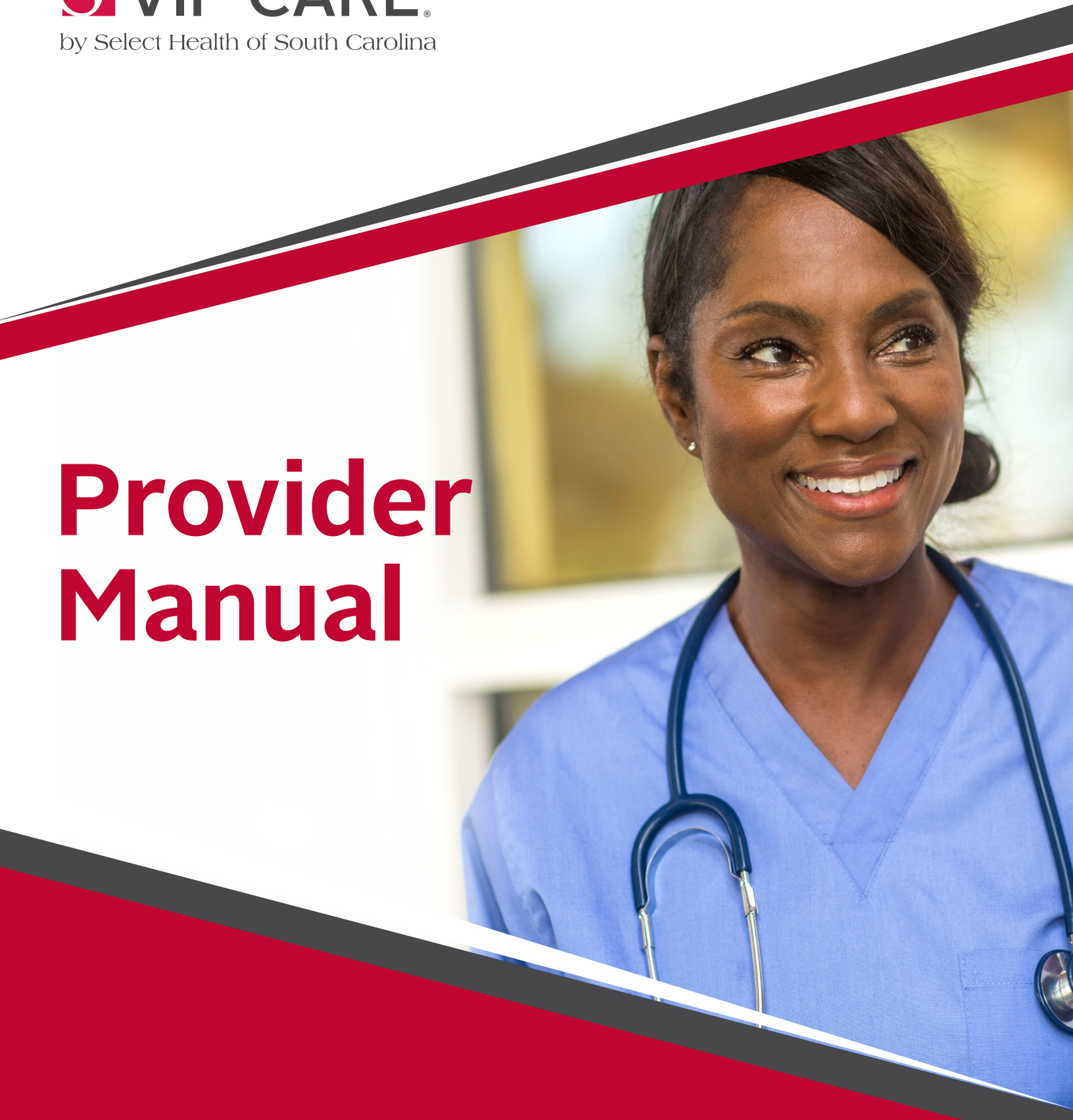
FirstChoice VIP CARE®
by Select Health of South Carolina

Provider Manual



Foreword

Welcome to First Choice VIP Care, by Select Health of South Carolina. This *Provider Manual* was created as a guide to assist you and your office staff in providing services to our members, your patients. Providers can use this First Choice VIP Care *Provider Manual* as a reference pertaining to medical services for members of First Choice VIP Care.

No content found in this publication or in First Choice VIP Care's participating Network Provider Agreement is intended to be interpreted as encouraging providers to restrict medically necessary covered services or limit clinical dialogue between providers and their patients. Regardless of benefit coverage limitations, providers should openly discuss all treatment options that are available.

The provisions of this *Provider Manual* may be changed or updated periodically. Revisions will be posted on our website at www.firstchoicevipcare.com. First Choice VIP Care will provide thirty (30) days' notice of the updates and providers are responsible for checking regularly for updates.

Your review and understanding of this manual is essential, and we encourage you to contact our Provider Network Management department with any questions, concerns and/or suggestions regarding this *Provider Manual*.

Thank you for your participation with First Choice VIP Care.

Headquartered in Charleston, South Carolina, First Choice VIP Care is a mission-driven managed care organization.

Our Mission

We Help People:

Get Care

Stay Well

Build Healthy Communities

We have a special concern for those who are poor.

Table of Contents

I. Overview

First Choice VIP Care ("Plan") by Select Health of South Carolina is a member of the AmeriHealth Caritas Family of Companies, a leader in managing medically complex members. Through our Medicare Advantage Dual Eligible Special Needs Plan, First Choice VIP Care, we are continuing and reinforcing our vision and mission to lead in the provision of health care services to the underserved. When members enroll in First Choice VIP Care, they will also be enrolled in our First Choice Medicaid plan, integrating both the Medicare and Medicaid benefits within the same organization. This promotes improved coordination of these benefits, leading to improved member health outcomes.

First Choice VIP Care members will be enrolled in First Choice VIP Care's care management program. They will be assigned a Care Coordinator who will develop and follow the member's individualized care plan, monitor compliance with the care plan, and be available to the member when needs arise.

Our coordinated care approach, leading technology solutions, and innovative community outreach programs enable our members with debilitating conditions to lead more comfortable lives. Working with dedicated health care providers, our programs offer better outcomes for our members.
We are proud of the opportunity to provide health care to our most vulnerable members. AmeriHealth Caritas' decades of experience in Medicaid managed care makes us an excellent choice for chronically ill members covered by Medicare Advantage Plans.

About Our Program

- First Choice VIP Care is a type of Medicare Advantage plan known as a Dual Eligible Special Needs Plan (D-SNP), meaning we only enroll individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- Specifically, First Choice VIP Care is classified as a Highly Integrated Dual Special Needs Plan (HIDE-SNP).
- HIDE-SNPs go beyond a standard D-SNP by offering a more coordinated and aligned set of benefits, administration, and member services between the two programs.
- HIDE-SNPs must provide Medicaid benefits in addition to Medicare Advantage coverage.
- When members enroll in Select Health's First Choice VIP Care, they will also be enrolled in Select Health's First Choice Medicaid plan, integrating both the Medicare and Medicaid benefits within the same organization.
- Seamlessly providing access to high-quality care through coordination of services traditionally covered separately by Medicare and Medicaid.
- This brings South Carolina into alignment with the new Centers for Medicare & Medicaid Services (CMS) Final Rule requiring Medicare and Medicaid integration for the dual eligible population.

Program Eligibility

Members are eligible to enroll in First Choice VIP Care if they meet all these qualifications:

- Aged 18 and older at the time of enrollment.
- Entitled to Medicare Part A, and enrolled in Medicare Part B.
- Enrolled in the Healthy Connections Medicaid program.
- Classified as Full-Benefit Dual Eligible under the Medicare Savings Program as a:
    - Qualified Medicare Beneficiary Plus (QMB+)
    - Special Low-Income Medicare Beneficiary Plus (SLMB+)
    - Full Benefit Dual Eligible (FBDE)
- Live in our service area.

However, individuals with End-Stage Renal Disease (ESRD) generally are not eligible to enroll in First Choice VIP Care unless the individual meets exceptions to ESRD eligibility rules outlined in Chapter 2, Section 20.2 of the Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual.

Plan Overview

First Choice VIP Care (H4739-001), by Select Health of South Carolina, is contracted to provide Medicare hospital (Part A), medical (Part B) services and prescription drug coverage (Part D) services in all SC counties. Members must live in one of these counties to join the plan. Please refer to Section III of this *Provider Manual* for a full description of Plan benefits including supplemental benefits.

Member Enrollment

First Choice VIP Care will accept only those members with dual Medicare/Medicaid eligibility.

First Choice VIP Care will not discriminate on the basis of religion, gender, sexual orientation, race, color, age, national origin, health status, pre-existing condition, or need for health care services and will not use any policy or practice that has the effect of such discrimination.

Primary Care Selection & Assignment

First Choice VIP Care members will be required to select a Primary Care Provider (PCP). If a PCP is not selected by a member, First Choice VIP Care will assign a PCP taking the following into consideration:

- Match of member's language preference (if available).
- Existing provider relationships in our system (if available).
- Selection of a PCP closest to the member's residence based on zip code.

Once the selection or assignment has been made, First Choice VIP Care will mail an identification card (ID) with the PCP's name to the member. Members are instructed to keep the ID card with them at all times. The member's ID card will include:

- The member's name and member ID number.

- First Choice VIP Care's name, mailing address and Provider Services number.

Member ID Card

Member Identification and Eligibility Verification

First Choice VIP Care member eligibility varies. Therefore, each participating provider is responsible for verifying member eligibility with First Choice VIP Care before providing services. Eligibility may be verified by:

- By calling Provider Services at 1-888-978-0151.
- Utilizing First Choice VIP Care's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Accessing a link on First Choice VIP Care's website via a free, web-based solution for provider access to electronic transactions and information through a multi-payer portal - NaviNet.

Please note that First Choice VIP Care cards are not returned to First Choice VIP Care when a member becomes ineligible. Therefore, the presentation of the First Choice VIP Care ID card is not sole proof that a person is currently enrolled in First Choice VIP Care. Providers should request a picture ID to verify that the person presenting is the person named on the ID card. If providers suspect a non-eligible person is using a member's ID card, please report the occurrence to First Choice VIP Care's Fraud, Waste, and Abuse Hotline at 1-866-833-9718.

Member Rights and Responsibilities

Federal law requires that health care providers and facilities recognize member rights. First Choice VIP Care informs its members of the following rights and responsibilities, but members also have the right to request and receive from their health care provider a completed copy of these Rights and Responsibilities.

Member Rights

- Receive information in accordance with CFR § 438.10, which is in a manner and format that may be easily understood and is readily accessible.
- Be treated with respect and with due consideration for his or her dignity and privacy. To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting medicalcare.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. To have their medical records remain private, according to HIPAA rules.
- To have timely and accessible access to services, both clinical and non-clinical, regardless of whether a member has limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes.
- To receive free translation services as needed, including help with sign language if hearing impaired.
- To participate in making decisions about their own medical care, including the right to refuse treatment. Refusal of treatment is not considered a reason to request disenrollment of the member from a physician's practice.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand, regardless of cost or benefit coverage.
- Participate in decisions regarding his or her health care, including the right to refuse treatment, and to expect to have such providers honor his or her decision if he or she chooses to accept the responsibility and the consequences of such a decision. In this event, members are encouraged (but not required) to:
    - Complete an advance directive, such as a living will and provide it to the contracted plan providers.
- Female members have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.
- To request and receive a copy of his or her medical records, and request that they be amended or corrected in accordance with applicable Federal and State laws.
- To have access to an adequate number of network providers who have been credentialed.
- To choose a PCP from the Plan's list of providers.
- To change a PCP and choose another one from the Plan's list of providers.
- To choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life-threatening medical condition and the specialist agrees to act as the PCP.
- To voice his or her complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the Evidence of Coverage or other procedures adopted by the plan for such purposes.
- To be provided good quality care without unnecessary delay.
- To receive a copy of the Evidence of Coverage.
- To continue in current treatment until a new treatment plan isin place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of incentive plans for Plan practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.

- To receive a copy of the prescription drug formulary.
- To receive a copy of the "Dispense as Written" policy for *prescription* drugs.
- To receive information about the Plan's services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To seek a second opinion from a participating or non-participating qualified health care professional at no cost to the member.
- To seek services from an out of network provider should a network provider be unavailable, and costs would equal to what they would be if furnished within the network.
- To be able to continue to use an independent care provider that a member has previously utilized or select a new provider that meets the state qualifications.
- To be informed of any cost-sharing obligations upon becoming a Plan member and at least 30 days prior to any change.
- To be informed about how and where to access any benefits that are available under the Medicaid program but are not covered by the Plan.
- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).
- To request information on the structure of the Plan.
- To be treated no differently by providers or by the Plan for exercising the rights listed here.
- To call or write the Plan any time with comments, questions, and observations regarding positive or constructive comments. Members may also make recommendations about the members' rights and responsibilities.
- To have control over his or her choice in identifying, accessing, and managing supports and services in accordance with his or her needs and personal preferences.

Member Responsibilities

- To understand, to the best of his/her ability, how the Plan is used to receive health care.
- To choose a PCP as soon as possible.
- To take his/her Plan ID card(s) to all medical appointments and to the pharmacy for prescriptions.
- To keep his/her scheduled appointments.
- To call his/her doctor's office at least 24 hours in advance of his/her appointment if the appointment must be re-scheduled.
- To tell his/her doctor about his/her medical problems.
- To ask questions about things he/she does not understand.
- To know the difference between a true emergency and a condition needing urgent/symptomatic care.
- To know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
- To follow the provider's orders and advice on care and treatment that the member has elected to receive.
- To inform providers of medical problems or any other issue that may conflict with following the plan of care.
- To assist with the transfer of his/her medical records.

- To receive services from his/her PCP unless referred elsewhere by his/her PCP or otherwise permitted by Plan policy.
- To comply with the rules of the Plan.
- To inform the Plan if his/her address has changed or any other changes that could affect his/her Medicaid eligibility or coverage under the Plan.
- To cooperate with all Plan inquiries and surveys.

Members should consult their Evidence of Coverage for more information on their rights and responsibilities.

Plan Privacy and Security Procedures

First Choice VIP Care complies with all Federal and State regulations regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All member health and enrollment information is used, disseminated and stored according to First Choice VIP Care policies and guidelines to ensure its security, confidentiality and proper use. **As a First Choice VIP Care provider, you are expected to be familiar with your responsibilities under HIPAA and to take all necessary actions to fully comply.**

II. Provider and Network Information

This section provides information for establishing and maintaining network privileges and sets forth expectations and guidelines for primary care providers (PCPs), specialists and facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is also provided in the "Behavioral Health Care" section of this *Provider Manual*.

Becoming a Plan Provider

First Choice VIP Care Medicare Provider Eligibility

Health care providers are selected to participate in the First Choice VIP Care network based on an assessment and determination of the network's needs. Providers must be enrolled with the Medicare, Medicaid, and contracted with the Plan in order to be credentialed with First Choice VIP Care.

Provider Credentialing and Re-Credentialing

First Choice VIP Care is responsible for the credentialing and re-credentialing of the provider network. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is provided in the "Behavioral Health Care" section of this *Provider Manual*.

Hospital-based physicians are not required to be independently credentialed if those providers serve First Choice VIP Care members only through the hospital. All providers credentialed by First Choice VIP Care must also be enrolled with the Medicare program and, as such, must agree to comply with all pertinent Medicare regulations.

First Choice VIP Care maintains criteria and processes to credential and re-credential practitioners, including, but not limited to the following:

- Audiologists
- Behavioral Health Providers
- Certified Nurse Midwives (CNMs)
- Certified Registered Nurse Practitioners (CRNPs)
- Doctors of Chiropractic Medicine (DCs)
- Doctors of Osteopathic Medicine (DOs)
- Doctors of Podiatric Medicine (DPMs)
- Medical Doctors (MDs)
- Occupational Therapists
- Optometrists (ODs)
- Physical Therapists
- Physician Assistants
- Psychologists
- Speech and Language Therapists

First Choice VIP Care maintains criteria and processes to credential and re-credential facilities, including, but not limited to the following:

- Ancillary facilities
- Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Federally Qualified Health Centers (FQHCs)
- Home health agencies/home health hospice
- Hospitals (acute care and acute rehabilitation)
- Imaging centers - free-standing
- Nursing homes
- Portable X-ray suppliers
- Providers of ESRD services
- Providers of outpatient diabetes self-management training
- Rural Health Clinics (RHCs)
- Skilled nursing facilities, including facilities providing sub-acute services
- Sleep center/sleep lab – free-standing
- Surgical centers - free-standing

The criteria, verification methodology and processes used by First Choice VIP Care are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty, or procedures performed.

First Choice VIP Care's credentialing/re-credentialing criteria and standards are consistent with the Centers for Medicare and Medicaid Services' specific requirements and National Committee for Quality Assurance (NCQA) standards. Practitioners and facility/organizational providers are required to be re-credentialed every three years.

First Choice VIP Care works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing.

Through CAQH, providers submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. First Choice VIP Care's goal is to have all providers enrolled with CAQH.

There is no charge to providers to submit applications and participate in CAQH. Providers may access these forms via First Choice VIP Care's website at www.firstchoicevipcare.com and submit to First Choice VIP Care as follows:

1. Register for CAQH if not already enrolled via the CAQH website at https://proview.caqh.org/PR/Registration.

2. Complete the CAQH application.
3. To initiate the credentialing process with First Choice VIP Care, send your CAQH ID number to First Choice VIP Care via an e-mail to a Provider Network Account Executive. Visit the provider area of our website for the most current contact information.

Providers who are not affiliated with CAQH or prefer a paper credentialing process may contact First Choice VIP Care's Provider Services department at 1-888-978-01511 or a Provider Network Account Executive for assistance.

Credentialing/Re-Credentialing Criteria and Standards

First Choice VIP Care verifies credentialing and re-credentialing criteria for all professional providers that, at a minimum, meet all applicable federal requirements.

To that end, First Choice VIP Care's criteria include:

1. Current unrestricted medical licensure.
2. No revocation or suspension of the provider's state license by the applicable State licensing board.
3. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106).
4. Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training.
5. Evidence of specialty board certification, if applicable.
6. Evidence of the provider's professional liability insurance coverage and claims history.
7. Satisfactory review of any sanctions imposed on the provider by Medicare or Medicaid.
8. The provider's NPI ID number and Medicaid ID number (or proof of Medicaid provider registration, if applicable).
9. The provider is eligible to enroll in or has not opted out of Medicare.

In addition, First Choice VIP Care's credentialing and re-credentialing processes include verification of the following additional requirements for physicians:

1. For primary care physicians and specialists – privileges in good standing at the hospital designated by the PCP as the primary admitting facility; or, if the PCP does not have admitting privileges, privileges in good standing at the hospital for another provider with whom the PCP has entered into an arrangement for hospital coverage.
2. Valid Drug Enforcement Administration (DEA) certificate, where applicable.
3. Current State Controlled Substance Certificate (CDS).

As part of the application process First Choice VIP Care will**:** Request information on health care provider sanctions prior to making a credentialing or re-credentialing decision. Information from the National Practitioner Data Bank (NPDB), Federation of State Medical Board (FSMB), Medicheck (Medicaid exclusions), and HHS Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE),

Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS), System for Award Management (SAM), and relevant State sanction and licensure databases as applicable.

Initial Site Visit Review

First Choice VIP Care's credentialing process includes provisions that new practitioners (and new practice locations) are required to meet minimal criteria for office settings and medical record keeping in order to be considered for inclusion in the provider network. These initial site visit requirements apply to practitioners joining previously surveyed locations, as well as the new practice locations of previously surveyed practitioners.

To address any areas of deficiency identified on the initial visit, First Choice VIP Care requires a corrective action plan be submitted to the Plan within one week of the visit. Re-survey of the site will occur within 30 days to ensure compliance has been met. Practitioners not meeting the minimal performance standard threshold of 85% will be reviewed by the First Choice VIP Care's Medical Director and Credentialing Committee for recommendation.

In addition to the initial site visit, all practice/site locations will receive a re-evaluation visit every five years.

Site Visits Resulting from a Complaint and/or Ongoing Monitoring

Member Dissatisfaction Regarding Office Environment

- The Provider Network Management or the Credentialing Department may identify the need for a Site Visit due to receipt of a Member Dissatisfaction regarding the provider's office environment
- At the discretion of the Provider Network Management Representative a site visit to address the specific issue(s) raised by a member may occur. Follow-up site visits are conducted as necessary.
- These focused site visits, where a full site visit evaluation is not performed, do not count toward the three-year site visit requirements.

Communication of Results

1. The Provider Network Management Account Executive reviews the results of the Site Visit Evaluation Form (indicating all deficiencies) with the office contact person.
2. If the site meets and/or exceeds the passing score:
    - The Site Visit Evaluation Form is signed and dated by both First Choice VIP Care and the office contact person.
3. If the site does not receive a passing score, First Choice VIP Care follows the procedures outlined below to follow-up on identified deficiencies.

Follow-Up Procedure for Identified Deficiencies

1. The Provider Network Management Account Executive requests a corrective action plan from the office contact person. The corrective action plan must be submitted to First Choice VIP Care within one week of the visit.

2. The Provider Network Management Account Executive schedules a re-evaluation visit with the provider office, to occur within 30 days of the initial site visit to review the site and verify that the deficiencies were corrected.
3. Each follow-up contact and visit is documented in the provider's electronic file.
4. The Provider Network Management Account Executive reviews the corrective action plan with the office contact person.
5. The Provider Network Management Account Executive reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact person.
    - If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both First Choice VIP Care and the office contact person.
    - If the site does not receive a passing score, the Provider Network Management Account Executive follows the procedures outlined below for follow-up for secondary deficiencies.

Follow-Up Procedure for Secondary Deficiencies

The Provider Network Management Account Executive will re-evaluate the site monthly, up to three times (from the first Site Visit date).

If after four (4) months, there is evidence the deficiency is not being corrected or completed, then the office receives a failing score unless there are extenuating circumstances.

Further decisions as to whether to pursue the Credentialing process or take action to terminate participation of a provider who continues to receive a failing Site Visit Evaluation score will be handled on a case-by-case basis by the First Choice VIP Care Medical Director and Credentialing Committee.

Re-Credentialing

First Choice VIP Care re-credentials network practitioners at least every three years. All practitioners involved in the re-credentialing cycle are sent a Re-credentialing Notification Letter three to six months prior to the re-credentialing due date. The following information is needed in order to complete the re-credentialing process:

- Application – Credentials Update Form or CAQH Universal Provider Data Source
- Practitioner CAQH reference number
- Office hours/service addresses
- Supporting Documents – State professional license, Federal DEA registration, State Controlled Substance Certificate, Malpractice Face Sheet, and/or CLIA certificate - (if applicable)

As with initial credentialing, all applications and attestation/release forms must be signed and dated no more than 90 days prior to the Credentialing Committee decision date. Additionally, all supporting documents must be current at the time of the decision date.

Facility Credentialing Criteria

First Choice VIP Care's credentialing criteria for facilities include:

- An unrestricted and current license.
- Accreditation certificate from a recognized accrediting body.
- Satisfactory CMS site visit report, for non-accredited facilities.
- Successful outcome of a quality site visit (for facilities that are not accredited and have not had a CMS site visit).
- Evidence of eligibility with state and federal regulatory bodies, including Medicare; and
- A copy of the current malpractice face sheet.

First Choice VIP Care performs initial site evaluations on facility providers who are not accredited and do not have a CMS site survey. For those providers who are either accredited or have had a CMS site survey, a copy of the accreditation or site survey must be submitted with the initial credentialing documentation. Additional site visits for accredited facility providers may be performed at First Choice VIP Care's discretion.

Practitioner Credentialing Rights

During the review of the credentialing application, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations, and other peer-review protected information.
- Be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner. As examples, practitioners will be notified of the following types of variances: actions on license, malpractice claim history, suspension or termination of hospital privileges, or board certification decisions; however, variances in information obtained from references, recommendations or other peer-review protected information are not subject to this notification. Practitioners have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
- Know the status of his/her application – if the application is current and complete, the applicant can be informed of the tentative date that his/her application will be presented to the Credentialing Committee for approval.

Questions regarding the status of a credentialing application may be directed to the First Choice VIP Care Credentialing Department at First Choice VIP Care, Attn: Credentialing Department, 200 Stevens Drive, Philadelphia, PA 19113 or contacting the Provider Network Account Executive.

First Choice VIP Care's Quality Assessment and Performance Improvement Program (QAPI) provides oversight of the Credentialing Program. For more information on the QAPI, refer to the Quality Program section of this *Provider Manual*.

Standards for Participation

By agreeing to provide services to First Choice VIP Care members, providers must:

- Be a Medicare-enrolled physician and comply with all pertinent Medicaid and Medicare regulations.
- Treat First Choice VIP Care members in the same manner as other patients.
- Provide covered services to all First Choice VIP Care members who select or are referred to you as a provider.
- Provide covered services without regard to religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status. All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1974.
- Not segregate members from other patients (applies to services, supplies, and equipment).
- Refrain from billing members for covered services, including any amounts in dispute with First Choice VIP Care.
- Not refuse to provide services to members due to a delay in eligibility updates.

Access to Care

First Choice VIP Care providers must meet standard guidelines as outlined in this Provider Manual to help ensure that First Choice VIP Care members have timely access to care.

First Choice VIP Care endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. First Choice VIP Care has established mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Office Accessibility

PCP office hours must be clearly posted and reviewed with members during the initial office visit.

The PCP is required to arrange for coverage of primary care services during absences due to vacation, illness or other situations that render the PCP unable to provide services. A Medicare eligible PCP must provide the coverage to First Choice VIP Care members.

Appointment Scheduling

Timely Access Standards for appointment availability for PCPs and Specialists:

Provider Type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Urgently needed services or emergency	Immediately - Twenty-four (24) hours per day, seven (7) days per week
	Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within seven (7) business days
	Routine and preventive care	Within 30 business days
	Medical Follow-Up to Inpatient Care	Within seven (7) calendar days of discharge
High-Volume Specialists (Cardiologist, Oncologist, Ophthalmologists, Orthopedic Surgeons, General Surgeons, Gastroenterologists, Pulmonologists, Otolaryngologists and Specialists in Physical Medicine and Rehabilitation)	Routine	Thirty (30) calendar days
Behavioral Health Providers	Urgently needed services or emergency	Immediately - Twenty-four (24) hours per day, seven (7) days per week
	Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within seven (7) business days
	Routine and preventive care	Within 30 business days
Wait Time in a Provider Offices	Not to exceed 45 minutes	
Use of Free Interpreter Service	As Needed Upon member Request During All Appointments	

Emergency services must be provided immediately upon presentation.

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for the missed appointment. The medical record should reflect any reasons for delays in providing medical care as a result of missed appointments and should also include any refusals by the member. The provider should alert the member's Care Coordinator for follow up.

After-Hours Accessibility

First Choice VIP Care members must have access to quality, comprehensive health care services 24 hours a day, seven days a week. PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider or instruct the member that the provider will contact the member within thirty (30) minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. First Choice VIP Care will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access

First Choice VIP Care monitors appointment waiting times using various mechanisms, including:

- Reviewing provider records during site reviews.
- Monitoring administrative complaints and grievances.
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care.
- Performing after-hour calls to verify coverage availability.

Non-compliant providers will be subject to corrective action and/or termination from the network as follows:

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

Panel Capacity/Not Accepting New Patients Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members. The panel remains open unless the following occurs:

- The PCP is under sanction.
- First Choice VIP Care approves a PCP request to voluntarily close his/her panel; or,
- The panel is closed by First Choice VIP Care due to member access issues.

All First Choice VIP Care providers who wish to close their panel or no longer accept new patients must provide a 90-day written notice to First Choice VIP Care. The notice should include the date the provider would like their panel closed or to no longer accept new patients and the reasons why the provider would like to close their panel or no longer accept new patients. Providers may not close their panel only to First Choice VIP Care members, or no longer accept only First Choice VIP Care members.

First Choice VIP Care will be providing each PCP a monthly member roster by paper or electronically via the online Provider Portal.

Practitioner & Provider Responsibilities

Responsibilities of All Providers

First Choice VIP Care is regulated by federal law. Providers who participate in First Choice VIP Care agree to comply with all pertinent Medicare regulations, including all responsibilities set forth as follows:

- Be Compliant with all applicable Federal, State, and local laws and regulations.
- Treat First Choice VIP Care members in the same manner as other patients.
- Communicate with agencies including, but not limited to local public health agencies for the purpose of participating in immunization registries and programs (e.g., communications regarding management of infectious or reportable diseases, special education programs, early intervention programs, etc.).
- Comply with all disease notification laws for the State of South Carolina.
- As appropriate, work cooperatively with specialists, consultative services, and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment, provide services, or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, genetic information, participation in governmental program (Medicaid), source of payment, marital status, or type of illness or condition, except when that illness or condition can be better treated by another provider type.
- Ensure that ADA requirements are met, including utilizing appropriate technologies in the daily operations of the physician's office, e.g., TTY: 711 and language services, to accommodate the member's special needs.
- Provide information to First Choice VIP Care and/or CMS as required.
- Inform members about all treatment options, regardless of cost or whether such services are covered by the Medicare Program or First Choice VIP Care.
- Abide by and cooperate with the policies, rules, procedures, programs, activities, and guidelines contained in your Provider Agreement (to which this *Provider Manual* and any revisions or updates are incorporated by reference).
- Accept First Choice VIP Care payment, plus any applicable member copayment, or third-party resources as payment-in-full for covered services.
- Comply fully with First Choice VIP Care's QAPI, Utilization Management, Integrated Care Management, Credentialing and Audit programs.
- Comply with all applicable training requirements, including Medicare Compliance training, Model of Care, and Fraud, Waste, and Abuse training.

- Promptly notify First Choice VIP Care of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to First Choice VIP Care or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all applicable laws and regulations, including HIPAA and HITECH requirements.
- Immediately notify First Choice VIP Care of adverse actions against license or accreditation status.
- Comply with all applicable federal, state, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify First Choice VIP Care of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement.
- Verify member eligibility immediately prior to rendering services.
- Obtain all required signed consents prior to rendering services.
- Obtain prior authorization and provide referrals for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Maintain all medical and Medicare-related member records and communications for a period of ten (10) years and in accordance with legal, regulatory, and contractual rules of confidentiality and privacy.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local authorities and have established procedures for these cases.
- Inform member(s) of the availability of First Choice VIP Care's interpretive services and encourage their use.
- Notify First Choice VIP Care of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the First Choice VIP Care Network Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by state and federal law.

Primary Care Provider (PCP) Responsibilities

A Primary Care Provider (PCP) serves as the member's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of First Choice VIP Care members. Practitioners in the following specialties may serve as Plan PCPs:

- Advanced Practice Registered Nurse (APRN)
- Family Practice
- General Practice
- Geriatrics
- Internal Medicine
- Naturopathic Physician

- Nurse Practitioner
- Osteopath
- Physician's Assistant

Additionally, clinics, Federally Qualified Health Centers, and Rural Health Centers may also serve as PCPs.

A PCP is responsible to First Choice VIP Care and its members for diagnostic services, care planning and Treatment Plan development. The PCP is expected to work with First Choice VIP Care to monitor the planning and provision of treatment.

In addition, the PCP is responsible for:

- Providing covered services to all First Choice VIP Care members assigned to the PCP and comply with all requirements for referral management and prior authorization.
- Providing the First Choice VIP Care member with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services and other community-based agency services.
- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the medical care of a member with a participating specialist(s), and/or behavioral health provider.
- Early identification of all members with special health care needs and notification to the First Choice VIP Care Integrated Care Management team regarding any such identification as soon as possible.
- Collaboration with First Choice VIP Care's Integrated Care Management programs to facilitate member care.
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets First Choice VIP Care's Medical Record Documentation Requirements.
- Providing follow-up services for members who have been seen in the Emergency Department.
- Promptly and accurately reporting all member encounters to First Choice VIP Care.
- Releasing medical record information upon written consent or request of the member.
- Providing preventive healthcare to members according to established preventive health care guidelines.
- Advising First Choice VIP Care's Care Management team at 1-888-978-0151 if outreach assistance is needed when a member does not keep an appointment and/or when a member cannot be reached during an outreach effort.
- Requesting transfer of the member to another PCP only for the reasons identified in the state regulation and continue to be responsible for the member as a patient until another PCP is chosen or assigned.

- Providing accurate information to First Choice VIP Care in a timely manner so that PCP information can be exchanged with CMS via the Provider Network File.

Specialist Responsibilities

A First Choice VIP Care specialist is responsible for:

- Providing specialty care as indicated by a referral.
- Verifying a member's eligibility prior to the provision of services.
- Reporting clinical findings to the referring PCP.
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner via the referral.
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets First Choice VIP Care's Medical Record Documentation Requirements, as described in the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*.
- Refraining from referring members to other specialists without the intervention of the member's PCP.

Provider Directory Data Responsibilities

As a Dual Special Needs Plan, First Choice VIP Care is required to ensure the accuracy of the required provider directory data. If there have been any changes to the provider's office, such as an address, phone number, or the termination of a provider, notification must be made to the plan by one of the following ways:

- Contacting the Provider Network Account Executive.
- Calling Provider Services at 1-888-978-0151.

In addition to basic demographic data, First Choice VIP Care, may collect the following information for the provider directory.

- Indicate if the provider's location is on a public transportation route.
- List any non-English languages (including ASL) spoken by the provider or offered onsite by skilled medical interpreters.
- Indicate if the provider has completed cultural competence training.
- For behavioral health providers, list areas the provider has training in and experience treating, including trauma, child welfare, and substance abuse.

Compliance Responsibilities

First Choice VIP Care providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities. Although not an exclusive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, Waste & Abuse (FWA)
- False Claims Act
- Advance Directives
- CMS Marketing Activities Guidelines

The Americans with Disabilities Act and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require First Choice VIP Care's providers to make their services and facilities accessible to all individuals. First Choice VIP Care expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

Health Insurance Portability and Accountability Act (HIPAA)

First Choice VIP Care is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Fraud, Waste and Abuse (FWA)

First Choice VIP Care has a designated Medicare Compliance Officer who carries out the provisions of First Choice VIP Care's compliance plan, which includes First Choice VIP Care's fraud, waste, and abuse (FWA) programs. Designed in accordance with Federal rules and regulations, First Choice VIP Care's compliance program is aimed at preventing and detecting activities that constitute FWA. The program includes FWA policies and procedures, investigation of unusual incidents and implementation of corrective action. First Choice VIP Care has provider reference materials that are available by contacting the Provider Services department. The materials include information regarding:

Fraud

"Fraud" is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law. As applied to the federal health care programs (including the Medicare and Medicaid programs), health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program. Some examples of fraud include:

- Billing for services not furnished.
- Submitting false information to obtain authorization to furnish services or items to Medicare recipients.
- Soliciting, offering, or receiving a kickback, bribe, or rebate; and/or,
- Violations of the physician self-referral prohibition.

Waste

"Waste" means to use or expend carelessly, extravagantly, or to no purpose.

Abuse

"Abuse" is defined as provider practices that are inconsistent with generally accepted business or medical practice and that result in an unnecessary cost to Medicare programs or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to Medicare programs. In general, program abuse, which may be intentional or unintentional, directly, or indirectly results in unnecessary or increased costs to Medicare programs. Some examples of abuse include:

- Charging in excess for services or supplies.
- Providing, referring, or prescribing medically unnecessary services or items.
- Providing services that do not meet professionally recognized standards.

False Claims Act

The Federal False Claims Act (FCA) is a Federal law that applies to fraud involving any contract or program that is federally funded, including Medicare. It prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including Medicare Advantage plans, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $5,000 to $11,000 for each false claim submitted to the United States government or its contactors, including Medicare Advantage plans, as well as possible exclusion from Federal Government health care programs.

The Federal FCA contains a "qui tam" or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a Federal FCA action.

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA). Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government contractors like First Choice VIP Care.
- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like First Choice VIP Care.
- Expands the definition of false record to include any record that is material to a false/fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Reporting and Preventing FWA

First Choice VIP Care receives Federal funding for payment of services provided to our members. In accepting claims payment from First Choice VIP Care, providers are receiving Federal program funds and are therefore subject to all applicable Federal laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the medical assistance program. Compliance with Federal laws and regulations is a priority of First Choice VIP Care.

If you, or any entity with which you contract to provide health care services on behalf of First Choice VIP Care beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact First Choice VIP Care by:

- Calling the toll-free Fraud Waste and Abuse Hotline at 1-866-833-9718.
- Mailing a written statement to:
  Corporate and Financial Investigations
  First Choice VIP Care
  200 Stevens Drive, Philadelphia, PA, 19113.

Below are examples of information that will assist First Choice VIP Care with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number)
- Name and Identification Number of the Suspected Individual
- Source of the Complaint (including the type of item or service involved in the allegation)
- Approximate Dollars Involved (if known)
- Place of Service
- Description of the Alleged Fraudulent or Abuse Activities
- Timeframe of the Allegation(s)

First Choice VIP Care cooperates in fraud and abuse investigations conducted by State of South Carolina and/or Federal agencies, including but not limited to the Health Connections Medicaid Fraud Control Unit, the Federal Bureau of Investigation, the Drug Enforcement Administration, the Health and Human Services Office of Inspector General, as well as the First Choice VIP Care may make referrals to appropriate law enforcement, CMS Program Integrity Contractors and/or the Healthy Connections Medicaid Fraud Control Unit.

Additionally, you may report potential Medicare FWA to the Inspector General: 1-800-HHS-TIPS (1-800-447-8477) or report suspected Medicaid FWA by contacting:

Healthy Connections Medicaid FWA by contacting: Attorney General's Healthy Connections Medicaid Fraud Unit at: 1-803-734-3660 or call toll free: 1-888-NO-CHEAT (1-888-662-4328).

Reporting Abuse, Neglect and Exploitation

All First Choice VIP Care providers are required to identify, prevent, and report abuse, neglect, and exploitations of enrollees in compliance with the Omnibus Adult Protection Act. As soon as a provider suspects that abuse is occurring, they are required to call the South Carolina Adult Protective Services. South Carolina provides a 24/7 toll free hotline in each county of South Carolina. Providers may find their specific counties number at the South Carolina Department of Social Services Website at: https://dss.sc.gov/content/customers/protection/aps/index.aspx. Providers are also required to alert the First Choice VIP Care Case Manager within 24 hours of making a report to South Carolina Adult Protective Services.

Advance Directives

All First Choice VIP Care providers are expected to discuss and offer to assist with facilitation of advance directives for individuals in compliance with 42 C.F.R 489.100. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under Federal law to decide what medical care that he/she wants to receive, if in the future the member is unable to make his/her wishes known about medical treatment. The member has the right to choose a person to act on his or her behalf to make health care decisions for them, if the members cannot make the decision for themselves.

In addition, First Choice VIP Care providers should maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers and/or organizations as required by Federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive; state law allows any health care provider or any agent of such provider to conscientiously object.

Provider Marketing Activities and Compliance

CMS is concerned with provider marketing activities for the following reasons:

- Providers may not be fully aware of all First Choice VIP Care benefits and costs.
- Providers may confuse the member if the provider is perceived as acting as an agent of the plan versus acting as the member's provider.
- Providers may face conflicting incentives when acting as a plan sponsor representative.

To the extent that providers can assist a member in an objective assessment of his/her needs and potential options to meet those needs, they may do so. Providers **may** engage in discussions with a member should the member seek the provider's advice.

Acceptable Marketing Practices

As a contracted provider, you are permitted to share the following with First Choice VIP Care members and prospective members:

- Provide the names of Medicare Advantage plans with which they contract and/or participate.
- Provide information and assistance in applying for the Low-Income Subsidy (LIS).
- Make available and/or distribute First Choice VIP Care marketing materials.
- Refer their patients to other sources of information, such as State Health Insurance Program (SHIP), plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or 1-800-MEDICARE.
- Share information with patients from CMS' website, including the "Medicare and You" Manual or "Medicare Options Compare" (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS.

However, providers must remain neutral when assisting with enrollment decisions and may NOT:

- Offer sales/appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade members to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of plan sponsors.
- Offer anything of value to induce plan enrollees to select them as their provider.

- Offer inducements to persuade members to enroll in a particular plan or organization.
- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from First Choice VIP Care for member enrollment activities.
- Distribute materials/applications within an exam room setting.

Provider Affiliation Information

Providers may announce new or continuing affiliations with First Choice VIP Care through general advertising, (e.g., radio, television, websites). New affiliation announcements are for those providers that have entered into a new contractual relationship with First Choice VIP Care.

Providers may make new affiliation announcements within the first 30 days of the new contract. An announcement to patients of a new affiliation which names only First Choice VIP Care may occur only once when such announcement is conveyed through direct mail, e-mail, or phone. Additional direct mail and/or e-mail communications from providers to their patients regarding affiliations must include a list of all plans with which the provider contracts.

First Choice VIP Care's Compliance department will secure CMS approval on any provider affiliation communication materials that describe First Choice VIP Care in any way, (e.g., benefits, formularies).

Materials that indicate the provider has an affiliation with First Choice VIP Care and other plan sponsors and that only list plan names and/or contact information do not require CMS approval.

Provider Network Management

First Choice VIP Care's Provider Network Management Account Executives function as a provider relations team to advise and educate First Choice VIP Care providers, and can help providers to become familiar with policies, processes, and First Choice VIP Care initiatives. Providers will be contacted by First Choice VIP Care representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- Credentialing or Re-credentialing Site Visits
- Health Management Programs
- Marketing Compliance
- The Plan's Model of Care
- Orientation, Education and Training
- Program Updates and Changes
- Provider Complaints
- Provider Responsibilities
- Quality Enhancements
- Self-Service Tools

New Provider Orientation

Upon completion of First Choice VIP Care's contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all First Choice VIP Care providers to online resources, including First Choice VIP Care Provider Orientation Training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding First Choice VIP Care's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to assist the provider to comply with all provider contract requirements. The welcome letter explains how a hard copy of the *Provider Manual* may be obtained by contacting the Provider Network Management Department.

Overall Ongoing Training

First Choice VIP Care's training and development are fundamental components of continuous quality and superior service. First Choice VIP Care offers ongoing educational opportunities for providers and their staff. First Choice VIP Care has a commitment to provide appropriate training and education to help providers achieve compliance with First Choice VIP Care standards, as well as federal and state regulations. This training may occur in the form of an on-site visit or in an electronic format, such as online training sessions or interactive training sessions. Detailed training information is available in the "Provider" section of our website at www.firstchoicevipcare.com. Plan providers also have access to the Provider Services Department at 1-888-978-0151 and your Provider Network Account Executive for questions.

Overall Ongoing training and education is conducted throughout the calendar year, through seminars, webinars, meetings with individual providers/facilities/associations, fax blasts, newsletters, provider manual, reference guide, and the website.

- Training is available to all providers and topics include, but are not limited to:
    a. Overview of the First Choice VIP Care plan
    b. Benefits
        - Medicare benefits
        - Supplemental benefits
        - Coordination with Medicaid Benefits
    c. Claims
        - Submission Process
        - Payment Process
        - Dispute Process
        - Balance Billing Regulations
        - Fraud, Waste, and Abuse
        - Payment Integrity Processes
    d. Cultural Competency
        - Links to Culturally Competent Care Trainings
        - Disability Competency
    e. Eligibility – Member

- Service areas
- Medicare Savings Program requirements
- Verifying eligibility process

f. Model of Care (MOC)
   - MOC training requirements
   - Importance of the MOC
   - Dual Eligible Characteristics
   - Working with an Interdisciplinary Care Team
   - Individual Care Plans
   - Person-centered planning processes

g. Prior Authorization
   - How to obtain prior authorization
   - Prior authorization requirements

h. Provider Resources
   - Provider manual (Network information, Compliance Responsibilities, Rights and Responsibilities, etc.)
   - Website
   - Reference guide

i. Appeals and Grievance Process
j. Access and availability standards
k. Quality Metrics
l. Risk Adjustment
m. Stars (CMS Five-Star Quality Rating System)
n. Other topics identified through:
   - Provider complaints
   - Provider claim's submission issues
   - Claim denials
   - Current industry trends
   - CMS and State updates
   - Provider interests

Annual Model of Care Training

The Model of Care (MOC), described more fully in Section IV, is a high quality, patient-centric medical care delivery system for dual eligible Medicare-Medicaid members and is designed to maintain the member's health and encourage their involvement in their health care.

As a Dual Special Needs Plan, First Choice VIP Care is required by the Centers for Medicare and Medicaid Services (CMS) to provide initial and annual training of its MOC and requires providers who care for our beneficiaries to annually participate in and attest to completing our MOC training. Annual MOC training is also a First Choice VIP Care contractual requirement for all participating providers.

This required training can be accessed in any of the following ways:

- An online Model of Care training module on our website, www.firstchoicevipcare.com, under the Provider Training link.

- In person from a First Choice VIP Care Account Executive or training seminar.
- Review faxed MOC training materials.

The MOC may be revised from time to time, based on performance improvement activities. More information regarding the Model of Care is also provided in section four of this *Provider Manual*.

Annual Fraud Waste and Abuse Training

As required by CMS, First Choice VIP Care providers and their staff are required to complete CMS-approved fraud, waste, and abuse training on an annual basis. First Choice VIP Care recognizes training that providers complete to fulfill compliance requirements for traditional Medicare. If a First Choice VIP Care provider needs assistance in accessing this training, the provider may call Provider Services or contact the Account Executive.

Provider Specific Ongoing Training

First Choice VIP Care Account Executives will perform routine site visits to answer questions and assist with any issues or concerns the provider may encounter.

Additional provider site visits will occur at the request of the provider or upon the identification of a specific issue by First Choice VIP Care for example:

- Outcome of a site visit.
- Complaints and/or Grievances.
- Claim denials.
- Prior Authorizations Issues.
- Credentialing.
- New programs or processes.
- Review of trend data: and/or
- Additional training needs.

Plan-to-Provider Communications

Providers will receive or have access to regular communications from First Choice VIP Care including, but not limited to the following:

- Provider Manual.
- Provider Newsletters.
- Website Updates and Information.
- Provider Letters and Announcements.
- Surveys.
- Faxes.
- E-mails. and/or
- Miscellaneous Other Materials.

Provider Complaint System

Complaints

First Choice VIP Care providers may file an informal complaint about First Choice VIP Care's policies, procedures, or any aspects of First Choice VIP Care administrative functions. First Choice VIP Care will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions. All pertinent facts will be investigated and considered. First Choice VIP Care's policies and procedures will also be considered.

Providers may call Provider Services at 1-888-978-0151 or their Account Executive to notify First Choice VIP Care of a complaint.

Provider Contract Terminations

First Choice VIP Care Provider Agreements specify termination provisions that comply with CMS requirements. Provider terminations are categorized as follows:

- Provider Initiated.
- Plan Initiated "For Cause".
- Plan Initiated "Without Cause"; or
- Mutual.

Aside from those requirements identified in the Provider Agreement, First Choice VIP Care will comply with the following guidelines, based on category of termination.

Provider Initiated

- The provider must provide written notice to First Choice VIP Care if intending to terminate from the First Choice VIP Care Network. For single practitioners, written notice must be provided at least sixty (60) days before the termination date. Group practices must provide written notice at least ninety (90) days before the termination date. Under either circumstance, written notice must be delivered in accordance with the method(s) specified in your Network Provider Agreement, and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
- If the provider is a PCP, First Choice VIP Care will send a written notification to the members who have chosen the provider as their PCP no less than fifteen (15) calendar days after receipt of the termination notice.
- If a First Choice VIP Care Medicare member is in a prior authorized, on-going course of treatment with a provider who becomes unavailable to continue to provide services, First Choice VIP Care will notify the member in writing within ten (10) calendar days from the date First Choice VIP Care becomes aware of the unavailability.

First Choice VIP Care Initiated "For Cause"

First Choice VIP Care may initiate termination of a Provider Agreement if the provider breaches the First Choice VIP Care Network Provider Agreement. A "for cause" termination may also be implemented when there is an immediate need to terminate a provider's contract. If terminating a Provider Agreement for cause, First Choice VIP Care will:

- Send applicable termination letters in accordance with the notification provisions of the Network Provider Agreement.
- Notify provider, CMS and the member immediately in cases where a First Choice VIP Care member's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the State Board of Medicine or other governmental agency.
- Offer appeal rights for physicians as applicable.

First Choice VIP Care Initiated "Without Cause"

First Choice VIP Care may terminate a Provider Agreement "without cause" for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, First Choice VIP Care will:

- Send applicable termination letters in accordance with the notification provisions of the Network Provider Agreement.
- Notify First Choice VIP Care Network provider and members in active care at least sixty (60) calendar days before the effective date of the termination.
- Offer Coordination of Care to transition members to new providers.

Mutual Terminations

A Mutual Termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to the First Choice VIP Care Network's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any First Choice VIP Care Network Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members and effectuate continuity of care. A mutual agreement termination date should not be a retroactive date.
- First Choice VIP Care will notify all members in active care at least sixty (60) calendar days before the effective date of the termination.

Continuity of Care

Plan members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or

- Until the member changes to a new provider.

First Choice VIP Care will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

For continued care, First Choice VIP Care and the terminated provider will continue to abide by the same terms and conditions as outlined in the Network Provider Agreement and in the Quality section of this *Provider Manual*. These provisions for continuity of care set forth above will not apply to providers who have been terminated from First Choice VIP Care for cause.

Medical Record Requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized, and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality, and organization of records at all times.

Providers are required by contract to make medical records accessible to the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), First Choice VIP Care and their respective designees in order to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations, and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking, history of alcohol use, and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.

- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- An immunization record is up to date or an appropriate history has been made in the medical record.
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.

Providers must maintain medical records for a period not less than 10 years from the close of the Network Provider Agreement and for a longer period if the records are under review or audit (until the audit or review is complete).

Medical Record Audits

First Choice VIP Care conducts medical record audits to assess the provision and documentation of primary care according to established standards. PCP sites with ten (10) or more linked members undergo a Medical Record Review (MRR) a minimum of once every three (3) years. A PCP practice may include both an individual office and a large group facility site. Ad-hoc reviews of OB-GYN's and specialists may also be conducted, as needed, using the same process.

A minimum of five (5) records are reviewed for each site. Records are selected using a random number methodology among members who have been assigned to the PCP for a minimum of six (6) months.

III. Provision of Services

First Choice VIP Care offers a Medicare Advantage Dual Special Needs Plan that provides the member's Medicare benefits.

No content found in this publication or in the First Choice VIP Care's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, medical care, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with First Choice VIP Care members.

The following information regarding First Choice VIP Care's covered services is provided as a brief overview. For detailed information about our benefits, please call Provider Services or visit our website at www.firstchoicevipcare.com. For detailed information about Medicare basic benefits and limitations please refer to www.Medicare.gov or provider resources available at www.cms.gov. Summary of Benefits

The following Medicare covered health services are included in First Choice VIP Care's benefit package:

- Ambulance Services
- Cardiac and Pulmonary Rehabilitation Services
- Chiropractic Services
- Dental Services
- Diabetes Program and Supplies
- Diagnostic Tests, X-Rays, Lab Services, and Radiology Services
- Doctor Office Visits
- Durable Medical Equipment
- Emergency Care
- Hearing Exams
- Home Health Services
- Inpatient Hospital Care
- Inpatient Mental Health Care
- Services to treat Kidney Disease
- Outpatient Mental Health Care
- Outpatient Physical Rehabilitation
- Outpatient Services/Surgery

- Outpatient Substance Abuse Care
- Podiatry
- Preventive Services and Wellness/Education
- Prosthetic Devices
- Skilled Nursing Facility
- Urgent Care

Pharmacy

- Long Term Care (LTC) Pharmacy
- Mail Order Prescriptions
- Out-of-Network Prescriptions
- Outpatient Prescription Drugs
- Retail Pharmacy
- Out-of-Network Catastrophic Coverage

Supplemental Benefits

The following supplemental services (refer to the member's Evidence of Coverage for a complete listing/coverage) are also covered by First Choice VIP Care:

- Dental – Preventive and Comprehensive Services
- Fitness Benefit
- Hearing – Routine Exams and Aids
- Personal Emergency Response System (PERS)
- Podiatry – Routine Foot Care
- Vision – Routine Exams and Materials
- Over the Counter (OTC) Pharmacy Items
- Transportation Services

Health Management Program

First Choice VIP Care cares about our members' health and wellness. To help our members stay healthy and improve their quality of life, First Choice VIP Care has special programs available for members to address heart disease, diabetes, and asthma, and can provide information about health education and wellness services such as our smoking cessation program. We also have a 24/7 nurse hotline, 1--855-707-0850 where members can get personalized help from a registered nurse.

Emergency Services

First Choice VIP Care ensures the availability of emergency services and care 24 hours a day, seven days a week (24/7).

First Choice VIP Care is responsible for coverage and payment of emergency services and post-stabilization services regardless of whether the provider that furnishes the services has a contract with First Choice VIP Care.

First Choice VIP Care's financial responsibility for post-stabilization care services that has not been pre-approved ends when:

- First Choice VIP Care's physician with privileges at the treating hospital assumes responsibility for the member's care.
- First Choice VIP Care's physician assumes responsibility for the member's care through transfer.
- First Choice VIP Care's representative and the treating physician reach an agreement concerning the member's care; or
- The member is medically appropriately discharged.

First Choice VIP Care will not deny payment for treatment obtained when a member had an emergency medical condition or when the condition was in fact non-emergent in nature but appeared on presentation and/or during medical screening to be an emergency condition under the "prudent layperson" standard. An emergency medical condition exists when the absence of immediate medical attention would place the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, result in serious impairment to bodily functions, or result in serious dysfunction of any bodily organ or part. First Choice VIP Care does not require prior authorization for emergency services provided by network or non-network providers when a member seeks emergency care.

First Choice VIP Care will not refuse to cover emergency renal dialysis services provided while the member was temporarily outside First Choice VIP Care's service area.

First Choice VIP Care's payment to a non-participating provider for emergency services will be limited to the lesser of:

- The limit for emergency service cost-sharing that is published by CMS in its annual guidance; or
- The amount the enrollee would be charged in-network if he or she obtained the services through First Choice VIP Care.

Out-of-Network Use of Non-Emergency Services

Prior approval from First Choice VIP Care is required for out-of-network non-emergency services. First Choice VIP Care will provide timely response to requests for authorization of out-of-network service(s) through the assignment of a prior authorization number (if the request is approved), which refers to and documents the determination. Written follow-up documentation of the determination will be provided to the out-of-network provider within one business day after the decision. The member will be liable for the cost of unauthorized use of covered services from non-participating providers.

Non-Covered Services

First Choice VIP Care will refer members to local resources for services that are not covered by First Choice VIP Care. Providers may contact the Care Management team at First Choice VIP Care at 1-888-978-0151**,** for assistance with coordination of non-covered benefits.

Private Pay for Non-Covered Services

Providers are required to inform members about the costs associated with services that are not covered under the First Choice VIP Care, prior to rendering such services. Should the patient and provider agree, the services would be rendered under a private pay arrangement. The provider must obtain a signed document from the member to validate the private payment arrangement.

IV. MODEL OF CARE

Integrated Care Management

The following information is in regard to First Choice VIP Care's Integrated Care Management (ICM) and Model of Care, which includes Case & Disease Management and Care Coordination for physical and mental health services provided to First Choice VIP Care members.

First Choice VIP Care's Integrated Care Management program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution, First Choice VIP Care delivers and coordinates care across all programs.

The ICM program includes assessment, coordination, and other care planning, as well as service coordination with behavioral health providers and community resources. The ICM program also incorporates health and illness self-management education. The program is structured around a member-based decision support system that drives both communication and treatment plan development through a multidisciplinary approach to management. The ICM process also includes reassessing and adjusting the treatment plan and its goals as needed.

First Choice VIP Care's ICM team includes nurses, social workers, Care Connectors, clinical pharmacists, Plan medical directors, primary care providers (PCPs), specialists, members and caregivers, parents, or guardians. This team works to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

First Choice VIP Care's Model of Care is an Integrated Care Management approach to health care delivery and coordination for dual eligible (Medicare and Medicaid) individuals.

Integrated Care Management Components

There are six core components to our Integrated Care Management (ICM) Program:

- Model of Care
- Interdisciplinary Care Team
- PCP/Medical Home
- Chronic Care Programs
- Clinical Practice Guidelines
- Care Management

Model of Care

First Choice VIP Care has created a Model of Care (MOC) that addresses the physical, mental, and external needs of the dual eligible population in South Carolina. The MOC will take into consideration medical conditions, challenges presented by the members' social conditions, limitations in activities of daily living, and the potential health status of the population eligible to enroll in the First Choice VIP

Care plan. First Choice VIP Care will assist the Interdisciplinary Care Team in creating the best plan of care and quality management for each member.

Interdisciplinary Care Team

Each member has an interdisciplinary care team that addresses the member's unique needs. Team members may include the primary care physician/medical home, physical and behavioral health specialists, First Choice VIP Care nurses, medical directors, pharmacists, home health care, social workers, community mental health workers and physical, speech and occupational therapists.

PCP/Medical Home

The PCP/Medical Home has an important role in the interdisciplinary team. Key responsibilities include assisting members in determining which services are necessary, connecting members to appropriate services, serving as a central communication point for the member's care, reviewing the plan of care sent by First Choice VIP Care and providing feedback to First Choice VIP Care**.** Updates are routinely made to the plan of care and come from multiple sources such as member or provider calls, updated Health Risk Assessments (HRAs), care transitions (hospital, nursing home), claim history, pharmacy or utilization triggers and care episodes.

First Choice VIP Care uses several mechanisms to identify vulnerable sub-populations. Claim data is analyzed to identify members with conditions targeted for chronic care improvement, such as diabetes, heart disease, and COPD; and health needs, such as missing preventive care or recommended condition monitoring.

Utilization of emergency room and inpatient services is reviewed to identify members with opportunities for improved outpatient management. Predictive Risk Scores are calculated to identify members who are at risk for future avoidable health care episodes and HRA data is reviewed for triggers identifying unmet health needs or the presence of chronic conditions.

Chronic Care Improvement Programs

First Choice VIP Care offers several chronic care improvement programs designed to improve the health outcomes for members with identified chronic health conditions. Programs are in place for asthma, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and heart failure. Members may self-refer, be referred by a provider, or be identified through claim data analysis.

Clinical Practice Guidelines

First Choice VIP Care clinical practice guidelines are adopted from nationally recognized organizations and serve as a guide to practitioners, but do not replace clinical judgment. These guidelines are available on the First Choice VIP Care website and hard copies are available from Provider Services upon request.

Care Management

This team is designed to address the needs of members and to support providers and their staff. The team is composed of registered nurses, social workers, and non-clinical Care Coordinators. Together, this team performs three functions on behalf of First Choice VIP Care members and providers: receiving inbound calls, conducting outbound outreach activities, and providing care management and care coordination support.

Providers may request Care Coordinators support by calling 1-888-978-0151.

Transition of Care

First Choice VIP Care is committed to facilitating seamless transitions for the member. Dual eligible members require high touch assistance in navigating the healthcare system. Seamless transitions are a key component of the Model of Care. Everyone plays a role.

First Choice VIP Care Staff

- Notify Medical Home/PCP of planned or unplanned transition for admission and at discharge
- Contact members to verify plans, establish point of contact
- Provide Plan of Care information to sending and receiving facility/provider, including changes at discharge

PCP

- Contact admitting physician to coordinate care
- Review and reconcile medications after discharge
- See the member at office visit post discharge

Hospital

- Send discharge summary and orders with medication list to Plan
- Admitting physician is available to speak with the Medical Home/PCP regarding the member's care needs

Care Coordination with the PCP

First Choice VIP Care recognizes that the PCP is the cornerstone of the member's care coordination and delivery system. Our care management staff contacts the PCP during a member's initial enrollment into the chronic care management program, as part of the comprehensive assessment and treatment plan development process. Program staff creates the member's treatment plan using the PCP's plan as a foundation. Through this approach, program staff complement the PCP's recommendations in the development of an enhanced and holistic treatment plan specific to chronic care management. The Care Coordinator remains in close communication with the PCP during the implementation of the treatment plan, should issues or new concerns arise.

Care Coordination with Other Providers

Program staff also contacts the member's key and/or current providers of care, as well as the member's mental health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Program staff also engage key providers to be part of the development of the member's treatment plan. As the member is reassessed, a copy of the treatment plan is supplied to both the provider and member.

Treatment Plans

In order to help match members with health care that meets their needs in a cost-effective manner, First Choice VIP Care uses a health risk assessment (HRA) to identify members who are at risk for chronic conditions and other health care needs. The HRA contained in the Member Welcome Packet contains questions about current health conditions and health care services. Our HRA identifies actual or potential barriers that may hinder the delivery of optimum health care. Each question in the HRA is designed to gather information in which a positive response will trigger program referrals or action to support a specific issue. The HRA offers opportunities to quickly identify and engage members who have chronic conditions or have special health-related needs.

Through the Integrated Care Management program, First Choice VIP Care works with practitioners, members, and outside agencies to develop treatment plans for members with special or complex health care needs. First Choice VIP Care's treatment plan specifies mutually agreed-upon goals, medically necessary services, mental health and alcohol and drug abuse services (as shared with the member's consent), as well as any support services necessary to carry out or maintain the treatment plan, and planned care coordination activities. treatment plans also take into account the cultural values and any special communication needs of the member, family and caregiver.

First Choice VIP Care treatment planning is based upon the comprehensive HRA of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

Through First Choice VIP Care's Integrated Care Management program, the member is assisted in accessing any support needed to maintain the treatment plan. First Choice VIP Care and the PCP are expected to jointly ensure that members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether First Choice VIP Care provides coverage for those treatments.

Treatment plans for members with special health care needs are to be reviewed and updated every twelve (12) months, at a minimum, or as determined by the member's PCP on the basis of the PCP's

assessment of the member's health and developmental needs. The revised treatment plan is expected to be incorporated into the member's medical record following each update.

Medicare Annual Wellness Visit

Medicare members have coverage for an annual wellness visit. During each office visit, please cover the following:

- Medical History
- Medication Reconciliation
- Family History
- Potential risk factors for:
    - Depression
    - Mood disorders
- Functional assessment and safety level
- Height, weight, BMI, and B/P
- Visual acuity screen
- Other factors deemed appropriate based on the patient's medical and social history and current
- Detect any cognitive impairment the patient may have
- Establish a list of current providers and suppliers
- Give advance care planning services at the patient's discretion
- Establish an appropriate written screening schedule for the patient, such as a checklist for the next 5 to 10 years
    - Cancer Screening
    - Mammography or Colonoscopy
    - Glaucoma Testing
- Establish a list of patient risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway
- Give the patient personalized health advice and appropriate referrals to health education or preventive counseling services or programs
- Recommend the Flu, Pneumonia, Shingle, or COVID-19 vaccine

Remember to list all relevant diagnoses on the claim.

Model of Care Evaluation

Data Sources

- Claims (medical, behavioral health, pharmacy)
- Authorization date
- HEDIS reports
- Member surveys
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
    - Health Outcomes Survey (HOS)

- Practitioner and Facility surveys
- Provider feedback
- Complaint and grievance analysis.

Methods of Communicating Updates and Outcome

- The Plan's website – Quality and Satisfaction Updates
- Member News Bulletin
- Provider News Bulletin
- Provider Workshops – presentations are interactive via the website and face-to-face workshop presentations, as well as provider site visits
- All communications are available in hard copy upon request or via the Plan's website at www.firstchoicevipcare.com

Providers may also contact the Provider Services department at 1-888-978-0151for assistance with questions.

V. Utilization Management

The First Choice VIP Care Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization Management activities are designed to assist our providers with the organization and delivery of appropriate health care services to members within the structure of the members' benefit plan. We do not structure compensation to individuals or entities that conduct utilization management activities in such a way as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Per agreement with First Choice VIP Care, providers are required to comply fully with First Choice VIP Care's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Involving the Plan's medical management nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes, and other clinical documentation as required.

Referrals

Referrals from PCPs to participating specialists for office visits are not required under First Choice VIP Care.

Prior Authorization

Prior authorization is required for certain services provided by all providers, with the exception of emergency services. The First Choice VIP Care UM department hours of operation are 8 a.m. to 5:00 p.m. Eastern time, Monday through Friday. To facilitate the availability to request authorization seven days a week, 24 hours a day, a Behavioral Health fax line is managed 24/7, a registered nurse, behavioral health clinicians, and Medical Director are available after business hours and on weekends to respond to authorization request for inpatient hospitalizations. The most up-to-date listing of services requiring Prior Authorization is maintained in the CPT Look-up Tool available at www.firstchoicevipcare.com. Prior authorization is not a guarantee of payment. First Choice VIP Care reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided.

How to Request Prior Authorization

Medical services (Excluding certain radiology – see below)

- Call the First Choice VIP Care prior authorization line at 1-877-375-4460.
- Complete one of the following forms and fax to 1-833-512-1700:

    - Prior Authorization Form
    - Skilled Nursing Facilities Prior Authorization Form
- You may also submit a prior authorization request via NaviNet.

Behavioral health services

- Call 1-866-426-7690.
- Complete one of the following forms and fax to 1-844-211-0972:
    - Behavioral Health Outpatient Treatment Request Form
    - Behavioral Health Clinical Fax Form PDF
    - Neuropsychological and Psychological Testing Request Form

Radiological Services

- For the following nonemergent outpatient radiological procedures, contact Evolent at 1-800-424-4788 or visit https://www1.radmd.com:
    - CCTA
    - CT/CTA
    - MRI/MRA
    - MUGA Scan
    - Myocardial Perfusion Imaging
    - PET Scan

Pharmacy Services

For prescription drugs not found on our formulary, an exception can be requested by completing one of the following:

- Request for Medicare Prescription Drug Coverage Determination Form
- To submit electronically, please submit an Electronic Prior Authorization (ePA) through your Electronic Health Record (EHR) tool software, or you can submit through any of the following online portals:
    - CoverMyMeds
    - SureScripts

If the request is denied, you can request an appeal on the member's behalf by completing the following:

- Request for Redetermination of Medicare Prescription Drug Denial Form – Online

Services that Require Prior Authorization by First Choice VIP Care

All requests for services are subject to Medicare coverage guidelines and limitations.

- All out of network services (excluding emergency services)
- All in-patient hospital admissions, including medical, surgical, skilled nursing and rehabilitation
- Elective transfers for inpatient and/or outpatient services between acute care facilities
- In-patient services
- Surgery

- Surgical services that may be considered cosmetic, including but not limited to:
    - Blepharoplasty
    - Mastectomy for gynecomastia
    - Mastopexy
    - Maxillofacial
    - Panniculectomy
    - Penile prosthesis
    - Plastic surgery/cosmetic dermatology
    - Reduction mammoplasty
    - Septoplasty
    - Gastric bypass/vertical band gastroplasty
- Transplants, including transplant evaluations
- Certain outpatient diagnostic tests
- Radiology outpatient services (**authorized by Evolent**):
    - CT Scan
    - PET Scan
    - MRI
    - MRA
    - MRS
    - SPECT Scan
    - Nuclear Cardiac Imaging
- Ambulance:
    - Elective/non-emergent air ambulance transportation
    - Certain types of scheduled, non-emergency ambulance trips
- Home health
- Cardiac and pulmonary rehabilitation
- Speech therapy, *occupational therapy and *physical therapy provided in home or outpatient setting, after the first visit per therapy discipline/type
- Durable Medical Equipment (DME):
    - All DME rentals and rent to purchase items
    - Purchase of all items in excess of $750 in total billed charges
    - Prosthetics and orthotics in excess of $750 in total billed charges
    - The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item
- Medications: All infusion/injectable medications listed on the Medicare Professional Fee Schedule; infusion/injectable medications not listed on the Medicare Professional Fee Schedule are not covered
- Pain management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and injections/nerve blocks
- Nutritional supplements
- Hyperbaric oxygen
- Religious Non-Medical Health Care Institutions (RNHCI)

- All miscellaneous/unlisted or not otherwise specified codes

All services that may be considered experimental and/or investigational

Behavioral Health Services Requiring Prior Authorization

The following is a list of behavioral health services requiring prior authorization review for medical necessity and place of service.

- Mental Health Partial Hospitalization Program
- Inpatient Detoxification Admissions
- Mental Health IP Inpatient Admissions
- Neuropsychological Testing
- Psychological Testing
- Electroconvulsive Therapy
- Individual and group sessions for Outpatient Substance Abuse

Services that Do Not Require Prior Authorization

- Emergency Room Services (in-network and out-of-network)
- 48-Hour Observations (except for Maternity – notification required)
- Low-level plain films - x-rays, EKGs
- Post Stabilization Services (in-network and out-of-network)
- Women's healthcare by in-network providers (OB-GYN Services)
- Outpatient Behavioral Health Counseling/Therapy, Evaluation, Medication Management Services, and Nursing Services

Services that Require Notification

- Inpatient Admissions within 24 hours
- Maternity Obstetrical Services (after the first visit) and outpatient care (includes 48-Hour Observations)
- All newborn deliveries
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care

Organization Determinations

An organization determination is any determination (i.e., approval or denial) made by First Choice VIP Care in regard to the benefits a member may be entitled to receive under First Choice VIP Care. Some examples may include:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the plan's network providers that the enrollee believes are covered under Medicare, or, if not covered under

Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan; Reduction, or premature discontinuation of a previously authorized ongoing course of treatment or Failure of UM staff to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Disagreements concerning organization determination decisions are resolved through the member appeals process described in Section VI of this *Provider Manual*.

Standard

First Choice VIP Care will notify the member of its determination as expeditiously as the member's health condition requires, but no later than seven (7) calendar days after First Choice VIP Care receives the request for the standard organization determination.

Expedited

The member's physician may request that First Choice VIP Care expedite an organization determination, including a request for authorization, when the member or physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. If First Choice VIP Care decides to expedite the request, we will render a decision as expeditiously as the member's health condition might require, but no later than seventy-two (72) hours after receiving the request.

If First Choice VIP Care requires medical information to make the determination, we are required to request the information within twenty-four (24) hours and to respond to the member within seventy-two (72) hours of receiving the request.

First Choice VIP Care can also have an additional fourteen (14) days if First Choice VIP Care documents that additional information is needed and the delay is in the member's best interest. If First Choice VIP Care needs more time, the member will be informed of the reason for the extension in writing within five (5) days. If the organization determination is not in the member's favor, the member or the member's authorized representative has the right to appeal the decision.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if a case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

First Choice VIP Care will provide an expedited organization determination if the member's physician indicates, either orally or in writing, that applying the standard time for making a determination could

seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If First Choice VIP Care denies the request for an expedited organization determination, we will:

- Automatically transfer the request to the standard timeframe and make a determination within seven (7) calendar days of the date the request was originally received
- Give the member prompt oral notice of the denial including the member's rights to appeal
- Deliver to the member a written letter of the member's rights that:
    - Explains that First Choice VIP Care will automatically transfer and process the request using the seven (7-day time frame for standard determinations.
    - Informs the member of the right to file an expedited grievance if he or she disagrees with First Choice VIP Care's decision not to expedite the determination.
    - Informs the member of the right to resubmit a request for an expedited determination. If the member gets a physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically; and
    - Provides instructions about the expedited grievance process and its time frames.

Medical Necessity Standards

Medically necessary or medical necessity is defined as:

Services or supplies that are needed for the diagnosis or treatment of the member's medical condition, and that meet accepted standards of medical practice.

The need for the item or service must be clearly documented in the patient's medical record. Medically necessary services or items are:

- Appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease, or injury; and
- Provided for the diagnosis or the direct care of the patient's condition, illness, disease, or injury; and
- In accordance with current standards of good medical practice; and
- Not primarily for the convenience of the patient or provider; and
- The most appropriate supply or level of service that can be safely provided to the patient.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively and appropriately furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary or a covered service/benefit.

The Utilization Management staff utilizes the following criteria and coverage guidelines to determine medical necessity of items and or services and Part B drugs:

- Medicare Coverage Database
- Medicare Benefit Policy Manual
- Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for Federal programs such as Medicare; The Law (Title 18 of the Social Security Act) The Regulations (Title 42 Code of the Federal Regulations (CFR)
- Change Healthcare InterQual© Adult Criteria (Condition Specific-Responder, Partial Responder, Non-responder)
- Change Healthcare InterQual© Pediatric Criteria (Condition Specific-Responder, Partial Responder, Non-responder
- Change Healthcare InterQual© Outpatient Rehabilitation & Chiropractic
- Change Healthcare InterQual© Home Care Criteria • Change Healthcare InterQual© Medicare Procedures Criteria
- Change Healthcare InterQual© Medicare Post Acute and Durable Medical Equipment Criteria
- Change Healthcare InterQual I Imaging
- Change Healthcare InterQual, Rehabilitation
- Change Healthcare InterQual Sub Acute & Skilled Nursing Facility
- Change Healthcare InterQual© Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
- Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content)
- Corporate Clinical Policies

When applying Medical Necessity criteria, UM staff also considers the individual member factors and the characteristics of the local health delivery system, including:

- Member Considerations
    - Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.
- Local Delivery System
    - Availability of sub-acute care facilities or home care in the First Choice VIP Care service area for post discharge support,
    - First Choice VIP Care benefits for sub-acute care facilities or home care where needed,
    - Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the medical director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the First Choice VIP Care medical

director or other designated practitioner under the clinical direction of the medical director. The First Choice VIP Care medical director is responsible for ensuring the clinical accuracy of all Organization Determinations and Reconsiderations involving medical necessity. The First Choice VIP Care medical director is a physician with a current license to practice medicine in South Carolina**.**

Medical necessity decisions made by the First Choice VIP Care medical director or designee are based on the above definition of Medical Necessity, in conjunction with the member's benefits, the medical director's/designee's medical expertise, First Choice VIP Care Medical Necessity guidelines (as outlined above), Medicare coverage guidelines and/or published peer-review literature. At the discretion of the First Choice VIP Care medical director/designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The First Choice VIP Care medical director or designee makes the final decision.

Upon request by a member or practitioner/provider, the criteria used for medical necessity decision making in general, or for a particular decision, is provided in writing by the First Choice VIP Care medical director or designee or is available on the Plan website. First Choice VIP Care will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member.

The Utilization Management staff involved in medical necessity decisions is assessed for consistent application of review criteria annually. An action plan is created and implemented for any variances among staff outside of the acceptable range. Both clinical and non-clinical staff are audited for adherence to policies and procedures.

Notice of Adverse Determination

If First Choice VIP Care decides to deny authorization for services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment, then it will give the member a written notice of its determination. First Choice VIP Care will provide notice using the most efficient manner of delivery to ensure the member receives the notice in time to act (e.g., via fax, hand delivery, or mail). If the member has a representative, the representative will be given a copy of the notice.

First Choice VIP Care uses CMS model notices for the Notice of Denial of Medical Coverage (NDMC) and Notice of Denial of Payment (NDP). First Choice VIP Care denial notices are written in a manner that is intended to be understandable to the member and provides the specific reason for the denial that takes into account the member's presenting medical condition, disabilities, and special language requirements, if any. The notice:

- Informs the member of the right to file an expedited grievance if he or she disagrees with First Choice VIP Care's decision not to expedite a coverage determination.

- Informs the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically; and

- Provides instructions about the expedited grievance process and its time frames.

Peer to Peer Review

Preservice requests – Must be requested during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the whole or partial denial determination is rendered.

Inpatient requests –

- Anytime during the inpatient stay.
- Within 5 business days of the verbal/faxed denial notification or up to 5 business days after the member's discharge date, whichever is later.

Post-Service Reviews

In certain situations, First Choice VIP Care conducts post-service reviews for medical services or items which have already been rendered or received, but for which prior authorization was not obtained. Further, requests for a post-service review may be honored under certain circumstances. Requests for post-service reviews may be made by members, individual practitioners, or facilities. A post-service review may be performed in the following circumstances:

- When pertinent coverage information is not available or incorrect, upon admission (member presented as self-pay or with altered level of consciousness).
- If urgent services requiring authorization were performed and it would have been to the member's detriment to take the time to request authorization.
- Cases of retroactive enrollment with the plan.
- When a provider can show that attempts were made to submit request prior to the service but the plan did not respond to the request.
- When a member has been admitted and discharged from a facility during a time when plan staff was not available (i.e., natural disasters).
- Failed information technology systems.
- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.

- The need for the new service was revealed at the time the original authorized service was performed.

If one of these circumstances is met and you would like to request a post-service review of an item or service, the request must be made within 180 calendar days from the date of service. Please be sure to include all the necessary supporting documentation with your request. Once a request is received, a determination will be reached within thirty (30) calendar days and notification will be sent. In the case of an adverse determination, the notification will include the reason for the decision and will include the member's appeal rights.

VI. Member Integrated and Unified Grievances and Appeals

Integrated and Unified Appeals Summary

The existing Medicare and Medicaid appeal processes require dually eligible individuals to navigate separate appeal pathways, depending on whether the benefit in question is covered by Medicare, Medicaid, or both. For example, even if an individual is enrolled in Medicare and Medicaid plans operated by the same parent company, these processes differ in certain respects, such as the timeframes in which a plan must make a decision about an enrollee's grievance.

The integrated appeal process resolves these misalignments by creating a single appeal pathway at the plan level for all Medicare (other than Medicare Part D) and Medicaid benefits for enrollees in applicable integrated plans. The process begins when an individual requests coverage for a particular service or benefit from their plan. Regardless of whether the service or benefit would typically be covered by Medicare, Medicaid, or both, the plan must make a decision about the request as expeditiously as the enrollee's health condition requires. If the plan denies the request, or if it reduces, suspends, or terminates a previously authorized benefit, the enrollee may file an appeal with the plan. As in the Medicaid appeal process, the integrated appeal process allows individuals to continue their benefits subject to an appeal if they meet certain requirements. This continuation of benefits is available for all ongoing services, including those covered by Medicare. The integrated appeal process does not modify any post-plan appeal processes, including Medicare Independent Review Entity decisions and Medicaid state fair hearings.

Integrated and Unified Grievances Summary

Like the integrated appeal process, the integrated grievance process offers individuals a single pathway to file a grievance with their plan, regardless of whether the grievance involves the delivery of a Medicare or a Medicaid benefit. An individual may file a grievance verbally or in writing at any time with their plan.

Integrated Standard and Expedited Grievances (Complaints)

If a member has a complaint regarding the quality of care, waiting times, customer service, etc. he/she has received, he/she should contact the Member Services department at the toll-free number on the back of their identification card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance.

A grievance expresses dissatisfaction about matters related to the services offered by First Choice VIP Care. The member may file a grievance in writing or by phone at any time. It may be filed by the provider (or another authorized representative) on behalf of the member with the member's written consent. A grievance may be filed about such things as the quality of the care the member receives from First Choice VIP Care provider, rudeness from a First Choice VIP Care employee or a provider's

employee, a lack of respect for their rights by First Choice VIP Care or any service or item that did not meet accepted standards for health care during a course of treatment.

Standard grievances will be resolved within thirty (30) calendar days and Expedited grievances will be resolved within 24 hours of receiving the grievance.

Quality of Care Grievances

For grievances pertaining to quality of care, members may register their complaint either through First Choice VIP Care, which will follow the same process as all other grievances, or through KEPRO, an independent organization under contract to the Federal Government to monitor and improve the care given to Medicare members (the "Quality Improvement Organization" or "QIO").

Filing a Grievance

To file a grievance, the member, or the member's physician or other representative, may call Member Services at 1-888-996-0499 (TTY: 711)**;** or write to:

First Choice VIP Care
Attn: Member Grievances Department
P.O. Box 7140
London, KY 40742-7140

To file a quality of care grievance with the QIO, the member, the member's physician, or the member's representative may contact Acentra through their website.

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services toll free at 1-888-996-0499 (TTY: 711). Interpreter services, if needed, will be made available free of charge to the member.

Appeals (Reconsiderations)

Following the receipt of an Adverse Benefit Determination notice, called the Coverage Decision Letter, from First Choice VIP Care denying payment for a service, denying authorization of a service or discontinuing services the member is in the process of receiving, the member, a member's authorized representative (physician, family member or any other person who has received authorization), or a non-contracted provider may file a request for an appeal. The request may be filed in writing or verbally by contacting Member Services.

Two types of appeals may be filed: a standard appeal or an expedited appeal. A standard appeal can consist of appealing an action that denies payment for a service, denies authorization of a service, or discontinues services a member may be in the process of receiving. An expedited appeal may be an appeal that as a result of the action by the Plan, the member's health may be jeopardized if the standard appeal process is followed.

An appeal regarding a standard service authorization decision must be filed within sixty (60) calendar days from the date of the Coverage Decision Letter. For appeals relating to termination, suspension, or reduction of previously authorized services, where the member requests continuation of such services, the member must file an appeal within ten (10) calendar days of the date of the Coverage Decision Letter.

Standard Appeal Process

Following receipt of a standard appeal request, First Choice VIP Care will send the member or member's representative an acknowledgement letter to confirm receipt of appeal request. First Choice VIP Care will provide the member or member's representative the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. First Choice VIP Care will also provide the member and his or her representative the opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeal process. Under certain circumstances certain categories of medical records and other documents may not be available to the member based on the type of record, including but not limited to behavioral health records.

Expedited Appeal Process

If the member's health is at risk, the member has the right to submit, either verbally or in writing, a request for an expedited appeal request. First Choice VIP Care will provide the member or member's representative the opportunity to present evidence, and allegations of fact or law, in person as well as in writing. First Choice VIP Care will also provide the member and his or her representative the opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeal process. Under certain circumstances certain categories of medical records and other documents may not be available to the member based on the type of record, including but not limited to behavioral health records. If First Choice VIP Care requires medical information to make the determination, they are required to request the information within twenty-four (24) hours and will issue a resolution within seventy-two (72) hours of receiving the request.

The Plan ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Appeal (Reconsideration) - Processing Timeframes

Expedited Appeal	The applicable integrated plan must provide notice of its expedited integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.
Standard Appeal	The applicable integrated plan must resolve integrated reconsiderations as expeditiously as the enrollee's health condition requires but no later than 30

	calendar days from the date of receipt of the request for the integrated reconsideration.
Extensions	The applicable integrated plan may extend the timeframe for a standard or expedited integrated organization determination by up to 14 calendar days if— (A) The enrollee or provider requests the extension; or (B) The applicable integrated plan can show that— (*1*) The extension is in the enrollee's interest; and (*2*) There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

Steps Following First Choice VIP Care Appeal Decisions

For expedited appeals, the Plan will make reasonable efforts to provide verbal notice to the member, member representative or member's provider of the appeal determination in addition to providing a written notice. For standard appeals, the Plan will notify of the appeal determination through a written notice. The written notices provided to the member or member representative will detail the resolution, how the resolution was determined and the next steps with respect to the resolution.

- For a **Medicare** service, the case will be sent automatically to the Medicare Independent Review Entity (IRE) for an External Appeal. The IRE will give you an answer within 30 calendar days of when it gets your appeal.
- If the IRE upholds the denial:
    - The member or a member's representative has sixty (60) days to file an appeal with the Office of Medicare Hearings and Appeals (OMHA). If the OMHA upholds the denial, then
    - The member or member's representative has sixty (60) days to file an appeal with the Medicare Appeals Council, then
    - If the Medicare Appeals Council denies claim, and if the amount in controversy is more than $1,350, the claim may be appealed to the Federal District Court.
- For a Medicaid service, the member can ask for a State Fair Hearing

Filing an Appeal

To file a reconsideration or for more information regarding the appeals process, participating providers, on behalf of a member, or the member may call Member Services at 1-888-996-0499 (TTY: 711); or write to:

First Choice VIP Care
Attn: Member Appeals Department
P.O. Box 80109

London, KY 40742-0109

Participating providers appealing on the member's behalf must complete the Appointment of Representative form found in the Member section under Appeals and Grievance at www.firstchoicevipcare.com.

If the member needs assistance in filing his/her request for a reconsideration or needs the help of an interpreter, the member may call the Member Services department.

Interpreter services are free of charge to the member.

Appeal for a Request for Payment of Denied Claims

Contracted providers do not have rights to appeal for the payment of denied claims. Denied claims for any reason, including lack of authorization, may be reviewed through the claim's dispute process (see the Claims Submission Protocols and Standards section).

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Member Appeals telephone line at 1-888-996-0499.

VII. Quality

Quality Assessment and Performance Improvement Program

The Plan's Quality Assessment and Performance Improvement (QAPI) program provides a framework for the evaluation of the standards of health care practice, including physical health care (primary and specialty care); behavioral health care and substance abuse treatment that focuses on recovery, resiliency and rehabilitation. The QAPI program supports the infrastructure essential to a seamless member experience for adequate access to high quality, coordinated and culturally competent clinical care and services across the care continuum, including transitions of care. The QAPI program description describes the quality improvement scope, goals, objectives, structure and functions for the Plan. The Plan's Board of Directors provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into the Plan's operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI program are delegated by the Board of Directors through the Chief Executive Officer and President, Medicare to the Quality Assessment Performance Improvement Committee (QAPIC).

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to the Plans' members by providers.

Included within the scope of the QAPI program are the following areas:

- Identification of the member health needs
- Accessibility and availability of physical and behavioral health care
- Integration of physical and behavioral health care
- Member, provider, and practitioner satisfaction
- Member grievance and appeal processes and trends
- Development, implementation, and adherence assessment of clinical and preventive health practice guidelines
- Preventive health care services
- Preventive behavioral healthcare services
- Continuity and coordination of medical care
- Continuity and coordination between medical and behavioral healthcare
- Assessment of care coordination and continuity of care
- Member safety
- Clinical quality initiative
- Review of quality-of-care concerns
- Review and reporting of critical incidents
- Chronic-condition management
- Behavioral healthcare management
- Monitoring of utilization, including over and under utilization
- Credentialing/re-credentialing activities

- Oversight of delegated activities
- Activities to reduce health care disparities
- Activities to improve health equity and linguistic and cultural competence
- Activities to support transitions of care
- Monitoring the performance and status of the MOC updates, MOC metrics and annual MOC program evaluation

The Plan develops goals and strategies considering applicable state and federal laws and regulations and other regulatory requirements, NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals, and national medical criteria.

The goals, objectives and related measures used to monitor and evaluate performance are incorporated into the QAPI work plan. The work plan outlines monitoring and evaluation activities relevant to the scope, purpose and objectives of the QAPI Program for the year. It outlines reporting activities/deliverables, their purpose/scope, frequency, responsibly parties/departments and planned timeframe for presentation to the QAPI Committee. The work plan is revised as necessary to add new initiatives.

Quality Management Activities

Providers play a key role in helping us to measure and report the quality of care delivered to our members by assisting with the following:

- Every provider in the Plan's provider network is required by contract to cooperate with and participate in the Plan's QAPI Program. We rely on your cooperation and participation to meet our own state and federal obligations as a D-SNP.
- The Plan's access to the medical records maintained by our providers is a critical component of our data collection as we seek to ensure appropriate and continued access to care for our member population. The Plan or its designee must receive medical records from providers in a timely manner for purposes of HEDIS data collection, NCQA accreditation, audits, and other quality-related activities that comprise our QAPI program. The Plan will reach out from time to time to request records for these purposes. It is important that requested records are provided within the timeframes set forth in these notices.
- As our technological capabilities continue to advance, the Plan will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including through the use of bi-directional automated data exchange with our providers. These exchange opportunities, as available, are intended to capture data related to gaps in care, and to identify social determinants of health that may also be targets for intervention. The Plan will work with our providers to identify and implement the most appropriate format and cadence for data exchange.

The Plan has clinical reviewers to fully investigate potential quality of care (QOC) grievances and concerns. Providers are expected to comply with QOC review processes, beginning with the timely submission of records in response to requests from the Plan. Provider/Practitioner support of and

participation in this critical review process helps to ensure the provision of high-quality care and service to the Plan's member population.

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) oversees the Plan's efforts to measure, manage and improve quality of care and services delivered to the Plan's members, and evaluate the effectiveness of the QAPI program. Additional committees and councils support the QAPI program and report into the QAPIC:

Medicare Policy Review Committee – The purpose of the Medicare Policy Review Committee (MPRC) is to ensure that policies and procedures are reviewed, updated timely and meet the standards to maintain compliance with federal and state requirements.

Pharmacy and Therapeutics Committee – The Pharmacy and Therapeutics (P&T) Committee monitors prescribing patterns of network prescribers, drug utilization patterns, develops policies for managing drug use and drug administration, pharmacy benefits management procedures and quality concerns, and identifies opportunities for provider and member education.

Health Equity and Culturally and Linguistically Appropriate Services (HECLAS) Committee – The Health Equity and Culturally and Linguistically Appropriate Services (HECLAS) Committee is a cross-departmental workgroup responsible for providing direction to First Choice VIP Plans HE and CLAS initiative. The HECLAS Committee provides direction to the activities that are relevant to the 15 National CLAS standards and NCQA's HE Accreditation standards that ensure that the Plan members are served in a way that is responsive to their cultural and linguistic needs and focused on addressing health disparities. HECLAS meets regularly and reports to the QAPI Committee on a quarterly basis. The QAPIC provides direction and oversight for the Health Equity Committee.

Credentialing Committee – The Credentialing Committee is responsible for reviewing practitioner and provider applications, credentials, and profiling data (as available) to determine appropriateness for participation in the Plan's network.

Utilization Management (UM) Committee – The UM Committee reviews Utilization Management, including prior authorization policies and reviews current National Coverage Determination (NCDs), Local Coverage Determination (LCDs), and other Traditional Medicare coverage policies. The UM Committee meets regularly and reports to the QAPIC quarterly. The UM Committee ensures that policies and procedures are reviewed, updated annually and meet the standards to maintain compliance with applicable state and federal guidelines and regulations including but not limited to CMS (Centers for Medicare & Medicaid Services).

Member Advisory Council – The Member Advisory Council (MAC) provides a regional forum for members, caregivers, and advocacy groups to provide input in plan operations that impact member care, services and plan operations. The council meets quarterly or as necessary with a minimum of four times a year and report to the QAPI Committee quarterly. to promote collaborative efforts to enhance the service delivery system in local communities while maintaining member focus.

Model of Care Steering Committee – The Medicare DSNP Model of Care (MOC) Steering Committee oversees efforts to develop, document, measure, manage and improve MOC processes delivered to plan members, as well as evaluate the effectiveness and timeliness of the MOC program. The focus of the meeting will be to evaluate and enhance outcomes for all aspects of the DSNP MOCs including but not limited to: QAPI alignment, Annual MOC evaluation, associate, vendor and provider annual training, plan implementation, Oversight and Compliance Committee Outputs.

Practitioner Involvement

We encourage provider participation in our QAPI program. Providers who are interested in participating in one of our Quality Committees should call the Provider Services Department at 1-888-978-0151 or contact their Provider Account Executive directly.

QAPI Program Activities

The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. QI program activities are conducted using Plan-Do-Study-Act (PDSA) methodology:

- **Plan –** Establish objectives and processes necessary to meet performance or outcome goals.
- **Do –** Implement the plan and processes and observe what happens; identify issues; collect data for further analysis.
- **Study –** Evaluate and compare the results to the performance/outcome goal/predications; identify differences between the actual/expected/target outcomes. Review the impact of the changes and identify lessons learned to plan for next steps.

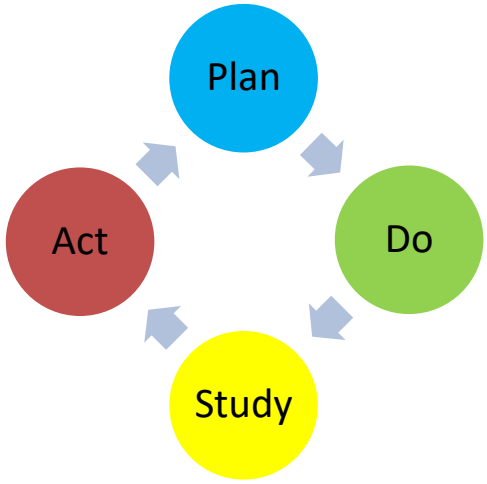


Figure 2: PDSA Quality Process

- **Act –** Develop and implement corrective action to address significant differences between the actual and planned results; conduct root cause analysis; as necessary, return to Plan step.

The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. Practitioners and providers agree to allow the Plan to use their performance data as needed for the organization's QI activities to improve the quality of care and services, and the overall member experience. On-going QAPI activities include:

Health Status – Prevalence Documentation and Baseline Assessment

The Plan analyzes available data to identify baseline measurements for clinical indicators associated with high-prevalence chronic conditions and overall health status. QAPI initiatives will be developed for low-performing indicators as appropriate.

Ensuring Appropriate Utilization of Resources

The Plan performs baseline utilization measurements to calculate inpatient admission rates and length of stay; emergency room utilization rates; and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

Chronic Care Improvement Program

The Plan develops, implements, monitors, and reports on a Chronic Care Improvement Program (CCIP) in compliance within compliance with 42 C.F.R. §422.152(c) and as reviewed and approved by the QAPI Committee. The CCIP is a three (3) year Plan initiative that is clinically focused and designed to promote effective management of chronic disease. Internal documentation is maintained, and annual attestation is completed.

Measuring Member Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Medicare Advantage and Prescription Drug (MAPD) Plans is conducted annually as required. The survey is administered by a CMS-approved vendor. The survey contains standardized questions which are used to evaluate the member's experiences with a wide range of health care services. All results are analyzed to identify opportunities for improvement and reviewed by the QAPI Committee.

Measuring Practitioner and Provider Satisfaction

The Plan conducts annual practitioner and provider satisfaction surveys to assess levels of satisfaction with specific areas of care delivery. They are used to measure and review the plans' processes, people and systems with which physicians interact. The results enable the plans to develop and implement interventions to increase satisfaction. Survey results are used by the QAPI Committee to determine satisfaction and opportunities for improvement with contracted practitioners and providers.

Clinical Practice and Preventive Health Guidelines

The Clinical Policy Department adopts and implements clinical practice guidelines (CPG) to improve patient outcomes, deliver cost-effective care, and promote consistency and delivery of evidence-based care the Plan's QAPIC is responsible for reviewing and adopting appropriate clinical practice guidelines for the use in guiding the treatment of our members with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. The guidelines are intended to inform, not replace, the practitioner's clinical judgment. The practitioner remains responsible for ultimately determining the applicable treatment for everyone. Health Care Equity

The Plan has a Health Equity committee to promote the delivery of services to people of all cultures, races, ethnic backgrounds, abilities, and religions in a manner that recognizes values, affirms and respects the worth of the individual members and protects and preserves the dignity of each. All health

equity related activities implemented are measured and evaluated using internal audits, member satisfaction surveys, other outcomes-based evaluations, and performance improvement methodologies. Health care equity is assessed and promoted through a variety of activities that leverage resources across the organization. Activities are outlined below:

Collect and analyze practitioner race/ethnicity and language data to determine if the network is responsive to the needs of the membership. Develop a plan to address network race/ethnicity and language gaps

- Support practitioners in providing appropriate language services
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities

Other Quality Initiatives

Adverse Action Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, First Choice VIP Care sends information on reportable events, (as outlined in the NPDB and HIPDB Reporting Manual instructions) to the respective entity and to the applicable State licensing board, as appropriate, in the state where First Choice VIP Care is located.

All review outcomes, including actionable information, are incorporated in the provider credentialing file and database.

Reporting & Managing Unusual Occurrences

Critical Incidents, Sentinel Events and Never Events

The Plan monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of First Choice VIP Care. This includes critical incidents, sentinel events and never events, as defined below. The phrase “or risk thereof” includes any process variation for which an occurrence (as in a ‘near miss’) or recurrence would carry a significant chance of a serious adverse outcome.

Important definitions include:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as “sentinel” because they signal the need for immediate investigation and response. Please note, the terms “sentinel event” and “medical

error" as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

- **Critical Incident** – Retrospective identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. Critical incidents differ from sentinel events only in terms of the timeframe in which they are identified.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above.
- **Quality of Care Grievance** - A complaint from a member or his/her authorized representative concerning the quality of medical care received.
- **Potential Quality of Care Concern** - An unsubstantiated deviation from expected provider performance, clinical care, or outcome of care

First Choice VIP Care's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.

Managing Unusual Occurrences

The Plan will not take punitive action or retaliate against any person for reporting an unusual occurrence. The practitioners involved will be offered the opportunity to present factors leading to the unusual occurrence and to respond to any questions arising from the review of the unusual occurrence.

Once a staff member of the Plan identifies or is notified of an unusual occurrence, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Plan's Medical Director is notified of the event via an incident report, telephone, email, or personal visit as soon as reasonably possible after identification of the occurrence.
2. The Plan's Medical Director will collaborate with the Medical Management, Quality and Grievance departments and to investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality department leads the investigation, analysis and reporting of all identified unusual occurrences.
4. All unusual occurrences require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance.

5. As appropriate, issues are identified for correction and corrective action plans are developed to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, timelines, and strategies for measuring the effectiveness of the actions.
6. Confirmed critical incidents and sentinel events will be reported to the appropriate authority for the Plan's contracted state as required.
7. As appropriate, information regarding unusual occurrences will be provided to the Credentialing Committee to support the re-credentialing process and to the QAPIC on a quarterly basis.

Reporting Provider Preventable Conditions

Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information regarding the First Choice VIP Care reimbursement policy on provider preventable conditions and how to report such conditions via the claims process.

Potential Quality of Care Concerns

The Plan will confidentially investigate, review, and report potential quality of care concerns in accordance with established policies and procedures for Quality of Care Grievances or Potential Quality of Care Concerns. The Medical Director's outcome determination of the quality of care concern may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's Network.

If the concern is referred to the QAPIC, follow-up actions are conducted based on the QAPIC's recommendation(s), which may include sanctioning the practitioner/provider.
If the QAPIC investigation involves a reportable action, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and State regulatory agencies as required.

The QAPIC reserves the right to impose any of the following actions, based on its discretion:

- Requiring the practitioner/provider to submit a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record audit.
- Requiring that the practitioner/provider conform to a corrective action plan (CAP) which may include continued monitoring by the Plan to ensure that adverse events do not continue. This requirement will be documented in writing. A CAP may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.

- Implementing formal sanctions, including termination from the Plan's network if the offense is deemed an immediate threat to the well-being of the Plan's members. The Plan reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

At the conclusion of the investigation of the QAPIC, the practitioner/provider will be notified by letter of the concern and of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

Formal Sanctioning Process

It is the goal of First Choice VIP Care to assure members receive quality health care services. In the event that health care services rendered to a member by a Network Provider represent a serious deviation from, or repeated non-compliance with, First Choice VIP Care 's quality standards, and/or recognized treatment patterns of the organized medical community, the Network Provider may be subject to First Choice VIP Care's formal sanctioning process.

Following a determination to initiate the formal sanctioning process, First Choice VIP Care will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with First Choice VIP Care on the proposed action
- The practitioner/provider has thirty (30) days following receipt of notification within which to submit a written request for a hearing. Otherwise, the right to a hearing will be forfeited. The practitioner/provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action he/she wishes to contest
- Notification that the practitioner/provider may waive his/her right to a hearing and that the right will be considered waived if no written request for a hearing is submitted.

Notice of Hearing

If the practitioner/provider requests a hearing in a timely manner the practitioner/provider will be notified of the following in writing:

- The place, date, and time of the hearing, which will not be less than thirty (30) days after the date of the notice
- That the practitioner/provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the First Choice VIP Care Medical Director and/or upon advice of First Choice VIP Care Legal Affairs department
- A list of witnesses (if any) expected to testify at the hearing on behalf of First Choice VIP Care.

Conduct of the Hearing and Notice

The hearing will be held before:

- A panel of individuals appointed by First Choice VIP Care (the Hearing Panel)

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions
- The Hearing Panel will be composed of physician members of First Choice VIP Care 's quality-related committees, First Choice VIP Care 's Medical Director and/or designee, and other physicians and administrative persons affiliated with First Choice VIP Care as deemed appropriate by First Choice VIP Care 's Medical Director, such as legal counsel
- First Choice VIP Care 's Medical Director or his/her designee serves as the hearing officer
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

Practitioner/Provider's Hearing Rights

The practitioner/provider has the right to:

- Representation by an attorney or other person of the practitioner/provider's choice.
- Have a record made of the proceedings (copies of which may be obtained by the practitioner/provider upon payment of reasonable charges associated with the preparation).
- Call, examine, and cross-examine witnesses.
- Present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law.
- Submit a written statement at the close of the hearing.
- Receive the written recommendation(s) of the Hearing Panel within fifteen (15) working days of completion of the hearing, including statement of the basis for the Hearing Panel's recommendation(s), which will be provided by certified mail or via another means providing for evidence of receipt. and
- Receive First Choice VIP Care written decision within sixty (60) days of completion of the hearing, including the basis for First Choice VIP Care decision(s), which will be provided by certified mail or via another means providing for evidence of receipt.

Appeal of First Choice VIP Care Decision

The practitioner/provider may request an appeal after the final decision of First Choice VIP Care.

The practitioner/provider must submit a written appeal by certified mail or via another means providing evidence of receipt, within thirty (30) days of the receipt of First Choice VIP Care decision; otherwise, the right to appeal is forfeited.

Written appeal will be reviewed and a decision rendered by First Choice VIP Care QAPIC within forty-five (45) days of receipt of the notice of the appeal.

Summary Actions Permitted

The following summary actions can be taken, without the need to conduct a hearing, by the President of First Choice VIP Care or by the First Choice VIP Care Medical Director:

- Suspension or restriction of First Choice VIP Care participation status for up to fourteen (14) days, pending an investigation to determine the need for formal sanctioning process, or

- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within thirty (30) days of the summary action to review the basis for continuation or termination of this action.

Prohibition on Payments to Excluded/Sanctioned Persons

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, First Choice VIP Care may not make payment to any person or an affiliate of a person who is debarred, suspended, or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of First Choice VIP Care, a Provider will be required to furnish a written certification to First Choice VIP Care that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to immediately notify First Choice VIP Care upon knowledge that any of its contractors, employees, directors, officers, or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that a Provider cannot provide reasonably satisfactory assurance to First Choice VIP Care that a Sanctioned Person will not receive payment from First Choice VIP Care under the Provider Agreement, First Choice VIP Care may immediately terminate the Provider Agreement. First Choice VIP Care reserves the right to recover all amounts paid by First Choice VIP Care for items or services furnished by a Sanctioned Person.

VIII. Cultural Competency Plan

Embedded in all of our efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

First Choice VIP Care routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five (5) percent of First Choice VIP Care's population. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Our Cultural Competency program, led by a cross-departmental workgroup, has been built upon the following fourteen (14) national standards for Culturally and Linguistically Appropriate Services (CLAS) as set forth by the U.S. Department of Health and Human Services:

- Each First Choice VIP Care member experiences culturally and linguistically competent care that considers the values, preferences and expressed needs of the member.
- First Choice VIP Care has built a staff that adequately mirrors the diversity of the member service area.
- First Choice VIP Care provides ongoing education and training in CLAS delivery to staff at all levels and across all disciplines.
- First Choice VIP Care offers language assistance services, including bilingual staff and interpreter services, at no cost, to members with Limited English Proficiency (LEP).
- First Choice VIP Care assures the competency of language assistance services and requires that friends and family are not providing interpretation services (except upon request by and with informed consent of the member).
- First Choice VIP Care informs members, in a language they can understand, that they have the right to free language services and that these services are readily available.
- The First Choice VIP Care language assistance program ensures that written materials routinely provided in English to members, applicants, and the public are available in commonly encountered languages other than English.
- First Choice VIP Care has developed, implemented, and promoted a written strategic action plan to ensure CLAS.
- First Choice VIP Care assesses CLAS-related activities and incorporates mechanisms to measure the success of these activities into our internal audits, performance improvement programs, member satisfaction surveys and outcomes-based evaluations.
- First Choice VIP Care validates that data on members' race, ethnicity, and spoken and written language are collected in health records and ensures that such data are integrated into our management information systems and updated as needed.
- First Choice VIP Care maintains a current demographic and cultural profile and needs assessment of our service area. This demographic and cultural profile is used in planning services that respond to the cultural and linguistic characteristics of our service area.

- First Choice VIP Care is committed to both community and member involvement in designing and implementing CLAS-related activities by our Member Advisory Council.
- First Choice VIP Care's grievance and appeals process is culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by members.
- First Choice VIP Care publicizes information regarding our progress and success in implementing CLAS standards and also provides public notice regarding the availability of this information.

Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

As a provider of health care services who receives federal financial payment through the Medicare and Medicaid programs, you are responsible to make arrangements for language services for members, upon request, who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to ensuring equal access to benefits and services for LEP, LLP and sensory impaired members is to ensure that you, our Network Provider, can effectively communicate with these members**.** Plan providers are obligated to offer translation services to LEP and LLP members upon request and to make reasonable efforts to accommodate members with other sensory impairments.

Providers should discourage members from using family or friends as oral translators. Members should be advised that translation services from First Choice VIP Care are available. Providers are required to:

- Provide written and oral language assistance at no cost to plan members with limited English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Provide members verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.

- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.

***Note**:* The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation services and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

When a member uses First Choice VIP Care's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner.

First Choice VIP Care contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at 1-888-978-0151.

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact First Choice VIP Care Member Services at 1-888-996-0499 (TTY: 711 and a representative will help locate a professional interpreter to communicate in the member's primary language.

Additionally, under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan Providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all members in a manner compatible with the member's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for plan members upon request; and,
- Routinely document preferred language or format, such as Braille, audio, or large type, in all member medical records.

Contact Information

For additional information and to view the CLAS standards go to https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. For language assistance services, contact First Choice VIP Care at 1-888-978-0151 or go to www.firstchoicevipcare.com.

IX. Claims Submission Protocols and Standards

Encounter Reporting

CMS defines an “encounter” as "an interaction between an individual and the health care system."

Encounters occur whenever a First Choice VIP Care member is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury. An encounter is any health care service provided to a member of First Choice VIP Care. Encounters must result in the creation and submission of an encounter record (CMS-1500 or UB-04 form or electronic submission) to First Choice VIP Care. The information provided on these records represents the encounter data provided by First Choice VIP Care to CMS.

Completion of Encounter Data/Claim Submission

Each provider must complete and submit a CMS-1500 or UB-04 form or file an electronic claim every time a First Choice VIP Care member receives services from that provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows First Choice VIP Care to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows First Choice VIP Care to identify the severity of illnesses of our members.

First Choice VIP Care can accept claim submissions via paper or electronically (EDI). To support timely statutory reporting requirements, we encourage all providers to submit claims within thirty (30) days of the visit. However, all claims must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for an encounter:

- Member’s (patient’s) name
- Member’s First Choice VIP Care ID number
- Member’s correct date of birth and address
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs for paper submissions)
- Information advising if member’s condition is related to employment, auto accident or liability suit
- Date(s) of service, admission, discharge
- Primary, secondary, tertiary, and quaternary ICD-10-CM/PCS diagnosis codes, coded to the highest level of specificity available
- Authorization number, as applicable
- Name and NPI of referring physician, if appropriate

- HCPCS procedures, services or supplies codes
- CPT procedure codes with appropriate modifiers
- Revenue codes
- CMS place of service code
- Charges (per line and total)
- Days and units
- Physician/supplier Federal Tax Identification Number or Social Security Number
- National Provider Identifier (NPI) and Taxonomy
- Billing Provider Information and Phone number - name, street number, street name, city, and zip code of the provider's physical service address. DO NOT USE THE "PAY TO" ADDRESS.
- Name and address of the facility where services were rendered
- NDC's required for physician administered injectable drugs
- Invoice date
- Signature
- Other required indicators based on service type

First Choice VIP Care monitors encounter data submissions for accuracy, timeliness, and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely, and incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to First Choice VIP Care within 365 days from the date of service**.** Network providers may also be subject to sanctioning by First Choice VIP Care for failure to submit accurate encounter data in a timely manner.

The First Choice VIP Care Provider Services Department at 1-888-978-0151 can address questions concerning claims submission.

Presence of Referring/Ordering Physician NPI on Claims Submissions

First Choice VIP Care requires the National Provider Identifier (NPI) of an ordering or referring physician on the claim submission. The presence of the ordering or referring provider's NPI makes it possible for First Choice VIP Care to determine whether the ordering or referring physician or other professional is not excluded or sanctioned. The ordering, referring, prescribing provider's information including name and NPI should be submitted on paper claims in box 17 and 17b for referring and ordering provider on the CMS-1500 form and field 78 for referring and ordering provider on the UB-04 form or any electronic version of the professional or institutional claim.

General Procedures for Claim Submission

First Choice VIP Care is required by state and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be **rejected** by First Choice VIP Care for correction and resubmission. Claims for billable services provided to First Choice VIP Care members must be submitted by the provider who performed the services.

Claims filed with First Choice VIP Care are subject to the following verification:

- All required fields are completed on the CMS-1500 or UB-04 forms.
- All diagnosis and procedure codes are valid for the date of service.
- Member was eligible for services under First Choice VIP Care during the time period in which services were provided.
- Services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Provider is eligible to participate with the Medicare Program at the time of service.
- Authorization or referral has been given for services that require prior authorization or referral by First Choice VIP Care.
- Whether there are any other third-party resources and, if so, verification that First Choice VIP Care is billed appropriately, and all applicable payments are reported to First Choice VIP Care.

First Choice VIP Care accepts paper and electronic claims. Plan providers and practitioners are encouraged to submit claims electronically for faster processing.

Integrated Claim Submission Process

Using crossover functionality, providers will only need to submit most* claims one time for processing under both the First Choice VIP Care Medicare plan and the First Choice Medicaid plan using the following guidance:

- For services covered by both Medicare and Medicaid, submit only one claim to First Choice VIP Care, using Medicare billing guidelines. Claims will adjudicate through First Choice VIP Care first for processing under Medicare.
- For Medicaid **only** covered services, file the claim using Medicaid guidelines. However, the claim may either be filed with First Choice VIP Care **or** providers can bypass the submission to First Choice VIP Care and the claim can be submitted directly to First Choice, using the information below:

    - Electronically using Payer ID # 23285
    - Send paper claims to:
      Select Health of South Carolina
      Attn: Claim Processing Department
      P.O. Box 7120
      London, KY 40742

**Claims submitted to Medicaid using a different bill type from Medicare (UB04 vs. CMS 1500) will not crossover and must be submitted separately with the First Choice VIP Care remittance.*

Providers will receive two separate remittance advices detailing how the claims were processed by each plan.

Electronic Claims Submission (EDI – Electronic Data Interchange)

For providers interested in electronic claim filing, please contact your EDI software vendor or one of the clearinghouses:

- Optum/Change Healthcare's Provider Support Line, available via online chat or by calling 1-800-527-8133, option 2, Monday - Friday, 7am to 5:30pm CST.
- Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 8 AM to 8 PM ET.
- Payer ID: **32456**

Submit Manual/Direct Entry Claims

Providers who do not have another clearinghouse/vendor, can submit claims electronically directly through Change Healthcare's ConnectCenter or PCH Global.

Change Healthcare's ConnectCenter:

- Go to ConnectCenter and click the *Sign Up* under *Get Started* to create a new account. Use vendor code: 214629.
- Electronic claims will need to be submitted to Change Healthcare using 4-digit ConnectCenter Payor identifiers (CPIDs).
    - Institutional Claims – 6087
    - Professional Claims – 9248
- ConnectCenter will automatically edit and validate claims for HIPAA compliance and will forward them directly to the appropriate plan.
- If you need assistance, Change Healthcare customer support is available through online chat or by calling 1-800-527-8133, option 2.

PCH Global:

- Go to PCH Global and click the *Sign-Up* link in the upper right-hand corner.
- Complete the registration process and log into your account.
- For a detailed walk-through of the registration process, refer to the PCH Global Registration manual (PDF), found on the PCH Global website in the Resource Menu.
- When you are ready to submit claims, use the following payer information:
    - 32456
    - First Choice VIP Care

Promo code Exela-EDI may be available for use under the *Subscription Details* screen, by entering it under the *More* option which can be found on the right-hand side.

SNIP Level 4

First Choice VIP Care uses a SNIP Level 4 claims editing process to meet industry compliance standards. This will increase auto adjudication and reduce pending claims. **Claims filed with the Plan are subject to the following procedures:**

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification of electronic claims against 837 edits at Change Healthcare™.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- ***All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, NPI and Location Numbers).***

Submission of Electronic Documentation (275 Transactions)

The 275 transaction functionality expands the options for providers to provide supplemental documents providing additional patient medical information that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries, and operative reports to support health care claims adjudication.

Availity

- Batch — You may either connect to Availity directly or submit via your EDI clearing house.
- Portal — Individual providers may also register at https://www.availity.com/Essentials-Portal-Registration to submit attachments.

After logging in, providers registered with Availity may access the Attachments - Training Demo for detailed instructions on the submission process via: Training Link [apps.availity.com] or refer to the Availity Claims Attachment Quick Reference guide located under Claims Resources at the bottom of this page.

Optum/Change Healthcare

- Batch — You may either connect to Optum/Change Healthcare directly or submit via your EDI clearing house.
- API via JSON — You may submit an attachment for a single claim.

General guidelines

- A maximum of 10 attachments are allowed per submission. Each attachment cannot exceed 10 megabytes (MB) and total file size cannot exceed 100MB.
- The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, doc, and txt.
- The 275 attachments must be submitted prior to the 837. After successfully submitting a 275 attachment, an Attachment Control Number will generate. The Attachment Control Number must be submitted in the 837 transactions as follows:
    - CMS 1500
        - Field Number 19
        - Loop 2300
        - PWK segment
    - UB-04
        - Field Number 80
        - Loop 2300
        - PWK01 segment

In addition to the attachment control number, the following 275 claim attachment transaction report codes must be used when submitting an attachment. Enter the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04.

Attachment Type	Claim assignment attachment report code
Itemized Bill	03
Medical Records for Hospital Acquired Conditions (HAC) review	M1
Single Case Agreement (SCA)/Letter of Agreement (LOA)	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price/Invoice	06
EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Ambulance Trip Notes/ Run Sheet	AM

Paper Claim Mailing Instructions

Please submit paper claims to the appropriate address below:

First Choice VIP Care
Claims Processing Department
P.O. Box 7182
London, KY 40742-7182

Electronic claim payment options

Our plan works with ECHO Health Inc. (ECHO®), a leading innovator in electronic payment solutions, to offer more electronic payment options to our health care providers. Providers can select the payment method that best suits their accounts receivable workflow.

Virtual credit card (VCC)

ECHO Health offers virtual credit cards as an optional payment method. Virtual credit cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. VCC payments have several advantages for providers:

- No need to enroll or fill out multiple forms in order to receive VCC.
- Personal information is never requested, such as practice bank account information.
- Payments are accessible the day the VCC is received.

Providers not registered to receive payments electronically will receive VCC payments as their default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, an instruction page for processing the payment, and a detailed Explanation of Payment /Remittance Advice (EOP/RA). Normal transaction fees apply based on your merchant acquirer relationship. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health at 1-888-492-5579.

Electronic funds transfers (EFT)

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be available on the ECHO provider portal (http://www.providerpayments.com).

If you are new to EFT, you will need to enroll with ECHO Health for EFT. Please note: Payment will appear on your bank statement from PNC Bank and ECHO as “PNC — ECHO”. To sign up to receive EFT

from our plan visit https://enrollments.ECHOhealthinc.com/efteradirect/enroll . There is no fee for this service.

To sign up to receive EFT from all of your payers that process payments on the ECHO platform, visit https://enrollments.ECHOhealthinc.com A fee may be required to receive EFT if you select the all payers option.

If you already receive payments from ECHO Health, you may be able to enroll for EFT with our plan using your existing account. Please make sure you have an ECHO Health draft number and corresponding payment amount so your enrollment request can be validated.

A draft number is listed as the EPC draft number on ECHO Health's explanation of payments. If you need assistance locating an ECHO payment to register or if you have questions on how to enroll, contact ECHO at 1-800-946-4041**,** Monday through Friday, from 8 a.m. to 6 p.m. ET.

Electronic remittance advice (ERA)/835 file

Electronic Remittance Advices (ERAs) (often referred to as an 835 file) are also available through ECHO Health. To receive ERAs from our plan, it is important to check with your practice management/hospital information system vendor to see if the system includes both the First Choice VIP Care Payer ID 32456 and the ECHO Health Payer ID 58379.

If you are not receiving any payer ERAs, please contact your current practice management or hospital information system vendor to ask if your software can process ERAs. Your software vendor is then responsible for contacting ECHO to enroll you for ERAs under our plan name and payer ID 77741 and the ECHO Health Payer ID 58379.

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health enrollment team at 1-888-834-3511.
If you have additional questions regarding VCC, EFT, or ERAs, please call the ECHO Health support team at 1-888-492-5579.

Claim Filing Deadlines

All original paper and electronic claims must be submitted to First Choice VIP Care **within 365 calendar days** from the date services were rendered (or the date of discharge for inpatient admissions). Please allow for normal processing time before resubmitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Rejected claims are defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number, that are returned to the provider or EDI source without registration in the claim processing system. Rejected claims are not registered in the claim processing system and can be resubmitted as a new claim. Claims originally rejected for missing or invalid data elements must be resubmitted with all necessary and valid data **within 365 calendar days** from the date services were rendered (or the date of discharge for inpatient admissions).

Denied claims are registered in the claim processing system but do not meet requirements for payment under First Choice VIP Care guidelines. They should be resubmitted as a corrected claim. Claims originally denied may be resubmitted as a corrected claim within **365 calendar days** of the date of service (or the date of discharge for inpatient admissions) for any reason(s) other than timely filing.

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within sixty (**60)** days of the date on the primary insurer's EOB.

Claims recovered by First Choice VIP Care, which can be corrected, must be resubmitted within sixty (60) days from the date of the remittance advice containing the recovered claim or from the date of the recovery notice.

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Number Invalid or Missing — A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 76 (Attending Physician ID) of the UB-04 (CMS-1450) claim form. A valid medical license number is formatted as two alpha, six numeric, and one alpha character (AANNNNNNA) **OR** two alpha and six numeric characters (AANNNNNN).

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis Code Missing Digits or Not Coded to the Highest Level of Specificity – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM/PCS manual to ensure the highest level of specificity is coded. Look for the digit number symbols in the manual to determine when additional digits are required.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM/PCS, CPT, HCPCS or successor codes) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third-party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages.

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis.

Future Claim Dates – Claims submitted for Medical Supplies or Services with future claim dates will be denied; for example, a claim submitted on October 1 for bandages that are delivered for October 1 through October 31 will deny for all days except October 1.

Handwritten Claims –Illegible handwritten claims will be rejected. (See "Illegible Claim Information")

Highlighted Claim Fields – (See "Illegible Claim Information")

Illegible Claim Information – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed or printed in black ink, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing, and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.

Member Name Missing – The name of the member must be present on the claim form and must match the information on file with First Choice VIP Care**.**

Member Plan Identification Number Missing or Invalid – First Choice VIP Care assigned member identification number must be included on the claim form or electronic claim submitted for payment.

Member Date of Birth Does Not Match Member ID Submitted –Member's date of birth must match what is on file from the eligibility file received from CMS. First Choice VIP Care has no ability to alter this date.

Payer or Other Insurer Information Missing or Incomplete – Include the name, address and policy number for all insurers covering First Choice VIP Care member.

Place of Service Code Missing or Invalid – A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS-1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with First Choice VIP Care**.**

Provider NPI Number Missing or Invalid –A valid individual NPI and, if applicable, the group NPI numbers for the service provider must be included on the claim form.

Referring Provider Name Missing – The name of the referring provider of service must be present on the claim form and must match the service provider name and TIN on file with First Choice VIP Care.

Referring Provider NPI Number Missing or Invalid – The individual NPI and, if applicable, the group NPI numbers for the referring provider must be included on the claim form. Nontraditional providers who are not required to obtain an NPI use their Tax Identification Number or Social Security number when rendering services to members.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

Tax Identification Number (TIN) Missing or Invalid – The Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with First Choice VIP Care**.**

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work-related illness/injury, no-fault or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

Type of Bill – This is a code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims.

Taxonomy – Include a valid provider taxonomy number, which must match the provider's National Plan and Provider Enumeration System (NPPES) record.

Common Errors on Claims Submissions

CMS-1500 (02/12) Paper Claims Reject Criteria

Field #	CMS-1500 (0212) Field/Data Element	"Reject Statement" (Reject Criteria) Effective April 1, 2015 This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
1A	ID Number	Plan or government issued ID number
2	Patient's Name	Member first and last name
3	Patient's Birth Date and Sex	Member date of birth (mm/dd/yyyy) and sex
5	Patient's Address (number, street, city, state, zip)	Patient's address
17	Name of Referring or Ordering Physician	The referring/ordering physician's name
17A	Leave Blank	Not required
17B	NPI of Referring or Ordering Physician	The referring/ordering physician's NPI must include appropriate qualifier
19	Narrative	Required field for the purposes outlined below.

Field #	CMS-1500 (0212) Field/Data Element	"Reject Statement" (Reject Criteria) Effective April 1, 2015 This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
		• Enter the drugs name, strength, and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs • Enter a concise description • Use the 275 Claim Attachment Transaction Process How to submit a 275 Claim Attachment Transaction: • Batch — You may either connect to Change Healthcare directly or submit via your EDI clearing house • API via JSON — You may submit an attachment for a single claim • Portal — Individual providers can register at Change Healthcare to submit attachments The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, xml, doc, and txt. View the Change Health Care 275 claims attachment transaction video for detailed instructions on this new process. **The following 275 claims attachment report codes are currently being accepted.** When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04. (see 275 attachment table in previous section).
21	Information Related to Diagnosis/Nature of Illness/Injury	Diagnosis code
24	Supplemental Information`	National Drug Code (NDC) data
24A	Date of Service	"Date of service (DOS)" Both the "From" and "To" DOS are missing. (If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	Place of service

Field #	CMS-1500 (0212) Field/Data Element	"Reject Statement" (Reject Criteria) Effective April 1, 2015 This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
24D	Procedure, Services or Supplies	Procedure code
24E	Diagnosis Pointer	For each service line with a "From" DOS, at least one diagnosis pointer is required
24F	Line-item Charge Amount	A value greater than or equal to zero must be present on each valid service line
24G	Days/Units	For each line with a "From" DOS, days/units are required
24J	Rendering Provider identification	Enter appropriate NPI number in the lower unshaded portion
27	Assignment Number	"Assignment acceptance must be indicated on the claim" and either "Yes" or "No" must be checked
28	Total Claim Charge Amount	"Total charge amount is required." (A value greater than or equal to zero)
31	Signature of Physician or Supplier Including Degrees or Credentialing	Field cannot be blank and must include provider name, including degrees or credentials and date. Name can be computer generated or noted as signature on file
32	Name and Address of Facility Where Services Were Rendered	Name, address, and ZIP code of the facility if the services were furnished in a physician's office, hospital, clinic, laboratory, or facility other than the patient's home. A PO box is not acceptable For DME only, the name and address of the location where the order was accepted must be entered DO NOT INCLUDE THE "PAY TO" ADDRESS IN THIS FIELD
33	Billing Provider Information and Phone number	The name, street number, street name, city, and zip code Field 33 of the CMS1500 claim form requires the provider's physical service address. **DO NOT INCLUDE THE "PAY TO" ADDRESS IN THIS FIELD**.

U/B04 Paper Claims Reject Criteria

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) **Effective April 1, 2015** This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
1	Billing Provider Name, Address and Telephone Number	Name, address, and ZIP code Field 1 of the UB04 claim form requires the provider's physical service address. **DO NOT INCLUDE THE "PAY TO" ADDRESS IN THIS FIELD.**
3a	Patient Account/Control Number	Account or Control Number
8b	Patient Name	Member first and last name
9a-e	Patient Address	Complete address
10	Patient Birth Date	MMDDYYYY
11	Patient Sex	Required
12	Admission Date	Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If IP, the date billed must not be a future date
13	Admission Hour	Use bill type table to identify if it is an IP or OP claim. If IP, the bill type must be 21x and a numeric value
14	Admission Type	A numeric value must be present
15	Point of Origin for Admission or Visit	Required except for Bill Type 014x
16	Discharge Hour	Use bill type table to determine if it is an IP or OP bill type. If IP, the frequency code must not be either 1 or 4 nor blank
17	Patient Discharge Status	Required (for all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services)
31	Occurrence Codes and Dates	Based on situational requirements
32	Occurrence Codes and Dates	Based on situational requirements
33	Occurrence Codes and Dates	Based on situational requirements
34	Occurrence Codes and Dates	Based on situational requirements
42	Revenue Code	Revenue code

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective April 1, 2015 This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
45	Service Date	MMDDYYYY
46	Service Days/Units	Service days/units {lines 1-22} for each line with a "From" DOS
47	Total Charges	Line-item charge amount (lines 1-22) must be a value greater than or equal to zero
50a-c	Payer Identification	A - Required B - Situational C - Situational
52a-c	Release of Information Certification Indicator	A - Required B - Situational C - Situational
53a-c	Assignment of Benefits	A - Required B - Situational C - Situational
56	Billing Provider National Provider ID (NPI) Statement	Required
58a-c	Insured's Name	A - Required B - Situational C - Situational
59a-c	Patient's Relationship	A - Required B - Situational C - Situational
60a-c	Insured's Unique ID	A - Required B - Situational C - Situational
63	Treatment Authorization Code	Required when an authorization or referral number is assigned
64	Document Control Number (DCN)	Required for a corrected claim. The control number (claim number) assigned to the original bill by the health plan
66a-q	Diagnosis and Procedural Code Qualifier Required	ICD10 = 0

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective April 1, 2015 This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
67	Principal Diagnosis Code / Other Diagnosis Codes	Other diagnosis codes are situational
69	Admitting Diagnosis Code	Admitting diagnosis code if an IP claim
70a-c	Patients Reason for Visit	Situational
74a-e	Principal and other Procedure Code and Date	Required on inpatient claims when a procedure was performed. Not used on outpatient claims A - E -Required on inpatient claims when additional procedures must be reported. Not used on outpatient claims
76	Attending Provider Name and Identifiers (including NPI)	Required when claim/encounter contains any services other than nonscheduled transportation services
77	Operating Provider Name and Identifiers (including NPI)	Required when a surgical procedure code is listed on the claim
78 - 79	Other Provider Name and Identifiers (including NPI)	Situational - The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) **Effective April 1, 2015** This is a required field and if it is missing, invalid, illegible, incomplete, or otherwise noted, this claim will be rejected.
		combined claim, i.e.., a claim that includes both facility and professional fee components (e.g.., a Medicaid clinic bill or Critical Access Hospital claim)

References:
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf
https://www.cgsmedicare.com/jb/help/cms1500_form_tutorial.html
https://www.nubc.org/
https://www.nucc.org/images/stories/PDF/1500_claim_form_faqs_2012_02_2023.pdf
https://www.palmettogba.com/internet/eLearn.nsf/cms1500/story_html5.html
https://www.palmettogba.com/internet/eLearn2.nsf/ub04/story.html

Prospective Claims Editing Policy

First Choice VIP Care claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Claims Inquiry

If a provider has concerns regarding claim status, processing, denial or payment, information is available by:

- Using the NaviNet's Claim Inquiry option to:
  - Check the status of a claim
  - Utilize the Claim Investigation function, which lets providers request an adjustment and track responses on claims that were previously finalized.
- Calling Provider Services at 1-888-978-0151.

Balance Billing Members

- Per Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997, Medicare providers cannot collect Medicare Parts A and B deductibles, coinsurance, or copays from members enrolled as a Qualified Medicare Beneficiary (QMB).
- First Choice VIP Care **members** will have no out-of-pocket responsibility for all Medicare and Medicaid services. Providers must accept payment for these services as payment in full and ***may not balance-bill*** the First Choice VIP Care member.
- First Choice VIP Care **providers** will have Medicare deductibles and coinsurance applied to payments.
- Balances from Medicare deductible or coinsurance will crossover to be processed under Medicaid and will be paid if appropriate.
- Providers may also not bill for contractual disallowances and non-covered services (unless a prior written agreement was signed by the member and provider).
- All providers should use the claims inquiry/disputes process to resolve any outstanding claims payment issues.

Balance Billing FAQs

What is Balance Billing? For members of a Medicare Advantage Dual Eligible Special Needs Plan, balance billing is billing the patient for any balances left after what Medicare and Medicaid pays for your services, such as remaining cost share balances or contractual disallowances. **Providers must accept payments from Medicare and Medicaid as payment in full.**

Why can't providers bill members of this Plan? Federal law bars Medicare providers from balance billing a Qualified Medicare Beneficiary (QMB) under any circumstances. QMB is a Medicaid program for Medicare beneficiaries that exempt them from paying any Medicare Part A or Part B cost-sharing for deductibles, coinsurance, and co-payments related to Medicare-covered services and prescription drugs. Most members enrolled in our plan are considered QMBs. Please note, providers who inappropriately balance bill are subject to sanctions.

Why are you providing this information? Despite Federal law, providers and suppliers continue to improperly bill individuals enrolled in our plan. Many members are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies or fear providers may deny services for non-payment.

What can providers do to prevent balance billing? Learn which Medicare Advantage plans are considered DSNPs or what patients have both Medicare and Medicaid and if possible, suppress patient billing in your accounts receivable system for any patients with this type of plan. Remember to always bill the Medicaid payer for any balances after the Medicare payment.

What can be billed to members? Non-covered items and services, however, providers must give members advanced notice that such items or services will be non-covered and have a written

agreement with the member for these non-covered items or services. If such notice is not given and the agreement is not in place, providers may not bill members for such items or services.

What if I have questions regarding balance billing or payment of a claim? Please contact your Account Executive or Provider Services. You may also use the claims inquiry/disputes process to resolve any outstanding claims payment issues. Additionally, for more information from the Centers for Medicare & Medicaid Services see the MLN Fact Sheet, "Prohibition on Billing Qualified Medicare Beneficiaries".

Claim Disputes

A claim dispute is a request from a provider for First Choice VIP Care to review and reconsider a payment amount made by First Choice VIP Care. Providers may dispute full or partial payments made by First Choice VIP Care if the provider disagrees with First Choice VIP Care's payment amount. Examples of circumstances that may give rise to a provider dispute are:

- Where the amount allowed for a Medicare-covered service is less than the amount that would have been paid under Original Medicare.
- Where First Choice VIP Care paid for a different service or more appropriate code than what was billed.

If you believe the payment amount you received for treating our member is less than the expected payment, you have the right to dispute that payment. Requests for a claims dispute may be submitted by calling Provider Services at 1-888-978-0151 or in writing **within one hundred eighty (180) calendar days of the date of the initial remittance advice** from First Choice VIP Care using the Provider Claims Dispute form which is available on our website. If the form is not used, you must include the following:

1. Submitter contact information (name, phone number)
2. Provider information (name, phone number, NPI number, Tax ID number)
3. Member information (name, DOB, member ID number)
4. Claim information (claim number, DOS, billed amount)
5. Reason for dispute
6. Any documentation which supports your position that the plan's reimbursement is not correct.

Submit your claim's dispute via:

- Fax to 1-888-599-1478
- Mail to:
  First Choice VIP Care
  Claims Processing Department
  P.O. Box 7182
  London, KY 40742-7182

We will review your request and respond to you within 30 calendar days. If we agree with you, we will adjust the claims and pay any additional money that is due. We will also inform you if the decision is to uphold the original payment decision.

Claim Appeals

Contracted providers may only appeal claim denials as the member's authorized representative. Participating providers appealing on the member's behalf must complete the Appointment of Representative form found in the Member section under Appeals and Grievance at www.firstchoicevipcare.com. See section VI, Member Integrated and Unified Grievances and Appeals, for more information.

Refunds or Recoveries for Improper Payment or Overpayment of Claims

If a First Choice VIP Care provider identifies improper payment or overpayment of claims from First Choice VIP Care within a four-year lookback period, the improperly paid or overpaid funds must be returned to First Choice VIP Care. Providers are required to return the identified funds to First Choice VIP Care by submitting a refund check directly to the appropriate claims processing department:

First Choice VIP Care
Attn: Provider Refunds
P.O. Box 7182
London, KY 40742-7182

Note: Please include the member's name and ID, date of service and claim ID.

If First Choice VIP Care identifies an overpayment, the provider will receive a remittance or notice explaining the overpayment. The notice will identify the reason for the overpayment, including claim payment detail, the amount of the overpayment, and time-frames for responding to the overpayment notice. The notice will also include processing instructions, which are as follows:

If you…	Then…
Agree with the overpayment notice	• The provider does not need to do anything • The claims will be reprocessed and all overpayments will be recovered from future payments
Have questions regarding the recovery or the calculation of the overpayment amount	• Contact Provider Claim Services 1-888-978-0151 • Refer to the **Project Number** from the letter when calling or sending an e-mail
Do not agree with our findings and would like to dispute the overpayment notice	**The provider must notify us in writing.** The letter should include the following: • A copy of the letter the provider received from us with the Project Number • The reason for the dispute with our findings • Supporting documentation for the dispute including claims information Send correspondence to: First Choice VIP Care P.O. Box 7182 London, KY 40742-7182
Would like to send a check for the recovery amount	The provider submits a check **AND** a copy of the letter the provider received from us with the Project Number to the following address: First Choice VIP Care 200 Stevens Dr. Attn: CRRU CC286 Philadelphia, PA 19113

Program Integrity

First Choice VIP Care is obligated to ensure the effective use and management of public resources in the delivery of services to its members. First Choice VIP Care does this in part through its Program Integrity Department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of First Choice VIP Care, regarding payments or recovery of potential overpayments. The Program Integrity Department utilizes both internal and external resources,

including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

Prospective (Pre-claims payment)

- Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies, as applicable, or First Choice VIP Care medical/claim payment policy) are applied to prepaid claims.
- Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
    - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe*.
- Coordination of Benefits ("COB") - Process to verify third party liability to ensure that First Choice VIP Care is only paying claims for members where First Choice VIP Care is responsible, i.e. where there is no other health insurance coverage.
- Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

Retrospective (Post-claims payment)

- Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation –The effect of this rule is if First Choice VIP Care determines a member has other health insurance coverage, payments made by First Choice VIP Care may be recovered.
- Please also see Section IX for further description of TPL/COB/Subrogation.
- Data Mining – Using paid claims data, First Choice VIP Care identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
- Medical Records Review/Itemized Bill review – a medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider may also be reviewed. Other medical record reviews include, but are not limited to, place of service validation, readmission review and pharmacy utilization review.

Please note if medical records are not received within the requested timeframe, First Choice VIP Care will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.

Credit Balance Issues

- Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
- Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. First Choice VIP Care reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

Readmission Review Program

First Choice VIP Care's readmission review program involves the retrospective review of a patient's subsequent admission to the same acute, general, short-term hospital or hospital system within thirty (30) calendar days of discharge for the same diagnoses-related group (DRG). This applies to acute inpatient admissions only and neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred. Although First Choice VIP Care is not a Quality Improvement Organization (QIO), First Choice VIP Care is following CMS guidelines on readmission reviews in the Medicare Quality Improvement Organization (QIO) Manual (Chapter 4, Section 4240 Readmission Review), as a means to monitor the quality of care delivered to our members.

A readmission is clinically related to an earlier admission if it is for the same, similar, or related diagnosis as the initial admission. Clinically-related readmissions may fall into any of the following categories:

1. The readmission is for a same or similar reason as the initial admission (e.g., readmission for hypertension following an initial admission for hypertension; readmission for a kidney stone following an initial admission for a urinary tract infection; readmission for ketosis following admission of poorly controlled diabetes).
2. The readmission is for an acute decompensation of a chronic problem that was not related to the initial admission but was plausibly related to care either during or immediately after the initial admission (e.g., a readmission for previously diagnosed hypertension in a patient whose initial admission was for an acute myocardial infarction).
3. The readmission is for an acute medical complication plausibly related to care during the initial admission (e.g., a patient with a colostomy repair discharged with a colostomy bag readmitted for treatment of infection at the surgical site).
4. The readmission is due to an unplanned surgical procedure to address a continuation or a recurrence of the problem causing the initial admission (e.g., a patient readmitted for a subdural

hematoma evacuation following an initial admit for mental status changes, headache, and hypertension); or

5. The readmission is due to an unplanned surgical procedure to address a complication resulting from care during the initial admission (e.g., a readmission for drainage of a post-operative wound abscess following an initial admission for a colostomy bag placement).

Upon determination that a readmission is clinically related to an earlier admission, the readmission will be further reviewed to determine if it was potentially preventable, meaning that it could have been prevented by one or more of the following:

1. Providing optimal quality care during the initial hospitalization
2. Providing optimal discharge planning
3. Providing optimal post-discharge follow-up
4. Optimal coordination between inpatient and outpatient health care teams

First Choice VIP Care has contracted with a third-party vendor to assist us with the readmission review process. This vendor will be responsible for the initial review of the claim to determine if it meets the criteria of a readmission; for requesting medical records and conducting a review to determine if the readmission was clinically related to the first admission, and to help determine if it was a potentially preventable admission. If all criteria are met, the vendor will send the findings to First Choice VIP Care's Medical Director for review and validation. If the review findings are validated, the vendor will send a denial notice to the hospital on behalf of First Choice VIP Care. The denial will result in the full take back of claim payment for the readmission claim; however, the Provider may then submit a replacement claim combining the two admissions into one claim. Providers have the right to appeal this determination as noted in this Provider Manual. Results of First Choice VIP Care's review of readmissions may also result in a referral of a potential quality of care concern to First Choice VIP Care's Quality Department.

Third Party Liability/Subrogation

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under the First Choice VIP Care contract, First Choice VIP Care will be entitled to recover any funds up to the amount owed by the third-party payer.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to First Choice VIP Care must first pass Change Healthcare HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and resubmitted with all necessary and valid data elements within the required filing deadline of 365 days from the date the initial claim was rejected. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor to identify and resubmit these claims accurately.

Monitoring Reports for Electronic Claims

Change Healthcare will produce an Acceptance Report* and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. To verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare Acceptance Report and the R059 Plan Claim Status Report.

*Acceptance Report verifies acceptance of each claim at Change Healthcare.

**R059 Plan Claim Status Report is a list of claims that passed Change Healthcare's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

Plan Specific Electronic Edit Requirements

First Choice VIP Care currently has two specific edits for professional and institutional claims submitted electronically.

- **837P – 005010X098A1** – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- **837I – 005010X096A1** – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

As a reminder member numbers must be less than 17 alphanumeric characters and statement dates must not be earlier than the date of service.

Electronic Billing Exclusions

Certain claims are excluded from electronic billing and must be submitted by paper. These exclusions fall into two groups:

Excluded Claim Categories
Claim records requiring supportive documentation (but not including secondary claims with COB information).
Claim records for medical, administrative or claim appeals.
Excluded Provider Categories
Providers not transmitting through Change Healthcare or providers sending to vendors not transmitting through Change Healthcare.
Pharmacists through Change Healthcare.

Common Rejections

Invalid Electronic Claim Records – *Common Rejections from Change Healthcare*
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10 etc.).
Claims without member ID numbers.
Invalid Electronic Claim Records – *Common Rejections from First Choice VIP Care (EDI Edits within the Claim System*)
Claims received with invalid provider numbers (including NPI and Taxonomy, or Plan ID, as applicable).
Claims received with invalid member ID numbers.
Claims received with invalid member date of birth.

Rejected Claims

Front-end rejected claims are those returned to the provider without being processed or adjudicated due to a billing issue.

- **Rebilling of a previously rejected claim should be done as an *original* claim.**
- If the claim was previously rejected, it is as if the claim never existed and does not appear on any remittance advice.
- Since rejected claims are considered original claims, timely filing limits must be followed. Claims timely filing limit is 365 days from the date of service.
- Note: Rejected claims are assigned a document control number (DCN); however, a DCN is not the same as a First Choice VIP Care claim number.

Corrected or Replacement Claims

Corrected claims are provider-submitted replacements for previously submitted claims. There are various reasons that a provider may submit a corrected claim including, but not limited to, wanting to update or correct submitted charges, procedural codes, number of units, etc.

- In cases where resubmission serves to correct a claim that has already been partially denied/paid, the claim must be clearly identified as a corrected claim and resubmitted within 365 days from date of service.
- If there is an identified overpayment beyond 365 days from date of service, please contact Provider Services to arrange repayment. You may either send a refund check with documentation

directly to the First Choice VIP Care, P.O. Box 7182, London, KY 40742-7182, or arrange to have the repayment withheld from future payments.

- Corrected claims may be submitted electronically or by paper.
- A corrected or replacement claim and must include the most current processed claim number.
    - You can find the First Choice VIP Care claim number on the 835 ERA, the paper Remittance Advice, or from the claim status search in NaviNet.
    - If you do not have the First Choice VIP Care claim number, then you must wait for the current claim to be processed or conduct further research on NaviNet to get the First Choice VIP Care claim number.

How to Submit Corrected or Replacement Claims

- Only submit a corrected claim once the previously submitted incorrect claim has finalized.
- Corrected/replacement and voided claims may be sent electronically or on paper.
    - If sent electronically, the ***claim frequency code*** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement (correction) of a prior processed claim or '**8**' for the Void of a prior processed claim. The value '**6**' should no longer be used.
    - In addition, you must also provide the most current processed claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated *HIPAA Version 5010 Implementation Guide*.
- If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
    - On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" and the Plan's most current iteration of the claim number must be in Field 22.
    - On an Institutional UB-04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the Plan's most current processed claim number must be in Form Locator 64A Document Control Number.

Reminders:

- You may only resubmit as a corrected or replacement claim when you have received an original First Choice VIP Care claim number.
- Rebilling of a previously rejected claim is not considered a resubmission or replacement, but an original claim.

Provider Preventable Conditions

First Choice VIP Care will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) with regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

The category of Health Care Acquired Conditions (HCAC) applies to inpatient hospital settings only. Under this category, First Choice VIP Care does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis After Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric Populations

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, First Choice VIP Care will not reimburse providers for any of the following never events in any inpatient or outpatient setting:

- Surgery Performed on the Wrong Body Part
- Surgery Performed on the Wrong Patient
- Wrong Surgical Procedure Performed on a Patient

Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make prepayment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a “Present on Admission” indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; First Choice VIP Care will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the diagnosis codes, such as Y65.51, Y65.52 or Y65.53 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the ICD-10, including applicable external cause of injury codes on the claim in field 67 A – Q. Examples of ICD-10 diagnosis codes include:

- Wrong surgery on correct patient Y65.51.
- Surgery on the wrong patient Y65.52.
- Surgery on wrong site Y65.5.
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.**

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member’s medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the “Present on Admission” (POA) indicator on the claim submitted for payment. The applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300; segment K3, data element K301.

Valid POA Indicators Include:

- “Y” = Yes = present at the time of inpatient admission

- “N” = No = not present at the time of inpatient admission
- “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not “null” = Exempt from POA reporting

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