first and last name. Prior to name (to the left of the dotted vertical line), enter one of the qualifiers as appropriate to identify the role this physician is performing <ul style="list-style-type: none"> • DN Referring Provider • DK Ordering Provider • DQ Supervising Provider
	Enter the appropriate qualifier and the Elderplan provider number. Enter the NPI ID number of the referring or supervising physician or non-physician practitioner.
18 Hospitalization dates related to current services	Enter the dates that apply to current services. If code 21 is entered in field 24b, then completion of fields 18 and 32 are required
19 Reserved for Local Use	Leave this field blank
20 Outside Lab Charges	Leave this field blank
CMS 1500 BOX NUMBER	REQUIREMENT
21 Diagnosis or Nature of Illness or Injury	Enter patient's diagnosis/condition for the date of service. Enter the diagnoses in priority order. It may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending on the dates of service. The "ICD Indicator" identified the ICD code set being reported. Enter <ul style="list-style-type: none"> '9' for ICD-9-CM diagnosis '0' for ICD-10-CM diagnosis Do not report both ICD-9-CM and ICD-10-CM codes on the same claim. If there are services you wish to report that occurred on dates when ICD-9-CM codes were in effect and others that occurred on dates when ICD-10 codes were in effect, send separate claims, Enter up to 12 diagnosis codes. Do not insert a period in the ICD-9-CM or ICD-10-CM code.
22 Medicaid Resubmission/Original Reference Number	Leave this field blank
23 Prior Authorization Number	If the provider is billing for a service, which required prior approval, enter the approval number specified by Elderplan.
24a Date of Service	Indicate in 2-digit numbers the month, day and year on which a service was rendered. Be sure to enter a date of service for each procedure code listed. Dates should include the "from and to" dates in which the service was performed including same day services.

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
24b Place of Service	<p>This code indicates the type of location where each service was rendered. Enter the appropriate CMS 2-digit codes Note: these are the most commonly used codes. Additional codes can be found in the Medicare Claims Processing Manual- Chapter 26, Section 10.5.</p> <p>CMS 1500</p> <p>Office</p> <p>Home</p> <p>21 Inpatient Hospital</p> <p>22 Outpatient Hospital</p> <p>23 Emergency Room-Hospital</p> <p>24 Ambulatory Surgical Center</p> <p>25 Birthing Center</p> <p>26 Military Treatment Facility, Skilled Nursing Facility or Nursing Home</p> <p>Nursing Facility</p> <p>41 Ambulance</p> <p>00-09 Other</p> <p>62.Comprehensive Outpatient Rehab Facility</p> <p>65 Independent Kidney Disease Treatment Center</p> <p>81 Independent Lab</p> <p>89 Ambulate</p> <p>Note: If Code 21, 22, 23, 24 or 00-09 is entered in field 24b for any claim line, the name and address where procedure was performed must be entered in field 32.</p>
24c EMG	Complete if appropriate.

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
24d Procedures, Services, or Supplies	<p>This is a required field. CPT/HCPCS</p> <ul style="list-style-type: none"> • This code identifies the service, which was rendered to the patient. Enter the appropriate 5-digit number using the current CPT-4 codes corresponding to the service date. • All anesthesia claims must be submitted with anesthesia CPT-4 codes followed by the “AA” modifier, and not surgical codes. Time must be in hours and minutes and include the start and completed time of anesthesia. <p>Modifier</p> <p>The 5-digit CPT-4 code identifying a specific procedure may be expanded by two additional characters called a modifier to further define the nature of the procedure. Anesthesia services (service code 00100-01999) must be reported with an “AA” modifier. See above notation for anesthesia coding specificity.</p>
24e Diagnosis Pointer	<p>For each line enter the appropriate number that corresponds to the code which best describes the main condition or symptom of the patient for which the procedure was performed. At all times coding to the highest specificity is required.</p>
24f Charges	<p>Enter amount billed for the procedure, even if the service is capitated and is being submitted for encounter reporting purposes.</p>
24g Days or Units	<p>Procedures performed more than once on the same date of service should be entered with the correct number of times it was performed. When a procedure is only performed once it should be noted as “1” in the space provided.</p>
24h EPSDT	<p>Leave this field blank</p>
24i ID Qualifier	<p>Enter the appropriate ID Qualifier</p>
24j Rendering Provider ID. # Rendering Provider NPI ID. #	<p>Enter the rendering Elderplan provider number in the box directly below the section title.</p> <p>Enter the rendering provider NPI number in the box below the Elderplan provider number.</p>

CMS 1500 (Ver 0212) BOX NUMBER	REQUIREMENT
25 Federal Tax ID number	Enter the Employer Federal Tax ID number or the Social Security Number of the payee and check the appropriate box.
26 Patient's Account number	Enter your patient account number. This Will appear on the explanation of payment.
27 Accept Assignment	Leave this field blank
28 Total Charges	Insert Total Billed Amount
29 Amount Paid	If payment from other medical insurance is received, attach the Explanation of Benefits/Payment form to the claim from that insurer.
30 Balance Due	Leave this field blank
31 Certification (Signature of Physician or Supplier including Degrees or Credentials) Date	The physician must sign the claim form or a signature stamp may be used. Please note that the certification statement is on the back of the claim form.
32 Service Facility Location Information 32a Provider NPI # 32b E.P. Provider ID #	If you entered Code 21, 22, 23, 24, 31,32,33 or 00-09 in field 24b, enter the name and address where the service was rendered Enter the NPI # of the service facility. Enter the Elderplan provider number of the facility.
33 Billing Provider Info & Ph. #	Enter the providers billing name, address, zip code and phone number.
33a Provider NPI # 33b E.P. Provider ID #	Enter the NPI # of the billing provider or group. Enter the Elderplan provider number assigned to the billing provider or group.

UB04 CLAIMS SUBMISSION REQUIREMENTS (PAPER AND EDI)

Facilities and other institutional providers such as ambulatory surgical centers must submit on UB04s. Submit reporting data on the UB-04 form using the standard CMS data requirements. In addition to the member, provider and procedure information, please ensure the Revenue Codes are accurate. DRG assignments should also be noted where applicable.

All correspondence should be mailed to:

Elderplan
745 64th Street
Brooklyn, NY 11220

Claims requiring operative or medical reports, EOBs/EOPs, or attachments may not be submitted electronically.

EDI claims pass through multiple edits in search of missing information. Should there be missing information on first pass you will receive an error report and you must correct before resubmitting the claim electronically. Claims that pass the initial electronic edits may require additional information for accurate pricing. If such information is missing, these claims will be reviewed manually and follow the paper claims review process.

Paper claims will be reviewed for completeness. Paper claims with missing information will be returned to you. The claim will be accompanied by an Elderplan letter outlining the deficiencies on the claim.

Claims Payment Reconsideration

Claims denied for the following reasons: no record of an authorization, authorization exceeded, untimely filing, reimbursement, invoices and records, etc. may be disputed for payment reconsideration. Request for reconsideration needs to be received by Elderplan within 180 days of the notice of denial.

Corrected Claims Resubmission

Submission of corrected claim; (invalid/ missing codes, such as cpt, place of service, missing units, etc.) should contain the original claim number for reference and indicate “Corrected Claim” visibly on the form resubmitted. Any supporting documentation must

be attached at the time of resubmission. Corrected Claims must be submitted within 180 days of the date of service.

Claims Status:

Providers may call Elderplan at (718) 921–7979 to obtain information regarding the status of their claims. Please have the DOS, member name and ID number, Elderplan provider ID number available when making a claims status inquiry.

PROCESSING GUIDELINES

Modifier Guidelines

When applicable, the circumstance requiring use of a modifier should be appropriately noted. Elderplan recognizes the modifier codes as outlined in the standard coding documents. When modifiers are used appropriately and follow the guidelines for reimbursement noted in the standard coding documents, Elderplan will reimburse accordingly unless Code Review identifies a coding error.

Elderplan uses a system that edits claim coding based on a clinical database that detects and initiates corrective coding action on CPT4 and HCPCS coded claims. This consistent and objective review initiates corrective coding on medical, surgical, laboratory, pathology, radiology, and anesthesiology services. The system’s function is to identify coding inconsistencies such as:

- Bundling
- Mutually exclusive procedures
- Procedures to be excluded from global arrangements
- Fragmentation of claims
- Misuse of modifiers

The EOPs submitted to the provider will outline any changes. These changes reflect coding practices generally accepted in the industry.

In addition, Elderplan uses CMS Correct Coding Initiative (CCI) edits and other Medicare processing guidelines.

Multiple Surgeries

Elderplan recognizes the incidence of multiple surgeries occurs on the same day, during the same surgical session and/or from one incision. Multiple surgeries from the same incision, multiple surgeries on the same day or during the same surgical session having separate incisions are reimbursed accordingly:

100% for the first or primary surgery

50% for the second approved surgery

0% for any additional surgeries in the same incision

EXPLANATION OF PAYMENT REMITTANCE

Checks and EOPs are generated and sent to the providers and members on a weekly basis. Mailing addresses are pulled from our provider files and claims forms therefore provider name, address and Tax ID number accuracy in our provider files is critical to sending you reimbursement and explanation for services rendered. In addition annual 1099 mailing depend on the accuracy of our records. Please ensure your office updates your office information as soon as it changes.

Capitated Providers-Monthly Member Rosters

On a monthly basis the Network Planning and Operations Department generates member rosters and capitation payments to all providers under capitation. Inquiries on your monthly roster or payment should be directed to Customer service.

Recoupment of Overpayments

Elderplan utilizes a systematic rolling recoupment process. Your explanation of payment (EOP) will outline how the recoupment was made. Within a given pay period, if more payments are taken back then paid, you will see a negative balance on your EOP. As such, future claims paid for to you will recoup against the negative balance until the balance is satisfied. You will receive an EOP with a "claims paid this run" total, but you will not receive a check. The attached check amount will read \$0. Once the balance is satisfied, checks will be attached to the EOPs.

In the recoupment process, in addition to the EOP you will receive a report for that weekly check run that lists the claims that were processed for recoupment as well

as a notation as to whether the balance was partially or fully recovered. If the balance was partially recovered the balance that remains will be noted and processed against the next week's claims.

Elderplan has provided you with this EOP and report as a means of assisting you with managing your accounts receivable. Such history is not readily accessible at Elderplan and as such Elderplan requests you pay close attention to recoupment reports when received.

COORDINATION OF BENEFITS

Elderplan expects providers to seek payment for services rendered to members from all payors the member has coverage with. In cases where multiple coverage exists, benefit reimbursement is coordinated between payors.

The following instances require the provider to investigate whether additional payor coverage exists:

- A retired member has supplemental health benefits through a previous employer
- A disabled member has supplemental insurance
- A member is dually eligible and covered for Medicare and Medicaid
- The member's injuries/illness initiates no-fault or worker's comp coverage
- The member is under 65 years of age
- The member is currently employed and has additional insurance

In cases where supplemental insurance exists to the member's Elderplan coverage the following is the order used to determine the primary payor:

- Elderplan members over 65 or disabled have Elderplan's Medicare plan coverage as primary unless the injury sustained is the result of an auto or work-related illness covered by no-fault insurance or worker's compensation. In this instance, no fault or worker's compensation is primary and Elderplan may be secondary.
- Elderplan will not cover benefits for any services, which are covered under the Working Aged Provision of Medicare. The provider of services shall bill the primary insurance carrier and bill Elderplan as the secondary insurance carrier for members covered under the Working Aged Provision.

- Dual-eligible Elderplan members covered by Medicare and Medicaid. Medicare is primary and Medicaid is secondary.

Elderplan will not cover benefits or coordinate benefits for care in hospital or any other institution, which is owned, operated or maintained by the Veterans Administration, the federal government.

Medicaid only services: Elderplan will not deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless Elderplan has a “reasonable basis” to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if Elderplan requests information from the member regarding other coverage, and does not receive the information within 45 days; Elderplan will adjudicate the claim. The claim will not be denied on the basis of non-receipt of information about other coverage.

No fault/Worker’s Compensation Claims

Claims qualifying for payment under the member’s no-fault insurance plan must be submitted to the no-fault carrier first. A copy of the statement, EOP or EOB from the no-fault carrier outlining the name of the individual that was paid and the amount that was paid should be submitted with claims to Elderplan.

Claims for work-related injuries or illnesses must be submitted to the worker’s comp carrier as primary. Once accepted by that carrier as a work related claim, all claims should be sent to them as the primary carrier. There is no coordination of benefits on worker’s compensation claims with Elderplan. In cases where the worker’s comp carrier denies the initial claim as work related, Elderplan will provide coverage only when the denial of coverage from worker’s comp accompanies the claim.

GRIEVANCES AND APPEALS

Grievances

Members have the right to file a complaint with Elderplan. A complaint is also known as a grievance. Grievances are complaints that do not involve coverage determinations such as the denial or reduction in payment or service. Examples of grievances include but are not limited to:

- Complaints about the quality of service
- Complaints about office wait time, physician or office staff behavior, inadequacy of the facility
- Involuntary disenrollment
- Reimbursement questions
- Other non-clinical determination complaints

Members must follow the following process when submitting a grievance to Elderplan. Every attempt will be made to resolve telephonic grievances at the time of the call. Usually a grievance results from misinformation, a misunderstanding or a lack of information. If a more formal process is needed to resolve a grievance the member will be requested to submit their grievance to:

Elderplan

Attn: Appeals & Grievances Department

745 64th Street

Brooklyn, NY 11220

Upon receipt of the written grievance, Elderplan will advise the member in writing of receipt of the grievance and notification that a determination will be made within thirty (30) days. If Elderplan is unable to respond within thirty (30) days and requires an extension, the member will be notified in writing of the need for an extension of up to 14 days. In quality of care instances, a determination received from Elderplan will be accompanied by information on how to file a complaint with the Quality Improvement Organization.

Appeals

Members and providers also have the right of appeal when an initial determination denies service or payment for service rendered (see Medical Management for detailed description of Adverse Determinations).

Please follow the grid below when determining the type of appeal being filed, the timeframe in which it must be filed and the time frame in which you can expect a response:

Type of Appeal	Time Frame for Submission	Time Frame for Response	Examples of Appeals
Standard Service Appeal (clinical denial)	Within sixty (60) Days from the date of the adverse determination	Elderplan must respond within thirty (30) days of the written appeal from the provider/facility/member an extension of up to 14 calendar days is permitted if requested by the member or provider or if Elderplan decides extra time is needed and the extension is in the best interest of the member.	Adverse Determination: clinical denial of service, procedure or admission, denial of extension of treatment
Standard Appeal- (non clinical denial) 1) Incomplete Claim Form 2) Complete Claim Form	1. If additional information is requested: within one hundred eighty (180) Days from the date of service. 2. If no additional information is requested: within one hundred eighty (180) days from the date of the EOP.	Elderplan must respond within sixty (60) days of the written appeal from the provider/facility/member	1. Request for medical records; mis-coding; incomplete fields, etc: 2. Lack of authorization; procedure out of scope of service; denial of payment, etc.

Type of Appeal	Time Frame for Submission	Time Frame for Response	Examples of Appeals
Expedited Service Appeal	Immediate if the member's care/health outcomes are jeopardized by the adverse determination	Elderplan must respond within seventy-two (72) hours of the request for an expedited appeal an extension of up to 14 calendar days is permitted if requested by the member or provider or if Elderplan decides extra time is needed and the extension is in the best interest of the member.	Denials of service, procedure or admission, denial of extension of treatment

Provider External Appeal and/or Alternative Dispute Resolution Process for Medicaid Services.

Providers may file an External Appeal in connection with concurrent adverse determinations. A provider will be responsible for the full cost of an external appeal that is upheld; Elderplan is responsible for the full cost of the external appeal that is overturned; and both the provider and Elderplan will evenly share the cost of partial overturned determinations. If the provider is acting as the member's representative, Elderplan is responsible for the cost of the external appeal. Article 28 facilities - an Article 28 licensed facility and Elderplan may agree to alternative dispute resolution in lieu of an external appeal. This provision does not impact a member's external appeal rights or right of the member to establish the provider as their designee. Where agreed to, facilities may be made aware of ADR by letter, in the notice with an initial adverse determination, or some other mechanism. Which party will bear the cost of the ADR process in lieu of an external appeal is a matter between the MCO and the provider. Note, if the member files an external appeal, the external appeal determination takes precedence over the ADR.

A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

RECONSIDERATIONS

A reconsideration can be made by the member, provider or member's designee. It is a request (to appeal) a determination. Members, providers and/or their designees must submit a reconsideration in writing with supportive documentation within sixty (60) days of receipt of the EOP. The request specifically requests the initial determination be overturned. The member, provider or designee filing the reconsideration will receive a letter from Elderplan confirming receipt of the reconsideration letter. Upon receipt the appropriate department will be forwarded the reconsideration:

- Technical denials (i.e. missing CPT code, missing diagnosis code) or payment questions will be forwarded to the Claims Department
- Medically Necessity denials will be forwarded to Medical Management
- DRG validations will be conducted by Medical Management through retrospective review

Elderplan is required to respond to a reconsideration request within sixty days.

Send all reconsiderations to:

Elderplan

Attn: Appeals & Grievances Department

745 64th Street

Brooklyn, N.Y. 11220

QUALITY MANAGEMENT

The Quality Management Department oversees all activities in the Quality Improvement Program (QIP). The goal of the QI Program is to improve the health outcomes of our membership through ongoing data analysis and quality improvement programs that continuously evaluate the care our members receive and improve the type and levels of care our members can access. The scope of the QI Program encompasses activities that have either direct or indirect influence on the service received by members, the quality of care received by members and the operational processes behind the service and care provided to members. Further, the Quality Management Department oversees the collection, submission, and analysis of HEDIS data and the annual medical record review process.

The Plan Quality Improvement Committee is the body that oversees all the subcommittee activities. The Plan Quality Improvement Committee reports to the Elderplan Board of Directors (BOD) who is responsible for the quality improvement program, annual Workplan, and annual QI Program evaluation. The Plan Medical Director is responsible to the BOD and PQIC for clinical strategies, clinical quality improvement projects and initiatives.

The Plan Quality Improvement Committee structure includes the following subcommittees:

- Appeals and Grievance
- Clinical Practice
- Credentialing
- Customer service
- Pharmacy and Therapeutics
- Utilization Review

The QI Program objectives are the following:

- Facilitate the identification, development and implementation of improvement activities throughout Elderplan
- Improve organizational processes
- Improve organizational communication
- Maximize the use of data collection and analysis for the purpose of improving member outcomes
- Assess the delivery system available to the membership on an ongoing basis
- Conduct an annual evaluation of the QI Program and develop new programs as needed
- Outline an annual QI Program work plan

Elderplan Quality Improvement Committee Structure

Elderplan Inc. has created a structure that facilitates the flow of information among the various subcommittees of the Plan and the Board of Directors. Data is gathered at the departmental level and aggregated and shared with the appropriate subcommittee. Quality improvement initiatives are data-driven. The Plan Quality Improvement Committee oversees and supports communication, discussion, input, and decision-making regarding clinical practice and operational performance. The committee structure consists of the following:

The Plan Quality Improvement Committee

The Plan Quality Improvement Committee is responsible to identify, prioritize, and oversee implementation, monitoring, and evaluation of the Quality Improvement Program, Workplan and Quality Improvement Projects. This multi-disciplinary committee accomplishes its responsibilities by review of regularly submitted presentations, reports, and minutes of various quality committees and subcommittee.

Chairperson: Assistant VP Medical Management and Quality Management

Co-Chair: Director of Quality Management

Committee Members: President, Managed Care; VP, QM of MJHS, Medical Director, VP, Elderplan; AVP of Member Operation; AVP of NPO; Director of NPO; Director of Medical Management; HR Assistant Director or designee; Corporate Compliance Officer; VP, Sales; Director of Customer Service; SVP of Claims; Pharmacy Benefit Manager.

Meeting Frequency: Quarterly

Plan Subcommittees

The Plan Subcommittees report trends and improvement plans to the Plan Quality Improvement Committee.

Appeals and Grievances (A&G)

The Appeals & Grievance (A&G) Subcommittee is responsible for reviewing and analyzing A&G data including but not limited to volumes, categories / reasons for appeal/grievance, overturns/upholds and IRE/IPRO activity. The purpose of the Subcommittee is to identify opportunities for improvement that will ultimately reduce the number of appeals / grievances received and increase customer satisfaction.

Chairperson: Director, Appeals and Grievances

Co-Chair: AVP, Medical Mgmt, Quality Mgmt, A&G

Committee Members: Claims Manager; Manager, A&G; Supervisor, A&G; Quality Management Coordinator; Manager, Review Operations; Director of NPO; Compliance Coordinator; Customer service Supervisor.

Ad Hoc Members: Managed Care Pharmacist

Frequency: Monthly

Clinical Practice Subcommittee (CPC)

The Clinical Practice Committee's (CPC) responsibilities include organizational processes related to all aspects of clinical care including but not limited to: peer review/clinical corrective action plans, review of clinical data and development of preventive health programs, disease state management program initiatives, approval of practice guidelines and review approval of clinical policy and procedures.

Chairperson: Medical Director

Co-Chairperson: Director of Quality Management

Committee Members: Plan Physicians - Five (5) with three (3) required for quorum, Physician Advisor for Active Health Management, Director of Medical Management, AVP of Medical Management / Quality Management

Ad Hoc: Director of NPO

Frequency: Quarterly

Credentialing Committee / Recredentialing Subcommittee (CRED/Re-Cred)

The Credentialing/Recredentialing Subcommittee is responsible for the provision and oversight of Elderplan Network by ensuring that it consists of qualified practitioners and facilities, which meets or exceed Elderplan standards for participation and quality of care. The Subcommittee ensures that all providers and candidates are evaluated by a committee of their professional peers.

Chairperson: Plan Medical Director

Committee Members: Elderplan Participating Physician (10), Supervisor of Credentialing, Quality Management Coordinator

Frequency: Monthly

Customer Satisfaction Subcommittee (CSC)

The goal of the Customer Service Subcommittee is to maintain and increase customer satisfaction. Our customers are defined as members, providers, and staff. The subcommittee is responsible for the tracking, trending, analysis, monitoring, and improving systems and processes that impact customer satisfaction. The Customer Satisfaction Subcommittee will make recommendations for change based on the data analysis and customer feedback, monitor implementation, and evaluate results of all initiatives.

Chairperson: Director of Customer service

Co-Chair: Assistant VP, Member Operations

Committee Members: Claims Manager; Director, QM or designee; Director of Contract; Manager Coordinated Care; Manager, Member Operations and Sales Administration; Supervisor, A&G

Frequency: Monthly

Pharmacy and Therapeutics Subcommittee (P&T)

The Pharmacy & Therapeutics (P & T) Committee is responsible for ensuring the Plan's compliance with the requirements of Part D formulary development and oversight. The Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. The P & T Committee bases clinical decisions on the strength of scientific evidence and standards of practice using peer-reviewed medical literature, pharmacoeconomic studies, and other appropriate resources.

The P & T Committee reviews policies that guide utilization management processes such as drug utilization review, quantity limits, etc. The decisions of the P & T Committee are forwarded to the Plan Quality Improvement Committee.

Chairperson: Pharmacy Benefits Manager

Co-Chairperson: Associate Medical Director

Committee Members: Plan Medical Director, Practicing Physicians (three including one non-affiliated), Pharmacist (two including one PBM rep and one non-affiliated) Director of Medical Management, Quality Management Coordinator, AVP of Medical Management / Quality Management

Ad Hoc Members as needed

Frequency: Quarterly

Utilization Review Subcommittee (UR)

The Utilization Review Subcommittee is responsible for the review and analysis of utilization data. This data is used as foundation for the UM programs, requirements, and performance improvement activities. Collection and analysis of claim, encounter and administrative data is used to establish baseline, evaluate performance, prioritize improvement initiatives, allocate resources and evaluate effectiveness.

Chairperson: Director of Medical Management

Committee Members: Manager, Review Ops; Informatics designee; Claims Auditor; Provider Service Manager; Manager, Coordinated Care; Managed Care Pharmacist;

Ad Hoc: Medical Director, Population Health Coordinator

Frequency: Bi- Monthly

Providers expressing an interest in joining any of the subcommittees with provider representation are encouraged to contact the Director of Quality Management Department at (718) 759-4095. Your input is invaluable for initiating and establishing health policies and overseeing quality improvement initiatives for Elderplan members.

PHYSICIAN OFFICE PERFORMANCE STANDARDS

Access to Care

Elderplan enforces compliance with the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access guidelines. Elderplan providers must accommodate the following types of appointments within the indicated time frames:

Type of Appointment	Scheduling Requirement
Urgent but non-emergency	within 24 hours
Non-urgent, but in need of attention	within one week
Routine and preventive care	within 30 days

Providers must maintain a mechanism for 24 Hour/7 Day patient telephone access and office coverage to respond to emergencies for their patients. Pre-recorded referral to a hospital Emergency Department does not constitute appropriate 24 Hours/7 Day coverage. Primary care physicians must have appropriate back-up for absences.

Providers who fail to meet office performance standards will need to prepare a corrective action plan for submission to the Quality Management Department. Providers deemed not in compliance with office performance standards may have their contract

terminated. On the day of an appointment, a member should not wait more than thirty (30) minutes past their scheduled appointment time. If an emergency arises for the provider and the wait time is more than fifteen (15) minutes, the member must be notified of the delay and given the option to reschedule.

Members should be notified in advance, if the situation permits, of any appointment cancellations or postponements and should be given the opportunity to reschedule cancelled appointments.

Telephone Response Time

Provider office telephone response time guidelines to member calls are the following:

Type of Call	Response Time
Emergency condition	Immediate
Urgent condition	Within 4 hours
Semi-urgent condition	Within the provider office hours
Routine condition	Within 2 business days
After Hours calls	When the condition level is not made clear a 30 minute response time is expected

Elderplan defines these levels of conditions accordingly:

Emergency: those conditions whose onset are acute and may occur with or without a prior medical history of the condition. Symptoms are of sufficient severity that a prudent layperson could reasonably expect the absence of immediate medical attention could result in serious damage or death.

Urgent: usually occur over a period of a few days and may occur with or without a prior medical history of the condition. These illnesses and injuries need to be evaluated and/or treated urgently, but will not immediately cause permanent damage or death.

Semi-urgent: usually conditions that last greater than a few days duration that are persistent and may occur with or without a prior medical history of the condition.

Routine: conditions that are chronic in duration. Preventive health care services are associated with keeping the member healthy.

MEDICAL RECORDS

Elderplan performs an annual Medical Record Documentation audit as a component of the Plan's Quality Management Program. All Elderplan primary care physicians are required to achieve an aggregate score of 80% compliance. Results are analyzed by Quality Management and communicated to the physician. Practitioners who fail to meet this standard will be notified in writing of the area(s) that are subject to an individual performance improvement plan and monitoring.

Providers are required to allow Elderplan, the New York State Department of Health, and the Centers for Medicare and Medicaid Services access to Elderplan member medical information.

The medical record must be written in ink or computer generated and contains at minimum the following elements:

Core Elements
Each page of the medical record contains identifying information for the member
All entries must contain author identification and professional title.
All entries must be dated
All entries must be in ink or computer generated.
Identification of all providers participating in care and information on services furnished are found in the record
An up-to-date problem list, including significant illnesses and medical/psychological conditions, is present in the record.
Each note describes presenting complaints, diagnoses and treatment plan
A medication list containing prescribed medications, including dosages and dates of initial or refill prescriptions is present in the record
Information on allergies and adverse reactions (or notation that patient has no known allergies or adverse reactions) is contained in the record.
The record contains documentation of past medical history, physical examinations, necessary treatments and possible risk factors for the member relevant to a particular treatment
Information on Advance Directives (or notation of discussion whereby member does not have or wish to have an Advance Directive)
The record is legible to other than the writer
If member was discharged from an inpatient facility or nursing home, the medication reconciliation was completed within 30 days of discharge.
Body Mass Index (BMI) measurement is present in the chart
Member is assessed for pain.
Functional status assessment is present.

CHART REVIEWS

In addition to existing medical record audits, Elderplan conducts random, on-site record reviews and/or requests specific medical record information be submitted by mail. The purpose of these audits is to improve the identification and tracking of patients' chronic conditions. All identified diagnoses for each patient should be accurately documented in the patient's medical record. The documentation should include the reason the member is seeking care as well as any co-morbidities either acute or chronic and/or pertinent past conditions that are part of the clinical evaluation and therapeutic treatment.

Elderplan utilizes claims data as well to audit encounters. As such, encounter claims should reflect all diagnoses related to an encounter including any co-morbidities either acute or chronic and/or pertinent

past conditions that are part of the clinical evaluation and therapeutic treatment. Claim diagnosis detail allows for up to four (4) ICD-10 codes per visit. Inclusion of this detail is required. In addition, ICD-10 codes should be coded to the highest degree of specificity. For your information, an example has been included:

- 401 Essential hypertension
- 401.0 Hypertension, malignant
- 401.1 Hypertension, benign
- 402 Hypertensive heart disease
- 403 Hypertensive renal disease
- 403.91 Hypertensive renal disease, unspec., w/ renal failure
- 404 Hypertensive heart and renal disease
- 405.01 Hypertension, renovascular, malignant
- 405.11 Hypertension, renovascular benign

Elderplan will, at its discretion, request medical information related to any member's grievances and/or appeal status. As a participating provider, your cooperation is appreciated. You are contractually obligated to submit to Elderplan's staff any medical information requested related to its quality assurance program at no charge to the plan.

Quality of Care Concerns

If a quality of care concern is uncovered during a medical record review or in response to a member quality grievance, Elderplan will share its findings with the provider. The provider will have the opportunity to respond to Elderplan's findings within 30 days of receipt of the notice. If no response is received within 30 days of the notice, Elderplan may request a plan of correction from the provider. Quality of care grievances issues will be filed with Network Planning and Operations for further review and action.

Non-Compliance with Medical Record Requests

Providers who are not compliant with Elderplan's requests for medical records will be notified by phone and/or mail of their non-compliance. The Provider Relations Department will be made aware of non-compliance issues. Non-compliance events will be documented in the provider's file for further review and action.

HEDIS

Elderplan, as a Medicare Advantage managed care organization (MCO), reports on HEDIS measures. HEDIS measures performance against a set of standardized measures of preventative services and general services, utilization, and member health outcomes. Elderplan annually collects data from a number of sources to report its performance on the HEDIS set of measures including:

- Encounter/claims data
- Medical records from provider offices

As a participating provider with Elderplan you may receive a request for on-site chart reviews to assist Elderplan in reporting the most accurate values on their HEDIS report. Elderplan will conduct these reviews with its own staff. Your support during the scheduling and visits is appreciated. HEDIS reviews occur annually from February to June. Elderplan will do its best to keep office disruption to a minimum. You cannot refuse an Elderplan representative from conducting an onsite review.

For your information Elderplan has listed below the HEDIS measures that are required for Elderplan to monitor: (*indicates onsite medical record review)

Effectiveness of Care / Prevention and Screening

- Adult BMI Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening*
- Glaucoma Screening in Older Adults
- Care for the Older Adults

Effectiveness of Care / Respiratory Conditions

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation

Effectiveness of Care / Cardiovascular

Cholesterol Management after Acute Cardiovascular Events*

- LDL-C Screening
- LDL-C level <100

Controlling High Blood Pressure*

Persistence of Beta Blocker Treatment after A Heart Attack

Effectiveness of Care / Diabetes

Comprehensive Diabetes Care *

- HbA1c Testing
- HbA1c Poor Control (>9%)
- Hb1Ac Good Control (<7.0%)
- Eye Exam
- LDL-C Screening
- LDL-C level <100
- Monitoring for Diabetic Nephropathy

- Blood Pressure Controlled <140/90 mm Hg
- Blood Pressure Controlled <130/80 mm Hg

Effectiveness of Care / Musculoskeletal

- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture

Effectiveness of Care / Behavioral Health

- Antidepressant Medication Management
- Follow-up after Hospitalization for Mental Illness

Effectiveness of Care / Medication Management

- Annual Monitoring for Patients on Persistent Medications
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
- Use of High-Risk Medications in the Elderly

Access/Availability of Care

- Adults' Access to Preventive/Ambulatory Health Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Call Abandonment
- Call Answer Timeliness

Use of Services

- Frequency of Selected Procedures (per 1000 members per year)
- Ambulatory Care
- Inpatient Utilization - General Hospital/Acute Care
- Inpatient Utilization - Non-Acute Care
- Identification of Alcohol and Other Drug Services

- Mental Health Utilization - Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient and Intermediate Care and Ambulatory Services
- Antibiotic Utilization
- Outpatient Drug Utilization

HEDIS measures are added annually and as such the list above may not be all encompassing. For an update of the measures, please contact Elderplan's Quality Department.

CPT CATEGORY II CODES

Elderplan encourages providers to use CPT Category II Codes in order to facilitate medical record reviews. CPT Category II Codes were developed for performance measurement to decrease the need for record abstraction and chart review, thereby minimizing administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. According the American Medical Association, these codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

Examples of CPT Category II Codes that are helpful with HEDIS measures and medical record review include the following:

Code	Description
1123F	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
1124F	Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
3017F	Colorectal cancer screening results documented and reviewed
3044F	Most recent hemoglobin A1C (HbA1c) level <7.0% (Diabetes Mellitus)
3045F	Most recent hemoglobin A1C (HbA1c) level 7.0 – 9.0% (Diabetes Mellitus)
3046F	Most recent hemoglobin A1C (HbA1c) level > 9.0% (Diabetes Mellitus)

Code	Description
3048F	Most recent LDL-C < 100 mg/dL (Diabetes Mellitus)
3049F	Most recent LDL-C 100 -129 mg/dL (Diabetes Mellitus)
3050F	Most recent LDL-C >= 130 mg/dL (Diabetes Mellitus)
3074F	Most recent systolic blood pressure < 130 mm Hg (HTN)
3075F	Most recent systolic blood pressure 130 to 139 mm Hg (HTN)
3077F	Most recent systolic blood pressure >= 140 mm Hg (HTN)
3078F	Most recent diastolic blood pressure < 80 mm Hg (HTN)
3079F	Most recent diastolic blood pressure 80 – 90 mm Hg (HTN)
3080F	Most recent diastolic blood pressure >= 90 mm Hg (HTN)

IMPORTANT DEFINITIONS

HEDIS: Healthcare Effective Data and Information

Set a set of quality standards established by the NCQA National Committee for Quality Assurance to assist buyers of healthcare plans evaluate the value and performance of one plan equally against another.

NCQA: the National Committee for Quality Assurance is an independent accrediting organization whose mission is to improve the quality and service of managed care organizations/health plans by evaluating their performance against a set of established standards.

Quality Improvement Program: a quality program developed annually to focus on the improvement of member health outcomes, process improvement organizationally, and network care/care delivery evaluation.

Risk Management: the process in quality designed to evaluate, reduce, prevent, and/or eliminate situations leading to financial loss.

Grievance: complaints that do not involve coverage decisions. Such complaints may include but are not limited to: quality of service, office wait time, physician/professional staff/office staff behavior, and adequacy of facilities, involuntary disenrollment situations.

Determination: a decision to pay for, provide, authorize, deny, or discontinue service

Adverse Determination: a denial of service, admission, or extension of admission or service. Clinical rationale for the adverse determination is included in all verbal and written notifications.

Appeal: appeals are a second level review following an adverse determination.

Reconsideration: a request to reevaluate payment and services following receipt of an Explanation of Payment EOP or denial

Emergent Condition: conditions whose onset are acute and may occur with or without a prior medical history of the condition.

CUSTOMER SERVICES

Important Definitions

Member: a subscriber who has met Elderplan’s requirements for eligibility and for whom his/her monthly premium has been received thus making the member eligible to receive covered services as outlined in their EOC.

Evidence of Coverage (EOC): a document that outlines to all eligible members the services covered under the Elderplan benefit plan.

Service Area: Elderplan currently services Brooklyn, Queens, Manhattan, Staten Island, Bronx, Nassau, Westchester, Suffolk, and Monroe counties.

Grievance: a complaint about any type of problem with Elderplan or its providers

Appeals: a complaint about a decision Elderplan made regarding services covered or payment made. Appeals are reviewed by Elderplan and when appropriate may be reviewed by an independent outside agency.

Eligibility

A Medicare beneficiary is generally eligible to enroll in Elderplan provided he or she is:

- As a Medicare Advantage plan, Elderplan's contract with CMS limits enrollments to beneficiaries who obtain Medicare status through age or disability
- Entitled to Medicare Part A and enrolled in Medicare Part B – If the prospect has Medicare Part B only, he or she is not eligible to enroll in Elderplan.
- Does not suffer from End Stage Renal Disease – Or permanent kidney failure which requires regular kidney dialysis or a transplant to maintain life. If an individual was already enrolled with Elderplan when he or she developed ESRD, he or she may remain as an enrollee of Elderplan and cannot be disenrolled from the Plan for health reasons.
- Permanently resides in the Elderplan Service Area at least six months of the year – As defined in the Member's Evidence of Coverage.

Member Enrollment

Eligible individuals may enroll in Elderplan during the Annual Enrollment Period between October 15 and December 7 of each year, for enrollment effective the first day of the following year. Additionally, individuals may disenroll from Medicare Advantage plans and return to Traditional Medicare during the Annual Disenrollment Period, January 1 through February 14th, the individual can add a stand-alone prescription drug plan to accompany Traditional Medicare. However, there are exceptions that may allow an individual to enroll in Elderplan outside of these election periods. The Elderplan individual election form must be submitted to CMS in order to

be processed. Generally, an enrollment received prior to the end of the month will be effective the first of the calendar month following the date the election is made. As indicated above exceptions and other election periods apply; please contact Elderplan's Enrollment Department for exceptions and rules.

Individuals interested in becoming Elderplan Members may contact the Elderplan Enrollment Department, Elderplan- New Enrollee (Sales) at 1(866)703-5810 Monday through Friday between 8:00 a.m. and 5:00 p.m. Elderplan encourages providers to refer prospective members to the Enrollment Department.

Disenrollment

Generally, there are only certain times during the year when Medicare Advantage plan members may voluntarily end their membership. Every year from October 15 through December 7 during the Annual Election Period, anyone with Medicare may switch from one way of getting Medicare to another for the following year (effective January 1 of the following year). As with enrollments, exceptions and other election periods may apply. Please contact Elderplan's Customer Service department at (718) 921-7979, between 8:00 am and 8:00 pm seven days a week, for additional information.

Under no circumstances are participating providers, their staff, Elderplan staff, or other agents to encourage or request an Elderplan member to disenroll from Elderplan, join another plan, or change insurance coverage.

If a Primary Care Physician receives a request from a member to disenroll, the Primary Care Physician must tell the member to contact Elderplan Customer Service at (718) 921-7979, or 711 for TTY users, as soon as possible so that the request can be processed in a timely manner.

Written requests for disenrollment should be immediately sent by fax to Elderplan at (718) 630-2624, and then mailed to:

Elderplan Customer Service Department
745 64th Street
Brooklyn, NY 11220

In special cases, Elderplan may involuntarily disenroll a member. However, involuntary disenrollments require prior approval from the Centers for Medicare and Medicaid Services. Please note no member shall be disenrolled because of the member's health status.

For additional information about disenrollments, contact Elderplan Customer Service at (718) 921-7979.

Release of Information to Members

- Members are entitled access to, or copies of, records concerning their health care. All or part of the medical record may be released upon written authorization from the member or other "qualified person" in accordance with applicable state and federal law.
- Qualified persons other than the member who may request access or copies on behalf of the member include, but are not limited to:
 - Court-appointed committee for an incompetent person
 - Court appointed guardian
 - Other legally appointed guardian

Members Requesting Records

- A written request, either in the form of a letter or an authorization form signed by the patient should include:
 - Name of the physician from whom the information is requested
 - Name and address of the institution, agency, or individual that is to receive the information
 - Member's full name, address, date of birth, and Elderplan i-identification number
 - The extent or nature of the information to be released, including dates of treatment
 - The date of initiation of authorization
 - Signature of member or qualified person

Member requests should be honored within 10 days of the date of receipt of the written authorization.

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member or others, or would have a detrimental effect on the provider's professional relationship with the patient or his or her ability to provide treatment.

The physician may place reasonable limitations on the time, place, and frequency of any inspections of the patient information. Personal notes or observations may be excluded from any disclosure based on the provider's reasonable judgment.

Special authorizations, forms and procedures are required for HIV-related testing (both before and after the test is performed) and for release of any HIV-related information from the medical record. The informed consent form and the authorization for release of confidential HIV-related information must be the New York State Department of Health approved forms or must be forms that have been approved by the New York State Department of Health. All authorizations requesting the release of mental health records must specify that the information requested concerns mental health treatment.

Non-Compliance with Medical Record Requests

Providers who are not compliant with member's requests for medical records will be notified by phone and/or mail of their non-compliance. The Provider Relations Department will be made aware of non-compliance issues. Non-compliance events will be documented in the provider's file for further review and action.

CUSTOMER SERVICE

Elderplan offers members access to their coverage and benefit questions through contact with our Customer Service representatives in our Customer Service Department at (718) 921-7979.

Elderplan keeps in touch with our members on a regular basis to ensure their experience with the plan is good and their health and well being are maintained or enhanced. All new members receive a new member call from a Customer Service Representative within a few weeks of their enrollment. A representative will review the benefits, programs and services available to the member.

Elderplan also conducts annual member satisfaction surveys. All positive and negative experiences are reviewed and where needed service improvement action plans are initiated.

Members also receive invitations to special events and letters outlining programs and services that may have been developed or enhanced. A quarterly newsletter also updates the member on health information and programs offered through Elderplan.

Members have a process for voicing their grievances and appealing decisions made by Elderplan related to service decisions and payment decisions. The member handbook given to all members' outlines for them the process for submitting grievances and appeals.

Members may also file complaints with a Peer Review Organization (PRO) in their area should they have quality of care complaints. Their member handbook also outlines information on how to find a PRO in their area.

ELDERPLAN WEB SITE

Members can access a multitude of information on our web site at www.elderplan.org. Members can find:

- A provider
- Information about benefits
- Preventive health information
- Elderplan member program information

Compliance/Fraud Waste and Abuse (FWA) Program Training Materials

Providers may access information about the Elderplan compliance program on our website at www.elderplan.org/for-providers/compliance-fwa-training. Providers may also access required provider training and education information and materials on this website.

The Elderplan Compliance and Fraud Waste and Abuse (FWA) Programs and Training sections are designed to provide valuable information about Elderplan's Compliance/FWA programs for our partners, including providers and other entities that provide administrative or health care services under contract with Elderplan for government program lines of business. These training materials are designed for

providers and other first tier, downstream and related parties (FDRs) to meet their Elderplan compliance policy and procedure and fraud, waste and abuse contractual training obligations. These sections include both general information and trainings for all FDRs and Fully Integrate Dual Advantages (FIDA) Plan specific information and trainings. Elderplan compliance program training frequently asked questions (FAQs) are provided here.

1. Overview: Elderplan Compliance Program and Training

Elderplan maintains a Compliance Program which delineates its commitment to and comprehensive strategy for compliance with applicable federal and state laws and adherence to high ethical business standards. It also outlines the company's approach to prevent, identify and mitigate fraud, waste, and abuse.

2. What are Elderplan General Compliance/FWA Program Training

Elderplan maintains compliance program policies and procedures, educational documents, and training materials to educate providers and other business partners about its Compliance Program. These documents and materials include general compliance program content, such as our commitment to legal and ethical behavior, as well as information specific to the effective delivery of our health plan benefits and services in a compliant manner for plan types such as Medicare Advantage-Prescription Drug, Fully Integrated Dual Advantage (FIDA), Medicaid Advantage, Managed Long Term Care and Special Needs Plans. Training topics include areas, such as, standards of conduct; fraud, waste and abuse prevention.

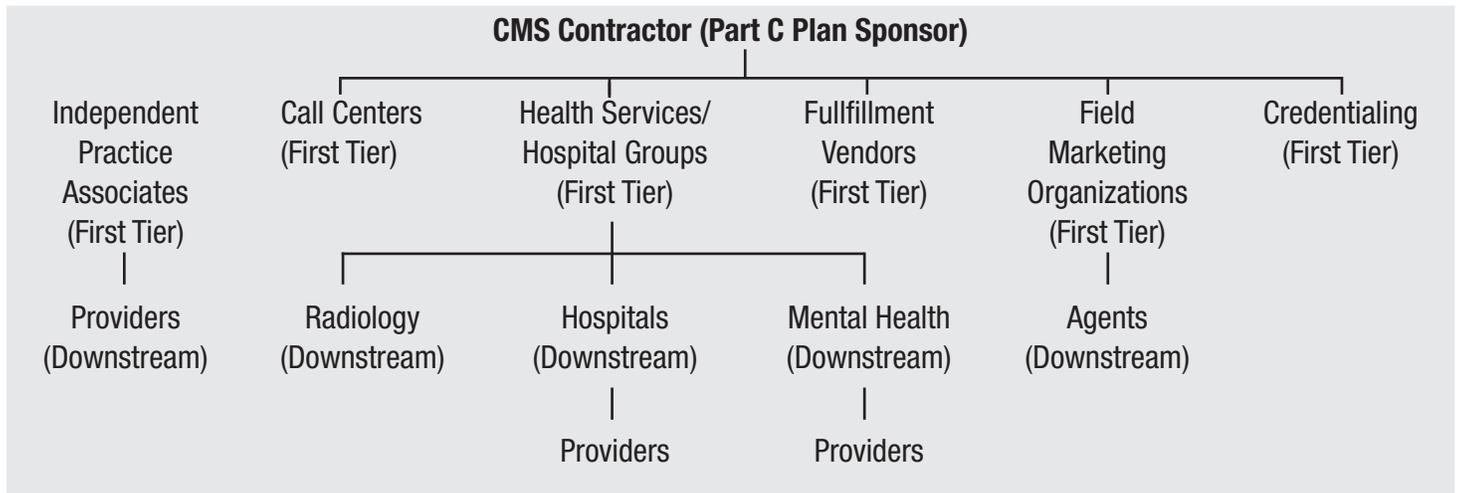
3. Who must complete Elderplan General Compliance/FWA Program Training Materials?

In brief, all first tier, downstream and related entities' (FDRs) employees and agents, including, but not limited to FIDA Plan medical, behavioral, and community-based and facility-based long term services and supports (LTSS) provider network staff ("FIDA Plan Network Staff"), must successfully complete Elderplan general compliance/FWA training materials or substantively equivalent materials. Topic assignments are listed under section 7. FIDA Plan Network Staff are required to complete additional training topics. These FIDA-specific trainings are described starting at Section 9: FIDA Plan Network Staff Specific training requirements.

First Tier, Downstream and Related Entities (FDRs)

Elderplan contracts with many partners to deliver health plan benefits and services. These business partners, whether individuals or entities, are broadly categorized as a first tier (a party that is directly contracted with Elderplan), downstream (a subcontractor or party that is indirectly providing care or services for Elderplan based on a higher level contract with another entity), or related party (a party that meets certain legal criteria relating it to Elderplan) (FDRs). Differentiating between these categories is relevant because a first tier entity has an additional obligation to ensure its downstream entities adhere to Elderplan compliance program requirements including training requirements. See Table 1 for a CMS developed graphic demonstrating a FDR hierarchy for a Medicare Advantage plan.

Table 1



4. May an entity use non-Elderplan Compliance Program Materials to train employees and agents?

Yes! Entities that maintain an effective compliance program, with compliance training materials in accordance with applicable U.S. Health and Human Services Centers for Medicare and Medicaid Services (CMS) and/or New York State Department of Health and Office of the Medicaid Inspector General (OMIG) requirements may use their own compliance program materials to train employees and agents on their compliance program. However, entities may need to augment their current training materials to include required Medicare, Medicaid and/or Integrated Medicaid and Medicaid health plan specific content related to the types of contracts they maintain with Elderplan (e.g., MA-PD, FIDA, MLTC). Overall, entities are required to have compliance programs and trainings comparable to those of Elderplan's. All non-Elderplan compliance program and training materials are subject to review and approval by Elderplan.

5. When must training be completed?

In most cases, training requirement timeframes not otherwise specified in the Elderplan agreement with an entity must be completed by contracted providers and other FDRs' employees and agents within 90-days of the contract effective date and then annually thereafter. For entities using their own compliance documents and training programs, Elderplan expects that these entities' employees and agents will be trained upon hire (within 90-days of hire) and then annually thereafter. Retraining on substantive training material revisions are also based on the above timeframes.

6. Where are the Compliance Program Training Materials located?

Elderplan providers and other FDRs, including their governing body members, managers, employees, volunteers, interns, and other agents, must satisfactorily complete Elderplan General Compliance and FWA training materials listed below or equivalent materials. Additional FIDA Plan Network Staff required trainings are discussed starting in Section 9 below.

- Health Plan Standards of Conduct
- Medicare Parts C & D Fraud, Waste and Abuse & General Compliance Training via Medicare Learning Network (MLN) website*.

* *Deemed training completion for the "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training"*

FDRs employees or agents who assist in the administration or delivery of Elderplan Medicare Advantage Prescription Drug plans who have met the FWA certification requirements through enrollment into the Medicare Parts A or B Program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements.

Elderplan general compliance/FWA program documents and training materials may be accessed through the Elderplan website via the following path: <http://elderplan.org/for-providers/compliance>. Training Materials are also available through the Elderplan secure Provider Portal. **FDR's may want to access and complete these trainings via the Elderplan secure Provider Portal where they may also record training completion.**

8. How should completion of training be documented and stored?

Elderplan requires that providers and other FDRs maintain thorough and accurate training records (including topic, content, attendance, and, if applicable, certificates of completion and test scores) of all compliance program trainings completed by their employees and agents. FDR training records must be maintained for at least 10 years from the date the training is completed and in accordance with their written agreement with Elderplan.

Demonstration of Training Completion

The Elderplan secure Provider Portal contains required training materials, as well as functionality for FDRs, including FIDA Plan Network Providers, to demonstrate training completion. Elderplan FDRs may logon to their Provider Portal accounts, click on Provider Training link and attest training completion for each employees and agents as appropriate.

Elderplan audits provider and other FDR training records. Upon request, FDRs will be asked to provide satisfactory evidence that employees and agents have completed required training. Examples of proof of training completion may include copies of course certifications, pre-post test and knowledge check results, and attestations.

9. What Compliance Programs are FIDA Plan Network Staff required participate in?

FIDA Plan medical, behavioral, and community-based and facility-based LTSS provider network staff (“FIDA Plan Network Staff”) are required to Complete the training required of all Elderplan FDRs. In addition, FIDA Plan Network Staff are required to participate in FIDA-specific training programs. Further, FIDA Plan Network Staff may be able to meet these requirements through demonstrating completion of another New York State FIDA Plans equivalent and credible training program.

Required compliance trainings are listed below with a brief description of program content. Training materials are posted at <http://elderplan.org/providers/compliance> and within the Elderplan secure Provider Portal.

- Health Plan Standards of Conduct
- Medicare Parts C & D Fraud, Waste and Abuse & General Compliance Training via Medicare Learning Network (MLN) website*
- Cultural Competency- Delivering linguistically- and culturally-competent services
- ADA Compliance: People with disabilities (barriers, awareness and prejudices); Accommodations and accessible health care services; Olmstead Act requirements; and Person-centered planning, independent living philosophy and the recovery model)

10. How should completion of FIDA Plan Network Staff training be documented and stored?

Like all Elderplan required trainings, providers and other FDRs must maintain thorough and accurate training records (including topic, content, attendance, and, if applicable, certificates of completion and test scores) of all compliance program trainings completed by their employees and agents. FDR training records must be maintained for at least 10 years from the date the training is completed and in accordance with their written agreement with Elderplan.

Demonstration of Training Completion

The Elderplan secure Provider Portal contains required training materials, as well as functionality for FDRs, including FIDA Plan Network Providers, to demonstrate training completion. Elderplan FDRs may logon to their Provider Portal accounts, click on Provider Training link and attest training completion for each employees and agents as appropriate.

Elderplan audits provider and other FDR training records. Upon request, FDRs will be asked to provide satisfactory evidence that employees and agents have completed required training. Examples of proof of training completion may include copies of course certifications, pre-post test and knowledge check results, and attestations.

11. How to report Information about Suspected Non-Compliance or Fraud, Waste and Abuse related to Elderplan Health Plans?

If you have information about possible non-compliance or fraud, waste and abuse against Elderplan health plans, you may report that information using the contacts below. Reports may be made anonymously.

Report to the health plan compliance officer:

Joan Furman
1-855-287-6810
jfurman@mjhs.org

Report to the corporate compliance officer:

Anne Dawson (718) 921-7971
adawson@mjhs.org

Report by phone anonymously 24 hours a day/7 days a week to:

Compliance Hotline at (718) 921-8400
FWA Hotline at 1-855-287-6810

Write to us:

Regulatory Compliance
Elderplan
745 64th Street
Brooklyn, NY 11220

Report Fraud via Email: at EPREGCOM@mjhs.org

Report Fraud Electronically: via our Elderplan Report Fraud Referral Form