



VNS Health Provider Manual

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Introduction

VNS Health is pleased to welcome you to our health plan provider network. You have joined a network of physicians and other providers who partner with us to advance our mission of promoting health and wellbeing through high-quality, cost-effective health care in the home and community.

Since our first member enrolled in 1998, our health plans have focused on the successful delivery of comprehensive care for our members. Our guiding principles include:

- Offering plan benefits that improve access to appropriate care, including assistance navigating an increasingly complex health care system.
- Shifting the focus of care from the institution to the home and community.
- Targeting and customizing interventions based on the need of the enrollee.
- Making care management the cornerstone of all our managed care plan options.

We understand the importance of the provider-member relationship and the administrative requirements of managing your patient's health care needs.

This manual is designed to help you and your office staff understand the requirements that govern the management of our members, while also serving as a resource for questions you may have about our programs. If we update the information in this manual, we will provide bulletins, as necessary, and post the changes on our website (vnshealthplans.org), where you can also find a copy of this manual.

We are proud of our relationship with our participating providers and are committed to working with you to help you meet the needs of your patients.

Keep Us Informed

Please read this manual and let us know if there are any sections that are unclear or if there were other topics where you would like more information. Our goal is to provide you with material that is timely, accurate, and easy to understand. We welcome your comments.

Helpful Links for Health Plan Providers

Each of the items below can be found at:

[vnshealthplans.org/helpful-links-for-providers](https://www.vnshealthplans.org/helpful-links-for-providers)

PROVIDER PORTAL	The Health Plans Provider portal gives users 24/7 access to authorizations, claims, eligibility, and more—without picking up the phone. Click here: https://www.vnshealthplans.org/provider-portal/
CONTRACTING	Contracting for new Line of Business <ul style="list-style-type: none"> ▪ NYDOH Provider Disclosure Certification ▪ IRS W-9 Form
CREDENTIALING	Provider Documents and Forms <ul style="list-style-type: none"> ▪ ADA Accessibility Questionnaire ▪ Disclosure of Ownership Control Interest Statement ▪ Facility Credentialing Application ▪ Demographic Update Request ▪ OMIG Annual Compliance Attestation SelectHealth ▪ HIV PCP Attestation – This online form can be used for either initiation or annual attestation MTLC ▪ Social Adult Day Site Visit Toolkit
CLAIMS	<ul style="list-style-type: none"> ▪ CMS-1500 Form ▪ UB-04 Form ▪ Required Data for Claims Forms ▪ Claims Submission for VNS Health Providers ▪ ICD-10 FAQs ▪ Provider Remittance Guide ▪ Billing Instruction for Nursing Home Providers ▪ Claims Layout for Provider Codes
DELEGATED ENTITIES	<ul style="list-style-type: none"> ▪ Delegated Roster Submissions
QUALITY	<ul style="list-style-type: none"> ▪ EMR Data Sharing Manual
PHARMACY	<ul style="list-style-type: none"> ▪ Opioid Safety Edits ▪ Medicare Part D Link for Formulary List ▪ SelectHealth – Opioid Safety Edits ▪ SelectHealth Link for Formulary List ▪ Medicare Part D Coverage Determination Form ▪ SelectHealth Link for Medication Request Form ▪ Medication Adherence Tip Sheet
OTHER	<ul style="list-style-type: none"> ▪ Quick Reference Guide ▪ SelectHealth Provider Reference Guide

SECTION I: Programs, Benefits, and Covered Services

1.1 • VNS Health MLTC

VNS Health Managed Long Term Care (MLTC) is a managed long-term care program for adults who wish to and are able to live safely at home but need assistance with day-to-day activities.

Eligibility

- At least 18 years old
- Eligible for Medicaid
- In need of community-based long term care services for 120 days or more as determined by the New York State Department of Health (NYSDOH)

Service Area

VNS Health MLTC is provided to members who live in the following counties: Albany, Bronx, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Kings (Brooklyn), Madison, Monroe, Montgomery, Nassau, New York (Manhattan), Oneida, Onondaga, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester until April 30, 2024. As of May 1, 2024, refer to the service area information on our website: <https://www.vnshealthplans.org/service-areas/>.

Covered Services

VNS Health MLTC offers a wide range of home-, community- and facility-based long-term care and health-related services. For a complete list of current VNS Health MLTC benefits and covered services, please go to:

<https://www.vnshealthplans.org/wp-content/uploads/2020/07/CHOICE-MLTC-Member-Handbook-Eng.pdf>.

More Information

For more information about the plan, call toll-free 866-783-0222 TTY users please call 711 for both numbers.

1.2 • VNS Health EasyCare Plus (HMO D-SNP)

VNS Health EasyCare Plus (HMO-DSNP) is a Dual-Eligible Special Needs Plan designed for those Medicare beneficiaries who are eligible for Medicare Parts A and B and receive assistance from New York State Medicaid.

Eligibility

- Have Medicare A & B
- Eligible for Medicaid or Medicare cost-sharing assistance under Medicaid
- Reside in Plan Service Area
- Be a U.S. citizen or lawfully present in the U.S.

Service Area

VNS Health EasyCare Plus (HMO D-SNP) services are available in New York City, Long Island, Albany, Rensselaer, Schenectady, and Westchester County.

Covered Services

For a complete list of current VNS Health EasyCare Plus benefits and covered services, please go to: <https://www.vnshealthplans.org/easycare-plus-member-resources/2024-plan-materials/>.

You can see the complete plan formulary (list of Part D prescription drugs) along with any limitations on our website, [Formulary Search](#), call us and we will send you a copy of the formulary.

More Information

For more information about the plan, call toll-free 866-783-0222. TTY users please call 711.

1.3 • VNS Health EasyCare (HMO)

VNS Health EasyCare is a plan designed for those Medicare beneficiaries who are eligible for Medicare Parts A and B.

Eligibility

- Must have Medicare Part A and Part B
- Reside in Plan Service Area
- Be a U.S. citizen or lawfully present in the U.S.

Service Area

VNS Health EasyCare services are available in New York City, Long Island, Albany, Rennselear, Schenectady, and Westchester County.

Covered Services

For a complete list of current VNS Health EasyCare benefits and covered services, please go to: <https://www.vnshealthplans.org/easycare-member-resources/2024-plan-materials/>.

You can see the complete plan formulary (list of Part D prescription drugs) along with any limitations on our website, [vnshealth.org](https://www.vnshealth.org). Or call us and we will send you a copy of the formulary.

More Information

For more information about the plan, call toll-free 866-783-0222. TTY users please call 711.

1.4 • VNS Health TOTAL (HMO D-SNP)

VNS Health Total is a Medicaid Advantage Plus plan that brings together Medicare and Medicaid benefits for people who need long term help with daily activities.

Eligibility

- At least 18 years old
- Eligible for Medicare and Medicaid
- In need of community-based long-term care services for 120 days or more as determined by NYSDOH
- Eligible for nursing home level of care
- Able to live safely at home with assistance with Activities of Daily Living

Service Area

VNS Health Total services are available in New York City, Long Island, Albany, Rensselaer, Schenectady and Westchester County.

Covered Services

For a complete list of current VNS Health Total benefits and covered services, please go to: https://www.vnshealthplans.org/our-plans/vns-health-total/2023-plan-materials/ Handbook_Eng.pdf.

You can see the complete plan formulary (list of Part D prescription drugs) along with any limitations on our website, [vnshealthplans.org](https://www.vnshealthplans.org). Or call us and we will send you a copy of the formulary.

More Information

For more information about the plan, call toll-free 866-783-0222. TTY users please call 711.

1.5 • SelectHealth from VNS Health

SelectHealth from VNS Health is a specialized Medicaid plan. This plan is for people living with HIV or individuals of transgender experience, and gender non-conforming or homeless individuals, regardless of HIV status.

SelectHealth is dedicated to providing high-quality personalized care to people with complex health needs. Dependent children can also join the plan.

Eligibility

- Eligible for Medicaid
- Living with HIV
- Of transgender experience or gender non-conforming, regardless of HIV status
- Individuals experiencing homelessness, regardless of HIV status

Service Area

SelectHealth's special care and services are available in Brooklyn, the Bronx, Manhattan, Queens, Nassau County, and Westchester County.

Covered Services

SelectHealth from VNS Health provides easy access to a variety of specialists in HIV and transgender healthcare at hospitals, physician groups, and private practices.

More complete information about SelectHealth and covered services can be found in the Member Handbook: <https://www.selecthealthny.org/for-members/member-forms-materials/>.

More Information

For more information about the plan, call 866-783-0222. TTY users please call 711.

SECTION 2: Provider Networks

2.1 • Description of the Networks

VNS Health Health Plans serve the healthcare needs of its members through comprehensive provider networks for each of its various programs (Total, EasyCare Plus, EasyCare, MLTC, and SelectHealth). While each network is separate and unique, most Health Plans providers participate in one or more of these networks. Each network includes the clinical practitioners necessary to offer the full spectrum of covered healthcare services.

2.2 • Provider Rights & Responsibilities (All Plans)

Provider Rights

VNS Health Health Plans will not discriminate against any healthcare professional acting within the scope his/her license or certification under state law regarding participation in the network, reimbursement, or indemnification solely on the basis of the practitioner's license or certification. Nor will the Health Plans discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions. Consistent with this policy, the Health Plans may differentiate among providers based on the following:

(These three bullet points represent plan rights, not provider rights. Suggest: moving these three paragraphs to section 2.1.

- The Health Plans providers will be given written notice of material changes in participation rules and requirements at least 30 days before the changes are implemented. These communications will be circulated in special mailings and posted on the provider portal.
- The Health Plans will not prohibit or otherwise restrict a healthcare professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member regarding the following:
 - The member's health status,
 - medical care,
 - treatment options, including any alternative treatments,

- The risks, benefits, and consequences of treatment or non-treatment, or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Provider Responsibilities

VNS Health Health Plans maintain provider agreements that incorporate provider and health plan responsibilities consistent with industry standards in compliance with New York State Managed Care Legislation and requirements for individuals and organizations receiving federal funds. The following requirements are applicable to Health Plans participating providers.

*** Nondiscrimination**

Providers must provide care to all VNS Health Health Plan members and must not discriminate on the basis of the following:

- Age
- National origin
- Race
- Disability
- Sex or sexual orientation
- Economic, social, or religious background
- Health status
- Claims experience
- Legally Defined Disability Duplicative. Choose one.

Providers are required to be in compliance with Title VI of the Civil Rights Act of 1975, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), and other laws applicable to recipients of federal funds. The New York State Department of Health (NYSDOH) has adopted specific guidelines for ADA compliance by managed care organizations, including their affiliated provider networks. The Health Plans developed a plan for achieving full compliance with these regulations and may request information from your practice as part of this program. The scope of the guidelines includes ensuring appropriate access to services through physical access to the site of

care (wheelchair accessibility), access within the site (exam rooms, tables, and medical equipment), and access to appropriate assessment and communication tools that enable disabled individuals to receive needed services and to understand and participate in their care.

- **Cultural Competence**

Providers must ensure that services and information about treatment are provided in a manner consistent with the member's ability to understand what is being communicated. Members of different racial, ethnic, and religious backgrounds, as well as individuals with disabilities, should receive information in a comprehensive manner that is responsive to their specific needs. If language barriers exist, a family member, friend, or healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator.

The VNS Health Health Plan Member Services department can provide assistance for members who do not speak English, either through their multilingual staff or by facilitating a connection with a telephone-based language interpretation service. It is essential that all efforts be made to ensure that the member understands diagnostic information and treatment options, and that language, cultural differences, or disabilities do not pose a barrier to communication.

- **Program Participation and Compliance**

VNS Health Health Plans has developed Quality Improvement, Medical Management, and other programs to identify opportunities to improve the delivery of health services and related outcomes.

In addition, the Health Plans have operating agreements with Federal, State, and County governments that govern the terms of its participation in the Medicaid Managed Care, and Medicare Advantage. Regulatory authorities periodically review Health Plans' operations and data reporting (i.e., complaints, enrollment, and financial information). Pursuant to their provider agreements with VNS Health Health Plans, participating providers are required to cooperate with us to meet its regulatory responsibilities as well as comply

with its internal programs to ensure compliance with contractual obligations. This applies to the policies set forth in this Provider Manual as well as to any new programs developed by VNS Health Health Plans.

Providers are expected to refer VNS Health Health Plan members to Network providers whenever possible. When members are referred for out-of-network (OON) services, contracted providers are required to participate with the plan's prior authorization program, e.g., providing a rationale for the OON referral.

It is expected that providers inform members under their care about specific healthcare needs requiring follow-up and will teach members appropriate self-care and other measures to promote their own health.

Providers must discuss potential treatment options, side effects, and management of symptoms (without regard to plan coverage). The member has the final say in the course of action they will take about their health.

- **Release of Member Information**

Medical information about VNS Health Health Plan members must be released to Health Plans upon request. (There is no such section.) The Health Plans will only release medical information to persons authorized by VNS Health to receive such information for medical management, claims processing, or quality and regulatory reviews. Providers must also adhere to the appeals and expedited appeals procedures for Medicare members, including gathering and forwarding information on appeals to the Health Plans, as necessary.

- **Billing**

Providers must submit claims for reimbursement of services provided. These claims also serve as encounter data for services rendered under a capitation arrangement. Claims must be accurate and be submitted according to the guidelines described in Section 11.3. Failure to comply with the Health Plans' policies in this regard may result in nonpayment for services or termination from the Health Plans' provider network. Providers should never bill a Health Plans' member for covered services.

- **Provider Information**

Providers are responsible for reporting any changes in their practice demographics to the Health Plans. It is essential that the Health Plans maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Changes and updates should be submitted at least two weeks prior to the effective date. Any changes to the following list of items should be reported to VNS Health using our electronic Demographic Change Form found on the VNS Health website .

The Demographic Change form should include full contact information, and a comprehensive request on the provider or group letterhead that includes the provider's license number and identifies the practice record for update. Any

supporting documentation (such as a W9 form or a Board Certificate) should be attached these requests, including updates in:

- Provider or Group name and Tax ID number (W-9 Form required)
- Provider/group practice address, zip code, telephone, or fax number (full practice information required)
- Provider/group billing address (W-9 Form required)
- NY license, such as a new number, revocation, or suspension (new certificate or information on action required, if applicable)
- Closure of a provider panel (reason for panel closure)
- Hospital affiliation (copy of current and active hospital privileges)
- Or addition of specialty (copy of board certificate or appropriate education information)
- Practice's office hours
- Provider's board eligibility/board certification status
- Participation status
- NY Medicaid Number (if applicable)
- National Provider Identification Number (if applicable)
- Wheelchair accessibility
- Covering provider
- Languages spoken in the provider's office

The Role of the Primary Care Provider/Selecting a Provider

All members of VNS Health Total, EasyCare Plus, EasyCare and SelectHealth from VNS Health must choose a participating Primary Care Provider (PCP). Upon enrollment, every member selects a PCP from the Health Plan Provider Directory. For members of the SelectHealth from VNS Health, every participating PCP that follows HIV-infected members must be an HIV-Specialist who has met the criteria of one of the following recognized bodies:

- a) The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider.
- b) HIV Specialist status accorded by the American Academy of HIV Medicine.
- c) Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB).

If a member does not choose a PCP within 30 days of notification of enrollment, Member Services will assign a PCP to the member.

Enrollees in VNS Health MLTC are not required to select a PCP, however, their physician or Nurse Practitioner must be willing to work with the plan. Members may change their designated PCP at any time by contacting Member Services at the telephone number listed in Section 1 of this provider manual. .

As a PCP, you are the manager of your patients' total healthcare needs. PCPs provide routine and preventive medical services, authorize covered services for members, and coordinate all care that is given by Health Plan participating specialists, VNS Health participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

Providers may contact the plan to request a standing referral to a specialist provider.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Pediatricians, Geriatrics, OB/GYNs, physicians that specialize in infectious disease, and Nurse Practitioners in Adult Medicine, Gerontology Family Medicine, and Gynecology.

One of the cornerstones of VNS Health Health Plans' healthcare philosophy is the availability of services. All PCPs must arrange to have coverage available to provide medical services to their members, 24 hours a day, seven days a week.

In becoming a VNS Health Health Plans PCP, you and your staff agree to follow and comply with our Health Plans' administrative, medical management, quality assurance, and reimbursement policies and procedures.

2.3 • Provider Rights & Responsibilities (SelectHealth from VNS Health Specifically)

The following four sections apply to providers of members of SelectHealth from VNS Health.

Specialist Services Provided by PCPs HIV Specialist Criteria

One of the distinguishing characteristics of the SelectHealth from VNS Health provider network is that every participating primary care provider (PCP) that follows members living with HIV must be an HIV-Specialist who has met the criteria of one of the following recognized bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider.
- HIV-Specialist status accorded by the American Academy of HIV Medicine. Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB). Eligibility requirements include:
 - Current and valid MD, DO, PA, or NP state license year.
 - Provision of direct, ongoing care to at least 20 HIV patients over the 24 months preceding the date of application.
 - Completing a minimum of 30 credits of HIV-related Category 1 CME/CEU/CE within the 24 months preceding the date of application.

For Enrollees Experiencing Housing Insecurity in SelectHealth from VNS Health

Enrollees who are experiencing housing insecurity may select any participating PCP that the plan contracts with to provide PCP services to enrolled “homeless” members.

- A. If a homeless enrollee is seeking care from a non-participating provider due to the proximity to the shelter, the provider will need to request authorization from the Plan to conduct an Evaluation and Management or provide urgent care to the member. SelectHealth from VNS Health will approve the initial visit when a homeless enrollee presents at a non-participating shelter provider or non-participating community provider

but participates in the Medicaid fee-for-service program. Requests for prior authorization are approved.

- B. For an assessment, the plan will reimburse the non-participating provider at the fee-for service non-facility global fee for E&M (evaluation and management) code 99203.
- C. Urgent care needs identified during the initial assessment may be treated by a non-par provider with reimbursement by the plans at the FFS rate. Any follow-up and/or specialty care needed must be prior authorized by the plan or referred by the PCP to a participating provider. If urgent care is needed, the MCO must consider whether any delay in seeking treatment may result in the member not accessing care, and should, in that case, be authorized. The provider must seek authorization on the next business day if care was provided during non-business hours.
- D. SelectHealth from VNS Health will allow a member (or her/his designee) to change PCPs, upon request:
 - a. To the participating shelter provider
 - b. To a PCP closer to shelter locationSelectHealth from VNS Health will coordinate with the homeless member, their designee (if any), the shelter program staff (if any), and with VNS Health to disenroll and enroll transfer the member into another Plan in order to continue the relationship with a provider, if the provider does not participate in SelectHealth from VNS Health.
- E. Providers at homeless shelters may function as PCPs for the homeless population if their total hours worked, at all locations, is a minimum of 16 hours weekly. This provision is only for the homeless population who wish to use the providers at a shelter site. These providers will not be listed in the provider directory unless they meet all credentialing requirements. SelectHealth from VNS Health will inform members that providers affiliated to shelters are available as PCPs even though they are not listed in the directory.

PCP Teams

Teams of physicians/nurse practitioners may serve as PCPs for members of SelectHealth. Such teams may include no more than four physicians/nurse practitioners and when a member chooses or is assigned to a team, one of the practitioners must be designated as “lead provider” for that member. All such team practitioners must meet HIV Specialist PCP criteria.

In the case of teams comprised of medical residents under the supervision of an attending physician, the attending physician must be designated as the lead physician and must meet HIV Specialist PCP criteria.

Member to Provider Ratios

PCPs agree to adhere to the member-to-PCP ratios referenced in the Provider Agreement that governs their relationship with SelectHealth from VNS Health (Individual Provider or Hospital). These ratios are for Medicaid enrollees only, are VNS Health-specific and assume that the PCP is a full-time equivalent (FTE) defined as a provider practicing 40 hours per week for SelectHealth from VNS Health. These ratios will be prorated for PCPs that represent less than an FTE to VNS Health.

Minimum Office Hours

A SelectHealth PCP must practice a minimum of 16 hours a week at each primary care site. Providers must promptly notify VNS Health of changes in office hours and location as soon as this information becomes available, but no later than three business days after the change takes effect.

The minimum office hour requirement may be reduced under certain circumstances. Please contact the VNS Health Provider Relations Department at the telephone number listed in Section 1 of this provider manual for further information.

Responsibility to Your Patients

The PCP coordinates all aspects of a member's care covered under the plan. As a SelectHealth from VNS Health PCP, you agree to provide the following, where applicable.

All the services of a PCP or other health professional typically received in a PCP's office. These include but are not limited to:

1. Treatment of routine illness.
2. Health consultations and advice.
3. Injections.
4. Conducting baseline and periodic physical exams, including any tests and any ancillary services required to make your appraisal. (Members of SelectHealth from VNS Health are to be assessed by the PCP within four weeks of the effective date of enrollment.)
5. Diagnosing and treating conditions not requiring the services of a specialist.
6. Initiating referrals from non-primary care service as required by the specific plan in which the member is enrolled.
7. Arranging inpatient care.
8. Consulting with specialists, behavioral health providers, laboratory, and radiological services when medically necessary.
9. Coordinating the findings of consultations and laboratories.
10. Interpreting such findings for the member and his/her family, subject to regulatory requirements regarding confidentiality.
11. Coordinating dental care as part of the overall health care management of SelectHealth from VNS Health members.
12. Assessing the member's need for mental health and/or alcohol/substance abuse services during initial, subsequent, and annual visits.
13. Providing documentation of member HIV and AIDS status to VNS Health Health Plans. (For further information, see Section 2 Verifying Eligibility for Covered Services.)
14. Assisting the plan in securing laboratory results (CD4 measurements/viral loads) and prescription information.
15. Maintains a current medical record for the member.

16. Appropriate coverage for your patients who may be in a hospital or skilled nursing facility.
17. Educational services including:
 - a. Information to assist members in using healthcare services appropriately
 - b. Information on personal health behavior and lifestyle
 - c. Information on achieving and maintaining physical and mental health
18. Maintenance of certain standards for your office, service, and medical records.
19. C/THP screening for children and adolescents.
20. SelectHealth requires HIV pre-test counseling with clinical recommendation of testing for all pregnant women. Those women and their newborns must have access to services for positive management of HIV disease, psychosocial support, and case management for medical, social, and addictive services.
21. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.
22. Conspires with others to get a false or fraudulent claim paid by the federal government.
23. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

2.4 • Appointment Availability and 24-Hour Access Standards (SelectHealth)

Office Hours

Each PCP must practice at least two days per week and maintain a minimum of 16 office hours per week at each primary care site. HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement. Medicare and commercial providers must maintain a minimum of 10 office hours per week at each primary care site. Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

Participating providers must be accessible 24 hours a day, seven days a week throughout the year, either directly or through back-up coverage arrangements with other VNS Health participating providers. Each provider must have an on-call coverage plan acceptable to VNS Health that outlines the following information:

- Regular office hours, including days, times, and locations.
- After-hours telephone number and type of service covering the telephone line (e.g., answering service).
- Providers who will be taking after-hours calls.
- Facilities as well as individual practitioners must conform to the following requirements.
- Members will be provided with a telephone number to use for contacting providers after regular business hours. Telephone operators receiving after-hours calls will be familiar with VNS Health and its emergency care policies and procedures and will have key VNS Health telephone numbers available at all times.
- The VNS Health provider will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member as soon as possible, but in no case to exceed 30 minutes.
- It is expected that VNS Health providers will be familiar with VNS Health and will be able to act in accordance with VNS Health emergency policies and procedures, such as notifying Medical Management of emergency care or admissions. These policies are further discussed in

Section 8. Please be aware that hospital-based providers may have their own particular on-call group relationships.

- If the covering provider is not located at the usual site of care for the member, the covering provider must provide clinical information to the member's PCP by the close of business that day, or, if on a weekend, by the next business day, so that it can be entered into the member's medical record.

VNS Health members must be able to locate a VNS Health participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs members to the emergency room in lieu of appropriate contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

Waiting Time Standards

In addition to access and scheduling standards, VNS Health providers are expected to adhere to site-of-care waiting time standards. They are as follows:

- **Emergency Visits:** Members are to be seen immediately upon presentation at the service delivery site.
- **Urgent Care and Urgent Walk-in Visits:** Members should be seen within one hour of arrival. Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment with prescribed pharmaceuticals.
- **Scheduled Appointments:** Members should not be kept waiting for longer than one hour.
- **Non-Urgent Walk-in Visits:** Members with non-urgent care needs should be seen within two hours of arrival or scheduled for an appointment in a time frame consistent with the VNS Health scheduling guidelines.

Missed Appointments

VNS Health expects providers to follow up with members who miss scheduled appointments.

When there is a missed appointment, providers should follow these guidelines to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained.

At the time an appointment is scheduled, confirm a contact telephone number with the member. If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone.

To encourage member compliance and minimize the occurrence of "no shows," provide a return appointment card to each member for the next scheduled appointment.

SelectHealth Providers

- Emergency Care: Immediately upon presentation at a service delivery site.
- Urgent medical or behavioral problem: Within 24 hours of request
- Non-urgent "sick" visits: Within 48–72 hours of request, as clinically indicated.
- Routine non-urgent, preventive appointment: Within four weeks of request.
- Specialist referral (non-urgent): Within four to six weeks of request.
- Initial prenatal visit: Within three weeks during first trimester, within two weeks during second trimester, within one week during third trimester.
- Adult baseline and routine physical: Within four weeks of enrollment (adults > 21 years old).
- Initial visit for members with ongoing treatment needs: Within seven days of enrollment if medically necessary.
- Wellness childcare: Within four weeks of request.
- Initial family planning visit: Within two weeks of request.

- In-plan mental health follow-up visit (pursuant to an emergency or hospital discharge): Within five days of request, or as clinically indicated.
- In-plan, non-urgent mental health visits: Within two weeks of request.
- Initial PCP office visit for newborn: Within 48 hours of hospital discharge.

Providers visit to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding member's ability to perform work when requested by Local Department of Social Services: Within 10 days of request.

Children's behavioral health services, including all six home and community-based service (HCBS) waivers currently operated by OMH, DOH, OPWDD and the Office of Children and Family Services (OCFS), are included in the Medicaid Managed Care benefit package. These expanded Behavioral Health services for Foster Care children and/or medically fragile children are coordinated between SelectHealth and its Behavioral Health Vendor, Carelon Health Options.

Please see Appendix VII SelectHealth Children's Behavioral Health Transition to Managed Care for further information.

2.5 • Fraud, Waste & Abuse (All Plans)

It is the policy of VNS Health to comply with all federal and state laws regarding fraud, waste, and abuse (FWA). We implement and enforce procedures to detect and prevent fraud, waste, and abuse regarding claims submitted to federal and state healthcare programs, and we provide protection for those who report in good faith actual or suspected wrongdoing.

VNS Health is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential FWA related to the NY state-funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

The Compliance Policy

VNS Health maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action, up to and including termination.

As part of our commitment to this zero-tolerance policy, VNS Health provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

In general, VNS Health has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or VNS Health from paying more for a service than it is obligated to pay.

Definitions

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste:** The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.
- **Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost or in the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Relevant Statutes and Regulations:

Stark Law

The Stark law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship—unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of Stark and Physician Self-Referral are to be reported to the Centers for Medicare & Medicaid Services (CMS) through an established self-disclosure process.

False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, “knowing and/or knowingly” means that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.
- Conspires with others to get a false or fraudulent claim paid by the federal government.
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

Reporting of Fraudulent, Wasteful, and Abusive Activities

VNS Health expects members, vendors, providers, interns (volunteers), consultants, board members, and First Tier, Downstream, and Related Entities (FDRs) as well as others associated with the business of VNS Health to bring alleged inappropriate activity which involves VNS Health to our attention. Providers may confidentially report a potential violation of our compliance

policies or any applicable regulation by contacting the following individuals/departments:

VNS Health Compliance Officer

220 East 42nd Street 6th Floor New York, NY 10017

Phone: [1-212-946-9100](tel:1-212-946-9100)

Email: SIUmailbox@vnshealth.org

Providers may also report fraud, waste, and abuse anonymously to Ethics Point, Inc., a contracted vendor, by using the VNS Health Hotline at 1-888-634-1558 or online at vnshealth.ethicspoint.com

2.6 • Credentialing, Recredentialing Requirements, and Provisional Credentialing

The VNS Health Credentialing/Recredentialing processes are components of the organization's Quality Improvement Program. These processes were designed to protect members and provide continued assurance that potential and/or current participating providers meet the requirements necessary for the provision of quality care and service.

The objectives of the VNS Health Credentialing Program are to ensure that:

- Members who join VNS Health will have their care rendered by appropriately qualified providers.
- Each provider applicant has equal opportunity to participate.
- Adequate information pertaining to education, training, relevant experience, and other credentialing criteria is reviewed by the appropriate individuals prior to approval or denial by the Credentialing Subcommittee.

Credentialing is required for all practitioners who provide services to VNS Health members and all other health professionals and facilities who are permitted to practice independently under State law and who provide services to VNS Health members, with the exception of hospital-based health care professionals.

Hospitals and freestanding facilities are required by law to credential providers exclusively operating within their setting. As such, VNS Health does not credential providers that practice exclusively within the inpatient hospital or a freestanding facility setting but instead relies on the hospital's credentialing program/appointment process for these providers. Providers in this category include, but are not limited to, providers employed by or contracted with the hospital who do not practice outside of the hospital.

Hospitals and other facilities must be licensed by and demonstrate good standing with state and federal regulatory agencies.

VNS Health does not discriminate in terms of participation or reimbursement against any physician or health care professional that is acting within the scope of his or her license.

Providers are obligated to submit their credentialing applications (and supporting documents) for initial and recredentialing in a timely manner.

VNS Health credentialing documents are available for download through the [Provider Toolkit](#), found on our website.

Delegation of Credentialing

VNS Health may choose to delegate provider credentialing and recredentialing in accordance with established policies. However, VNS Health is ultimately responsible for credentialing and recredentialing of providers and maintains the responsibility for ensuring that the delegated functions are being performed according to VNS Health standards.

Application Process

VNS Health completes credentialing activities and notifies providers within sixty (60) days of receipt of a fully completed application. The notification will indicate whether the healthcare professional is credentialed or whether additional time is needed due to a third party's failure to provide necessary documentation. If additional time is needed due to a lack of documentation, VNS Health makes every effort to obtain it as soon as possible and make a final determination within 21 days of receiving the necessary documentation.

Initial Credentialing

The applicant is responsible for supplying all requested documentation in a form that is satisfactory to the Credentialing Subcommittee. A fully executed provider agreement, or relevant facility contract is required to initiate the credentialing process. Providers are required to submit an initial credentialing request through our webform; which is provided by our contracting and/or provider relations representatives.

VNS Health requires all practitioner applicants to complete the Council for Affordable Quality Healthcare (CAQH) ProView® credentialing application form. If you do not have a CAQH number, register with CAQH Proview (proview.caqh.org/Login/Index) If you have any questions about how to obtain a CAQH number, call CAQH at **1-888-599-1771**.

In addition to the CAQH Provider Application, supplemental credentialing documents and certifications are requested and reviewed. Examples of requested information includes:

- New York State License and Registration
- Valid and Current DEA certification
- Board Certification
- Insurance Coverage (Participating providers are required to carry insurance coverage amounts as specified in their contract, as required by VNS Health policy, or as required by law or regulation.)
- Malpractice History
- Federal and/State Sanctions
- Medicaid/Medicare Participation Status
- Curriculum Vitae (CV)
- Hospital Privileges (Physicians only)
- HIV Specialist PCP Addendum (SH Only)
- Disclosure of Ownership and Control Interest Statement
- IRS-W9 Form
- Collaborative Physician Agreement (Physician Assistants, Nurse Practitioners, and Midwives only)

The Credentialing Subcommittee will consider all information gathered on the Credentialing Application and evaluate it in light of the criteria.

The Credentialing Subcommittee will then make a determination to recommend either approval or disapproval of the provider's application. VNS Health will provide written notice to a provider whom VNS Health declines to include in the network, setting forth the reason(s) for its decision.

Credentialing Requirement for HIV PCP/HIV Specialists (SelectHealth)

HIV PCPS/HIV Specialists must meet the following criteria:

- Completed 10 hours within the last 12 months of HIV-related CME that includes information on the use of antiretroviral therapy in the ambulatory care setting and provided direct, ongoing care to at least 20 HIV positive patients during the past year.
- Has recertification in the subspecialty of Infectious Disease in previous 12 months or has maintained a current HIV Specialist status by the American Academy of HIV Medicine (AAHIVM) or meets the definition of an HIV-experienced provider by the HIV Medicine Association (HIVMA) or is credentialed as an Advanced AIDS Certified Registered Nurse (ACRN) by the HIV/AIDS Nursing Certification Board (HANCB).

Note: HIV PCP Specialists must meet all of the following criteria:

- See patients at least 16 hours per week over at least two days at each primary care site.
- Participate in a practice that provides 24 hours/7-day telephone coverage.
- Have completed 10 hours of HIV-related CME within the last 12 months that includes information on the use of antiretroviral therapy in the ambulatory care setting.
- Have provided direct, ongoing care to at least 20 HIV infected patients within the last 12 months.

Providers agree to notify VNS Health promptly in the event of any material change in the status of their licensure, Medicare provider status, hospital medical staff appointments or privileges, physical or mental impairment or any other credentialing criteria that would affect their ability to practice.

All HIV PCPs must complete an annual assessment to confirm that they still meet the requirements to be an HIV PCP.

Credentialing Requirements for Organizational Providers

- Completed and signed Provider Application
- All regulatory licenses, registrations, and certifications
- Liability Insurance to include General/Commercial, Professional, Worker's Compensation Policy, as applicable
- Proof of Medicaid and Medicare (if applicable)
- Copy of Accreditation Certification
- Most recent federal or state regulatory body site visit report (with an approval letter of acceptance of corrective action plan)

Recredentialing

Participating Providers must be recredentialled every three years. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance indicators.

The recredentialing process requires that providers submit updated applications to VNS Health or its designated agent. VNS Health will contact the provider at least three months prior to the provider's recredentialing due date. In addition to the provider's recredentialing application, VNS Health may consider the following as part of its recredentialing process:

- Member complaints
- Quality of services
- Utilization management (compliance with protocols, standards, and procedures)
- Member satisfaction (access, availability, and waiting time)
- Medical record reviews

VNS Health will make available on a periodic basis, and upon the request of the provider, the information, profiling data and analysis used to evaluate provider performance. Upon receipt of profiling data, providers are afforded the opportunity to discuss the unique nature of their patient population that may have bearing on the data and to work cooperatively with VNS Health to improve performance.

VNS Health conducts medical record audits and measures performance using commonly accepted standards of care. HIV PCPs are also evaluated using HIVQUAL standards.

Confidentiality

At all times, information relating to a provider obtained in the credentialing/re-credentialing process is considered confidential.

Off-Cycle Credentialing

In the event information obtained by the VNS Health Credentialing Unit may indicate a need for further inquiry, the Credentialing Subcommittee may decide to conduct an off-cycle review of a provider's credentialing status. Information obtained during an off-cycle review includes, but is not limited to, changes in licensure, DEA certification, malpractice coverage, New York State OPMC actions, and Medicare and Medicaid sanctions.

Notwithstanding the above, providers who have had their licenses revoked or suspended, or who have been excluded from participation or who have opted out of the Medicare/Medicaid programs will be terminated immediately.

2.7 • Termination of Provider Agreements

Provider Termination and Disciplinary Action/Discipline of Providers

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

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

Examples of disciplinary action include, but are not limited to the following:

- Requiring the provider to submit and adhere to a corrective active plan

- Monitoring the provider for a specified period of time, followed by a Peer Review or Credentialing Subcommittee determination as to whether substandard performance or noncompliance is continuing
- Requiring the provider to use medical or surgical consultation for specific types of care
- Requiring the provider to obtain training in specific types of care
- Ceasing enrollment of new VNS Health members under the care of the provider
- Temporarily suspending the provider's participation status
- Terminating the provider's participation status with VNS Health

The Medical Director of VNS Health may determine at his/her sole discretion that the health of any VNS Health member is in imminent danger because of the actions or inactions of a participating provider, or that the provider is committing fraud or has received a final disciplinary action by a state licensing or governmental agency that impairs the provider's ability to practice ("Immediate Action Events") and in such case the Medical Director may immediately suspend and terminate the provider's participation status, during which time the Credentialing Subcommittee will investigate to determine if further action is required.

Provider Sanctions

All providers must comply with all laws and the rules, regulations, and requirements of all federal, state, and municipal governments.

Any provider who has been sanctioned, debarred, excluded, or terminated by Medicare or Medicaid and has been prohibited from serving Medicare or Medicaid recipients or receiving payment from the Medicare or Medicaid program is excluded from participating in the VNS Health provider network.

VNS Health's initial and ongoing credentialing process consists of a review of all federal and state sanctions including medical license or practice privilege probation, revocation, restriction, sanction, or reprimands. VNS Health's review of sanctions also includes Medicare and Medicaid reprimands, censure, disqualification, suspension, or fines, as well as conviction of or indictment for

a felony.

Additionally, VNS Health checks the following lists of excluded providers for parties which are excluded from receiving Federal contracts and subcontracts, and certain Federal financial and nonfinancial assistance and benefits:

- U.S. Department of Health and Human Services Office of the Inspector General (HHS- OIG) Exclusions Database (LEIE)
- New York State Office of the Medicaid Inspector General (OMIG)
- U.S. Government's System for Award Management (SAM)
- New York State Office of Professional Misconduct (OPMC-OPD)
- Social Security Administration's Death Master File (DMF)
- CMS Preclusion List

On confirmation of suspension, encumbrance, or revocation by a duly authorized government agency, VNS Health immediately imposes the same suspension, termination, encumbrance, or revocation of the provider's participation with VNS Health.

Procedure for Provider Termination

The Credentialing Subcommittee may recommend termination of the participation of a provider. Consideration of termination may be initiated by any information the Credentialing Subcommittee deems appropriate including, but not limited to the following:

- The provider fails to meet one or more of the administrative requirements or professional criteria as outlined in the VNS Health Credentialing program.
- The provider rendered(s) care to a member in a harmful, potentially harmful, personally offensive, or unnecessary or inefficient manner; or fails to provide access to care to an extent that continuity of care is provided to enrolled patients is adequate.
- The provider engaged(s) in abusive or fraudulent billing practices, including but not limited to submitting claims for payment that were false, incorrect, or duplicated.

- The provider fails to comply with VNS Health’s policies and procedures, including those for utilization management, quality management or billing.
- The provider’s privileges at a network institution, or any other institution, are lost or restricted for any reason.
- The provider’s license or DEA certification are limited, suspended, or revoked by any agency authorized to discipline providers.
- The provider is censured, suspended, debarred, excluded, or terminated as a Medicaid or Medicare provider.
- The provider is indicted or convicted of a felony.
- The provider fails to comply with the application, selection or recredentialing process.
- Submits false, incomplete, or misleading information with respect to credentials or fails to comply with any provision of the Program Agreement.
- The provider renders professional services outside the scope of his/her license or beyond the bounds of appropriate authorization.
- The provider fails to maintain malpractice insurance that meets approved guidelines.
- The provider experiences physical or mental impairment, including chemical dependency, which affects his/her ability to provide care to patients or fails to meet plan criteria.
- Provider Impairment Policy or the relevant policies of network institutions.

A provider cannot be prohibited for the following actions and VNS Health may not terminate or refuse to renew a contract solely for provider performance of the following actions:

- Advocacy on behalf of a member
- Filing a complaint against VNS Health
- Appealing a determination made by VNS Health
- Providing information or filing a report with an appropriate government body regarding prohibitions plans
- Requesting a hearing or review

If the Credentialing Subcommittee receives information which it believes suggests that the discipline or termination of a provider may be warranted for reasons relating to the provider's professional competence or conduct, it will request the Medical Director to investigate the matter.

If the Credentialing Subcommittee believes that further information is needed, it may obtain it from the provider or other sources. The Subcommittee may request or permit the provider to appear before the Credentialing Subcommittee to discuss any issue relevant to the investigation.

If the Subcommittee's recommendation is to impose any disciplinary action, including, but not limited to, termination of the provider, the Subcommittee shall provide to the provider a written explanation of the reasons therefore and notice of the opportunity for review and/or hearing. Such review shall take place prior to submission of the recommendation to the Board and implementation of any disciplinary action unless the reasons therefore involve imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the provider's ability to practice, in which cases the Credentialing Subcommittee may immediately suspend or restrict the provider's participation in the VNS Health provider network.

Subject to the provider's rights to appeal, the Credentialing Subcommittee's recommendations will be forwarded to the Board of VNS Health for final approval.

Review Procedure

The procedure for termination or denial of recredentialing will apply to providers who are terminated or denied recredentialing in one or more specific specialties or subspecialties, as well as those who are terminated or denied recredentialing in terms of their total participation in the plan.

The Credentialing Subcommittee shall notify the provider that he or she has a right to request a hearing or review, at the provider's discretion, of said recommendation.

VNS Health shall include in the termination notice:

- The reason for the proposed action.
- Notice that the provider has the right to request a hearing or review, at his or her discretion, before a panel appointed by the Medical Director.
- The provider has 30 days within which the provider may submit to the Medical Director a written request for a hearing and/or review.
- A time limit for a hearing date, which must be held within 30 days after the date of the Credentialing Subcommittee receipt of a request for a hearing.

Except for Immediate Action Events of VNS Health Health Plan providers, the termination shall not be effective earlier than 60 days from the provider's receipt of the notice of termination.

Upon receipt of a request for hearing or review, the Medical Director shall inform the Credentialing Subcommittee members and shall select a review panel consisting of three persons (the "Review Panel"), at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Subcommittee.

The Medical Director may appoint more than three persons to the Review Panel; provided that for appeals by providers in VNS Health Long Term Care plans (MLTC and Total) or SelectHealth, at least one-third of the Review Panel must be clinical peers of the provider under review and for appeals by providers in the plan, the majority of the Review Panel must be clinical peers of the provider under review. The Board shall appoint one of the Review Panel members as chairperson ("Review Panel Chairperson").

Within 14 days of receipt of a provider's written request for hearing, the Medical Director will notify the provider of the time and place of the hearing, which shall be no more than 30 days after receipt by the Medical Director of the request for hearing, unless the parties mutually agree upon a later date. In addition, said notice shall include the witnesses, if any, to be called by the

Credentialing Subcommittee in support of its recommendation, and a list of the members of the Review Panel.

The Hearing

The Credentialing Subcommittee will be represented by its chairperson or his or her designee during the appeal process. The Credentialing Subcommittee will be responsible for documentation and minutes of the hearing. The Review Panel Chairperson will facilitate the hearing and ensure the following procedure is followed:

- **Chairman's Statement of the Procedure:** Before evidence or testimony is presented the Chairman of the Review Panel will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of Evidence by Credentialing Subcommittee:** The Credentialing Subcommittee may present any oral testimony or written evidence it wants the Review Panel to consider. The provider or the provider's representative will have the opportunity to cross-examine any witness testifying on the Credentialing Subcommittee's behalf.
- **Presentation of Evidence by Provider:** After the Credentialing Subcommittee submits evidence, the provider may present oral testimony or written evidence to rebut or explain the situation or events described by the Credentialing Subcommittee. The Credentialing Subcommittee will have the opportunity to cross-examine any witnesses testifying on the provider's behalf.
- **Credentialing Subcommittee Rebuttal:** The Credentialing Subcommittee may present additional written evidence to rebut the provider's evidence. The provider will have the opportunity to cross-examine any additional witnesses testifying on the Credentialing Subcommittee's behalf.
- **Summary Statements:** After the parties have submitted their evidence, first the Credentialing Subcommittee and then the provider will have the opportunity to make a brief closing statement. In addition, the parties will have the opportunity to submit written statements to the Review Panel. The Review Panel will establish a reasonable time frame

for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.

- Examination by Review Panel: Throughout the hearing, the Review Panel may question any witness who testifies.

Evidentiary Standards

The evidence must reasonably relate to the specific issues or matters involved in the recommended action. The Review Panel has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider. An individual who objects to the presentation of any evidence must state the grounds for the objection and the Review Panel has the sole discretion to determine whether the evidence will be admitted.

Review Panel Determination

The Review Panel may, at its sole discretion, uphold, reject, or modify the recommendation of the Credentialing Subcommittee. The decision of the Review Panel will be made in a timely manner and based upon the affirmative vote of a majority of the Review Panel members. The Review Panel's decision may include (i) reinstatement of the provider; (ii) provisional reinstatement subject to conditions set forth by the Review Panel; or (iii) termination of some or all privileges of participation in the plan. The provider will be notified in writing by the Review Panel Chairperson of the decision and the basis, therefore. If a provider is terminated or his or her privileges are curtailed, the Credentialing Subcommittee will ensure that patients or clients of the plan who have or are currently obtaining services from the provider are notified and that access to alternative providers within the plan is made available to them. Decisions of termination will be effective not less than 30 days after receipt by the provider of the hearing panel's decision.

Provider Terminations and Continuity of Care

In the case of any provider termination, VNS Health will provide for continuity of care for members. Providers who terminate participation with VNS Health are obligated to the continuation of treatment and hold harmless provisions specified in their contracts.

Termination of hospital contracts will comply with Section 4406-c (5-c) of the NYS Public Health Law, which requires that the contracted hospital and VNS Health, continue to cover all services covered under the contract and abide by the terms of the contract, including reimbursement rates, for a period of two months from the effective date of termination or non-renewal. The exception to this requirement applies when both parties agree to the effective date of the scheduled termination or non-renewal, or when either the contracted hospital or VNS Health, requests a waiver of the “cooling off” period from DOH. The hospital will collaborate with VNS Health, so that an impact/ disruption analysis with regard to enrollee access to care is submitted to the NYS Department of Health within the Department’s required timeframes.

Duty to Report

VNS Health MLTC and SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 30 days of the following:

- Termination of a health care provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare.
- The voluntary/involuntary termination of a contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures.
- The termination of a health care provider contract in the case of a determination of fraud or in the case of imminent harm to patient health.
- VNS Health MLTC and Total and SelectHealth are legally obligated to report to the New York State Department of Health or appropriate disciplinary agency within 60 days of the date VNS Health obtains knowledge of any information that reasonably appears to show that a health care professional is guilty of professional misconduct as defined in Education Law.

Medical records are monitored for appropriate documentation of administrative and clinical requirements. The criteria for this review are based

on requirements and standards from the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health, including those of the Department of Health AIDS Institute.

SECTION 3: ELIGIBILITY AND MEMBERSHIP

3.1 • Eligibility Verification

VNS Health MLTC

While the Health Plan authorizes most services, providers are encouraged to verify member eligibility before providing the service. Providers are prohibited from billing VNS Health MLTC members for covered services. However, if a provider wishes to provide a non-covered service to a member, the provider must inform the member in writing prior to the initiation of the service, indicating the cost and the member's responsibility for payment.

VNS Health may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct, or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee's capacity for normal activity, or threaten some significant handicap.

To verify eligibility for all of the covered services listed above, with the exception of dental services, please call our Provider Services Line 1-866-783-0222 or Member Services 1-888-867-6555, Monday to Friday, 8am-5 pm. You may also check claims and eligibility status via the Provider Portal at: <https://www.vnshealthplans.org/provider-portal/>.

VNS Health will reimburse providers only for services rendered to currently eligible members. It is the responsibility of the provider to verify eligibility prior to providing services.

 VNS Health	HEALTH PLANS
VNS Health MLTC Managed Long Term Care Plan Member ID: Member Name: Care Team 1-888-867-6555 (TTY: 711) Monday – Friday, 9 am – 5 pm	
Transportation 1-877-718-4220 (TTY: 711) Monday – Friday, 8 am – 8 pm Dental - HealthPlex 1-800-468-9868 (TTY: 1-800-662-1220) Monday – Friday, 8 am – 6 pm Vision - Superior Vision 1-800-507-3800 (TTY: 1-800-201-7165) Mon – Fri, 8 am – 9 pm & Sat, 11 am – 4:30 pm This member is covered by fee-for-service Medicaid.	

VNS Health Medicare Health Plans

You may obtain information on VNS Health member eligibility by calling the Member Services at 1-866-783-1444, Monday through Friday from 8 am-8 pm.

You may also check claims and eligibility status via the Provider Portal at: <https://www.vnshealthplans.org/provider-portal/>.

Upon initial registration, you will be asked to complete a “Provider Portal Registration.” Upon proper completion, the registration is submitted, and an assigned password will be sent to you within two business days. If you have questions or need assistance, call Availity Client Services at 1-800-Availity (1-800-282-4548) Monday through Friday, 8:00 am to 8:00 pm Eastern Time.

The Provider Portal offers real-time access to member eligibility, claims status with details, and much more. In addition, the portal features self-service access (real-time registration, password reset capability, customizable quick links) and is easy to access and use, so that you can manage your patients’ information quickly and easily.

All VNS Health Medicare members are given an identification card (sample below). Members should present their ID cards when they request any type of

covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.


VNS Health
HEALTH
PLANS

<p><F_NAME M L_NAME> Member ID: <SBSB_ID> Plan: Total (HMO D-SNP) Effective Date: <MEIA_REQ_DT> PCP Name: <PRPR_NAME> PCP Phone Number: <PRAD_PHONE> Medicaid Number: <MEME_MEDCD_NO> Healthplex Dental Grp No: GG-385PLUS</p>	<p>RxBin: 015574 RxPCN: ASPROD1 RxGRP: VNS01</p>  <p style="font-size: 8px; margin-top: 10px;">CMS-H5549-003 ISSUER: (80840)</p>
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Care Team: 1-866-783-1444 (TTY: 711)
 7 days a week, 8 am – 8 pm (Oct. – Mar.); Weekdays, 8 am – 8 pm (Apr. – Sept.)
vnshealthplans.org

Transportation: 1-877-718-4219 (TTY: 711)

<p>Dental: Healthplex 1-800-468-9868 (TTY: 1-800-662-1220)</p> <p>Vision: Superior Vision 1-800-879-6901 (TTY: 1-800-201-7165)</p> <p>Provider Services: 1-866-783-0222 Electronic Payer ID: 77073</p>	<p>Behavioral/Mental Health: Carelon 1-866-317-7773 (TTY: 1-866-835-2755)</p> <p>Prescription Drugs: MedImpact 1-888-672-7205 (TTY: 711)</p> <p>Submit Claims to: VNS Health Medicare PO Box 4498, Scranton, PA 18505</p>
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Plan administered by VNS Health Medicare. Note: This card is void when eligibility terminates.



SelectHealth from VNS Health

The State is responsible for managing the enrollment process for HIV Special Needs Plans (SNP), which includes confirming eligibility criteria (valid Medicaid status and verbal confirmation from the client of HIV positive status). People who are transgender or gender non-conforming, people who are homeless, and children under 21 covered by an infected parent are also eligible to enroll with HIV SNP plans regardless of HIV status.

VNS Health reimburses providers for services rendered to eligible members currently enrolled in the plan. If a provider wishes to provide a non-covered service to a member, the provider must inform the member in writing prior to the initiation of the service, indicating the cost and the member's responsibility for payment.

VNS Health may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct, or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee's capacity for normal activity, or threaten some significant handicap.

Identification card: VNS Health generates an identification card to all actively enrolled members of the plan within 14 days of the member's effective date of enrollment.

 <p><F_NAME M L_NAME> Member ID: <SBSB_ID> Plan: SelectHealth Effective Date: <MEIA_REQ_DT> PCP Name: <PRPR_NAME> PCP Phone Number: <PRAD_PHONE> CIN: <MEME_MEDCD_NO></p> <p>NYRx RxBin: 004740 Plan Code: <000></p>	<p>Submit Medical Claims to: SelectHealth from VNS Health PO Box 4498 Scranton, PA 18505</p> <p>Electronic Payer ID: 77073</p> <p>Pharmacy Benefits: NYRx EMedNY 1-800-343-9000 - Option 1</p> <p>Provider Services: 1-866-783-0222</p> <p>Note: This card is void when eligibility terminates.</p> <p>SelectHealth Care Team* 1-866-469-7774 (TTY: 711) Monday – Friday, 8 am – 6 pm *At all other times your call will be handled by the after-hours call center.</p> <p>Behavioral Health Services 1-855-735-6098 (TTY: 1-866-727-9441) 24 hours a day, 7 days a week</p> <p>Superior Vision 1-800-507-3800 (TTY: 1-800-201-7165) Monday – Friday, 8 am – 9 pm Saturday, 11 am – 4:30 pm</p> <p>Plan administered by SelectHealth from VNS Health</p>
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Information on the card includes member name, client identification number (CIN), primary care provider name and telephone number, the 24-hour VNS Health toll-free number and the behavior health phone number. Plan code on the ID card identifies if a member is eligible for HCBS services (Home and Community Based Services).

Plan code “004” denotes a member who is not eligible for HCBS services and plan code “008” denotes a member who is eligible for HCBS services. At the time of the member’s visit providers should ask the member for their member identification card. Most providers make a copy of both sides of the card for their files.

EMEVS (Electronic Medicaid Eligibility Verification System) or ePACES:

Eligible members are verified by the code “VS” on the EMEVS/EPACES. Use this link to find additional information: [emedny.org/index.aspx](https://www.emedny.org/index.aspx)

Member Roster: Primary care providers member rosters for all products are available through the Provider Portal:

<https://www.vnshealthplans.org/provider-portal/>

Referral: Although members do not need a referral to seek care from an in-network specialist, they should have a prescription from the primary care provider.

Member Services: If you have questions regarding member eligibility, call Member Services at 1-866-469-7774, Monday through Friday, 8 am to 6 pm.

3.2 • Marketing, Advertising and Outreach

Managed Long Term Care (MLTC)

In compliance with NYSDOH regulation of Medicaid managed long-term care (MLTC) plans, VNS Health MLTC solicits the willing participation of healthcare providers and community influencers to develop its referral base. VNS Health ensures, through its contracts with network providers and subcontractors, that these network providers and subcontractors comply with all Marketing Requirements.

VNS Health does not pay network providers or their subcontractors any commission, bonus, or similar compensation that uses numbers of Medicaid eligible persons enrolled in the VNS Health MLTC plan as a factor in determining compensation.

Communication with Patients

- Participating VNS Health MLTC Providers who wish to let their patients know of their affiliations with one or more managed care organizations (MCOs) must list each MCO with whom they have contracts. Participating Providers who are communicating with patients about managed care options must direct patients to the State's Enrollment Broker for education on all managed care plan options.
- Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type.
- Upon termination of a Provider Contract with VNS Health MLTC, a provider that has contracts with other MCOs that offer MLTC products may notify their patients of the change in status and the impact of such change on the patient.

VNS Health Medicare

As a Medicare Advantage plan with a Part D component, VNS Health, and the providers we contract with must conform with regulations from both the federal Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH).

CMS defines plan-initiated activities as those where either a Plan/Part D sponsor requests contracted providers to perform a task or the provider is acting on behalf of the Plan/Part D sponsor. For the purpose of plan-initiated activities, the Plan/Part D sponsor must ensure compliance with requirements applicable to communication and marketing.

VNS Health Total requests for providers to discuss benefits and cost sharing would fall under the definition of marketing and are hence prohibited from taking place where care is being delivered.

Additionally, VNS Health Total providers may not do any of the following:

- Accept/collect scope of appointment forms.
- Accept Medicare enrollment applications.

- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Plans/Part D sponsors.
- Offer inducements to persuade their patients to enroll in a particular plan or organization.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials/applications in areas where care is being delivered.
- Offer anything of value to induce enrollees to select them as their provider.
- Accept compensation from the plan for any marketing or enrollment activities.
- VNS Health Total providers may do either of the following:
 - Make available, distribute, and display communication materials, including in areas where care is being delivered.
 - Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).

SelectHealth from VNS Health

SelectHealth from VNS Health is contracted with the New York State Department of Health (NYSDOH) and is subject to contractual terms and conditions including comprehensive marketing guidelines. By NYSDOH definition, marketing encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

Written Marketing Materials

Written marketing materials generated by providers must be approved by NYSDOH, Division of Health Care Access.

Written marketing materials must contain certain specified information to ensure that potential HIV SNP members receive basic information. The NYSDOH has developed a model letter for use by providers to communicate information about HIV SNPs to their patients. No further review is required if the model letter is used. Any modifications to this letter, however, must be approved by NYSDOH.

Marketing Encounters

Marketing encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular HIV SNP. All marketing encounters must communicate at least the following information:

- A statement that participation in an HIV SNP is voluntary and that persons with HIV/AIDS may choose instead to join or remain in a mainstream Medicaid managed care plan.
- The potential member has a choice among several alternative HIV SNPs.
- Upon enrollment in a SNP, the member is required to use their HIV Specialist PCP and other plan providers exclusively for medical care, except in certain limited circumstances.
- Newborns of a mother enrolled in a SNP are automatically enrolled in the mother's HIV SNP. The infant may be disenrolled at any time at the mother's request.
- Providers may market to persons enrolled in the mainstream health plan operated by the same organization as the HIV SNP but must inform the member that the change is optional and the members who change from a mainstream health plan to an affiliated SNP must sign a new enrollment form.
- Providers who wish to let their patients know of their affiliation with one or more HIV SNPs must list each HIV SNP with whom they hold contracts.

SECTION 4: Regulatory and Quality Reporting Requirements

4.1 • Quality Improvement Program (QIP)

VNS Health's Quality Improvement Program mission is to serve as a best-in-class health plan and continually improve the quality of healthcare for our members. This is accomplished by providing access to affordable, appropriate, and timely healthcare and services, which is routinely assessed for compliance with established standards. VNS Health develops its Quality Improvement standards in consultation with participating providers. Participating providers must comply with all VNS Health Quality Management policies, procedures, and programs. The overriding principle of the VNS Health Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improving care and service to meet or exceed our members' expectations.

Program Description

The VNS Health QIP provides a framework for the evaluation of the delivery of health care and services provided to members. This framework is based upon the philosophy of continuous quality improvement and includes:

- Development of quality improvement initiatives
- Quality measurement and evaluation
- Corrective action implementation and evaluation
- Communication with and education of our members and providers
- Annual evaluation of the program's effectiveness

Program Scope

The goal of the QIP is to improve the health outcomes of care to our membership by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care. The QIP encompasses both clinical care and non-clinical activities, which have either direct or indirect influence on the services

members receive from VNS Health participating providers and on the quality of care.

Authority

As the governing body of the plan, the Board of Directors is accountable for the QIP. The President of VNS Health Health Plans is responsible for its implementation. The plan's Chief Medical Officer in conjunction with the Senior Vice President and Chief Quality and Performance Improvement Officer has overall responsibility for the plan's quality improvement strategies and activities. The Vice President of Care Management plays a key role in operationalizing the quality improvement clinical activities. The Board of Directors receives written reports on the progress of the QIP Work Plan for all product lines.

Program Objectives

- Implement and manage a Quality Improvement structure that facilitates the identification, development, and implementation of clinical and non-clinical quality improvement activities throughout VNS Health.
- Improve organizational processes to evaluate their ability to support VNS Health's current or new health care products, by identifying, developing, and implementing strategies to facilitate improvement.
- Improve organizational communication, by identifying, developing, and implementing strategies to facilitate improvement.
- Improve data collection and analysis for the purpose of identifying and developing improvement activities.
- Collaborate with the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (NYSDOH), the Island Peer Review Organization (IPRO) and the NYSDOH AIDS Institute to ensure quality monitoring efforts align with methodologies and compliance with regulatory requirements.
- Assess the health care delivery system's access and availability of services, and identification, development, and implementation of strategies to facilitate improvement.

- Evaluate the QIP's effectiveness by performing an annual evaluation of the activities generated by the program.
- Develop an annual QIP Work Plan based upon the results obtained from the prior year's evaluative process.
- Establish thresholds and evaluate patterns or trends through the analysis of data for all products.

QI Work Plan

On an annual basis, the Quality Improvement Committee (QIC) will oversee the development of the QIP Work Plan. The QIP Work Plan outlines the quality improvement monitoring and evaluation activities for the upcoming year. The QIP Work Plan is a document in progress and activities can be re-evaluated or updated as needed. The QIP Work Plan is presented to the QIC for recommendations and approval. The QIP Work Plan is then presented to the Board of Directors for final approval.

Each year VNS Health will develop an annual QIP Work Plan that includes specific quality improvement initiatives and measurable objectives for each scheduled initiative. The QIP Work Plan activities are derived from:

- The opportunities for improvement that were identified during the previous year
- Data Analysis
- Analysis of customer satisfaction surveys
- Any other activities that are required by state, federal and accreditation entities
- The following are some of the issues monitored through the QIP plan:
 - Member satisfaction
 - Member complaints and compliments
 - Medical record documentation
 - Utilization management
 - Access and availability of services
 - Medical and psychosocial case management
 - Provider credentialing/recredentialing
 - Network compliance, quality, and provider issues

- Quality of Care Concerns and Incident Reports

Annual Review and Evaluation

The QIP and Work Plan are reviewed on an annual basis for its effectiveness. The results of this evaluation process are contained within a document known as the Quality Improvement Program Evaluation (QIPE). The QIPE is presented to the Quality Improvement Committee for review and to establish VNS Health's quality improvement activities for the following year. Due to the dynamic process of continuous quality improvement, the need to comply with external accrediting organizations, regulatory requirements, and business decisions, the QIP and Work Plan can be subject to change at any time during the year to improve care and service to its members. This QIPE will elicit the information necessary to assist in development of the QIP Work Plan for subsequent years.

Clinical and Investigational Studies

The Medical Management Department makes recommendations to the QIC concerning proposed clinical studies. The QIC, with oversight by the Board of Directors, is responsible for allocating resources, assigning responsibilities, and determining methods for communicating results to providers and staff.

VNS Health conducts an internal study addressing services provided to its adult members and an internal study addressing services to its pediatric/adolescent members on an annual basis.

4.2 • Standards of Care

VNS Health has adopted practice guidelines to support the medical, utilization and care management of its members enrolled in various products. These guidelines are evidence based and consistent with prevailing standards of medical practice. These standards are established and consistent with Federal and State requirements. These standards include, but are not limited to, CMS and the National Committee for Quality Assurance (NCQA) Special Needs Plan, NYSDOH Medicaid Managed Care, the New York State Department of Health AIDS Institute (e.g., the provision and monitoring of antiretroviral therapy) and/or the U.S. Department of Health and Human Services. VNS

Health clinical practice guidelines comply with the recommendations of professional specialty groups. Clinical practice guidelines are reviewed annually and updated, as necessary. Guidelines are disseminated to providers, with all relevant updates, as they are released by the state or federal government.

HIV Clinical Guidelines

Introduction: The HIV Clinical Guidelines Program is a collaborative effort of the [New York State Department of Health \(NYSDOH\) AIDS Institute \(AI\)](#), Office of the Medical Director (OMD), and the Johns Hopkins University (JHU) School of Medicine, Division of Infectious Diseases.

Conflict of Interest

To ensure that all quality issues are reviewed, without bias, and actions taken are in the best interest of VNS Health members, VNS Health mandates the following policies:

- To avoid actual or perceived conflicts of interest, VNS Health requires all committee members to provide appropriate disclosure.
- Any committee member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such member about the recommendation in question, which might reasonably be construed as adverse to the VNS Health's interests. This includes, but is not limited to, situations in which a committee member is a competitor of the provider in question.
- If the committee determines that a conflict of interest exists, it shall require the disclosing member to excuse him or herself from voting on the issue at hand.

Access and Availability Standards

All Primary Care and Specialist Services provided by participating providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with i) the generally accepted medical and surgical

practices and standards prevailing in the applicable professional community at the time of treatment; ii) the provisions of VNS Health's QIP and Medical Management Program; iii) the requirements of State and Federal Law; and iv) the standards of accreditation organizations such as NCQA and the Joint Commission for Accreditation of Healthcare Organizations.

Each participating provider is required to provide advance written notice to VNS Health in the event of any change in the capacity of the participating provider to continue services under the terms of the participating provider's agreement with VNS Health.

Participating providers are solely responsible for the medical care and treatment of members and will maintain the physician-patient relationship with each member. Nothing contained in the participating provider's agreement is intended to interfere with such physician-patient relationship, nor is the participating provider agreement intended to discourage or prohibit participating providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by participating providers.

VNS Health assesses that its panel of participating providers can meet the racial, ethnic, cultural, and linguistic needs of its members. VNS Health also requires that network providers assist members with limited English-speaking proficiency and physical disabilities.

4.3 • Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high-volume participating specialists are subject to be included in an accessibility audit/review for all categories and appointment types. Member complaints may also trigger an ad hoc measurement of a provider's accessibility. Data will be analyzed on a system wide and individual provider level for the development of system wide and/or individual improvement activities. VNS Health participates in established AIDS Institute research on access to care, member satisfaction and quality of life and other specific QI studies developed by the AIDS Institute.

4.4 • Quality Management Subcommittee Structure

The full organizational structure of committees reporting to the VNS Health Quality Improvement Committee is available by contacting the plan and requesting this information. The Quality Improvement Committee meets on a quarterly basis. responsible for identifying, selecting, and prioritizing quality improvement issues. The QIC identifies opportunities for improvement, directs the selection of indicators and reviews trended information related to quality of service and satisfaction for both internal and external customers. The primary responsibility of the QIC is to develop and implement an annual QI program and work plan which includes monitoring of clinical care and performance indicators and evaluation of any implemented improvement actions. The QIC receives recommendations and approves the formation of all Quality Process Improvement initiatives to address issues that affect the delivery of care and service to members. Representation of the Quality Improvement Committee include the Medical Director, an HIV Specialist, and member representation. Below are the committees most important to providers.

Member Advisory Subcommittee

The responsibilities of the Member Advisory Subcommittee are to identify opportunities for improvement through evaluation of internal statistics, member complaints, medical record reviews, and satisfaction surveys. To report results to the QIC regularly for corrective action and Solicit feedback and recommendations from key stakeholders to improve quality of care and member outcomes; key stakeholders may include members, family members, subcontracted Plans, RPCs, and other member serving agencies.

Behavioral Health and Utilization Management

The BH UM review assists in the development of baseline data measurements of utilization and determines outlier thresholds. It develops and implements corrective action plans, monitors results, and reports its findings to the QIC. The UM review analyzes, trends, and tracks utilization data for inpatient and outpatient services to identify potential under or overutilization of services

and quality of care issues through identified clinical indicators. It evaluates intervention strategies for measurable outcomes and improvements.

Behavioral Health and Quality Management

The Behavioral Health subcommittee's responsibilities include carrying out the planned activities of the Behavioral Health Quality program. The Plan's BH Medical Director and BH QM Administrator/Director shall lead the quarterly BH QM Subcommittee meetings and maintain records documenting attendance by members, family members and providers as well as committee findings, recommendations, and actions. A summary of Subcommittee meetings will be submitted to the QIC and Board of Directors for final review and approval.

Policy and Procedures Subcommittee

The Policy and Procedure review includes identifying the need for new policies, and the review and revision of existing policies across the Plan to maintain compliance with regulatory, plan needs and operational efficiencies.

Utilization Management Care Management (UMCM) Committee

The responsibilities of the UMCM Committee are to:

- Review and analyze utilization data from claims, encounters, referrals, authorizations, and denials to determine potential over and underutilization.
- Review and edit prior authorization lists.
- Review quality of care issues.
- Target utilization management efforts accordingly.
- Develop baseline data measurements of utilization and determine outlier thresholds.
- Monitors results and reports the findings to the QIC.

Out-of-plan utilization will be reviewed on a monthly basis to identify possible areas of under/over utilization.

Behavioral Health utilization data is also reviewed with a focus.

The Medical Director and Director of UM are Co-Chairpersons of the UCMC Committee.

Credentialing Subcommittee

The responsibilities of the Credentialing Subcommittee are to recommend approval or denial of providers and facilities for either initial or continued participation in the healthcare delivery system to the plan QIC. The Lead Medical Director is the Chairperson of the Credentialing Subcommittee.

The Psychosocial Committee exists to integrate and coordinate the delivery of psychosocial case management services for SelectHealth members. Its responsibilities include:

- To review, evaluate and update policies and procedures related to psychosocial case management including those in accordance with guidelines prescribed by the New York State Department of Health AIDS Institute.
- To identify opportunities for improvement through evaluation of encounter information, member/provider complaints and satisfaction surveys. To report results to the QIC regularly for corrective action.
- To evaluate the effectiveness of implemented quality improvement initiatives and to assess the compliance with case management guidelines throughout the plan.
- To ensure optimal communication between the members' medical and psychosocial care teams.
- To evaluate and make recommendations to the QIC concerning proposed quality studies.

4.5 • Data & Reporting

VNS Health complies with all Federal and State reporting requirements.

HEDIS Reporting

The Healthcare Effectiveness Data and Information Set (formerly known as the Health Plan Employer Data Information Set – HEDIS), developed by NCQA, is the most widely used set of performance measures in the managed care industry. VNS Health collects and reports HEDIS data for its Medicare lines of business on an annual basis. The auditor approved HEDIS rates are used to identify opportunities to improve the quality of healthcare for Medicare beneficiaries.

QARR Reporting

The NYSDOH Quality Assurance Reporting Requirements (QARR) are an integral component of the VNS Health Quality Improvement Program. VNS Health collects and reports QARR data for the SelectHealth line of business on an annual basis. The auditor approved QARR rates are used to identify opportunities to improve the quality of healthcare for SelectHealth beneficiaries.

Submission and Oversight

VNS Health relies on accurate and timely encounter data from its providers to submit data for HEDIS and QARR. VNS Health staff may request medical charts and/or medical record data in the form of electronic medical record data feeds to provide clinical documentation to fulfill the selected HEDIS and QARR measures. Staff requests for medical records for chart reviews can happen throughout the year.

The Quality Improvement Committee provides oversight of HEDIS and QARR reporting. The Quality Management Department maintains responsibility for the day-to-day operations of HEDIS and QARR reporting.

Diseases and Conditions Data

Physicians are required by Article 11 of the New York City Health Code to report certain diseases, conditions and events to the New York City Department of Health and Mental Hygiene (NYC DOHMH).

Section 11.03 of the New York City Health Code requires the immediate reporting by telephone of a suspected outbreak among three or more persons of any disease or condition (whether or not it is listed among reportable conditions), and of any unusual manifestation of disease in an individual.

VNS Health account managers are available to assist providers with identification and implementation of NYC DOHMH regulations regarding the reporting of mandated diseases. Educational literature will be made available to providers about reporting diseases and conditions specified in NYC Health Code. The necessary literature and forms will be made available to providers through a newsletter, the VNS Health web site, and in Appendix D of this Provider Manual.

VNS Health also monitors provider performance through the following process and methodology:

VNS Health uses claims, lab, and medical record data to support annual HEDIS/QARR reporting. Monthly gaps in care reports are produced for ongoing monitoring of member, measure, and provider performance. Gaps in care reports are shared with providers to highlight opportunities for improvement and facilitate patient engagement aimed at improving health outcomes. A clinical Quality Manager from VNS Health Quality Management conducts a detailed review of the Gaps in Care report and provider performance which facilitates targeted education and training efforts to address care gaps.

Provider performance is evaluated against the methodology outlined in their Value-Based agreement or other incentive program. For SelectHealth

providers, this performance is measured against the state recognized benchmarks associated with the eQARR and HIV SNP Quality Incentive Program. VNS Health has the ability to generate and disseminate provider quality performance reports upon the request of the provider and is committed to reviewing their quality performance and discussing patient population needs. Further, in accordance with the Quality Management and Performance Improvement Program (QIP/CCIP), the Quality Improvement Committee (QIC) receives recommendations and approves the formation of all Quality Process Improvement Teams to address issues that affect the delivery of care and service to members. The QIC takes every opportunity to improve quality by communicating results of evaluations conducted by the plan, New York State Department of Health, and the New York State Department of Health AIDS Institute. The Plan's QIC communicates findings SelectHealth providers and staff, via letters and departmental meetings, and reviews the recommended action plans. Findings are also communicated via Provider and Member Newsletters.

4.6 • Reporting Requirements

VNS Health requires its practitioners to maintain accurate medical records. The primary purpose of the record is to document the course of the member's health, illness and treatments and serve as a mode of medical record of an active member must remain in the primary care physician's office and must be consistent with all relevant local, state, and federal laws, rules, and regulations.

VNS Health reviews medical records as part of the following activities:

- Credentialing and recredentialing
- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level of care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding
- Monitoring for compliance with approved Practice Guidelines and Standards of Care

- Reporting for Quality Improvement and Peer Review Organization studies

HEDIS and QARR measure adherence

- Monitoring of provider compliance with public health regulations on reporting requirements
- Monitoring for compliance with VNS Health Medical Record Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical record review or a review conducted by regulatory agencies, providers will be required to participate in a corrective action plan, as necessary.

CMS Risk Adjustment Medical Records Reporting

Medical records play a critical role in CMS' reimbursement for our members. Records must show all conditions evaluated during the visit; as such, it is important to evaluate and document all chronic conditions at least annually. You should report the appropriate diagnosis code for all documented conditions that coexist at the time of the visit that require or affect care.

For accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the member's condition in words. This should include specific diagnosis, symptoms, problems, or reasons for the visit. ICD-10-CM codes when used alone, are not sufficient to describe the member's condition. Also adding supportive documentation of monitoring, evaluating, assessing or treatment provided of these reported diagnoses ensures they are active and not historical for our members. You are responsible for making sure that ICD-10-CM coding adheres to ethical standards.

We may review the charts to identify chronic diseases not coded on claims. CMS conducts assessments to confirm that the Hierarchical Condition Categories (HCCs) triggered for payment, based on ICD10-CM coding, are

supported by chart documentation. CMS works through us to obtain these records. We require your cooperation with this.

Providers must make member records and encounter data available to VNS Health to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration, United States Department of Health and Human Services, the Controller of the State of New York, the Controller General of the United States and The Centers for Medicare and Medicaid Services (CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

4.7 • Medical Record Reviews and Documentation Standards

Well documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private office or clinic settings, the medical record is an essential tool for communication between providers.

All providers rendering healthcare services to VNS Health members must maintain a member health record in accordance with standards adopted by VNS Health and in compliance with National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Review. Providers should maintain compliance with professional standards and take steps to safeguard confidentiality when sharing medical-record information with other network providers.

Medical Record Review

A VNS Health representative may request that records are sent to VNS Health offices for review to obtain information regarding medical necessity, regulatory and internal chart audits, and quality of care for VNS Health members. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below. VNS Health applies

guidance from NCQA and CMS in reviewing medical record documentation and standards.

VNS Health Medical Record Review Documentation Criteria

1. Date all entries and identify the rendering provider including their credentials. Acceptable physician authentication includes handwritten and electronic signatures or signature stamps.
2. The record must be legible to someone other than the author.
3. Clearly document changes to a medical record entry by including the author and date of change. You must retain a copy of the original entry.
4. Include demographic information including name, gender, date of birth, member number, emergency contact name, relationship, phone number(s), and insurance information.
5. Include family and social history, including marital status and occupational status or history.
6. Document information on whether the member has executed an advance directive or where a discussion of advanced care planning was completed with the member or caregiver.
7. Include a problem list with medical history, chronic conditions, and significant illnesses.
8. Accidents, operations and hospitalizations.
9. Include the chief complaint and diagnosis and treatment plan at each visit.
10. Include name of current medications, dosages, and route as well as over-the-counter drugs, allergies and adverse reactions or notation of no known allergies or adverse reaction.
11. Document member history and health behaviors including but not limited to blood pressure, height and weight, body mass index and other preventive screening services.
12. Reflect all services provided, clinical decisions and safety support tools in place to help ensure evidence-based care and follow up care, including and not limited to lab results, X-ray, consultation reports, behavioral health reports, ancillary care providers' reports (example eye care specialist related to medical eye exams), facility records and outpatient records.

All information contained in the records are kept strictly confidential. Providers must make medical records available upon request by VNS Health or by CMS,

NYS Department of Health, or any other regulatory agency with jurisdiction over Medicaid or Medicare programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501 and CFR 506, and therefore the member's explicit consent is not required for the release of such records and information to VNS Health. However, the member's authorization to allow VNS Health to review records is also obtained by VNS Health at the time of the member's enrollment.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of six years after the last visit date or, in the case of minor children, for six years from the age of majority for New York State programs and 10 years for Medicare programs and for New York State of Health (NYSOH) enrollees.

4.8 • Fraud and Abuse Prevention

VNS Health is committed to preventing and detecting any fraud, waste, or abuse in the organization, related to Federal and State health care programs. To this end, VNS Health maintains a vigorous compliance program and strives to educate our workforce, members and providers on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments.

All VNS Health employees, board members, administrators, members, providers, volunteers, and those with which we do business are required to comply with the organization's Compliance Program.

Submitting False Claims

VNS Health prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. Such a submission is a violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a Federal statute that allows private citizens to help reduce fraud against the United States

government. In addition, in New York State the submission of a false claim can result in civil and criminal penalties under portions of the New York Social Services Law and Penal Law.

What Can You Do to Promote a Culture of Compliance?

- **Commit to “Doing the Right Thing”**
- **Obey** the regulations and policies that apply to you
- **Put** the VNS Health Code of Conduct in an accessible spot
- **Lead** by example
- **If** in doubt, check it out
- **Attend** training sessions
- **Notify** your supervisor of possible wrongdoings
- **Communicate** openly and honestly
- **Ethics** is part of all activities

Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) introduced incentives for the States to enact False Claims Act statutes and established compliance program and educational requirements for health care entities that receive \$5 million or more annually in Medicaid reimbursement or payments (including VNS Health). Because compliance with the DRA provisions is a condition of payment, entities that do not update their compliance policies and educational materials risk otherwise qualified reimbursement and potential False Claims Act liability.

Specifically, Section 6032 of the DRA provides that any entity that makes or receives at least \$5 million in annual payments under a State Medicaid program must undertake certain measures. These measures include:

- Establishing written policies for all of their employees that furnish information on the federal False Claims Act, federal administrative remedies under that act, applicable State false claims acts, and whistleblower protections under these laws.
- Including provisions as part of those policies in the entity's policies and procedures for:
- Detecting and preventing fraud, abuse, and waste.

- Including in employee handbooks and provider handbooks a specific discussion of these various laws, the rights of employees to be protected as whistleblowers, and the entity's policies for detection and prevention of fraud, abuse, and waste.

Federal False Claims Act

The False Claims Act (FCA) permits any person who discovers a fraud on federal government to report it through the law's specialized procedures. If the government collects from the fraudulent contractor, it permits the whistleblower to share in the proceeds. Source: [usdoj.gov/opa/pr/2002/December/02_civ_720.htm](https://www.usdoj.gov/opa/pr/2002/December/02_civ_720.htm).

The FCA is the major law utilized to “ferret out fraud against the federal government.” It was enacted during the Civil War to “control fraud” in federal contracts” and was subsequently amended in 1986 to encourage whistleblower protection.

The law contains two sections highly relevant to whistleblowers. The first is a qui tam provision which permits private citizens and “original sources” (i.e., whistleblowers) to file suit on behalf of the United States to recover damages incurred by the federal government as a result of contractor fraud or other false claims. In return for filing the suit, the whistleblower is entitled to a sizable portion of the proceeds, should they prevail. The whistleblower can obtain a large monetary award if he or she follows the “complex” procedures set forth in the FCA when seeking to enforce the anti-fraud law.

The second section contains an anti-retaliation provision that prohibits the discharge or harassment of a whistleblower who makes FCA-protected disclosures or files a qui tam suit. The anti-retaliation section permits the whistleblower to file a wrongful discharge suit for double back pay and other damages. The anti-retaliation provision was modeled after other whistleblower laws and operates under the basic principles underlying employment discrimination cases.

Risk Management Program

The Risk Management Process is concerned with reducing, preventing, and eliminating situations that could lead to member risk and/or monetary loss. The Risk Management Program is an ongoing, integral component of the Quality Assessment & Improvement Program. It is designed to identify and resolve potential and/or actual administrative, clinical, and service-related risk issues of the organization.

Issues that have the potential to cause immediate and/or significant adverse health outcomes(s) may be referred to the Medical Director for review. The Chief Medical Officer or designee, using an educational approach, will collaborate with the provider to develop and document a Corrective Action Plan (CAP) addressing the areas of concern for the provider to implement clinical issues that result in individual provider monitoring will also be considered during re-credentialing. Providers who are noncompliant with required corrective action(s) may be subject to further action(s). A decision to suspend or terminate a VNS Health participating provider is subject to approval by the Quality Improvement Committee of the Plan. If the provider is suspended or terminated, he or she has the right to appeal the decision.

SECTION 5: Primary Care

5.1 • Responsibilities of a Primary Care Provider (PCP)

Selecting a Provider

All members of VNS Health Health Plan (Medicare products) and SelectHealth from VNS Health must choose a participating primary care provider (PCP). Upon enrollment, every member selects a PCP from the VNS Health Health Plan Provider Directory.

For members of SelectHealth from VNS Health, every participating PCP servicing HIV-infected members must be an HIV-specialist who has met the criteria of one of the following recognized bodies: (a) The HIV Medicine Association (HIVMA) definition of an HIV-experienced provider, (b) HIV-Specialist status accorded by the American Academy of HIV Medicine or (c) Advanced AIDS Credited Registered Nurse Credential given by the HIV/ AIDS Nursing Certification Board (HANCB).

If a member of VNS Health Total or SelectHealth from VNS Health does not choose a PCP within 30 days of enrollment notification, Contact Center agent will assign a PCP to the member.

Enrollees in the VNS Health Managed Long Term Care Plan are not required to select a PCP; however, their physician or Nurse Practitioner must be willing to work with the plan. All non- MLTC Members may change their designated PCP at any time by contacting contact Center Shared Services at the telephone number for their plan (see page 3). Members will receive a new ID card with updated PCP information.

Specialty Care Providers as Primary Care Providers (PCP)

A Specialty Care Provider may act as the PCP for a member with a life-threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member or the member's PCP may initiate the request for the specialist to act as the member's PCP. Such requests should be made to the Utilization Management Department.

Member to Provider Ratios

PCPs agree to adhere to the member-to-PCP ratios referenced in the Provider Agreement that governs their relationship with VNS Health Health Plans (Individual Provider or Hospital). These ratios are for Medicaid enrollees only, are VNS Health Health Plan -specific, and assume that the PCP is a full-time equivalent (FTE) defined as a provider practicing 40 hours per week for SelectHealth from VNS Health. These ratios will be prorated for PCPs that represent less than an FTE to VNS Health Health Plans.

HIV Specialist PCP assigned member ratios are based on a 40-hour work week full-time equivalent (FTE). HIV Specialist PCP physicians and nurse practitioners may have no more than 350 SNP members per FTE. A physician HIV Specialist PCP practicing with a physician extender may have no more than 500 SNP members per FTE. Assigned member ratios are prorated for HIV Specialist PCPs with fewer than 40 hours per week.

Minimum Office Hours

A SelectHealth from VNS Health PCP must practice a minimum of 16 hours a week at each primary care site.

Providers must promptly notify VNS Health Health Plans of changes in office hours and location as soon as this information becomes available, but no later than three business days after the change takes effect.

The minimum office hour requirement may be waived under certain circumstances. Please contact the VNS Health Health Plans Provider Service Department at the telephone number listed in Introduction of this provider manual for further information.

5.2 • Primary Care Panels and Member Enrollment Rosters

VNS Health members select a primary care physician (PCP) at the time of enrollment. PCPs can receive enrollment rosters indicating the VNS Health members assigned to their panel each month by calling our Provider Service department. In addition to that, the provider can also reach out to their designated Provider Relations account manager and request a copy of their

roster.

The enrollment roster contains demographic information for each member in the provider's panel and also reflects the VNS Health product the member is enrolled in. Each time a VNS Health member visits their PCP, the eligibility verification steps outlined in Section 3.1 should be followed.

5.3 • Preventive Care Standards

VNS Health provides its members with access to routine and preventive healthcare services; these services are provided and coordinated by the member's PCP. Direct access to a women's health specialist is provided within the network for routine and preventive women's healthcare services. Adult routine physicals and screenings are recommended according to age and risk factors.

Please note: VNS Health Total members do not require a referral to obtain an influenza or pneumococcal vaccine. Additionally, there is no copayment for administering the influenza or pneumonia vaccine. Participating SelectHealth providers serving members living with HIV must comply with professional medical standards of practice, the Contractor's practice guidelines, and all applicable federal, state, and local laws. These include but are not limited to, standards established by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the U.S. Task Force on Preventive Services, and the New York State Child/Teen Health Program. These standards and laws recognize that Family Planning counseling is an integral part of primary and preventive care.

SECTION 6: Delegated Vendor Operations

6.1 • Description of the Network

VNS Health has participation agreements with a broad network of providers and other licensed professionals, community agencies, inpatient and outpatient facilities that specialize in the management of behavioral health issues and the treatment of mental health and chemical dependency diagnoses. The Delegated Vendor Operations Department specializes in maintaining the relationship with these contracted third-party vendors.

In addition to Behavioral Health, VNS Health is contracted with vendors for claims payment, dental, vision, and non-emergent transportation.

6.2 • Delegated providers

Carelon Behavioral Health

Carelon Behavioral Health manages the Behavioral Health and Substance Abuse benefits on behalf of VNS Health Easy Care, Easy Care Plus, Total, and SelectHealth. Carelon Behavioral Health has been delegated to manage the following services: appeals, claims processing and payment, credentialing and recredentialing, customer service, network development and management, and utilization management. For more comprehensive information on Carelon providers, please use this link:

carelonhealthoptions.com/providers/carelon/

Healthplex

Healthplex provides in-network only dental and administrative services on behalf of VNS Health Easy Care, Easy Care Plus, Total (Medicaid only), MLTC, and SelectHealth lines of business. Healthplex is delegated to manage the following services: appeals, claims processing and payment, credentialing and recredentialing, customer service, network development and management, and utilization management. All dentists will receive a Healthplex provider manual and the appropriate forms when they contract with Healthplex. For additional information: healthplex.com/provider

Superior Vision

Superior Vision is a specialty health benefits company that manages routine (wellness) exams and eyewear. Superior Vision is delegated to complete claims processing and payments, customer service, and credentialing and re-credentialing on behalf of VNS Health Easy Care, Easy Care Plus, Total, MLTC, and SelectHealth lines of business. For additional information:

superiorvision.com

ModivCare

ModivCare, the largest non-emergency medical transportation company in the country, is responsible for managing non-emergency medical transportation for VNS Health Easy Care, Easy Care Plus and Total members. ModivCare works with a variety of modes of transportation, including public transportation, rideshare, livery sedan, wheelchair, van, or non-emergent ambulance—to coordinate transport. For more information: modivcare.com

Availity

Availity, a Cognizant company, is the third-party administrator for VNS Health performing a comprehensive suite of administrative services on the Plan's behalf, including billing, capitation, claims payment, and enrollment/disenrollment. For more information: availity.com/web/welcome

- Consult the VNS Health Health Plan Medical Management staff to obtain required authorization for services.
- Collaborate with the member's PCP and Medical Management staff to ensure continuity of care and appropriate services.

Role of VNS Health MLTC in Nursing Homes

As a managed long term care plan, VNS Health is responsible for nursing home care that is traditionally covered by Medicaid. As the payer, VNS Health must play a significant role in the ongoing management of a nursing home stay.

Regulatory Compliance

VNS Health is bound by Medicaid and Medicare regulations. Consequently, the nursing home will be asked to provide the most recent State DOH, CMS and/or other regulatory/accreditation surveys on an annual basis. If there are ever any regulatory sanctions that prohibit Medicaid or Medicare admissions, VNS Health must be notified at once.

Coordination of Care

During the nursing home stay, Care Managers continue to play a role in monitoring the member's care and status. A VNS Health nurse Care Manager will contact our member and review the plan of care. They may request to speak to nursing home staff and attend the care planning meeting for their member. Regardless of whether the admission is from a hospital or directly from the community, the VNS Health Care Manager plays a significant role in the admission process and is the point person for ongoing communication regarding the member's specific health needs.

Any Hospital Admission or Other Significant Change

VNS Health must be contacted if there are any significant changes to a member's status (hospital admission, discharge AMA, or death). Care Managers continue to monitor their patients if there is a hospital admission.

The nursing home MUST contact the Care Manager or VNS Health immediately so that they can be involved and make any decisions or authorizations needed such as bed hold for the member.

Services and Reimbursement

VNS Health is contracted with the nursing home and pays for the same set of services that are required under Medicaid. The program acts as the payer in the place of Medicaid. VNS Health generally follows Medicaid rules for payment. For example:

- Bed hold: The same timeframes and notification processes apply, but communication is with the VNS Health Care Manager.
- Effective January 1, 2006, pharmacy services are no longer a covered benefit in the VNS Health program.

NAMI and Medicaid Recertification

VNS Health will continue to collect any Medicaid surplus for its members until the member's placement becomes permanent, i.e., a custodial stay. VNS Health will coordinate with the nursing home's billing department regarding the timing and amount of the NAMI, and payments will be adjusted accordingly. Upon placement, the nursing home should follow through with the conversion packet for Institutional Medicaid with HRA. VNS Health manages all Medicaid recertification activity with HRA and will coordinate with the nursing home for any necessary information.

Nursing Home Admission Procedures

It is the goal of VNS Health to care for members in the home for as long as it is clinically appropriate to do so. However, we recognize that for some members, nursing home services are appropriate following a hospital stay or as a long-term care placement. The following procedures have been developed to ensure that the nursing home has the information it needs to admit a VNS Health member, and to facilitate a smooth transition for our members and their families during this stressful time.

If the member is being admitted directly from the hospital:

- The VNS Health Care Manager works with the hospital discharge planner to identify a nursing home in the VNS Health Provider Network that is appropriate to meet the member's needs. The member and family must agree to the placement and the choice of facility.

- The hospital's discharge planner will check with the nursing home to be sure that an appropriate bed is available for the member.
- The hospital staff completes the PRI and forwards it to the nursing home.
- The nursing home reviews the PRI and assigns the member to a floor and bed that is appropriate for his/her needs.
- Upon hospital discharge, the hospital arranges transportation to the nursing home and informs the nursing home that the member is coming.
- The nursing home follows its standard admission process. The member must be seen by a physician within 48 hours of admission to the nursing home.
- The Care Manager will contact the nursing home within one week to discuss the member plan of care. During this call or visit, the Care Manager will talk with the nursing home's staff and will establish a communication plan for ongoing care management.

If the member is being admitted directly from the community:

- The VNS Health Care Manager works with the member and his/her family to identify a nursing home in the VNS Health Provider Network that is appropriate to meet the member's needs. The member and family must agree to the placement and the choice of facility.
- The Care Manager will check with the nursing home to be sure that an appropriate bed is available for the member.
- The care manager request PRI be completed by a partnering vendor.
- The nursing home reviews the PRI and assigns the member to a floor and bed that is appropriate for his/her needs.
- On the agreed upon admission date, the care manager assists the family to arrange transportation to the nursing home and informs the nursing home that the member is coming.
- The nursing home follows its standard admission process. The member must be seen by a physician within 48 hours of admission to the nursing home.

- The Care Manager will contact the nursing home within one week to discuss the member's plan of care and will establish a communication plan for ongoing care management.

The New York State Money Follows the Person, (MFP)

The Money Follows the Person (MFP) Demonstration is part of Federal and State initiatives designed to rebalance long-term care services and promote consumer choice. As New York State continues to shift the focus of its long-term care systems away from institutional care and towards integrated home- and community-based care, support from the MFP program becomes valuable to Managed Care Organizations (MCOs). Managed Care Organizations and Money Follows the Person share the common goals of promoting choice, enhancing quality of life, and expanding options for community-based care delivered in the least restrictive setting.

MFP is designed to streamline the process of deinstitutionalization for vulnerable populations including older adults, individuals with physical, intellectual, and/or developmental disabilities, and individuals with traumatic brain injury. Under the name Open Doors, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home (with a maximum of four unrelated people).

Certain adults with significant medical needs can receive cost-effective home and community-based services to remain in the most integrated settings.

As NYS Medicaid transforms itself into a system of care management for all consumers, MFP becomes an essential and valuable partner in helping MCOs to meet their goals.

The New York State MFP Demonstration grant is awarded by the Centers for Medicare and Medicaid Services (CMS) under Section 6071 of the Deficit

Reduction Act of 2005. The Affordable Care Act of 2010 extended the MFP Program through 2020.

The primary objective of MFP involves increasing the use of home and community-based services and reducing the use of institutionally based services. MFP also strives to eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds for home and community-based services; strengthen the ability of Medicaid programs to provide home and community-based services to people who choose to transition out of institutions; and support procedures to provide quality assurance and improvement of home and community-based services. The program's goals serve a dual purpose of empowering individuals to lead more integrated lives while simultaneously lessening the economic impact that traditional institutionally based care settings often place upon the long-term care system. The New York MFP Demonstration has partnered with multiple New York State governmental entities to ensure that vulnerable persons have access to home and community-based services. To date, over 1,500 New Yorkers have successfully transitioned via New York State's MFP Dem.

7.3 • Pharmacy

VNS Health Medicare beneficiaries will obtain all covered medications using the MedImpact Pharmacy Network. VNS Health offers a very comprehensive formulary that addresses all medically necessary drugs. VNS Health's formulary can be accessed at VNSHealth.org.

For SelectHealth from VNS Health beneficiaries: Starting April 1, 2023, prescriptions will not be covered by SelectHealth. They will be covered by Medicaid NYRx, the New York State Medicaid pharmacy program. All providers need to be enrolled with NYS Medicaid to provide services to SelectHealth beneficiaries.

Medications Requiring Prior Authorization

Certain medications require authorization to determine if their use follows acceptable medical practice or if they are being taken for a covered condition before they are dispensed to members. In some cases, clinical documentation is necessary to review medication requests. VNS Health reviews all requests promptly and follows Medicare and Medicaid requirements when applicable in communicating decision to the physician or, when applicable, to the member.

For VNS Health Medicare beneficiaries, for a list of medications requiring prior authorization, please refer to the VNS Health's formulary which can be accessed at VNSHealth.org.

For SelectHealth beneficiaries, for a list of medications requiring prior authorization, please refer to NYS FFS Reimbursable Drug List which can be accessed at the following link: <https://www.emedny.org/info/fullform.pdf>.

To obtain authorization for one of these medications, providers should call the below telephone number:

- For VNS Health Medicare beneficiaries: 1-888-672-7203 (MedImpact).
- For SelectHealth beneficiaries: 1-877-309-9493 and select option “1” for prescriber (NYRx). The clinical call center is available 24 hours a day, 7 days per week.

Complete the general prior authorization form for the medication and fax it to the fax number listed on the forms:

- For VNS Health Total beneficiaries: <https://www.vnshealthplans.org/wp-content/uploads/2020/07/VNSNY-CHOICE-Coverage-Determination-Form.pdf> complete form for the medication and fax to 1-858-790-7100. Providers can also complete the process by visiting <https://www.covermy meds.com/main/>.
- For SelectHealth beneficiaries: https://newyork.fhsc.com/providers/pa_forms.asp Complete the general prior authorization form for the medication and fax to 1-800-268-2990 (NYRx). Providers can also complete the process by visiting [covermy meds.com/main/](https://www.covermy meds.com/main/).

Providers are encouraged to call for prior authorization to expedite the review process and allow for transition coverage where applicable.

Formulary exceptions

A provider may determine that a member requires a non-covered prescription in certain cases. When this occurs, the provider may request an exception from the formulary by calling

- For VNS Health Medicare beneficiaries: 1-888-672-7203 (MedImpact)
- For SelectHealth beneficiaries: 1-877-309-9493 and select option “1” for prescribers (NYRx). The clinical call center is available 24 hours a day, 7 days per week. Providers can complete the form for the medication and fax it to the number listed on the form.
- For VNS Health Medicare beneficiaries: vnsnychoice.org/wp-content/uploads/2020/07/VNSNY-CHOICE-Coverage-Determination-Form.pdf complete form for the medication and fax to 1-858-790-7100.

Providers can also complete the process by visiting <https://www.covermy meds.com/main/>.

- For SelectHealth beneficiaries: https://newyork.fhsc.com/providers/pa_forms.asp. Complete the general prior authorization form for the medication and fax to 1-800-268-2990. (NYRx). Providers can complete the process by visiting [covermy meds.com/main/](https://www.covermy meds.com/main/).

OTC Medications

For VNS Health Medicare beneficiaries who need to purchase OTC products, please advise members to present their OTC card to their pharmacist. Please refer to OTC catalogue for covered items at <https://www.vnshealthplans.org/> and refer to the OTC catalogue from the respective plan your member is enrolled in.

For SelectHealth beneficiaries who need to purchase covered OTC medications, please refer members to NYRx formulary: <https://www.emedny.org/info/fullform.pdf>.

Medicare Part B Medications

Generally, Part B covers drugs that usually are not self-administered. These drugs can be given in a doctor's office as part of their service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection. If the injection usually is self-administered or is not given as part of a doctor's service, Part B generally won't cover it, but Medicare drug plan (Part D) may cover these drugs under certain circumstances. For list of Medicare Part B medications that may be on the list of covered drugs please refer to the VNS Health's formulary which can be accessed at [VNSHealth.org](https://www.vnshealth.org).

If the Medicare Part B medication is not found on the formulary to obtain authorization, providers should call Medical Management at 1-866-783-0222, Monday to Friday, 8am – 5 pm.

SECTION 8: Medical Management

8.1 • Program Overview

The VNS Health Medical Management Department has been designed to maximize the quality care delivered to VNS Health members. The program focuses on assisting providers in planning for, organizing, and managing the healthcare services provided to VNS Health members to promote member health and well-being. Information and data collected through medical management procedures are used by the Medical Management department to properly allocate resources and to foster efficient and effective care delivery.

The Medical Management department emphasizes collaboration with network providers, contracted vendor organizations, and other VNS Health staff to ensure that high-quality healthcare is provided at the most appropriate level by the most qualified panel of providers.

The Medical Management department is responsible for the following areas:

- Care Management and Coordination
- Authorization and Notification Processes
- Continuity of Care

8.2 • PCP Directed Care

VNS Health endorses the philosophy that clinical care is best rendered when a member's PCP is given the authority and responsibility for coordinating the overall healthcare of a member.

Providers of VNS Health Medicare and SelectHealth members do not need to submit referrals to VNS Health for approval when referring to participating specialists in the VNS Health network.

Please be sure that you are referring members to VNS Health network physicians, ancillary facilities, and providers. If a required specialty is not represented in VNS Health's Provider Directory or Directory Addendum, call

VNS Health Health Plan's Medicare Provider Services Department at the telephone number listed in the Introduction of the provider manual. However, there are no non-emergent, out-of-network benefits for any plan, and the provider must obtain approval from VNS Health Health Plan's Medical Management department if the provider wishes to refer a member to a non-participating provider.

General Guidelines

The following guidelines may assist in ensuring referrals are appropriately managed:

Members should be referred to in-network specialists who can best communicate with the member in accordance with the principles of cultural competence. This is to ensure optimal communication between providers and members of various racial, ethnic, and religious backgrounds, as well as disabled individuals. For example, members should be referred to in-network specialists who speak the member's language when the member does not speak or understand English. The Provider Directories provide data on languages spoken by the provider, as well as other relevant information.

If possible, the PCP, OB/GYN, or the office staff should assist the member in making appointments with in-network specialists and should provide directions to the specialist's office. This is important for ensuring member compliance with specialty referrals and for obtaining prompt access to specialty services for members requiring urgent care. MLTC members and certain Medicare members are entitled to transportation assistance.

8.3 • Referrals

VNS Health Medicare Plans

No referral is required for a VNS Health member to see a specialist in our network. Please be sure that you are referring members to VNS Health Health Plan's network physicians, ancillary facilities, and providers.

SelectHealth Special Needs Plan

Upon determination that specialty care is required, a PCP or appropriate staff, may use the VNS Health Provider Directory to identify a network specialty provider and directly schedule an appointment. Alternatively, PCPs or appropriate staff, may contact us to coordinate and schedule the visit. We will schedule the referral on behalf of the PCP/office and communicate the appointment information to the member. Generally, this service is restricted to use with private specialty providers, as referrals to hospital-based specialty clinics are most efficiently processed by HIV clinic based administrative staff.

Referring providers should ensure that all necessary clinical information is forwarded to the consulting specialist in advance of the member's scheduled appointment.

Referrals to Specialty Care Centers

Members with a life-threatening, degenerative or disabling disease, or condition which requires prolonged specialized medical care, may be referred to an accredited or designated specialty care center. Every effort should be made to refer the member within our Health Plan provider network. These referrals are made pursuant to a treatment plan developed by the specialty care center and approved by VNS Health in consultation with the PCP (or specialist provider approved by the Health Plans to coordinate a member's primary and specialty care) and the member or the member's designee.

Specialist as Coordinator of Primary Care

Members with a life-threatening, degenerative, and disabling disease, or condition which requires prolonged specialized medical care, may receive a referral to a specialist who will then function as the coordinator of primary and specialty care for that member. These referrals are made in consultation with the PCP or specialist provider approved by VNS Health to coordinate a member's primary and specialty care, and the member or the member's designee.

If the specialist does not meet the qualifications of an HIV Specialist, a co-management model will be employed in which an HIV Specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist.

Direct Access for OB/Gyn Care

Female members have direct access to primary and preventive obstetrics, gynecology services and follow-up care as a result of a primary and preventive visit and any care related to pregnancy from our Health Plans OB/Gyn network providers without a referral from the PCP.

Self-Referrals

Members may self-refer for the following services:

- Unlimited self-referrals to an in-network provider for an initial evaluation for outpatient behavioral health and substance use. A treatment plan is developed during the initial evaluation and shared with SelectHealth.
- Routine refraction for vision services.
- Diagnosis and treatment of tuberculosis by public health agency facilities.

Family planning and reproductive health services.

Family planning services include but are not limited to emergency contraception and follow up, sterilization and abortion. Members may receive HIV counseling, HIV testing, referral, and partner notification services as part of the family planning visit. Other HIV pre- and post-test counseling may be performed regardless of whether the provider participates in the VNS Health Health Plans network. Enrollees may receive family planning services from any qualified Medicaid provider regardless of whether the provider is a participating or a non-participating provider without a referral from the member's PCP and without approval from VNS Health.

Managed Long Term Care (MLTC) Plan

Upon enrollment, every member is assigned to a Health Plan Care Management Team (a nurse or social worker along with care management navigators). The Care Management team works closely with the member, his/her family, and physician to develop a plan of care, which includes all required covered services and medical services. The Care Management team helps members obtain these services from network providers, including making appointments and arranging for transportation.

Specialty Care

VNS Health MLTC Care Management team coordinates the member's medical, home- and community-based services. The plan of care is developed in collaboration with the member, providers, and an interdisciplinary team.

Physician and hospital services are not part of the MLTC covered services and members may continue to use their existing providers under the Medicare and/or Medicaid programs.

For those services that are MLTC covered benefits, VNS Health MLTC staff will help members obtain these services from network providers, including making appointments and arranging transportation.

Self-Referral Services

Members may self-refer for the following services:

- Dental: Up to two routine dental check-up examinations per year.
- Vision Care: Routine eye exam once a year and eyeglasses every two years.

As with all covered services, it is important that members inform their VNS Health Care Management team of self-referred services.

8.4 • Authorization of Services

Other than for emergency care, providers must obtain prior authorization for all VNS Health Health plans for acute inpatient admissions; selected outpatient procedures and services, including certain ancillary services; and all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist who has received a referral from the PCP who is caring for this member. Requests for authorizations and authorization status is available via the Provider Portal:

<https://www.vnshealthplans.org/provider-portal/>.

The following information must be supplied when requesting prior authorization of services:

1. Member's name and VNS Health Health Plan ID number
2. Attending/requesting provider's name and telephone number
3. PCP's name (if not the attending/requesting provider)
4. Diagnosis and ICD-10 Code
5. Procedure(s) and CPT-4 Code(s) and procedure date(s)
6. Services requested and proposed treatment plan
7. Medical documentation to demonstrate medical necessity
8. For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay

Please be sure that ALL the listed information above is included when you submit a prior authorization request. If you are calling in the request, please have the information available when you call the Health Plan.

Services Requiring Prior Authorization

- All elective and urgent inpatient admissions
- All Skilled Nursing Facility (SNF) admissions
- All Rehabilitation facility admissions
- All subacute admissions
- All out-of-network services
- All potentially cosmetic procedures
- All procedures considered experimental /investigational that are required by Medicare to be covered services

- All transplants and all transplant evaluations

Certain durable medical equipment, prosthetics, orthotics, and supplies

- Home Infusion Procedures/services

Concurrent and Retrospective Authorizations

VNS Health Health Plan process Concurrent Review Requests for home health care services following an inpatient admission. Retrospective reviews are used to authorize health care services already provided, that could not be reviewed in the usual preauthorization process. SelectHealth makes a utilization review determination involving health care services which were already delivered within 30 days of receipt of the necessary information.

A standard decision will generally be rendered within 14 days of being requested. The plan is allowed a 14-day extension if the time is needed to review additional documentation.

For VNS Health MLTC Members

Prior Authorization and Concurrent Reviews – Expedited and Standard

A. Service Authorization Requests

The plan makes a service authorization determination as fast as the member's condition requires and no more than:

- Expedited: 72 hours after receipt of the Service Authorization Request, subject to extension
 - If the request for an expedited review is denied, the plan processes the request under the standard review timeframe.
- Standard: Three business days after receipt of the necessary information, but not greater than 14 days after receipt of the Service Authorization Request, subject to extension.

B. Concurrent Review Service Authorization Requests

The plan makes a concurrent review service authorization determination as fast as the member's condition requires and no more than:

- Expedited: One business day after receipt of necessary information, but no more than 72 hours after receipt of the service authorization request, subject to extension.
 - If the request for an expedited review is denied, the plan processes the request under the standard review timeframe.
- Standard: One business day after receipt of necessary information, but no more than 14 days of receipt of the service authorization request, subject to extension

C. Service Authorization Extensions

The plan extends a service authorization request's timeframe up to 14 calendar days when requested by the member or provider (written or verbal), or the plan requires additional time to determine medical necessity and can demonstrate how the extension is in the member's best interest.

For VNS Health Medicaid and Medicare Advantage Members

Standard requests are processed as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for Standard Organization Determination. Medicare Part B drugs are processed no later than 72 hours after the date the organization receives the request.

Expedited Determinations may be requested when the enrollee or his/her physician believes that waiting for a decision under standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. The health plan must automatically provide an expedited determination if a physician indicates, orally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee.

Expedited determinations must be made as expeditiously as the enrollee's health requires, but no later than 72 hours after receiving the request or 24 hours for Medicare Part B drugs.

The Medicare health plan may extend the time frame up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. Medicare Part B drug requests are not subject to extensions.

For SelectHealth Members

A request for an expedited review of a service can be made when SelectHealth or the service provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member can also request an expedited review. The decision on whether to expedite is made within one business day of receipt of the request for an expedited review and the member and service provider are notified by phone and in writing.

If the request for an expedited review is denied, SelectHealth handles the request under the standard review timeframe.

Please be sure that ALL the information at the beginning of this subsection (8.4) is included when you fax a prior authorization request. If you are calling in the request, please have the information available when you call the Health Plan.

Please note timeframes below for SelectHealth are as follows:

Prior authorization requests:

- Expedited within 72 hours
- Standard three business days after all information received but not more than 14 days
- Homecare after inpatient stay one business day after all info but no more than 72 hours; 72 hours if the next day is a Friday or holiday
- Pharmacy 24 hours; immediate auth for 72-hour emergency supply; immediate access to 5-day supply for SUD treatment medication; immediate auth of 7-day supply for opioid withdrawal/ stabilization

Concurrent Review:

- Expedited one business day after all info but no more than 72 hours.
- Standard one business day after all info but no more than 14 days.

Retrospective Review within 30 days of all information. Notice is mailed to member on date of decision.

If SelectHealth fails to make a decision within the timeframes advised above, the decision will be deemed an adverse determination which is automatically subject to appeal.

A written notice of an adverse determination (initial adverse determination) will be sent to the member and provider and will include:

- The reasons for the determination including the clinical rationale if any.
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
- Notice of the availability, upon request of the enrollee or the enrollee's designee of the clinical review criteria relied upon to make such determination.

The notice will also specify:

- What, if any, additional information must be provided to, or obtained by, the managed care organization (MCO) to render a decision about the appeal
- A description of action to be taken
- A statement that the MCO will not retaliate or take discriminatory action if appeal is filed
- A process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review
- Notice of the enrollee's right to contact NYSDOH, with a 1-800 number, regarding their complaint
- Fair Hearing notice, including right to aid continuing

- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

SelectHealth may reverse a pre-authorized treatment, service, or procedure on retrospective review under the following conditions:

- Relevant medical information presented to the MCO or utilization review (UR) agent upon retrospective review is materially different from the information that was presented during the pre-authorization review.
- The information existed at the time of the pre-authorization review but was withheld or not made available.
- The MCO or UR agent was not aware of the existence of the information at the time of the pre-authorization review.
- Had the MCO or UR agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

For adverse determinations rendered without provider input, the provider has the right to re-consideration. The reconsideration occurs within one business day of receipt of the request and is conducted by the member's health care provider and the clinical peer reviewer making the initial determination.

For Delegated Vendor Services

Carelon Health Options:

General provider handbook: Carelonhealthoptions.com

(Utilization Management starts on page 48)

HARP program specific provider handbook: network/nyc_health_plans/NY-HARP-Provider-Manual.pdf

MedImpact:

mp.medimpact.com/mp/public/Login.jsp

Healthplex:

healthplex.com/doc/no/HEALTHPLEX_PROVIDER_MANUAL

8.5 • Out-of-Network-Services

Authorizations for services from a non –contracted provider should only be requested in situations where a contracted provider is not available (I.e., specialty care is not available within the network or in continuity of care situations.

VNS Health MLTC

VNS Health MLTC has a network of providers available to meet its members' needs. It is recognized, however, that under defined circumstances, members may need to utilize out-of- network providers for covered services.

Members may not elect to use a non-participating provider unless no such provider exists in the network, or the network providers are unable to provide the service. In all such cases, when VNS Health MLTC is the primary payer, the member must get prior approval before accessing out-of- network services. The member needs to consult with his/her Care Manager who will coordinate the referral with the non-participating provider, health plan, and member's physician (if appropriate), incorporate it into the approved treatment plan and document appropriately to ensure proper follow-up and payment.

When an approved referral to an out-of-network provider for covered services is made, VNS Health MLTC will enter into a letter of agreement (LOA) with the provider to specify payment terms, period of coverage, quality assurance measures and rates

VNS Health MLTC has an established policy and procedure that specifies those instances in which a referral to an out-of-network provider for covered services may be made, including:

- Continuation of care
- Emergent/urgent care
- Clear and compelling medical service need that can only be met by an out-of-network provider.
- Provider in the process of being contracted
- Required network inadequacy covered services which Medicare is the primary payer

VNS Health Medicare

VNS Health Medicare has a network of providers available to meet its members' needs. It is recognized, however, that under defined circumstances, members may need to utilize out-of-network providers for covered services.

Members of VNS Health Total may not elect to use a non-participating provider unless no such provider exists in the network or those in the network are unable to provide the service. In all such cases, when a VNS Health Medicare is the primary payer, the member must get prior approval before accessing out-of-network services. The member should consult with his/her Coordinated Care Manager who will coordinate the referral with the non-participating provider, health plan, and member's physician (if appropriate), incorporate it into the approved treatment plan and document appropriately to ensure proper follow-up and payment.

When an approved referral to an out-of-network provider for covered services is made, VNS Health Medicare will enter into a letter of agreement (LOA) with the provider to specify payment terms, period of coverage, quality assurance measures and rates.

VNS Health Medicare has an established policy and procedure that specifies those instances in which a referral to an out-of-network provider for covered services may be made, including:

- Continuation of care
- Emergent/urgent care
- Clear and compelling medical service need that can only be met by an out-of-network provider
- Provider in the process of being contracted
- Additional service capacity needed

SelectHealth

If a PCP determines, in conjunction with SelectHealth from VNS Health Medical Management Department, that a specific physician resource is either not available within the network, or that the most appropriate choice of a specialist exists out-of-network, the PCP and/or SelectHealth from VNS Health will make a referral to an appropriate non-participating provider. The resulting treatment plan will be reviewed and approved by SelectHealth from VNS Health in consultation with the PCP, the non-participating provider and the member or the member's designee. Approval from SelectHealth from VNS Health is required for all out-of-network referrals.

8.6 • Transition of Care /Continuation of Care

VNS Health MLTC

Transition of Care is the continuity of care for a member when a practitioner's contract with VNS has terminated or when a newly enrolled member requests to continue under the care of his/her non contracted physician. The following types of situations will be considered for Transitions of Care for up to 90 days if the following conditions are met:

- I. The non- contracted practitioner agrees to continue the member's treatment, and
- II. The member is receiving ongoing health care services for an acute, chronic, or terminal illness, or
- III. The member is an inpatient at the time of provider termination

Transition of care is accomplished on a case-by-case basis, taking into consideration the unique medical requirements of the member. As of a new members effective date, he or she is entitled to full benefits through VNS Health.

Upon enrollment, a member may be under care for audiology, dental services, optometry, or podiatry services with a provider who is not included in the VNS Health network.

The member will be given the option of completing this course of treatment with the current out-of-network provider for a maximum of sixty (60) days or transitioning at the time of enrollment to a VNS Health provider.

The member will be informed of the need to transfer to a network provider upon completion of the current course of treatment, even if there is a medical need for additional services. This transition will take place within sixty (60) days after the enrollment date.

VNS Health will ensure that all required services are available for its members. When a provider leaves the network (either voluntarily or through the termination of a subcontractor) the program will assist members in changing to another service provider.

Members who are in the process of a course of treatment with a provider who is terminating participation in the network may continue to receive care from this provider until the course of treatment is completed, or 90 days, whichever is sooner.

VNS Health will notify members of providers who terminate their participation in the plan within 15 days of learning of the termination.

VNS Health Medicare

Continuation of Care is the process used to review and evaluate authorizations to non-participating providers during a transitional period.

Continuation of Care will be considered in either of these circumstances:

- When a newly enrolled VNS Health member is under active treatment at the time of enrollment with a provider who does not participate in the VNS Health network
- When a current member's healthcare provider has left the VNS Health network (except when the provider was terminated from participation under circumstances involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing

board or other governing agency that impairs the health care professional's ability to practice).

The out-of-network provider must agree to accept VNS Health reimbursement as payment in full and agrees to comply with all of VNS Health UM/QI policies and procedures.

A request for continuity of care may be made utilizing our "Transitional Care Request Form" and must be submitted to our Medical Management Department.

SelectHealth

Members Whose Healthcare Provider Leaves the Network

VNS Health permits members whose provider leaves the plan's network, for reasons other than imminent harm to patient care, or a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with that provide during a transitional period.

The transitional period may continue up to 90 days and begins on the date the provider's contractual obligation to provide services to Select Health members terminates or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care related to the delivery through 60 days post- partum.

During this transitional period, the non-participating provider agrees to:

- Accept reimbursement from VNS Health at rates established as payment in full.
- Adhere to VNS Health's quality assurance requirements and agrees to provide to VNS Health necessary medical information related to such care.
- Otherwise adhere to VNS Health policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by VNS Health.

New Members

If a new member has an existing relationship with a health care provider who is not a member of the VNS Health network, VNS Health permits the member to continue an ongoing course of treatment by the non-participating provider during a transitional period of 60 days from the member's effective date of enrollment if:

- 1) The member has a life-threatening disease or condition or a degenerative and disabling disease or condition.
- 2) The member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall be extended to include the provision of post-partum care related to the delivery.

The non-participating provider must agree to adhere to the conditions outlined in the paragraph "Members Whose Health Care Provider Leaves the Network" above for VNS Health to authorize continuation of care for a new member whose current provider does not participate in the VNS Health network.

8.7 • Hospital Services & Emergency Services

Observation services- Observation care is a well-defined set of specific, clinically appropriate services which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require admission to the hospital.

An emergency services is where a medical condition manifest itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical treatment may result in the following:

- 1) Serious impairment to bodily functions.
- 2) Serious dysfunction of any bodily part or organ.
- 3) Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of an unborn child or woman.
- 4) Emergency services means covered inpatient and outpatient services that are furnished by a provider qualified to provide emergency services and needed to evaluate and treat a medical condition.

Hospital Transfer from Out-of-Network Providers

VNS Health will attempt to coordinate all out-of-network care both locally and out of the service area, including informing the network practitioner. Call the Medical Management Department at the telephone number located in Introduction of this provider manual if you become aware that one of your patients is receiving out-of-network care. If you are called upon to facilitate transfer to an in-network facility for one of your patients, you must provide the necessary medical guidance for a safe transfer. You must notify us of an admission to an out-of-network hospital or to request our assistance with a transfer into our network. To do so, call Medical Management at the telephone number listed in Introduction of this provider manual.

Second Opinions

VNS Health may require that your patient see a physician, determined by VNS Health, for a second opinion. VNS Health reserves the right to require a second opinion for any surgical procedure or healthcare service. There is no formal list of procedures requiring second opinions.

Procedures or services requiring a second opinion will be decided on a case-by-case basis.

Members may request a second opinion relating to the need for surgery or for a major non-surgical diagnostic and therapeutic procedure. Members may obtain a second opinion from a participating provider within the VNS Health network. If the recommendation of the first and second physician differs regarding the need for the surgery or other major procedure, a third opinion from a participating provider shall also be covered.

Notification Requirements for Hospitals

Hospitals are required to provide VNS Health with notification within 24 hours of each admission to verify eligibility, confirm authorization, including level of care.

For emergency admissions, notification should occur once the member has been stabilized in the emergency department or, for members who are not stabilized, within one business day when reasonably feasible based on the member's medical condition and information available. Proper timely notification is required to facilitate communication between VNS Health Medical Management and insure timely and accurate payment of hospital claims upon receipt.

Notification requirements apply whether the emergency and treatment occurred in or out of VNS Health's service area. This notification allows VNS Health's Medical Management Department to assure information is shared as part of transitional care, assure medical necessity, and appropriate care setting and help facilitate the implementation of a transition plan to next level of care in collaboration with the facility designated staff.

Participating hospitals are required to notify VNS Health of updates in status, and the anticipated discharge date at least 48 hours prior. The facility is expected to provide confirmation of member's discharge on the actual day.

Emergency Room Services

An emergency is the sudden or unexpected onset of a condition requiring medical or surgical care, without which a patient could reasonably be expected to suffer serious physical impairment or death using the prudent layperson standard. In an emergency, a member should seek care as soon as possible; there is no requirement for the member to obtain an authorization from his/her physician or from VNS Health. VNS Health distinguishes emergency services from urgently needed services.

Below is a list of urgently needed services and procedures to follow:

When to Use the Emergency Room

It is appropriate for a member to use a hospital emergency room when an emergency condition exists, such as: We should not be calling out any specific dx in the provider manual:

- Heart attack or severe chest pain, in adults

- Stroke
- Severe shortness of breath or difficulty breathing
- Cyanosis
- Hemorrhaging
- Poisonings
- Major burns
- Spinal injuries
- Shock
- Allergic reaction accompanied by swelling of the face or lips, or wheezing in the chest
- Severe or prolonged bleeding from anywhere on the body
- Loss of consciousness
- Severe or multiple injuries
- Sudden change in mental status
- Convulsive seizures
- Other acute conditions that are determined to be emergencies

In-Area Versus Out-Of-Area Emergency Services

In-Area, no authorization is required, however, at the PCP's discretion, the member may be at the hospital, directed to the nearest emergency room, or recommended to be seen in the treating physician's office. In the event the member cannot notify the PCP before seeking care in the Emergency Room, the member should call the PCP as soon as possible after the encounter to advise the PCP of the encounter and to facilitate follow up care.

Out-of-Area coverage is limited to care for accidental injury, unanticipated emergency illness, or other emergency conditions. VNS Health will cover out-of-area emergency room services and urgent care services when they are medically necessary, using a prudent layperson standard.

Notifying VNS Health

Regardless of whether your patient is in or out of the VNS Health service area when the emergency condition begins, the PCP or the member should contact VNS Health as soon as possible, but no more than 48 hours after the onset of the emergency so that we may facilitate any care needed after the

emergency room encounter. If the patient is unable to contact us within 48 hours because of a medical condition, she/he should do so at the earliest possible time.

Coverage

In most cases, hospital emergency room services are covered by VNS Health without an authorization. Additional care after the doctor says it was not a medical emergency will only be covered at the usual coverage if an in-network provider provides the additional care. Follow-up emergency room visits, within VNS Health 's service area, are not covered. Follow-up services are covered when they take place in the PCP's office.

Urgently Needed Services

Urgently needed care is medical care for a condition that needs immediate attention for an unforeseen illness or injury, and it is not reasonable, given the situation, for the member to get medical care from their PCP or other plan provider regardless of whether the member is in the VNS Health service area at the time of service. In these cases, the patient's health is not in serious danger or life threatening.

Members should call their PCP if they think they need urgently needed services. If a member is hospitalized after having received urgently needed services, the member (or someone on their behalf) must contact VNS Health within one business day of the hospital admission.

If a member needs urgent care while outside the plan's service area, we request that he/she call their PCP first, whenever possible. However, urgently needed services will be covered by the plan when the member is away. In addition, VNS Health will cover follow-up care that is provided by non-plan providers outside the plan's service area if the care still meets the definition of "urgently needed care."

Admission to a Skilled Nursing Facility (SNF) and Rehabilitation Facilities
Transfer from hospitals to a SNF or Acute rehabilitation facilities will be facilitated by the hospital discharge planning staff and requires

preauthorization. Supporting documentation is required at time of notification. Member should be directed to an in network or contracted facility.

Readmissions

A readmission is defined as a subsequent inpatient readmission within 30 days after discharge, which is clinically related to the initial admission and is determined to be a potential preventable readmission and is to the same hospital or within the same hospital systems. VNS Health has implemented a process for reviewing inpatient admissions that are deemed to be readmissions.

VNS Health reserves the right to evaluate subsequent admissions as outlined above prior to payment. We will identify which admissions are most likely avoidable or preventable based on billed DRG's as well as the same or similar diagnoses found on the two related hospital claims

SECTION 9: Billing & Claims Processing

9.1 • Member Eligibility

Payment for services rendered is subject to verification that the member was enrolled in VNS Health at the time the service was provided and to the provider's compliance with the VNS Health's UM Care Management and prior authorization policies at the time of service. Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made. Providers must verify member eligibility at the time of service to ensure the member is enrolled in VNS Health. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with VNS Health after the date of service. Therefore, verification of eligibility is not a guarantee of payment by VNS Health.

In certain cases, a managed care plan member, including VNS Health members, may change health plans during a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

9.2 • General Billing and Claim Submission Requirements

Instructions for Submitting Claims

Claims status is available through Provider Portal at:

<https://www.vnshealthplans.org/provider-portal/>. Instructions for claims submission are available on our website. Service providers are responsible for submitting claims to VNS Health. Provider claims should be submitted either on a CMS-1500 form or UB-04 form or the related electronic format (837P or 837I). Claims for non-HIPAA covered services may be submitted on a non-standard form at the approval of VNS Health. For exceptions to the standard form, please contact your Account Manager. Claims may be submitted by mail to the VNS Health Claims Department at the address listed below and in the [Quick Reference Guide](#) found in the Helpful Links on page 4 of this Manual.

- VNS Health MLTC/Total/EasyCare Plus/EasyCare/Select Health: P.O. Box 4498, Scranton, PA 18505
- For electronic submissions: Use VNS Health Payer ID# 77073.

9.3 • Time Frames for Claim Submission, Adjudication and Payment

Timely Filing and Prompt Payment of Claims

- Providers are expected to submit claims within the timelines specified in their contract.
- This will be applied to the date of service (or discharge for inpatient services.) Claims received after the Timely Filing Limit may be denied.
- “Clean Claims,” those submitted fully according to VNS Health standards, will be paid, or denied according to State or Federal Prompt Payment requirements.
- For Medicare lines of business, other claims, including those with incomplete information from non-network providers, will be paid or denied within 60 calendar days.
- Network providers will be paid according to the terms of their contract.
- Non-network providers will be paid according to CMS or New York State Medicaid regulations.
- The prompt payment of your claim is contingent on VNS Health’s receipt of complete and legible claims information. Missing or incomplete information may delay payment.
- All claim submissions must include the providers National Provider Identification (NPI) and Tax ID number on the claim.

Late Claim Submission

In certain circumstances (see chart below), VNS Health will process claims submitted after the time required under the provider’s agreement with VNS Health. Please note that “unclean” claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time required.

The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider’s control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim	Within ninety (90) calendar days from the time the submission came within the provider's control.
Medicare or other third-party processing delays affecting the claim.	Within ninety (90) calendar days from the time the submission came within the provider's control
Original claim rejected or denied due to a reason unrelated to the 180-day rule.	Within ninety (90) calendar days of the date of notification (submit with original EOP)
Administrative delay (enrollment process, rate change) by NYSDOH or other State agencies.	No time frame
Delay in member eligibility determination	Within ninety (90) days from the time of notification of eligibility (submit with documentation substantiating the delay)
Members' enrollment with VNS Health was not known on the date of service.	Within ninety (90) days from the time the member's enrollment is verified. Providers must make diligent attempts to determine the member's coverage with VNS Health

9.4 • Coordination of Benefits (COB)

If a member has coverage with another plan that is primary to VNS Health, please submit a claim for payment to the other plan first. The amount payable by VNS Health will be determined by the amount paid by the primary plan, Medicare secondary payer law and policies, or New York State Medicaid standards for coinsurance payments. Please submit a copy of the primary carrier's Explanation of Payment with your claim to VNS Health. Any cost sharing for a member that is considered Dual Eligible must be billed to Medicaid or other insurer.

You may not bill a member for a non-covered service unless:

- 1) You have informed the member in advance that the service is not a covered service.
- 2) The member has agreed in writing to pay for the non-covered service.

If a member loses their Medicaid eligibility while they are enrolled in a VNS Health “dual- eligible” plan, they will be deemed temporarily eligible to remain in the plan for up to six months because they may regain Medicaid eligibility. During this time, the member can receive the same benefits as any other member. If a participating provider receives a denial from Medicaid for such member’s cost sharing for services provided during this period, the provider will look to the plan for reimbursement. Providers should contact Provider Services to initiate such reimbursement.

9.5 • Explanation of Payment (EOP) / Electronic Funds Transfer (EFT)

The EOP describes how claims for services rendered to VNS Health members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

The EOP shall include the following elements:

- Name and address of payor
- Toll-free number of payor
- Subscriber’s name and address
- Subscriber’s identification (ID) number
- Member’s name
- Provider’s name
- Provider tax identification number (TIN)
- Claim date of service
- Type of service
- Total billed charges
- Allowed amount
- Discount amount
- Excluded charges
- Explanation of excluded charges (denial codes)
- Amount applied to deductible

- Copayment/coinsurance amount
- Total member responsibility amount
- Total payment made and to whom the EOP is arranged numerically by member account number. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:
 - **Paid claim lines:** If the paid amount field reads greater than zero, the claim was paid in the amount indicated.
 - **Denied claim lines:** If the not covered field is greater than zero and equal to the allowed amount, the service was denied.
 - **Claim processed as a capitated service:** If the amount in the prepaid amount field is greater than zero, the service was processed as a capitated service.
 - **End of claim:** Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Electronic Claims Submissions

VNS Health encourages providers to submit clean claims to us electronically. Electronic claims submission can offer you the following benefits:

- More efficient claims payment
- Improved cash flow
- Increased convenience: one universal form to complete for all carriers
- Greater reliability than paper systems
- Decreased postage and mail time
- Reduced paperwork for office staff

9.6 • Claim Inquiries, Claim Reconsideration and Appeal Process

The aforementioned are all available via the Provider Portal at:

<https://www.vnshealthplans.org/provider-portal/>. If you have questions regarding the status of a claim or other inquiries, contact the Provider Services at Department telephone number listed in Introduction of this provider manual. For Member Services, call 1-866-783-0222, Monday to Friday, 8am – 5 pm. TTY users, call 711.

Please have the following information available:

- Provider's name and NPI
- Member's name and members identification number
- Date of service and date of claim submission

Difference between Claim Dispute and Claim Appeal

When to use the Provider Claim Dispute Form ([vnshealthplans.org/provider-claims-dispute-form](https://www.vnshealthplans.org/provider-claims-dispute-form) [dispute-form](https://www.vnshealthplans.org/provider-claims-dispute-form)):

- Coding denials
- Underpaid/overpaid claims
- Invalid procedure code/revenue code/diagnosis code
- Incorrect modifier

The form, instructions on how to use and more detailed Information about filing claim disputes and appeals is available on the VNS Health website at this link: [vnshealthplans.org/health-professionals/claims-billing-and-payments](https://www.vnshealthplans.org/health-professionals/claims-billing-and-payments) .

When to Submit a Claim Appeal:

If your claim is denied and you wish to challenge the decision, you can use the Grievance and Appeal Process. This will lead to an internal clinical or administrative review of the denial.

Examples of appealable denials include:

- Services not authorized
- Not medically necessary
- Non-covered service/benefit

- Benefit exhausted
- Charges previously considered/duplicate
- Claim denied as duplicate

Claims Dispute Process:

Please go to our Claims, Billing and Payments page on our website:

vnshealthplans.org/health-professionals/claims-billing-and-payments-health-professionals-overview/claims-billing-and-payments/

Please go here for complete instructions for submitting a Provider Claim Dispute: wpengine.com/wp-content/uploads/2020/09/Submit-Claims-Instructions.pdf

1. When submitting a disputed claim, you must include an excel attachment. Download the Provider Payment Dispute Template (find the link in the expandable section labeled “How to File a Claims Dispute”) and use that Excel sheet to enter the information listed in each column. We will need it to process your payment dispute. (Note: if you do not see the template right away, check your browser’s download status bar or the download file on your computer.)
2. Attach the file in the field labeled “File upload” when you submit your dispute using this Claim Dispute Form: [vnshealthplans.org/provider-claims-dispute-form form](https://vnshealthplans.org/provider-claims-dispute-form-form).
3. Look for an email confirmation of your submission.

Claim Appeal Process

It is VNS Health’s policy to ensure fair, appropriate resolution and timely handling of providers’ appeals. The provider appeal process and the provider’s contract provide a mechanism by which participating providers may submit appeals resulting from claim denials.

The following applies to claims for each health plan.

Type	Submission Timeframe	Necessary Information to be Provided (in writing*)
Standard reconsideration request of a denial of payment or medical necessity	Please refer to your provider contract	<ul style="list-style-type: none"> • Copy of Denied Claim • Copy of Remittance • Any requested or substantiating documentation not previously provided

***Appeals may be faxed or mailed to the address indicated in Section 10 on page 103 of this manual.**

The following applies to VNS Health MLTC claims.

Appeal Type	Submission Timeframe	Necessary Information to be Provided (in writing*)
Standard reconsideration request for a denial of payment due to Medical Necessity	Please refer to your provider contract.	<ul style="list-style-type: none"> • Copy of denied claim • Copy of remittance • Any requested or substantiating documentation not previously provided.
Requests for a denial of payment due to no authorization, non-covered, benefit exhausted, duplicate submission, etc.	Please refer to billing/claims contact number in the Introduction.	Any requested or substantiating documentation not previously provided.

*** Appeals may be faxed or mailed to the fax or mailing address below:**

All appeals must be submitted within 60 calendar days from the date of the *initial* Explanation of Payment (EOP) or according to the timeframes indicated in the contract of the participating provider’s agreement with VNS Health.

Fax: 866-791-2213

Mail: PO Box 445 Elmsford, NY 10523

Attn: VNS Health Grievance & Appeals Department

Claims Appeal Review Process and Timeframes

VNS Health will thoroughly review the provider's request and all supporting information and documentation.

If additional information is needed, a request will be sent to the provider within 15 calendar days. To resolve the appeal, the provider has 30 calendar days from the date of requested information to submit additional information or the dispute will be closed.

Written determination of the resolution of the appeal will be issued within 60 calendar days of receipt, or for clinical appeals, within 30 days of receiving the necessary documentation to conduct the review, but no later than 60 calendar days. If the resolution requires a claim payment, the payment will be issued within 10 business days of the determination.

If VNS Health decides against the provider, VNS Health will notify the provider in writing as to the rationale for the decision.

9.7 • Overpayments

VNS Health periodically reviews payments made to providers to ensure the accuracy of claim payment pursuant to the terms of the provider contract or as part of its continuing utilization review and fraud control programs. In doing so, VNS Health may identify instances when we have overpaid a provider for certain services. When this happens, VNS Health provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

VNS Health will not pursue overpayment recovery efforts for claims older than 24 months after the date of the original payment to a provider unless the overpayment is

- 1) Based upon a reasonable belief of fraud, intentional misconduct, or abusive billing
- 2) Required or initiated by the request of a self-insured plan
- 3) Required by a state or federal government program

In addition, we may at times apply the procedures described in this section to recoup duplication claims payments but reserve the right to use other procedures to do so. In addition, if a provider asserts that VNS Health has underpaid any claim(s) to a provider, VNS Health may offset any underpayments that may be owed against past underpayments made by VNS Health dating as far back as the claimed underpayment.

If VNS Health has determined that an overpayment has occurred, VNS Health will provide 30 days written notice to the provider of the overpayment and request repayment. This notice will include the member's name, service dates, payment amounts proposed adjustment, and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding or remit payment as outlined below. Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made payable to VNS Health within 30 days from the date of the overpayment notice.

Providers should further include a statement in writing regarding the purpose of the refund check or include the Overpayment Notice with the refund check to ensure the proper recording and timely processing of the refund. **Refund checks should be mailed to:**

VNS Health
220 East 42nd St, 3rd Floor New York, NY 10017
Attention: Claims Payment Integrity/Recoveries

If a provider disagrees with VNS Health's determination concerning the overpayment, the provider must submit a written request for an appeal within 30 days from the date of the overpayment notice and include all supporting documentation in accordance with the provider appeal procedure described above in the previous topic to VNS Health, P.O. Box 445, Elmsford, NY 10523.

9.8 • Submitting Claims for Non-Credentialed Practitioner in a Group Arrangement or for a Non-Credentialed Substitute Practitioner

All providers who are part of a VNS Health contracted medical group – and individually credentialed providers who have a non-contracted provider as part of their group and share a TIN, NPI, specialty/taxonomy code – are considered contracted providers for the purposes of claim payments and are considered “Substitute Practitioners.” Claims for Substitute Practitioner services should be billed by the medical group or by the regular participating practitioner and will be reimbursed at the regular participating practitioner’s contracted fee schedule.

Substitute Practitioners are not required to enroll with the health plan and should not bill the health plan directly.

- Please note the following to ensure your claims for the Substitute Practitioner’s services are documented correctly.
- Claims that include services provided by a Substitute Practitioner or must include the credentialed provider’s billing name, address, and national provider identifier (NPI) in Block 33 of the claim form.
- The name and mailing address of the Substitute Practitioner must be documented in Block 19, not Block 33.
- When billing for a service provided by a Substitute Practitioner physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the Substitute Practitioner.

9.9 • Claims from a Network Hospital Associated with a Non-Network Health Care Provider

VNS Health will not immediately process claims from a network hospital as out of network solely on the basis that a health care provider who is not participating with VNS Health treated the member.

9.10 • Claims from a Network Health Care Provider Associated with a Non- Network Hospital

VNS Health will not arbitrarily process claims from network health care providers as out of network solely because the hospital is not participating with VNS Health.

9.11 • Facility Claim Requirements

Ambulatory Patient Group (APG) Rate Codes

VNS Health pays claims billed with Ambulatory Patient Group (APG) rate codes (and their corresponding CPT codes) for services covered by APG reimbursement. The APG system is the New York State mandated payment methodology for most Medicaid outpatient services. APGs will pay hospital outpatient clinic, ambulatory surgery, and emergency department services when services are reimbursed at the Medicaid rate. APGs will not be used for services that are carved out of Medicaid managed care. Medicaid APG claims should be submitted:

- APG and non-APG services on separate claims
- Report a value code of 24 and an appropriate rate code
- Report CPT codes for all revenue lines

Claims without proper coding will be returned for correction prior to adjudication.

More information on APGs can be found at the New York State Department of Health's website at health.state.ny.us/health_care/medicaid/rates/apg/ as well as the DOH's Policy and Billing Guidance.

Ambulatory Patient Groups (APGs) Provider Manual

health.ny.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual.pdf

For documentation on known APG issues and HIPAA APG requirements, go to eMedNY's website emedny.org/apg_known_issues.pdf and emedny.org/HIPAA/index.html.

"Present on Admission" Indicator for Hospitals

The Deficit Reduction Act of 2005 mandates hospitals to report all diagnosis on a UB-04 (paper claims) or ASC X12N 837 Institutional (837I electronic transmissions) for Medicare and Medicaid patients. To comply with this government program, VNS Health requires a "present on admission" (POA) indicator for the following claims:

- Acute care hospital admissions
- All medical inpatient services
- Substance abuse treatment
- Mental health admissions

Note: Patients considered exempt by Medicare must also have POA indicators noted. If the diagnosis is exempt, enter a value of "1."

Because the HAC-POA payment applies to IPPS (Acute Inpatient Prospective Payment System) hospitals, all the hospitals below are exempt:

- Critical access hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Maryland waiver hospitals
- Long term care hospitals
- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as

defined in Section II of the ICD-10-CM Official Guidelines for Coding and Reporting, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition cannot be coded or reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, the POA indicator should not be billed.

ERM care hospitals

- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the ICD-10-CM Official Guidelines for Coding and Reporting, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.

Present on Admission (POA) Indicator List	
Code	Description
Y	Yes. The condition was present at the time of inpatient admission.
N	No. The condition was not present at the time of inpatient admission.
U	Unknown. The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

Note: Hospitals which are considered exempt by Medicare must also bill a POA indicators. If the diagnosis is exempt, enter a value of "1"–exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

Issues related to inconsistent, missing, conflicting or unclear documentation must be resolved by the practitioner.

More information and coding instructions, including the POA Fact Sheet, can be found on the CMS website

cms.gov/MLNMattersArticles/downloads/MM5499.pdf and cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf.

9.12 • Taxonomy Codes: Definition and Claims Use

Taxonomy codes are administrative codes set for identifying the practitioner type and area of specialization for health care practitioners. Each taxonomy code is a unique 10-character alphanumeric code that enables practitioners to identify their specialty at the claim level.

Taxonomy codes are assigned at both the individual practitioner and organizational practitioner level.

Taxonomy codes have three distinct levels: Level I is the Practitioner Type, Level II is Classification, and Level III is the Area of Specialization. A complete list of taxonomy codes can be found within the Health Insurance Portability and Accountability Act (HIPAA).

Taxonomy codes are self-reported, both by registering with the **National Plan and Provider Enumeration System (NPPES)** and by electronic and paper claims submission.

Taxonomy Codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the provider's assigned NPI number. Current taxonomy codes registered, including any subsequent changes, may be obtained on an inquiry basis by visiting the [NPI Registry website](#).

A practitioner can have more than one taxonomy code, due to training, board certifications, etc. It is critical to register all applicable taxonomy codes with NPPES and to use the correct taxonomy code to represent the specific specialty when filing claims. This will assist VNS Health in a more accurate and timely processing of claims.

Please provide Taxonomy codes on all VNS Health claims. The absence of these codes may result in incorrect payment.

Taxonomy codes on **electronic claim submissions** with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level.

For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier “ZZ” in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the “ZZ” qualifier for the billing level.

9.13 • HHAeXchange for Home Health Services

VNS Health has engaged HHAeXchange, a web-based software solution, for scheduling, communication, and billing of Home Health Services. The HHAeXchange Portal provides a direct connection from the agency to VNS Health for:

- Electronic case broadcasting, authorizations, plan of care management and entering confirmed visits
- Real-time two-way messaging
- Free EVV solution for time, attendance, and duty tracking
- Electronic billing

Billing Options

Based on how your agency currently works with OPS, below are the options you have in working with the HHAeXchange portal:

- Option 1: Entering data directly into OPS: You will be able to enter data directly into the HHAeXchange portal.
- Option 2: Currently using HHAeXchange: You will be able to continue using HHAeXchange, utilizing the system’s Linked Contract functionality.
- Option 3: Currently using another third party solution: Interface specifications will be available at no charge, enabling you to bring your data into the HHAeXchange portal.

Simple Claims Billing and EVV Implementation for VNS Health

VNS Health will be processing claims via a clearinghouse. VNS Health utilizes Availity.com for claims adjudications.

Participation and Additional Information

If you are interested in integration, please reach out to your assigned VNS Health Account Manager. Participation is optional. Additional information is located at: hhaexchange.com/vnshealth.org/

SECTION 10: Grievances & Appeals

10.1 • Provider Notice Requirements – ALL Plans

The objective of VNS Health’s Grievance and Appeals department is to provide practitioners with processes for resolving concerns that relate to service or claims payment. VNS Health manages Appeals in accordance with its policies and procedures, which are based on CMS and NYSDOH regulatory requirements. VNS Health informs each provider of the process and their right to file an appeal according to the plan-type regulatory requirements.

All participating providers must cooperate with VNS Health in the administration of the Grievance and Appeals process.

All VNS Health plans adhere to the following:

- Determinations of all clinical appeals involving clinical decisions are made by qualified clinical personnel.
- All appeals are handled confidentially. If requested, member anonymity is also ensured.
- VNS Health will not retaliate nor take any discriminatory action against a provider because he/she has filed an appeal.
- There will be no change in a member’s services because an appeal has been filed.
- The provider is informed of their option to file an appeal in writing by fax or mail as well the toll-free number to call to file an expedited appeal, and of their right to appeal to the appropriate regulatory agency.

VNS Health will give our providers any help that is needed to file an appeal. This includes interpreter services or help for those with a vision and/or hearing impairment.

Providers may call Member Services and speak to a Member Services Representative to file an expedited and standard service appeals. Claim appeals must be submitted in writing. After hours, the provider may leave a message that will be responded to no later than the next business day.

Member Services Representatives are available to assist in filing appeals, as necessary.

10.2 • Standard Service and Claim Appeals – All Plans

As discussed in section 8.4 and 8.5, a Service Authorization may be requested, however later denied or partially denied. When that happens, appeal rights are provided with the adverse decision. Similarly, submitted claims that were denied or partially denied may be appealed or disputed as described in Section 9.6 of this manual.

Filing an Appeal

When you, as a provider, are not satisfied with the decision we make concerning a service authorization or a claim decision, a second review of the issue can be requested by filing an appeal. As with the original request, you as the provider may request an appeal on behalf of the VNS Health member, with his/her consent. All appeals must be filed within 60 calendar days of our *initial* decision about the request/claim or as otherwise specified in your provider contract. Service appeals may be filed orally or in writing, while claim appeals must be filed in writing.

- Within 15 calendar days of receipt of the appeal, the plan provides a written acknowledgement of the appeal including the name, address and telephone number of the individual designated to respond to the appeal. VNS Health indicates what additional information, if any, must be provided for VNS Health to render a decision.
- Appeals of a clinical matter are decided by personnel qualified to review the appeal including licensed, certified, or registered health care professionals who did not make the initial determination, at least one of whom will be a clinical peer reviewer. The clinical peer reviewer is a physician or other healthcare provider who typically manages the medical condition, procedure, or treatment under review.
- Appeals of non-clinical matters are determined by qualified personnel at a higher level than the personnel who made the original appeal determination.

- Appeals are decided and notification is provided to the provider.

A Plan Service Appeal can be filed by phone call or in writing, and Claim Appeal in writing (only), to:

Phone: 1-866-867-6555

Fax: 1-866-791-2213

Mail: P.O. Box 445
Elmsford, NY 10523
Attn: VNS Health Grievance & Appeals Dept.

You can ask for the Plan Service Appeal to be fast tracked if you think a delay will cause harm to the member's health. A claim appeal cannot be fast tracked and must be submitted in writing. If you need help, or need a Plan Appeal right away, call us at 1-888-867-6555. Our timeframe to respond begins when the plan receives the appeal whether orally or in writing.

Plan Determinations

The notice of the Plan Appeal decision to deny the member's/member reps request or to approve it for an amount that is less than requested is called a Final Adverse Determination for our Medicaid Plans and Appeal Determination for our Medicare Plans. This notice will provide the member or their representative with the following information:

- Member's plan coverage type
- A summary of the appeal and date it was filed
- The date the appeal process was completed
- The service/benefit that was denied, including the provider/facility name or developer/manufacture of the service/benefit as available
- Name and contact information of the person who reviewed the appeal
- Description of the member's fair hearing rights and timeframes (for our Medicaid Plans and integrated Medicare/Medicaid Plan)

- Description of the member's external appeal rights and timeframes when applicable (for our Medicaid Plans and integrated Medicare/Medicaid Plan)
- The member's right to complain to the Department of Health at any time by calling 1-866-712-7197 or 1-800-206-8125 .
- A statement that our notices are available in other languages and formats and how to access these formats

Appealing a Final Adverse Determination (Medicaid Plans)

If you, member, or designee thinks our Final Adverse Determination is wrong:

- You, the member or designee can ask for a Fair Hearing. See the Fair Hearing section of this manual.
- For some decisions, you, the member, or designee may be able to ask for an External Appeal. See the External Appeal section of this manual.
- You, member or designee may file a complaint with the New York State Department of Health at 1-800-206-8125.

External Appeals (MLTC, Selecthealth, and Total)

When VNS Health affirms (upholds) or partially affirms (partially affirms) a Medicaid or integrated Medicare/Medicaid Plan appeal, a member, a member's designee and, in the case of concurrent or retrospective adverse determinations, the member's healthcare provider, have the right to request an external appeal when the plan said the service was:

- Not medically necessary
- Experimental or investigational
- Not different from care you can get in the plan's network
- Available from a participating provider who has the correct training and experience to meet your needs

For these types of decisions, the member or you, as their provider, may be eligible for an External Appeal. An External Appeal is a review of the case by health professionals that do not work for you're the plan or the State. A member may need your help to fill out the External Appeal application.

Before a member can ask for an External Appeal:

- They must file a Plan Appeal and get the plan's Final Adverse Determination.
- If the member asks for a Fast Track Plan Appeal, they may also ask for a Fast Track External Appeal at the same time.
- For Medicaid members, both the member and the plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal. If this occurs, the plan sends a letter with information regarding filing an external appeal to member within 24 hours of the agreement to waive the internal appeal process.

The timeframe to file an External Appeals is four months from when the member receives the plan's Final Adverse Determination, or from when the member and the plan agreed to skip the internal Plan Appeal process.

Aid to Continue for Service Appeals (MLTC, SelectHealth, and Total)

If we decided to reduce, suspend, or stop services the member is getting now, they may be able to continue the services while they wait for the Plan Appeal to be decided. You as the provider, the member or designee must ask for a Plan Appeal:

- Within ten days from the date of the notice.
- Within ten days from the date the change in services are scheduled to occur, whichever is later.

If the Plan Appeal results in another denial, the member may have to pay for the cost of any continued benefits they received.

For **Member Services**, call 1-866-469-7774. TTY users, call 711.

For **Behavioral Health Services Crisis Line**, call 1-855-735-6098. TTY users call 1-866-727-9441.

Timeframes for Plan Appeals

The timeframe for the Plan to make an appeal determination begins upon the Plan's receipt of necessary information. For Medicaid and Medicare, the

review timeframe begins upon first receipt of appeal, whether filed orally or in writing.

- **Standard service plan appeals:** If we have all the information we need, we will tell you, the member, or designee our decision within 30 calendar days from when they asked for a Plan Appeal.
- **Fast track service plan appeals:** If we have all the information we need, fast track Plan Service Appeal decisions will be made in 72 hours from the Plan Appeal from when they asked for a Plan Appeal. We will tell you, the member, or designee within in 72 hours if we need more information.
- **Claim plan appeals:** We will tell the provider of our decision with 60 calendar days from when we received the appeal.

For **fast track plan service appeals**, we will tell you and the member or designee our decision by phone and send a written notice later.

For **standard service and claim plan appeals** we will notify the provider in writing.

The member can also write to the NYS Department of Health, Bureau of Managed Care Certification and Surveillance, ESP Corning Tower Room 1911, Albany, NY 12237.

10.3 • Expedited Appeals – All Plans

Submission

VNS Health has established and maintains procedures for expediting appeals. These include establishing an efficient and convenient method for individuals to call or submit written requests for expedited appeals, documenting verbal requests, and maintaining the documentation in the case file.

VNS Health has designated the Grievance and Appeal department to receive both verbal or written requests and a telephone number 1-866-783-1444, 24 hours a day, seven days a week (including holidays), TTY 711 for verbal requests, and includes a secure facsimile number 1-866-791-2213 to facilitate

receipt of requests for expedited appeals. VNS Health promptly decides whether to expedite or follow the time frame for standard reconsiderations.

When the request is made and supported by a physician, VNS Health grants the expedited appeal request if the physician indicates (the physician you does not have to use this exact language in the verbal or written request) that the life or health of the member, or the member's ability to regain maximum function could be seriously jeopardized by applying the standard time frame in the processing of the appeal request.

- For a member request not supported by a physician, VNS Health's Medical Director or other licensed clinician determines whether the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame in the processing of the reconsideration request. When it is not supported, the Plan will notify the the member/appellant that the expedited track was denied and the appeal will be processed via the standard time frame.

An appeal may be expedited when:

- A delay would seriously risk the enrollee's health, life, or ability to function.
- You, as the provider says the appeal needs to be faster.
- The enrollee is asking for more of a service than they are getting now.
- The enrollee is asking for home care services after they leave the hospital.
- The enrollee is asking for more inpatient substance abuse treatment at least 24 hours before they are discharged; or
- The enrollee is asking for mental health or substance abuse services that may be related to a court appearance
- When the Plan does not honor a member's request for expedited review, the Plan denies the member request for expedited, and provides notice by phone immediately, followed by written notice in two days. The appeal instead is processed via the standard timeframe.

- The 72-hour time frame may be extended by up to 14 calendar days if the extension is in the interest of the member, e.g., the receipt of additional medical evidence from a non-contracted provider may change the VNS Health decision to deny. If the Plan requires information necessary to conduct an expedited appeal, the Plan immediately notifies the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information followed by written notification.

Process

When VNS Health extends the time frame, VNS Health notifies the member/provider in writing of the reasons for the extension and informs the member of the right to file an expedited grievance if he or she disagrees with the VNS Health decision to grant an extension.

The Grievance and Appeal Specialist notifies the member/provider of its determination as expeditiously as the member's health condition requires, but no later than the last day of the extension.

If medical information is required from non-contracted providers, the Grievance and Appeals Specialist requests the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited reconsideration.

Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist VNS Health in meeting the required timeframe.

Regardless of whether VNS Health must request information from non-contracted providers, VNS Health is responsible for meeting the same time frame and notice required as it does with contracting providers.

Each notice of final adverse determination/appeal determination will be in writing, dated, and include:

1. The words “final adverse determination” (Medicaid Plans/Integrated Medicare Medicaid Plan)
2. MCO contact person and phone number
3. Name and address of appeal reviewer, contact person and phone number
4. Standard description of external appeals process attached (Medicaid Plans/Integrated Medicare Medicaid Plan)
5. Notice of Fair Hearing with Aid Continuing if applicable (Medicaid Plans/Integrated Medicare Medicaid Plan)
6. Right of enrollee to complain to the Department of Health at any time with 1-800 number

Timeframes

Appeals must be decided as fast as member’s condition requires, but no more than:

- A. Expedited Service Appeal: as fast as the enrollee’s condition requires and within 72 hours from receipt of the appeal. (This time may be extended for up to 14 days upon enrollee or provider request); or if MCO demonstrates more information is needed and delay is in best interest of enrollee and so notices enrollee.
- B. Failure by the Plan to make a determination with the applicable time periods in this section for appeals that require clinical review, shall be deemed to be a reversal of the utilization review agent’s adverse determination (MLTC, SelectHealth, and Medicaid benefits under Total only).
- C. Standard Service Appeal: 30 calendar days from receipt of the request. (Can be extended 14 days).
- D. Provider Claim Appeals: 60 calendar days from receipt of the request.

Appeals are tracked and investigated by the Grievance & Appeals Department.

- For Medicaid Plans/Integrated Medicare Medicaid Plan, before and during appeal review period, the member or designee may see their

case file. The member may present evidence to support their appeal in person or in writing.

10.4 • External Review – All Plans

VNS Health Total information in this section applies to **all** of the member's Medicare and most of their Medicaid benefits. This information does not apply to their Medicare Part D prescription drug benefits.

Integrated Medicare/Medicaid Plan (VNS Health Total)

If we say **no** to your the level 1 appeal, the case will **automatically** be sent on to the next level of the appeals process, which is the Integrated Administrative Hearing Office. During the level 2 appeal, the **Hearing Office** reviews our decision for the level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about the appeal to this organization, and provide the member/appellant with the same information. This information is called the appeal "case file."
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all the information related to the appeal. The Hearing Office will contact the member and/or you, if you filed on behalf of the member, to schedule a hearing.
- If the member had a fast appeal to our plan at level 1 because their health could be seriously harmed by waiting for a decision under a standard timeframe, the appeal will automatically get processed as a fast appeal at level 2. The review organization must give an answer to the level 2 appeal within 72 hours of when it gets the appeal.
- If the Hearing Office needs to gather more information that may benefit the member, it can take up to 14 more calendar days.

If the member had a “standard” appeal at level 1, they will also have a “standard” appeal at level 2

- The review organization must give an answer to the level 2 appeal within 90 calendar days of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days or the hearing may potentially be rescheduled to allow for more time.

If the member qualified for continuation of benefits when they and/or you filed the level 1 appeal, the benefits for the service, item, or drug under appeal will also continue during level 2. Go to page 7 for information about continuing benefits during level 1 appeals.

The Hearing Office will tell the member and/or you its decision in writing and explain the reasons for it.

- If the Hearing Office says **yes** to part or all the request, we must authorize the service or give the member the item **within one business day of when we get the Hearing Office’s decision.**
- If the Hearing Office says **no** to part or all of the appeal, it means they agree with our plan that the request (or part of the request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down the appeal.”)

If the Hearing Office says no to part or to all of the appeal, you and/or the member can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after level 2 (for a total of four levels of appeal).
- If the level 2 appeal is turned down, you must decide whether you want to go on to level 3 and make a third appeal. The written notice received after the level 2 appeal has the details on how to do this.
- The Medicare Appeals Council handles the level 3 appeal. After that, you may have the right to ask a federal court to look at your appeal.

- The decision provided by the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

At any time in the process, the member, or someone the member trusts can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Medicare Plans (VNS Health EasyCare / EasyCare Plus)

If we say **No** to your the level 1 appeal, the case will **automatically** be sent on to the next level of the appeals process, which is Maximus Federal Services. During the level 2 appeal, **Maximus** reviews our decision for the level 1 appeal. This organization decides whether the decision we made should be changed.

- **Maximus is an independent Centers for Medicare & Medicaid Services (CMS) agency.** It is not connected with us. Medicare oversee its work.
- We will send the information about the appeal to this organization.
- Reviewers at Maximus will take a careful look at all the information related to the appeal.
- If the member had a fast appeal to our plan at level 1 because their health could be seriously harmed by waiting for a decision under a standard timeframe, the appeal will automatically get processed as a fast appeal at level 2. Maximus must give an answer to the level 2 appeal within 72 hours of when it gets the appeal.

If the member had a “standard” appeal at level 1, they will also have a “standard” appeal at level 2.

- Maximus must give an answer to the level 2 appeal within 60 calendar days of when it gets your appeal.

Maximus will tell the member and/or you its decision in writing and explain the reasons for it.

- If Maximus says **yes** to part or all the request, we must authorize the service or give the member the item **within 72 hours of when we get the decision.**

- If Maximus says **no** to part or all of the appeal, it means they agree with our plan that the request (or part of the request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down the appeal.”)

If Maximus says no to part or to all of the appeal, you and/or the member can choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after level 2 (for a total of five levels of appeal).
- If the level 2 appeal is turned down, you must decide whether you want to go on to level 3 and make a third appeal. The written notice received after the level 2 appeal has the details on how to do this.
- The Office of Medicare Hearings and Appeals (OMHA) handles the level 3 appeal. After that, you may have the right to ask for a level 4 appeal.
- The Medicare Appeals Council (MAC) handles level 4 appeals. After level 4 of the appeal process, you may have the right to ask a federal court to look at your appeal.
- The level 5 appeal process is handled by the Federal District Court.

External Appeals for MLTC and Select Health

You or the member can ask for an External Appeal for **Medicaid covered benefits only**. You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and the member asked for because it is:

- Not medically necessary
- Experimental or investigational
- Not different from care the member can get in the plan’s network.
- Available from a participating provider who has the training and experience to meet the member’s needs.
- If the enrollee’s attending physician has certified that the enrollee has a life threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more

beneficial standard health service or procedure covered by the health care provider or (c) for which there exists a clinical trial.

- The enrollee's attending physician. The physician must be licensed, board-certified or a board eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life-threatening or disabling condition. The physician must have recommended either:
 - a. ealHth service or procedure (including pharmaceutical product within the meaning of PHI. 4900(5)(b).
 - b. That based on two documents from the available medical and scientific evidence, it is likely to be more beneficial to the enrollee than any covered health service or procedure, or a clinical trial for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation.
- Or the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service is experimental or investigational.

Note that if the MCO offers two levels of internal appeals, the MCO may not require the enrollee to exhaust the second level of internal appeal to be eligible for an external appeal.

- This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. The enrollee does not have to pay for an external appeal.

Before you appeal to the state:

- You or the enrollee must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination.
- You or the enrollee may ask for an expedited External Appeal at the same time if the enrollee has not gotten the service and you or the

enrollee ask for a fast appeal. (The doctor will have to say an expedited Appeal is necessary).

- You or the enrollee, and the plan may agree to skip the plan's appeals process and go directly to External Appeal.
- You and the enrollee can prove the plan did not follow the rules correctly when processing your level 1 appeal.

You have **four months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within four months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at 1-866-783-1444 (TTY users call 711) if you need help filing an appeal.
- You and the enrollee will have to give information about your medical problem.
- The External Appeal application says what information will be needed.
- Here are some ways to get an application:
 - Call the Department of Financial Services, 1-800-400-8882
 - Go to the Department of Financial Services' website at dfs.ny.gov
 - Contact the health plan at 1-866-783-1444 (TTY users call 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five workdays) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if the doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you, or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Fair Hearings for MLTC and Select Health

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension, or termination of authorized services the enrollee is currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend, or terminate your services, whichever occurs later.

The enrollee's benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that the enrollee receives the disputed services promptly, and as soon as their health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If the enrollee received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, the enrollee may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: otda.ny.gov/oah/FHReq.asp
- Mail a Printable Request Form:
 - NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
 - Managed Care Hearing Unit
 - P.O. Box 22023
 - Albany, New York 12201-2023
- Fax a Printable Request Form: 518-473-6735
- Request by Telephone:
 - Standard Fair Hearing line – 1-800-342-3334
 - Emergency Fair Hearing line – 1-800-205-0110
 - TTY line – 711 (request that the operator calls 1-877-502-6155)

Request in Person:

New York City

14 Boerum Place, 1st Floor Brooklyn, New York 11201

Albany

40 North Pearl Street, 15th Floor Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:

otda.ny.gov/hearings/request/

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, or the service is not different from care the enrollee can get in the plan’s network, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State.

These reviewers are qualified people approved by New York State. The enrollee does not have to pay for an external appeal.

When we decide to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to five workdays) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two workdays after the decision is made.

You can get a faster decision if the doctor can say that a delay will cause serious harm to the enrollee's health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

10.5 • Notification to Members of Non-Coverage of Inpatient Care

Medicare

If VNS Health does not authorize coverage of the inpatient admission of a Medicare member, either directly or by delegation (or the admission constitutes an emergency or urgently needed care), VNS Health is required to issue the member a written notice of non-coverage: Integrated Denial Notice.

The Integrated Denial Notice will include:

- The services that have been requested.
- The services that have been denied.
- The reason for denial.
- The right for the member, the AOR, or the provider acting on behalf of the member to appeal the adverse determination.
- VNS Health will issue a Notice of Medicare Non-Coverage (NOMNC) to members receiving covered skilled nursing, home health, or comprehensive outpatient facility services. The NOMNC will be delivered at least two calendar days before the Medicare covered services end.
- The provider will be notified of the termination of services two days prior to the termination.
- The provider will deliver the NOMNC to the member explaining the member's rights regarding an expedited appeal through the BFCC/QIO Agency.
- The provider will return a copy of the signed NOMNC to VNS Health.

The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the member's request, the QIO must notify VNS Health that the member has filed a request for immediate review.
- VNS Health and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax or in writing by the close of business of the first full working day immediately following the day the member submits the request for review.

- In response to a request from VNS Health, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day VNS Health makes its request.
- The QIO must solicit the views of the member who requested the immediate QIO review.
- The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the member, the hospital, and VNS Health by close of business of the first working day after it receives all necessary information from the hospital, VNS Health, or both.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with VNS Health. VNS Health is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the 12 pm filing deadline and forwards that request to VNS Health. Thus, VNS Health would generally make an expedited decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the member in accordance with this section entitles the member to automatic financial protection by VNS Health. This means that if VNS Health authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, VNS Health continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the member of its review determination.

Hospitals must notify Medicare enrollees who are hospital inpatients about their in-patient hospital discharge appeal rights. Hospitals use 'An Important Message from Medicare About Your Rights' (IM) a statutorily required notice, to explain the enrollee's rights as a hospital in-patient, including discharge appeal rights. Hospitals must issue the IM (see Appendix) up to seven days before admission, or within two calendar days of admission, must obtain the signature on the form and provide the member with a copy of the signed notice. Hospitals may also need to deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two calendar days before discharge.

Hospitals must follow the procedures listed below in delivering the IM. Valid notice consists of the "Use of Standardized Notice." Hospitals must use the standardized form (CMS-R-193), dated 05/07. The notices are also available on cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice.

Delivery Timeframe: If the IM is not given prior to admission, hospitals must deliver it to the enrollee at or near admission, but no later than two calendar days following the date of the enrollee's admission to the hospital as an in-patient (The hospital may deliver the Important Message within seven days of admission but only in those cases where an enrollee has a scheduled inpatient visit, such as elective surgery). Hospitals may not deliver the Important Message to an enrollee who is in an outpatient or observation setting on the chance that the patient may end up receiving inpatient care.

In-Person Delivery: The IM must be delivered to the enrollee in person. However, if the enrollee is not able to comprehend the notice, it must be delivered to and signed by the enrollee's representative.

Notice Delivery to Representatives: CMS requires that notification of an enrollee who is not competent be made to a representative of the enrollee.

A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf, (e.g., the enrollee's legal guardian, or someone appointed in accordance with a properly executed "durable medical power of attorney").

Otherwise, a person (typically, a family member or close friend) whom the enrollee has indicated may act for him or her, but who has not been named in any legally binding document may be a representative for the purpose of receiving the notices described in this section. Such representatives should have the enrollee's best interests at heart and must act in a manner that is protective of the enrollee and the enrollee's rights. Therefore, a representative should have no relevant conflict of interest.

Regardless of the competency of an enrollee, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the enrollee's rights as a hospital in-patient, including the right to appeal a discharge decision.

When direct phone contact cannot be made, the hospital should send the notice to the representative by certified mail, return receipt requested or any method in which delivery may be tracked and verified (e.g., UPS, FedEx, etc.). The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. The hospital should place a copy of the notice in the enrollee's medical file and document the attempted telephone contact with the member's representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called. If both the hospital and the representative agree, hospitals may send the notice by email or fax. However, hospitals must meet the HIPAA privacy and security requirements when transmitting the IM by email or fax.

Ensuring Enrollee Comprehension: Notices should not be delivered during an emergency. Hospitals must make every effort to ensure the enrollee comprehends the contents of the notice before obtaining the enrollee's signature. This includes explaining the notice to the enrollee if necessary and providing an opportunity for the enrollee to ask questions. The hospital should answer all the enrollee's questions orally to the best of its ability. The enrollee should be able to understand that he or she may appeal a discharge decision without financial risk but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal.

These instructions do not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee can comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Enrollee Signature and Date: (Unless an appropriate reason for the lack of signature is recorded on the IM.) The IM must be signed and dated by the enrollee to indicate that he or she received the notice and understands its contents.

If a member disputes (appeals) the discharge and contacts the Quality Improvement Organization (QIO) for an immediate review, VNS Health will complete and fax the "Detailed Notice of Discharge" (DND) to the hospital administrator or nursing director on duty (the member's medical record must be faxed to VNS Health by 4 pm that day). The hospital must deliver a copy of the DND to the member. The hospital may not create its own DND and deliver it to the member without VNS Health's approval. VNS Health will also fax a copy of the DND to the QIO for review and/or an expedited reconsideration. The QIO and/or VNS Health will work with the hospital and attending physician to determine if discharge is appropriate.

If an appeal occurs during a weekend, a VNS Health Manager or Director will contact the nursing office or hospital administrator on duty to facilitate the delivery of the “Detailed Notice of Discharge.”

Template documents to be used for this new process are available on the CMS web site:

cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A member remaining in the hospital who wishes to appeal the VNS Health discharge decision that inpatient care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A member will not incur any additional financial liability if he/she:

- Remains in the hospital as an inpatient.
- Submits the request for immediate review to the QIO that has an agreement with the hospital.
- Makes the request either in writing, by telephone or fax.
- Makes the request before the end of the day of discharge.

Medicare

When VNS Health receives a request for payment or to provide services to a member, it must make an organizational determination to decide whether payment and or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member or provider has the right to request a reconsideration or appeal.

A member who disagrees with a practitioner’s decision about a request for a service or a course of treatment has a right to request an organizational determination from VNS Health. This member should be referred to Member Services for additional information.

VNS Health is required to make organizational determinations and process appeals as expeditiously as the member’s health status requires.

10.6 • Organization Determinations and Reconsiderations – VNS Health Medicare

When VNS Health receives a request for payment or to provide services to a member, it must make an organizational determination to decide whether payment and or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member or provider has the right to request a reconsideration, also known as an appeal.

Reconsiderations

Reconsiderations or Appeals, must be filed within 60 calendar days from the initial denial date, unless your contract states otherwise.

VNS Health will make decisions regarding Medicare appeals as shown below:

Appeal Type	Decision Timeframe	Rules / requirements
Expedited Part B Drug Appeal	72 hours	May be submitted verbally or in writing. The appeal will be expedited when: •A physician indicates or VNS Health determines that waiting for the appeal decision within the standard timeframe may risk or jeopardize the member’s health.
Expedited Part C Service / Benefit Appeal	72 hours, with a possible 14-day extension	•A member may also request to expedite an appeal; however, the Plan may deny the expedited track and process it within the standard track if the Plan determines that the member’s health will not be at risk or jeopardized if processed via the standard appeal track
Standard Part B Drug	7 days	May be submitted verbally or in writing.
Standard Part C Service / Benefit Appeal	30 calendar days, with a possible 14-day extension	
Claim Appeal	60 calendar days	<ul style="list-style-type: none"> •Must be submitted in writing •Cannot be expedited •Cannot be extended

10.7 • SNF/HHA Provider Service Terminations— VNS Health

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were revised for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers. Pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage to Medicare managed care members prior to the cessation of services, regardless of the reason for cessation. The delivery must be made to the managed care member two days prior to the termination of the covered services and will not be considered valid until the patient signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legal authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record (i.e., the family member involved in the plan of treatment). Although the caregiver is not a legal authorized representative, he/she has assumed responsibility for the member's medical treatment. If the member has no legal authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF Provider Service Terminations

A member receiving provider services in a SNF, HHA, or CORF who wishes to appeal a VNS Health decision to terminate such services because care is no longer necessary must request an immediate QIO review of the determination in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage (DENC)

Once the QIO receives an appeal, it must issue a notice to VNS Health that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, VNS Health is responsible for issuing the DENC, a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA, or CORF care is ending.

VNS Health must issue a DENC to both the QIO and the member no later than the close of business when the QIO notifies VNS Health that a member has requested an appeal.

VNS Health is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and VNS Health.

Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member's request, the QIO must notify VNS Health and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day of the appeal request date.

VNS Health must supply a copy of the "Notice of Medicare Non-Coverage," DENC and any medical information that the QIO requires to conduct its review. The information must be made available by phone, fax or in writing by the close of the business day that the QIO notifies VNS Health of an appeal. If a member requests an appeal on the same day the member receives the "Notice of Medicare Non-Coverage," then VNS Health has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary, and notify the member, the provider, and VNS Health by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, VNS Health, or both. If the QIO does not receive the information it needs to sustain the VNS Health decision to terminate services, then the QIO may decide based on the

information at hand, or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by VNS Health will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the “Notice of Medicare Non- Coverage”:

- The member submits a timely request for immediate review to the QIO that has an agreement with the provider.
- The request is made either in writing, by telephone or by fax, by 12 pm of the next day after receiving the notice.
- The QIO either reverses the VNS Health termination decision or the member stops receiving care no later than the date that the member receives the QIO’s decision. The member will incur one day of financial liability if the QIO upholds the VNS Health termination decision, and the member continues to receive services until the day after the QIO’s decision. This should be the same date as the VNS Health initial decision to terminate services.
- A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration/appeal with VNS Health. VNS Health will expedite the request for an expedited reconsideration/appeal if the QIO receives a request for an immediate QIO review beyond the noon filing deadline and forwards that request to VNS Health. VNS Health would generally make an expedited decision about the services within 72 hours. Financial liability applies in both the immediate QIO review and VNS Health expedited review situations.



Any questions? Call toll-free

1-866-783-0222 (TTY: 711)

8 am - 5 pm, Monday - Friday [vnshealth.org](https://www.vnshealth.org)

Provider Portal: <https://www.vnshealthplans.org/provider-portal/>

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SECTION 10: Grievances & Appeals

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