Established in 1993, Healthfirst® is a not-for-profit managed care organization that provides high-quality healthcare coverage to low-income individuals and families living in New York. Our mission is to improve the health and well-being of underserved populations by providing effective managed care services through comprehensive provider partnerships and reinvesting in our hospitals.

By working in partnership with our participating hospitals throughout the five boroughs of New York City, and in Long Island and Westchester, Healthfirst has developed a solid and effective approach to meeting the diverse needs of New York residents.

Member Hospitals/Health Systems

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<tr>
<th>BronxCare Health System</th>
<th>Northwell Health</th>
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<tr>
<td>The Brooklyn Hospital Center</td>
<td>NYC Health + Hospitals</td>
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<td>Interfaith Medical Center</td>
<td>NYU Langone Health</td>
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<td>Jamaica Hospital Medical Center</td>
<td>SBH Health System</td>
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<td>Maimonides Medical Center</td>
<td>St. John’s Episcopal Hospital</td>
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<td>Montefiore Health System</td>
<td>Stony Brook University Medical Center</td>
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<td>Mount Sinai Health System</td>
<td>SUNY Downstate Medical Center</td>
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<td>Nassau University Medical Center</td>
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Healthfirst, Inc. is part of the Healthfirst family of companies, which includes Healthfirst Health Plan of New Jersey, Inc. and HF Management Services, LLC, a hospital-owned company that provides comprehensive management services to healthcare organizations in New York, New Jersey, Pennsylvania, and Florida.

Healthfirst in New York (Healthfirst HFHP and Healthfirst PHSP, Inc.) and Healthfirst NJ (Healthfirst Health Plan of New Jersey, Inc.) each maintain separate provider networks. Members must see providers in their health plan’s network for services to be considered in-network. Services rendered without prior authorization by providers or facilities outside of the network designated by the member’s health plan are considered out-of-network and shall be the member’s financial responsibility (excludes emergent care).
Table of Contents

Healthfirst® .................................................................................................................................................. 2

1. Introduction .................................................................................................................................................. 7
   1.1 Introduction to the Provider Manual .................................................................................................... 7
   1.2 About Healthfirst, Inc ......................................................................................................................... 7
   1.3 Network Management and Provider Services .................................................................................. 8

2. Healthfirst Programs and Benefits ........................................................................................................... 11
   2.1 Healthfirst PHSP Programs .................................................................................................................. 11
   2.2 Healthfirst Medicare Plans .................................................................................................................. 11
   2.3 Healthfirst Commercial Programs ...................................................................................................... 13
   2.4 Benefits/Covered Services .................................................................................................................. 14

3. Healthfirst Provider Networks .................................................................................................................. 15
   3.1 Description of the Networks ................................................................................................................ 15
   3.2 Provider Rights and Responsibilities .................................................................................................. 19
   3.3 Fraud, Waste & Abuse ......................................................................................................................... 22
   3.4 Appointment Availability and 24-Hour Access Standards ................................................................ 32
   3.5 Provider Application Process .............................................................................................................. 33
   3.6 Credentialing, Recredentialing Requirements & Provisional Credentialing .................................... 33
   3.7 Provider Profiling ................................................................................................................................ 34
   3.8 Termination of Provider Agreements .................................................................................................. 35

4. Eligibility and Membership ....................................................................................................................... 39
   4.1 Introduction .......................................................................................................................................... 39
   4.2 Marketing, Advertising, Outreach and Enrollment ........................................................................... 40
   4.3 PHSP Enrollment and Disenrollment ................................................................................................. 41
   4.5 Member Rights and Responsibilities .................................................................................................. 45
   4.6 Member Services and Education ....................................................................................................... 46
   5.2 Medical Record Reviews and Documentation Standards ............................................................... 48
   5.3 Confidentiality ...................................................................................................................................... 49
   5.4 Advance Directives/Health Care Proxy ............................................................................................... 49
   5.5 Disclosure Restrictions for Services Paid Out-of-Pocket .................................................................. 50
   5.6 Critical Incident Reporting .................................................................................................................. 50

6. Primary Care ............................................................................................................................................... 52
   6.1 Responsibilities of a Primary Care Provider (PCP) ........................................................................... 52
   6.2 Primary Care Panels and Member Enrollment Rosters .................................................................... 54
   6.3 Preventive Care Standards .................................................................................................................. 54

7. Obstetrics and Gynecology ........................................................................................................................ 56
   7.1 Definition of Services .......................................................................................................................... 56
   7.2 Diagnostic Testing .............................................................................................................................. 57
   7.3 Consent Requirements for Hysterectomy – Medicaid, CHPlus, FHPlus, and Leaf Plans .................. 57
   7.4 Family Planning and Reproductive Health ......................................................................................... 58

8. Specialty Care ............................................................................................................................................ 61
   8.1 Definition of Specialty Care ................................................................................................................ 61

9. Behavioral Health Services ....................................................................................................................... 63
   9.1 Description of the Network ................................................................................................................ 63
   9.2 Benefits and Access to Care ............................................................................................................... 64
   9.3 Program Overview ................................................................................................................................ 67
   9.4 Utilization and Medical Management Guidelines ............................................................................. 67

10. Ancillary and Other Special Services .................................................................................................... 69
    10.1 Overview of Services and the Provider Network ............................................................................ 69
10.2 Laboratory ................................................................. 70
10.3 Pharmacy ................................................................. 70
10.4 Durable Medical Equipment (DME), Orthotics and Prosthetics, and Medical Supplies ...................................................... 72
10.5 Home Healthcare ......................................................... 72
10.6 Dental ............................................................................. 74
10.7 Routine Vision ............................................................. 74
10.8 Hospice – Medicaid, Personal Wellness Plan, CHPlus, Leaf Plans, Commercial, and Medicare .................................................. 75
10.9 Transportation ............................................................. 75
10.10 Custodial Long-Term Care Placement .................................. 77

11. EMERGENCY CARE ........................................................ 81
11.1 Emergent Care ............................................................. 81
11.2 Urgent Care ..................................................................... 82

12. Medical Management ....................................................... 83
12.1 Program Overview ....................................................... 83
12.2 PCP-Directed Care ......................................................... 83
12.3 Authorization of Services ............................................... 84
12.4 Out-of-Network Services ................................................ 86
12.5 Continuity of Care ......................................................... 87
12.6 Concurrent Review ....................................................... 89
12.7 Retrospective Review ..................................................... 90

13. Care Management .......................................................... 91
13.1 Overview for all Healthfirst Members .................................. 91

14. Clinical Performance Management ...................................... 95
14.1 Overview and Philosophy ............................................... 95
14.2 Reporting Requirements and Quality Programs .................. 95
14.3 Clinical Practice Guidelines ........................................... 102
14.4 Studies, Surveys, and Investigations .................................. 103
14.5 Quality Improvement – Medicare ...................................... 104
14.6 Quality Evaluation of Providers ...................................... 107

15. Appeals and Grievances .................................................... 109
15.1 Provider Notice Requirements – Medicare ........................ 109
15.2 SNF/HHA/CORF Provider Service Terminations – Medicare ................................................................. 109
15.3 Notification to Members of Non-Coverage of Inpatient Hospital Care – Medicare ......................................................... 111
15.5 Organization Determinations and Reconsiderations (Appeals) – Medicare ................................................................. 113
15.6 Expedited Organizational Determinations and Appeals ......... 115
15.7 Coverage Determinations for Part D Prescription Drugs – Medicare ................................................................. 117
15.8 Coverage Determinations for Prescription Drugs – Medicaid, CHPlus and Leaf Plans ......................................................... 120
15.9 Action Denial Notice – Medicaid/CHPlus ........................... 121
15.10 Action Appeals – Medicaid, and Medicaid Advantage Plus ................................................................. 121
15.11 Expedited Appeals – Medicaid, Medicaid Advantage Plus, and AbsoluteCare ................................................................. 123
15.12 Member Rights to a Fair Hearing – Medicaid, Medicaid Advantage Plus ................................................................. 123
15.14 Member-Initiated Complaints – Medicaid ................................... 124
15.15 Standard Appeals – Commercial, CHPlus .................................. 126
15.16 Appealing the Grievance – CHPlus, Commercial (Small Group) ................................................................. 126
15.17 Expedited Appeals – Commercial, CHPlus .................................. 127
15.18 External Review – Commercial, CHPlus .................................. 127

16. Provider Compensation .................................................... 129
16.1 Payees ............................................................................ 129
16.2 Primary Care Services/Primary Care Providers .................. 129
16.3 The Healthfirst Quality Incentive Program (HQIP) ............... 130
16.4 Specialty Care and Specialists ........................................... 131
16.5 Obstetrical Care ............................................................. 131
17. Billing & Claims Processing ............................................................................................................. 133
  17.1 Member Eligibility ...................................................................................................................... 133
  17.2 General Billing and Claim Submission Requirements ................................................................. 133
  17.3 Time Frames for Claim Submission, Adjudication, and Payment ........................................... 136
  17.4 Coordination of Benefits (COB) ............................................................................................... 137
  17.5 Explanation of Payment (EOP)/Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) ..................................................................................................................... 138
  17.6 Claim Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process .................... 140
  17.7 Overpayments, Duplicate Payments, and Underpayments ......................................................... 142
  17.8 Avoidable Readmission Reimbursement Policy ......................................................................... 144

18. Glossary of Terms .......................................................................................................................... 146

Appendix I — Appointment Availability and 24-Hour Access Standards ........................................ 155

Appendix II Credentialing .................................................................................................................. 157
  Appendix II-A — Credentialing Requirements ............................................................................... 157
  Appendix II-B — Healthfirst Office Site Evaluation Form ............................................................... 159
  Appendix II-C — Interpretive Guidelines for the Office Site Evaluation Form ............................... 161

Appendix III — Healthfirst Commercial Plans and Medicaid Managed Care Exclusions and Exemptions .................................................................................................................................................. 164

Appendix IV — Marketing Guidelines ............................................................................................... 166
  Appendix IV-A — Medicaid Marketing Guidelines for Medical Service Providers ...................... 166
  Appendix IV-B — Medicare Marketing Guidelines ........................................................................ 167

Appendix V — Medical Record Standards ....................................................................................... 171

Appendix VI — Healthcare Proxy ..................................................................................................... 173

Appendix VII — Preventive Care ....................................................................................................... 177
  Appendix VII-A — Preventive Care Standards and Required Documentation ................................ 177
  Appendix VII-B — Child/Teen Health Plan (C/THP) Guidelines and Immunization Schedule ........ 182
  Appendix VII-C — Guidelines for Adolescent Preventive Services (GAPS) ................................. 185
  Appendix VII-D — Primary Care Provider Behavioral Health Screening Tool ............................... 186
  Appendix VII-E Healthfirst Wellness Reward Card - PHSP ............................................................ 188
  Appendix VII-F Healthfirst Wellness Reward Card - Medicare ....................................................... 189

Appendix VIII — Description of Skilled Nursing Services ................................................................ 190

Appendix IX — Healthfirst Transportation ....................................................................................... 191
  Appendix IX-A — Provider Approval Form .................................................................................... 191
  Appendix IX-B — Member Transportation .................................................................................... 191
  Appendix IX-C — Non-emergent Transportation Services Policy – Livery and Ambulette ............. 192

Appendix X — Medicare Member Reimbursement Form .................................................................. 194

Appendix XI — Preauthorization Guidelines by Service Type ............................................................ 198
  Appendix XI-A — Preauthorization Guidelines for Healthfirst Medicaid, Child Health Plus, Medicare, and CompleteCare Plans .................................................................................................. 198
  Appendix XI-B — Preauthorization Guidelines – Leaf Plan .............................................................. 204

Appendix XII — Clinical Practice Guidelines .................................................................................... 206

Appendix XIII — Notice Of Medicare Noncoverage ........................................................................ 211
  Appendix XIII-B — Important Information for Healthfirst Medicare Plan Members’ Appeal Rights ................................................................. 212
  Appendix XIII-C — Standard Description and Instructions for Healthcare Consumers to Request an External Appeal .............................................................................................................................. 213
  Appendix XIII-D — Attending Physician’s Attestation for a Patient’s External Appeal ................... 216
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix XIII-E</td>
<td>Appointment of Representative Statement and Form</td>
</tr>
<tr>
<td>Appendix XIII-F</td>
<td>Detailed Notice of Discharge</td>
</tr>
<tr>
<td>Appendix XIII-G</td>
<td>Important Message from Medicare About Your Rights</td>
</tr>
</tbody>
</table>

**Appendix XIV — Codes, Claims and Reimbursable Services**
- Appendix XIV-A: Appropriate Codes for Claims/Encounter Data
- Appendix XIV-B: Reimbursable Services
- Appendix XIV-C: Glossary of EOP Code Messages

**Appendix XV — New York State Communicable Disease Reporting Requirements**

**Appendix XVI — HEDIS/QARR Quick Reference Guides (QRG)**

**Appendix XVIII - Behavioral Health Addendum**
- I. Primary Care Physicians’ Responsibilities
- II. Appointment Availability Standards for Behavioral Health Services and HARP Members
- III. Authorization, Continued Stay, and Discharge Criteria
- IV. Behavioral Health Utilization Management
- V. Clinical Practice Guidelines for Behavioral Health
- VI. Behavioral Health Care Management Automatic Call Distribution
- VII. Emergent Care
- VIII. Behavioral Health Services
- IX. Behavioral Health Quality Improvement Utilization Management Committee (BH QI-UMC)
- X. Behavioral Health Credentialing Criteria
- XI. Confidentiality
- XII. Provider Training
- XIII. Quality Assurance
- XIV. First-Episode Psychosis
- XV. Emergency Pharmacy Protocols for Enrollees with Behavioral Health Conditions
- XVI. Healthfirst Care Manager Responsibilities
- XVII. Continuity of Care
- XVIII. Behavioral Health Care Management Program – Supplement to Provider Manual Section 13.1
- XIX. Peer Reviewers
- XX. Health Home Care Management
- XXI. Children’s Medicaid Redesign

**Appendix XIX — Health and Recovery Plan (HARP)**
- I. Recovery-Oriented Principles
- II. Non-Urgent Care
- III. Behavioral Health Home and Community-Based Services (BH-HCBS)
- IV. Appointment Availability Standards for BH-HCBS
- V. Credentialing Criteria for Designated BH-HCBS Providers
- VI. Description of Referral Process for HCBS
- VII. HCBS Utilization Monitoring
- VIII. Utilization Management
- IX. Maintenance of Member Records
- X. Provider Education and Training
- XI. HCBS Plan of Care and Utilization Review Criteria
- XII. Billing Compliance
- XIII. Required Documentation for Reimbursement
- XIV. This section intentionally left blank
- XV. Appeals and Grievances

**Appendix XX — Provisions from the 2007 Managed Care Reform Bill**
1. Introduction

1.1 Introduction to the Provider Manual

Healthfirst is committed to ensuring that its members receive easily accessible, high-quality, comprehensive healthcare services. The Healthfirst provider network is a key partner in achieving this goal. The Provider Manual has been developed to assist our participating providers in understanding the administrative policies and procedures that govern the management of Healthfirst. It is designed to provide you with easy access to information that will enable you and your office staff to care for Healthfirst members within administrative guidelines. All the information in this manual applies to all Healthfirst members, unless specifically indicated.

Updates to the Manual

Healthfirst will update the Provider Manual and Appendices periodically and will make available electronic versions which can be downloaded from our website at www.healthfirst.org. Information related to these updates may appear on the Healthfirst website; in The Source, our provider newsletter; and in other mailings. These media provide the most current information on the Healthfirst programs and your responsibilities under these programs.

Keep Us Informed

Please take the time to read through the Provider Manual and let us know if there are any sections that are unclear or if there are other topics about which 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.

1.2 About Healthfirst, Inc.

Healthfirst, Inc.

Healthfirst was founded in the early 1990’s by a consortium of hospitals under the auspices of the Greater New York Hospital Association. An independent not-for-profit corporation since 1993, it has from its inception operated pursuant to a unique model that relies on population health management efforts on the part of its hospital sponsors and provider network supported by the infrastructure of an established and regulated health plan. Funds saved through higher quality and better care management are returned to the provider delivery system. Healthfirst has steadily expanded its product offerings from its start in Medicaid managed care to Medicare Advantage Prescription Drug (MAPD) plans, long term care, and commercial products offered on the New York State of Health (commonly known as the Exchange) branded at Healthfirst Leaf and Leaf Premier Plans. With more than a million members and top quality and member satisfaction rankings, Healthfirst’s business model relies on empowering and partnering with the provider system and the community to achieve the superior outcomes and culturally competent healthcare for its customers.

Healthfirst PHSP, Inc.

Since 1994, Healthfirst has operated a Prepaid Health Services Plan (PHSP) serving Medicaid members in New York City under a certificate of authority granted by the State of New York. In 1995, the Healthfirst operating area was expanded to include Long Island. Healthfirst PHSP was developed to meet the objectives of New York State’s Managed Care Act, which changed the way healthcare was delivered for Medicaid recipients. In 1999, Healthfirst implemented its Child Health Plus (CHPlus) program to expand its ability to provide healthcare services to eligible children through participation in the state’s CHPlus Program. This offers reasonably priced healthcare coverage for the children of working parents who do not qualify for Medicaid and cannot afford unsubsidized health insurance.

Healthfirst Health Plan, Inc.

Healthfirst Health Plan, Inc. (HFHP) is the licensed HMO doing business as Healthfirst Medicare Plan and Healthfirst New York (commercial). Formerly known as Managed Health, Inc., HFHP was first managed by Healthfirst in July 1997 and then became a subsidiary of Healthfirst in August 1998. The service areas for the Healthfirst Medicare Plan include the Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau and
Westchester counties (not all plans are available in all counties). The service areas for Healthfirst New York include the Bronx, Kings, Manhattan, Queens, Richmond, Nassau and Suffolk counties.

Provider Participation
Healthfirst hospitals and their affiliated providers may be contracted to participate in one Healthfirst program or in a combination of programs (see Section 2). Because contracting differs among the programs, it is important to note that a provider who is contracted to provide services for one program is considered to be out-of-network for all of the other programs. Additionally, participation is office-site specific. While a contract may cover multiple locations, if an application has not been submitted or approved for a particular office, services rendered there are considered out-of-network. To confirm the programs that you participate in, contact Provider Services.

Each of the Healthfirst companies, Healthfirst, Inc., Healthfirst PHSP, Inc. and Healthfirst Health Plan, Inc. do business under the “Healthfirst” name. Throughout this provider manual the term “Healthfirst” refers to all three companies collectively. When referring to a specific company or a specific line of business, the specific company name is used, i.e., “Healthfirst Health Plan, Inc.” or “Healthfirst PHSP, Inc.”, and the specific product name if a specific product is used, i.e., “Medicare” or “Medicaid.”

1.3 Network Management and Provider Services

Network Management
All participating hospitals, their affiliated providers and individual participating providers have a designated Healthfirst representative who serves as the liaison between the facility, its affiliated providers, participating providers, and Healthfirst. These representatives provide information, problem-solve, and respond as needed to provider concerns.

Provider Services
Healthfirst also has a dedicated phone unit available to assist providers with questions regarding Healthfirst policies and procedures, member care, reimbursement, claim information or general information about Healthfirst and its products. If you have any questions or need more information about Healthfirst and its products, please contact Provider Services at 1-888-801-1660, Monday–Friday, 9am–5:00pm.

Healthfirst Secure Provider Portal
Hospitals, providers, and their office staff can access information 24 hours a day, 7 days a week on the Healthfirst secure Provider Portal at www.healthfirst.org/providers. Quick and easy online registration to the Provider Portal provides access to tools that enable you to:

- Verify member eligibility
- Submit appeals, corrected claims and view claim status
- View the status of authorizations
- Submit questions to Healthfirst
- Request access to online reports and member enrollment rosters
- Submit files/documents to Healthfirst
- Request demographic information update
- Access Healthfirst policies and procedures
- Review the latest clinical guidelines, newsletters, reference materials, and more

For more information about our web site, send an e-mail to webmaster@healthfirst.org, and to register for access visit www.healthfirst.org/providers and click New Users – Sign Up Here.
Other Healthfirst Departments

In addition to Provider Services, there are other departments at Healthfirst that you may contact or work with on a regular basis. The following table highlights these areas and outlines their key functions. Healthfirst staff members from these departments are available to assist you in providing care to Healthfirst members.

<table>
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<tr>
<th>Department</th>
<th>Key Functions and Responsibilities</th>
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<td>Provider Services</td>
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<td>- Member Appeals and Grievances</td>
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<td>- Claims Appeals and Grievances</td>
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<td>- Claims Payment and Status Inquiries</td>
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<td>- Claim Review and Reconsideration</td>
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<td>- Transitional Care</td>
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<td>- Care Management and Disease Management</td>
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<td>- Assistance in Finding Appropriate Specialists</td>
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<td>- Utilization Review</td>
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<td>- Authorizations for Initial and Continuing Care</td>
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<td>Medical Management &amp; Behavioral Health Unit</td>
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<td>- Eligibility Verification</td>
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<td>- New Member Orientations</td>
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<td>- Quality of Care Investigations</td>
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<td>Clinical Performance Management Department</td>
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<td>Confidential Compliance Contact</td>
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<td>To report compliance concerns in addition to suspected fraud, waste and abuse, anonymously call</td>
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<td>1-877-879-9137</td>
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<td><a href="http://www.hfcompliance.ethicpoint.com">www.hfcompliance.ethicpoint.com</a></td>
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2. Healthfirst Programs and Benefits

2.1 Healthfirst PHSP Programs

Healthfirst Medicaid Managed Care Plan

Since 1994, Healthfirst has delivered managed healthcare services to the Medicaid-eligible population of New York City and Long Island. Healthfirst Medicaid offers the full range of New York State Medicaid benefits to individuals and families eligible to receive services under the following government programs: Temporary Assistance to Needy Families (TANF), Safety Net Assistance (SNA), Medicaid Only (MA-HR and MA-ADC) and Supplemental Security Income (SSI).

Healthfirst Child Health Plus (CHPlus)

In March of 1999, Healthfirst implemented the CHPlus Program to provide quality healthcare coverage for the children of uninsured and underinsured families. This program was developed in response to New York State’s CHPlus initiative. The CHPlus Program offers health care to children under age 19 who are above the Medicaid income levels or who are ineligible for Medicaid because of their immigration status.

CHPlus provides children with a comprehensive benefit package. The family must be income eligible for membership and may be responsible for contributing to a premium based on its income category. If the member is eligible for Medicaid upon recertification, the applicant’s application is referred to the appropriate district for an eligibility determination and he/she may be temporarily enrolled in the CHPlus plan while pending a Medicaid determination from the district.

Healthfirst Personal Wellness Plan (HARP)

Starting October 1, 2015 for NYC, Healthfirst implemented the Healthfirst Personal Wellness Plan - which is our version of the Health And Recovery Plan.

The Healthfirst Personal Wellness Plan is for Medicaid Managed Care members who may benefit from extra behavioral health or substance abuse services. It offers all the same Medicaid Managed Care coverage and benefits, plus extra services like community support programs, mental health treatment, substance abuse programs, and other behavioral health services to help the member live life to the fullest.

2.2 Healthfirst Medicare Plans

Healthfirst offers several Medicare Advantage Plans (MA Plans) under contract with the Centers for Medicare & Medicaid Services (CMS). Some of these MA Plans also include Medicaid benefits offered through a contract with the New York State Department of Health. The Healthfirst MA Plans are issued by Healthfirst Health Plan, Inc., part of the family of Healthfirst companies.

To meet the eligibility requirements for Healthfirst MA Plans, beneficiaries must have both Part A and Part B Medicare, live in the particular MA Plan’s service area, and not have end-stage renal disease (ESRD). An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary’s physician showing that the ESRD status has changed and the beneficiary is in fact eligible to enroll in the MA Plan. Generally, the benefits for MA Plans change on a yearly basis, and providers are informed of these changes through our provider newsmagazine, The Source; through a direct mailing to provider offices; and through updates on the Provider Secure Services website (www.healthfirst.org/providerservices). Most MA Plans include Standard Medicare Prescription Drug Coverage (Part D) unless otherwise noted.

Healthfirst MA Plans currently include the following Medicare Advantage HMO plans and Special Needs Plans (SNP):
Healthfirst 65 Plus Plan

Our 65 Plus Plan is designed to be the preferred plan for Medicare beneficiaries who do not qualify for “Extra Help,” either in the form of Low Income Subsidy (LIS) for Part D, or Medicare Savings Programs (MSP) for medical benefits. As such, this plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, but at a $0 monthly premium, making it a high-value yet affordable choice.

Healthfirst Increased Benefits Plan

The Healthfirst Increased Benefits Plan (IBP) is designed for Medicare beneficiaries who qualify for some level of Low Income Subsidy (LIS) for Part D and possibly some level of assistance in the form of Medicare Savings Programs (MSP) for medical benefits but are not fully dual eligible. While our IBP does charge the full Part D premium, members of this plan should qualify for “Extra Help” to cover the cost of the monthly premium, while also receiving a richer benefit package.

Healthfirst Coordinated Benefits Plan

The Healthfirst Coordinated Benefits Plan is a Medicare Advantage only plan, designed to be the preferred plan for Medicare beneficiaries who already receive creditable Prescription Drug Coverage from sources other than Medicare Part D (e.g., Veteran’s Administration, unions).

Healthfirst Life Improvement Plan

The Healthfirst Life Improvement Plan is a Dual-Eligible Special Needs Plan (SNP), designed specifically for those Medicare beneficiaries who are eligible for both Medicare and full Medicaid through New York State. Through our Model of Care, this Special Needs Plan provides the basic Medicare benefit package for members but coordinates the additional Medicaid benefits the member may be eligible to receive through New York State.

Healthfirst CompleteCare

Healthfirst CompleteCare is a Medicaid Advantage Plus (MAP) Special Needs Plan (SNP) that combines Medicare and Medicaid benefits with added long-term care services like medical social services and adult day health care. CompleteCare is designed specifically for beneficiaries who require nursing home level of care but can safely stay at home.

Healthfirst AbsoluteCare FIDA Plan

Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan) is a Fully Integrated Dual Advantage (FIDA) plan for beneficiaries age 21 or over who receive Medicare and full Medicaid and who require community-based long-term care services or reside in a nursing home. AbsoluteCare provides benefits of both Medicaid and Medicare to participants in the FIDA Demonstration.

<table>
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<tr>
<th>Plan Name</th>
<th>Counties of Service</th>
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<tr>
<td>65 Plus Plan</td>
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<td>Increased Benefits Plan</td>
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</tr>
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</tr>
<tr>
<td>Life Improvement Plan</td>
<td>Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester</td>
</tr>
<tr>
<td>CompleteCare</td>
<td>Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester</td>
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2.3 Healthfirst Commercial Programs

Healthfirst offers a range of commercial products. Qualified Health Plans (QHP) are offered via the NY State of Health (New York State’s health benefit exchange) and are marketed as Healthfirst Leaf Plans. These plans are available for eligible individuals and families. Healthfirst also offers individual and family health plans off the NY State of Health. The benefits and cost-sharing of these off-Exchange plans mirror those of the on-Exchange Leaf Plans, but are marketed as Healthfirst HMO A, B, C, and D plans ("HMO Plans").

Healthfirst Leaf and HMO Plans are comprehensive health insurance plans that meet all state and federal QHP requirements. These plans are offered at a range of premium and coverage levels to meet the needs of a wide variety of consumers:

- **Healthfirst Platinum Leaf Plan/Healthfirst Premier Platinum Leaf Plan/HMO A**: Highest premiums, with $0 annual deductible, low copays, and an annual out-of-pocket limit of $2,000. Adult dental and vision coverage is available with Platinum Leaf Premier plans.

- **Healthfirst Gold Leaf Plan/Healthfirst Premier Gold Leaf Plan/HMO B**: $600 annual deductible, modest copays, and an annual out-of-pocket limit of $4,000. Adult dental and vision coverage is available with Gold Leaf Premier plans.

- **Healthfirst Silver Leaf Plans/Healthfirst Premier Silver Leaf Plans/HMO C**: Modest premiums, with $2,000 annual deductible, modest copays, and an annual out-of-pocket limit of $5,500. Subsidies are available that can help reduce the Silver Leaf copays and deductibles. Adult dental and vision coverage is available with Healthfirst Leaf Premier plans.

- **Healthfirst Bronze Leaf Plan/Healthfirst Premier Bronze Leaf Plan/HMO D**: Lowest premiums, with $3,500 annual deductible, 50% coinsurance, and an annual out-of-pocket limit of $6,850. Adult dental and vision coverage is available with Healthfirst Leaf Premier plans.

- **Healthfirst Green Leaf Plan/HMO E**: Catastrophic coverage for individuals under 30 years of age

These plans offer the following essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic-disease management
- Pediatric services, including oral and vision care

Healthfirst's Healthy NY program plan is offered by Healthfirst Health Plan, Inc., a subsidiary company of Healthfirst, Inc. The Healthy NY program is coverage available to eligible small employer groups. This
program was discontinued for individuals and sole proprietors on December 31, 2013.

2.4 Benefits/Covered Services

Members who participate under a government-sponsored program (Medicaid, Child Health Plus, and Medicare) are entitled to receive all services covered by that program. Benefits among the programs vary. For example, Medicaid members are entitled to receive all the services covered under the Medicaid program, but some services are covered directly by Medicaid Fee-for-Service. Medicare members are entitled to receive all the services under the Medicare program. Further, for Medicare members, the Healthfirst Medicare Plan offers a variety of products that not only cover the services available under Original Medicare, but also offer additional benefits such as dental and vision. Commercial health plan members are entitled to receive all services covered by their plan.

To view a detailed summary of the benefits offered by the Medicaid and CHPlus programs, please refer to the Healthfirst Provider Portal or to our member handbooks located on our website, www.healthfirst.org. For the Medicare programs, please refer to the applicable Summary of Benefits. Any changes to a particular benefit package will be noted in The Source, our provider newsletter, or in other mailings. Copies of these materials are located on our website at www.healthfirst.org/providerservices.

To view a detailed summary of the benefits offered by the Healthfirst Leaf or HMO A–D plans, please refer to the Summary of Benefits available on our website at www.healthfirst.org/health-insurance/healthfirst-leaf-plans.

Consent to Receive Noncovered Services

If you are unsure whether a requested service is covered by Healthfirst, you must do the following:

- Determine if the member has coverage through one of the Healthfirst Medicare programs. If they do, refer to Section 15 for instructions.
- For non-Medicare programs, inform the member that their Healthfirst program may not cover the service. You should contact Member Services directly to confirm whether the service is covered. You should explain to the member that they may also contact Member Services.
- If Member Services confirms that the service is not covered, advise the member that, they may file a grievance if they disagree with Healthfirst's interpretation. Information on the process for filing grievances may be obtained by calling Member Services.
- If Member Services confirms that the service is not covered and the member asks that you provide the noncovered service anyway, you must tell the member the cost of the noncovered service. You must also explain that the member will be billed directly for, and must pay for, the noncovered service, and that Healthfirst will not be financially responsible for the cost of any noncovered service.
- You must obtain the member’s written consent, acknowledging that they were advised of the cost of the noncovered service and agreeing to be financially responsible for it. A general consent signed by the member accepting financial responsibility for any services not paid for by Healthfirst is insufficient. The written consent must indicate the specific services and costs for the noncovered service that will be provided.
3. Healthfirst Provider Networks

3.1 Description of the Networks

Healthfirst serves the healthcare needs of its members through comprehensive provider networks for each of its various programs (Healthfirst Medicaid, Child Health Plus, Medicare, Healthfirst Leaf Plans, and Healthy New York). While each network is separate and unique, most Healthfirst 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.

The networks are organized around each Healthfirst hospital or designated group of hospitals. This includes all inpatient and outpatient facilities, primary care and specialty care providers, and other healthcare personnel affiliated with the hospital’s delivery system, so that providers can refer members and coordinate treatment according to their normal practices and referral patterns. Medical services are generally rendered by hospital and community-based providers within each hospital system. Additional services such as behavioral health, home care, dental, and other ancillary services are provided and managed by either Healthfirst, selected hospitals, or other organizations specializing in these areas.

While our network is organized around the Healthfirst hospitals so that existing referral and practice patterns among providers are maintained, members may see any participating provider within the network for a given Healthfirst program.

Hospital Responsibilities

Healthfirst was started by its member hospitals seeking to provide high quality, comprehensive, managed healthcare services to members covered under government-sponsored and other health benefit programs. Healthfirst has contracted with these and other hospitals to provide inpatient care, outpatient services, and diagnostic testing to its member population. The hospitals and their associated delivery system of providers, allied and ancillary health personnel, therapists and other affiliated providers, comprise the core of the Healthfirst provider network. A listing of participating Healthfirst hospitals can be found in the Provider Directories.

The following is an overview of responsibilities for hospitals participating with Healthfirst:

- Provide all contracted services within the scope of the hospital’s operating certificate
- Verify member eligibility for all services
- Obtain prior authorization for all elective admissions from the Healthfirst Medical Management Department
- Report all obstetrical admissions for delivery to Healthfirst at the time of the delivery or on the next business day
- Provide Healthfirst with Client Identification Numbers (CIN) for all newborns delivered to Healthfirst members
- Refer members back to their primary care providers (PCPs) for coordination of specialty care following an emergency room visit
- Refer all Healthfirst Leaf Plan Members to In-Network specialists prior to the specialist service being rendered using the appropriate referral request form
- Ensure continuity of care by coordinating discharge arrangements with the member’s PCP, specialty care provider (as appropriate), and other post-discharge providers, such as certified home health agencies and the Healthfirst Medical Management department
- Ascertain whether the member has executed an Advance Directive, include an executed Advance Directive in the member’s medical record, and honor the member’s wishes as documented in the Advance Directive
- Notify Healthfirst Medicare members receiving inpatient hospital care (or their representative) when services will be discontinued and/or their original Medicare or Medicare Advantage Plan will no longer pay for their benefits. (See Section 15 for more information)

- Adhere to provider Appointment Availability and 24-Hour Access Standards as specified by the New York State Department of Health

- Implement operating procedures required to comply with the Healthfirst policies and procedures

**Primary Care**

Healthfirst primary and specialty care providers practice in a variety of settings including hospital outpatient departments, hospital-sponsored independent community-based practices, and private provider offices located either on member hospital campuses or within the community.

Primary Care Providers (PCPs) are providers or Nurse Practitioners who specialize in Family Practice, Internal Medicine, Geriatrics or Pediatrics. All members enrolling in Healthfirst select a participating PCP. Generally, members choose geographically convenient providers and hospitals. Members may change their PCP at any time and select a new provider from the Healthfirst network.

PCPs are responsible for coordinating all of the care a member receives and are expected to refer members to specialists in the Healthfirst network for care that is outside of the scope of primary care. Written referrals are not required for most Healthfirst members to receive care from in-network specialists. However, PCPs are responsible for monitoring all member care and promoting the return of the member for services and management. PCPs are also responsible for requesting authorizations from Medical Management. Referrals or authorizations, when required, are essential for prompt claims payment. Please refer to Section 12 for more details on referral and authorization processes.

Because the PCP is the member’s first contact with Healthfirst, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions using appropriate diagnostic procedures and recommending them to Care Management for intensive review and follow-up. If the case meets Care Management selection criteria, the PCP, along with Care Management, formulates and implements a time-specific treatment plan, taking into consideration the member’s input. The PCP should also make referrals for an adequate number of visits to specialists to accommodate the treatment plan, and update treatment plans periodically. Please refer to Section 13 of this manual for more information.

**Primary Care for Leaf Plan and Leaf Premier Plan Members**

Primary Care Providers for Leaf Plan members will be required to generate referrals for Leaf Plan members for most specialist services. Referrals should be generated by the PCP prior to the specialist service being rendered, and can be submitted online through the Healthfirst Provider Portal.

**Primary Care for HIV Positive Members**

All HIV Specialist PCPs must meet additional credentialing requirements to serve this population. (See Appendix II-A) These multi-disciplinary providers coordinate care throughout the service delivery system.

**Treatment Adherence**

At every visit, the HIV Specialist PCP should discuss and document in the medical record the member’s adherence to their treatment plan. For members who do not adhere to their treatment plan, the provider should either provide directly or ensure access to additional treatment adherence support services. To arrange for community-based treatment adherence support services, contact the Healthfirst Care Management Department at 1-888-394-4327.

**Co-Management with an HIV Specialist**

If a member has a life-threatening or degenerative and disabling condition or disease (other than HIV), either of which requires specialized medical care, the member may request a standing referral to a specialist to act as the PCP. A co-management model will be used in this circumstance. In these situations, 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. Providers are expected to cooperate in the process.

**Harm Reduction Services**

Providers must ensure harm reduction services are provided to HIV positive members. These services include:

- Education and counseling regarding reduction of perinatal transmission
- Individual and group HIV prevention and risk reduction education and counseling
- Harm reduction education
- Counseling and supportive services for partner/spousal notification

If you are not sure where to refer a member, the Healthfirst Care Management Department can assist you in securing these services. Call **1-888-394-4327** for more information.

**Specialist Providers (excluding Behavioral Health Providers)**

Healthfirst has contracted with specialist providers and other specialty healthcare professionals to provide care and services to its members whose treatment falls outside the scope of the PCP’s training. For most Healthfirst products such as Medicaid, CHP, and FHP, members are able to access these specialty services without a referral from their PCP or authorization by Healthfirst. Healthfirst Leaf Plan and Leaf Premier Plan members require a referral for most specialty services as outlined in Section 12 of the Provider manual.

Specialist providers also have the responsibility of identifying individuals with complex or serious medical conditions. Once identified, the condition should be assessed and monitored using appropriate diagnostic procedures. These cases should be referred to Care Management for intensive review and follow-up. The specialist, along with Care Management, should establish and implement a time-specific treatment plan taking into consideration the member’s input and coordinating with the PCP.

Specialty care services are provided by clinicians practicing within the Healthfirst Network. Healthfirst may make special arrangements to accommodate referrals to specialists affiliated with non-network institutions when appropriate.

**Tertiary Care**

Healthfirst negotiates system-wide arrangements for the provision of selected tertiary care services.

**Behavioral Healthcare**

Healthfirst has contracted with providers, community agencies and other licensed professionals to provide Behavioral Healthcare services, including mental health and chemical dependency (addiction) treatment, outside the scope of the PCP’s training. Special delegated arrangements for management of behavioral health services apply to members affiliated with certain hospitals. See Section 9 for more information.

**Ancillary Services**

Healthfirst has established both network-wide and hospital-specific arrangements to provide ancillary services such as vision care, home healthcare, and dental services, as well as other services to its members. Healthfirst provides specialized healthcare services, diagnostic testing, therapies and medical items, supplies, devices, DME, and chiropractic services through contracted ancillary providers. Members can access ancillary services via a written prescription or a direct call from the PCP or Specialist provider. Please refer to **Section 10** for a detailed description of all Ancillary Services policies and procedures.

**Levels of Participation**

The relationship between Healthfirst and its participating providers is characterized by three levels (e.g., employed, community-based, etc.). In some cases, the participation level of the provider determines which ancillary service vendors may be used. The levels are as follows:
• **Level I** providers are employees of participating hospitals. They are credentialed by the hospital with delegated oversight by Healthfirst, and are bound by the terms of the agreement executed by the participating hospital which employs that provider. Payment for services rendered by these providers is made to the hospital, not to the individual provider.

• **Level II** providers are contracted with Healthfirst directly on an individual basis or as members of a professional corporation or diagnostic and treatment center. These providers are credentialed by the Healthfirst hospital(s) with which they are affiliated, with delegated oversight by Healthfirst. Payment for services is made directly to the provider or designated contracting entity.

• **Level III** providers are PCPs based in the community who do not have admitting privileges at a Healthfirst participating hospital. These providers hold individual contracts with Healthfirst and are credentialed by Healthfirst. Providers are compensated directly for services rendered.

**Partnering with Healthfirst - Mutual Expectations**

Healthfirst is committed to working with its participating providers to ensure that high-quality services are provided in an atmosphere of collaboration and respect. Mutual expectations are as follows:

**From Healthfirst**

- Open, respectful, and receptive communication
- Knowledgeable and helpful staff
- Timely response to questions and concerns
- Timely communication of policy changes
- Timely, comprehensive orientation, training and educational programs
- Timely processing of provider applications
- Timely payment for covered services rendered
- Responsive appeals and grievance processes
- Assistance with complex member issues
- Feedback on performance and utilization

**From Participating Providers**

- Professional, respectful and responsible healthcare for members
- Timely response to inquiries
- Assistance with problem-solving and other issues
- Maintenance of all contractual credentialing standards and licensing obligations
- Adherence to access and scheduling standards
- Compliance with medical management protocols
- Timely and accurate claims submission
- Compliance with quality improvement protocols and requests
- Cooperative office and administrative staff

**Quality Improvement and Commitment to Providers**

Healthfirst has implemented a uniform Integrated Quality Plan and Quality Improvement Program throughout
the network with oversight maintained by the Healthfirst Chief Medical Officer and Healthfirst Clinical Performance Management staff. This program supports processes designed to improve the quality and safety of clinical care and the quality of service provided to members to ensure members receive the highest quality of care. This includes clinical and service quality indicators, public health reporting, quality investigations, focused clinical studies, quality programs, and member satisfaction surveys. All Healthfirst providers are required to participate in quality improvement efforts.

In addition, any Quality Improvement plans developed by participating providers must adhere to the Healthfirst program standards. Healthfirst offers provider education and training programs regarding quality improvement initiatives conducted by the Clinical Performance Management and Network Management departments. Healthfirst works closely with participating facilities to build consensus and support for critical network policies and procedures and to find solutions to operational issues.

3.2 Provider Rights and Responsibilities

Provider Rights

Healthfirst will not discriminate against any healthcare professional acting within the scope of 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 Healthfirst discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions. Consistent with this policy, Healthfirst may differentiate among providers based on the following:

- Healthfirst may refuse to grant participation status to healthcare professionals whom Healthfirst, at its sole discretion, deems not necessary or appropriate for its provider network
- Healthfirst may use different reimbursement methodologies for different clinical specialties or for different hospital affiliations
- Healthfirst may implement measures designed to maintain quality and control costs consistent with its responsibilities
- Healthfirst providers will be given written notice of material changes in participation rules and requirements in this Provider Manual at least 30 days before the changes are implemented. These communications will generally be circulated in newsletters or special mailings.
- Healthfirst will not prohibit or otherwise restrict a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a Healthfirst member regarding the following:
  - The member's health status, medical care, or treatment options, as well as any alternative treatments that may be self-administered (This includes providing sufficient information to the individual so that there is an opportunity to decide among all relevant treatment options.)
  - The risks, benefits, and consequences of treatment or non-treatment
  - The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Provider Responsibilities

Healthfirst maintains 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 Healthfirst participating providers.

Non-Discrimination

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

- Age
- National Origin
- Race
- Disability
• Sex
• Economic, Social, or Religious Background
• Sexual Orientation
• Health Status
• Claims Experience
• Source of Payment
• Legally Defined Handicap
• Veteran Status
• Marital Status

In addition, 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. Healthfirst has 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. For more information on compliance and guidelines of the Americans with Disabilities Act, click here and read through some answers to Commonly Asked Questions on the ADA.

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. In addition, the Healthfirst Member Services and Medical Management departments 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

Healthfirst has developed Quality Improvement, Medical Management, and other programs to identify opportunities for improving the delivery of health services and their related outcomes. In addition, Healthfirst has operating agreements with Federal, State, and County governments that govern the terms of its participation in the Medicaid managed care, CHP, Healthfirst Leaf Plan, Leaf Premier Plan, and Medicare programs. Regulatory authorities periodically review Healthfirst operations and data reporting (i.e., complaints, enrollment, and financial information). Pursuant to their provider agreements with Healthfirst, participating providers are required to cooperate with Healthfirst 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 Healthfirst develops.

Healthfirst invites its providers to participate on committees that address medical management and quality improvement issues. Providers may sit on the Health Care Quality Council and its subcommittees, or they may provide expertise as provider consultants for peer review and specialty utilization management review. You may contact the Clinical Performance Management department to inquire about participation and refer to Section 14 of this Provider Manual for more information.
In addition, Healthfirst providers are responsible for supporting the member care components of the Member Rights and Responsibilities document found in Section 4 of this Provider Manual. It outlines member rights related to access to care, complete treatment information, privacy and confidentiality, non-discrimination, refusal of medical treatment, and other fundamental elements of the member’s relationship with Healthfirst. It is expected that providers will 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. Further, providers must discuss potential treatment options, side effects, and management of symptoms (without regard to plan coverage).

Please note: The member has the final say in the course of action they will take about their health.

**Release of Member Information**

Medical information about Healthfirst members must be released to Healthfirst upon request and in compliance with the Confidentiality Policy detailed in Section 5.3 of this Provider Manual. Healthfirst will only release medical information to persons authorized by Healthfirst 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 Healthfirst 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 submitted according to the guidelines described in Section 16. Failure to comply with Healthfirst policies in this regard may result in nonpayment for services or termination from the Healthfirst provider network. See Section 2 for information on non-covered services. Providers should never bill Healthfirst members for covered services, except for any applicable deductible, coinsurance or copayment amount.

**Provider Information**

Providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst 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. Any changes and updates to your provider record or participation with Healthfirst, including hospital affiliation, should be submitted at least 30 days before the effective date. Use our electronic Demographic Change Form, found on the Healthfirst Secure Provider Portal, to report to Healthfirst any changes to the list of items below. Changes can also be faxed to Healthfirst at 1-646-313-4634 / Attn: Demographic Update Request. These should be submitted with a fax cover sheet that includes 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 faxed with these requests.

- Update in the provider or group name and Tax ID Number (W9 required)
- Update in provider/group practice address, zip code, telephone or fax number (full practice information required)
- Update in provider/group billing address (W9 required)
- Update in the member age limits for service at the practice (if applicable)
- Update in 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)
- Update in hospital affiliation (copy of current and active hospital privileges)
- Update or addition of specialty (copy of board certificate or appropriate education information)
• Update in practicing office hours (PCP’s need at least 16 hours)
• Update in provider’s board eligibility/board certification status
• Update in participation status
• Update in NY Medicaid number (if applicable)
• Update in National Provider Identification Number (if applicable)
• Update in wheelchair accessibility
• Update in covering provider
• Update in languages spoken in the provider’s office

3.3 Fraud, Waste & Abuse

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

Healthfirst 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 fraud, waste and abuse 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

Healthfirst 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, Healthfirst 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, Healthfirst has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or Healthfirst from paying more for a service than it is obligated to pay. Therefore, Healthfirst established a Special Investigations Unit (SIU), which ensures that Healthfirst is in compliance with all applicable state and federal regulations.

The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if fraud or abuse has occurred. Therefore, Healthfirst employees and contracted entities have a responsibility to report any inappropriate activities to the SIU and the Regulatory Affairs Department or their immediate supervisor, if applicable.

For further information on our compliance program, please visit our provider web page at www.healthfirst.org and select “A Guide to the Compliance Program.”

Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in 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.

**Fraud** - An intentional deception or misrepresentation made by a provider, person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person or entity. 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.

### 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 and Medicaid Services through an established self-disclosure process.

#### Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other Federal or State funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

#### 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., whistle-blowers) 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 a 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.

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Healthfirst
- Knowingly failing to provide members with access to services for which Healthfirst has received premium payments
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports

False Claims Act Penalties

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $10,957 and $21,916) for every false claim, and the claimant's costs and attorneys' fees, as adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1). If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

Protection for Whistle Blowers

Whistle-blower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates in anyway, whistle-blower protection might entitle the employee to file a charge with a government agency, sue the employer or both.

To report information about fraud, waste or abuse involving Medicare or any other healthcare program involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

The following are the applicable false claim act regulations, for reference:

**Federal False Claims Act Civil Remedies Act**

31 U.S.C. 3801-3812

For a copy of this citation, please visit https://federalregister.gov/a/E9-12170.

This act provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. As of August 1, 2016, False Claims Act civil penalties increase to between $10,781 and $21,563 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. It is important to note that when False Claims Act penalties increase, so do the financial rewards for whistleblowers, increasing their incentive to allege false or fraudulent claims. The amount of the false claims penalty is adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1).


**NY False Claims Act (State Finance Law, §§187-194)**

The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on
individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $10,781 to $21,563 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government’s legal fees.

The FCA allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25% to 30% of the proceeds if the government does not participate in the suit and 15% to 25% if the government participates in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person’s family’s needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five (5) years for 4 or more offenses.

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Responsible Parties – Health Care Fraud:

Special Investigations Unit

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste and abuse awareness, detection, investigation and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention and reporting.

Healthfirst Contracted Vendor

Healthfirst contracts with a vendor to assist in the identification of potential fraud, waste and abusive billing practices as mandated by federal and state regulations. Through the use of state-of-the-art detection software, this vendor identifies billing patterns that are not within industry norms. Providers selected for review will be asked to submit medical records for examination. Please note that it is important to provide the Healthfirst contracted vendor with all requested supporting documentation upon request. This will minimize any future disputes regarding any identified issues. Failure by a provider to provide the requested records within thirty (30) calendar days of a request or to send the requested records to the address indicated in the record request letter
will result in the denial of payment and/or recoupment of previously paid claims.

If, after a complete review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Healthfirst will utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. If appropriate education will be provided to ensure further billings are submitted according to established guidelines. The results of these reviews are presented to the Healthfirst Fraud, Waste and Abuse Committee.

Failure to cooperate may result in the non-renewal or termination of your contract with Healthfirst and/or additional reporting to state and/or federal authorities.

Fraud, Waste and Abuse Committee

The Fraud, Waste and Abuse Review Committee (FWAC) is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers. The Committee has the authority to make determinations and/or recommendations to the Healthfirst Credentialing Subcommittee regarding allegations including, but not limited to, placement of a provider on pre-payment review, termination of the provider agreement according to the guidelines described in Section 3.8, referral of the Provider to the applicable regulatory or law enforcement agencies, and recovery of overpayments.

Upon referral by the FWAC, the Credentialing Subcommittee will conduct a separate review of the allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. The Credentialing Subcommittee will render the final decision as to whether a provider should be terminated. Except in instances of immediate termination, when termination is recommended, a Notice of Proposed Adverse Action will be issued to the provider and the provider shall have the opportunity to appeal the decision as outlined in Section 3.8.

The Fraud, Waste and Abuse Committee meets approximately fifteen (15) during the year and is comprised of the following Healthfirst staff members:

- Vice President Deputy General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President Claims
- Vice President Regulatory Affairs
- Vice President Compliance and Audit
- Vice President Network Management
- Director Special Investigations Unit

Pre-Payment Review

As part of its fraud, waste and abuse prevention and detection program, Healthfirst maintains a pre-payment review program (PPR) in which providers must submit records to support the claims billed prior to payment being issued. After a provider is placed on PPR via the below detailed procedures, no claim will be paid unless medical records are (1) submitted timely; (2) submitted to Healthfirst at address indicated in the record request letter; and (3) support the services billed including, but not limited to, the medical necessity and the level of services billed.

Where the FWAC determines that a provider should be placed on PPR due to identification or reasonable suspicion of fraud, waste or abuse, Healthfirst’s vendor administer (the “Vendor”) will notify the provider of the FWAC’s decision and that they will be on PPR for a period of at least six months. The FWAC will review the provider after at least each six month period that a provider is on PPR to determine if the provider has changed their behavior, is maintaining the required documentation, and, where applicable, has resolved any overpayment requests. The Vendor will also send a request(s) for medical records to the provider for all subsequently submitted claims to ensure that claims submitted for payment are supported by appropriate documentation meeting all applicable laws, rules and regulations, coding, and contractual requirements. Providers will have a period of 30 days to submit requested records. In the event records are not submitted within 30 days of the request, the claims at issue will be
denied. Records received after the 30 day deadline will not be considered.

All records must be sent to the address listed in the PPR medical record request letter from the Vendor. Records sent to any other address will not be considered.

The submitted medical records will be reviewed to determine if the claim lines billed by the provider are supported by appropriate documentation. If the records support the claim (e.g. that the services billed were rendered, were medically necessary, and were appropriately performed and documented, etc.), the claim will be approved for payment. The provider should submit all necessary information and records including, but not limited to, records to indicate that the services were rendered, all test results, records to indicate an ongoing course of treatment, evidence of a referral, etc. If the documents are not supportive of the services billed, the claim will be denied. Claim lines with no records, either because the provider failed to maintain such records or failed to provide such requested records, will be denied for payment. Providers will be informed of the PPR decisions through the provider portal or an explanation of payment.

If providers disagree with the PPR claim determination, they may submit a review and reconsideration (e.g. first level appeal) within ninety (90) calendar days of the claim decision. Providers must submit additional supporting documentation directly to the Vendor at the address listed in the PPR medical record request letter for reconsideration and review in a timely manner. Thereafter, if a provider disagrees with the decision on review and reconsideration, a further appeal is available pursuant to the “Claims Appeal Process” detailed in section 17.6 of the Provider Manual. All Appeals must be submitted to Healthfirst at the address indicated in section 17.6 of the Provider Manual and include a cover letter noting that this is an appeal from a PPR determination. The review and reconsideration and the appeal processes shall otherwise be conducted in accordance with section 17.6 of the Provider Manual.

**Retrospective or Post-Payment Review**

Periodically, the Vendor and the SIU conducts audits of claims that have previously been paid by Healthfirst. In such audits, Vendor or the SIU will request documentation from providers which is required to be maintained in accordance with applicable laws, rules and regulations, coding requirements and contractual requirements. Vendor then presents the audit outcome to the provider in an Audit Findings Report (AFR). If the provider disagrees with the findings in the AFR, the provider must follow the review and reconsideration and appeal processes noted in the above “Pre-Payment Review” Section. If a timely request for review and reconsideration or appeal is not initiated by the provider, the determination of the AFR will be deemed final and sent for overpayment recovery in accordance with section 17.7 of this Provider Manual and any other available means of recovery (e.g. collections agency, litigation, etc.). Most retrospective reviews are based on a statistically valid sample, however, in some instances, audits may be conducted based on specific ICD 9/10 code issues.

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste and abuse awareness, detection, investigation and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention and reporting.

**Prescription FWA - Premier Audit Meetings**

In addition to the Fraud, Waste and Abuse Committee discussed above, Healthfirst also conducts quarterly Premier Prescription FWA Audit meetings. This committee is concerned with fraud, waste and abuse and potentially hazardous prescription use within the Prescription Drug Program. The committee meets to review reports prepared by CVS Caremark, the plan’s contracted Pharmacy Benefit Manager. The committee is responsible for directing all further investigative activities and reporting of suspect questionable activities to the plan’s Fraud, Waste and Abuse Committee for further direction.

The committee is composed of the following Healthfirst staff members:

- Vice President Pharmacy
- Pharmacy Director or pharmacist alternate
• Director Special Investigations Unit
• Supervisor Special Investigations Unit
• CVS Caremark Representatives

**Restricted Recipient Program**

Restricted Recipient Program (RRP) is a program whereby selected enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more RRP Providers for receipt of medically necessary services.

Restricted Enrollee means an enrollee who has engaged in abusive practices or demonstrated a pattern of misuse of a category of Medicaid or FHP benefits and has been restricted by either the contractor or OMIG to receive certain services only from an assigned RRP Provider. The amount, duration and scope of the Medicaid or FHP benefit are not otherwise reduced.

**Member Review and Restriction Committee (MRRC)**

The Member Review and Restriction Committee oversees the Restricted Recipient Program (RRP) which is intended to reduce the cost of inappropriate utilization of covered services by identifying and managing enrollees exhibiting abusive or fraudulent behavior. Through increased coordination of medical services, the number of providers that the enrollee may select for care and the referrals to services, medications, and equipment is controlled; enrollees targeted for the Restricted Recipient Program are ensured access to medically necessary quality health care and unnecessary costs to the Medicaid program are prevented.

The MRRC is a professional team comprised of, at a minimum, a physician, a registered professional nurse and a pharmacist. The MRRC shall review and determine whether the enrollee has demonstrated a pattern of over-utilization, under-utilization or mis-utilization of services included in the Benefit Package and whether such behavior should be managed by the Restricted Recipient Program. The MRRC is also responsible to ensure that the directives of the team regarding placing restriction of recipients are carried out. The MMRC consists of the following staff members

• Vice President Associate General Counsel
• Chief Medical Officer (or his/her representative)
• Vice President Claims
• Vice President Regulatory Affairs
• Vice President Compliance and Audit
• Vice President Network Management
• Pharmacy Director or pharmacist alternate
• Director Special Investigations Unit

**Common Methods of Fraud and Abuse**

In order to assist you with understanding and/or identifying what may constitute fraud, waste and/or abuse, we have provided some typical examples for your reference.

**Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate member names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:
• Submitting claims for services not rendered
• A provider who, using existing information on his or her members, creates claims for office visits or services that never took place
• A provider who, in the course of billing for actual member treatments, adds charges for x-rays or laboratory tests that were never performed
• A durable medical equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up

Falsification of Claims: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:
• A provider performs medically unnecessary services solely in order to bill and be paid for doing so
• A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery
• A provider falsifies the dates on which services were provided, so that they fall within a given eligibility period of the member
• A provider falsifies the identity of the provider of services so as to obtain payment for services rendered by a noncovered and/or nonlicensed provider
  o For example, submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy
• A provider upcodes the services rendered to obtain greater reimbursement
• Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision making than was actually rendered; encounters that required straightforward decision-making are reported as having required highly complex decision-making
• Reporting more intensive surgical procedures than were actually performed
• Anesthesiologist bill for more intensive surgical procedures than reported by the surgeon

Unbundling: Provider submits a claim reporting comprehensive procedure code (Resection of small intestine) along with multiple incidental procedure codes (Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure.

Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Fragmentation: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

Duplicate claim submissions: Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

Fictitious Providers: Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

Examples of FWA within the Prescription Drug Program

Plan Sponsor
- Failure to provide medically necessary services
- Marketing schemes offering beneficiaries inducement to enroll
- Unsolicited marketing
- Misrepresenting prescription drug products
- Payment for excluded drugs
- Multiple billing
- Inaccurate data submission

**Pharmacy Benefit Manager (PBM)**

- Prescription drug switching
- Steering a beneficiary to a certain plan or drug
- Inappropriate formulary decisions
- Failure to offer negotiated prices

**Pharmacy**

- Inappropriate billing practices
- Prescription drug shorting
- Bait and switch pricing
- Prescription drug forging or altering
- Payment for excluded drugs
- Dispensing expired or adulterated drugs
- Prescription refill errors
- Failure to offer negotiated prices

**Prescriber**

- Prescription drug switching
- “Script” mills
- Provision of false information
- Theft of DEA number or prescription pad

**Wholesaler**

- Counterfeit or adulterated drugs through black markets
- Drug diversions
- Inappropriate/false documentation of pricing information

**Manufacturer**

- Lack of data integrity to establish payment or determine reimbursement
Kickbacks, inducement, or other illegal remuneration
Inappropriate relations with formulary committee members
Inappropriate relations with providers
Illegal “off-label” promotion
Illegal use of free samples

Beneficiary

- Misrepresentation of enrollment status
- Identity theft
- Prescription forging or altering
- Drug diversion or inappropriate use
- Prescription stockpiling
- “Doctor shopping” for drugs

FDR & Affiliate Compliance Requirements

Healthfirst’s commitment to compliance includes ensuring that our First Tier, Downstream and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. Healthfirst contracts with these entities to provide administrative and healthcare services to our enrollees; we are ultimately responsible for fulfilling the terms and conditions of our contract with the Center for Medicare and Medicaid Services (CMS) and meeting the Medicare and Medicaid program requirements. Therefore, Healthfirst requires each FDR and Affiliate to comply with the compliance and fraud, waste and abuse expectations.

Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with Healthfirst.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with Healthfirst policy and applicable Federal and State statutes and regulations. A copy of the Healthfirst compliance attestation and the FDR & Affiliate Compliance Guide can be found at www.healthfirstfdr.org.

Reporting of Fraudulent, Wasteful and Abusive activities

Healthfirst wants to make sure that our providers understand that we expect 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 Healthfirst to bring any alleged inappropriate activity which involves Healthfirst to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

<table>
<thead>
<tr>
<th>Healthfirst Compliance Officer at:</th>
<th>Special Investigations Unit (SIU) at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 Church Street, New York, NY 10007</td>
<td>100 Church Street, New York, NY 10007</td>
</tr>
<tr>
<td>By phone – 212-453-4495</td>
<td>By phone - 212-801-3292</td>
</tr>
<tr>
<td>E-Mail – <a href="mailto:compliance@healthfirst.org">compliance@healthfirst.org</a></td>
<td>E-Mail - <a href="mailto:SIU@healthfirst.org">SIU@healthfirst.org</a></td>
</tr>
</tbody>
</table>

Providers may also report fraud, waste and abuse anonymously to EthicsPoint, Inc., a contracted vendor, by using the Healthfirst Hotline at 1-877-879-9137 or online at www.hfcompliance.ethicspoint.com. This service is available 24/7.
3.4 Appointment Availability and 24-Hour Access Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New York State requirements. Healthfirst and the NYSDOH actively monitor adherence to these standards (Appendix I). Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage. All participating providers are expected to provide care for their Healthfirst members within these access guidelines.

**Office Hours**

Each PCP that participates with Medicaid, Child Health Plus, HARP, and Essential Plans must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care site. Providers credentialed as both an HIV PCP and specialist working at academic institutions may have some flexibility with this requirement. PCPs who participate with Medicare and commercial lines of business must maintain a minimum of ten (10) office hours per week at each primary care site. PCPs who have a participating location that services the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

**24-Hour Coverage**

Participating providers must be accessible 24 hours a day, 7 days a week throughout the year, either directly or through back-up coverage arrangements with other Healthfirst participating providers. Each provider must have an on-call coverage plan, acceptable to Healthfirst, 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 Healthfirst and its emergency care policies and procedures, and will have key Healthfirst telephone numbers available at all times.
  - The Healthfirst 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 Healthfirst providers will be familiar with Healthfirst and will be able to act in accordance with Healthfirst emergency policies and procedures such as notifying Medical Management of emergency care or admissions. These policies are further discussed in Section 11. 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.
- Healthfirst members must be able to locate a Healthfirst 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, Healthfirst 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 (1) 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 (1) hour.

Non-urgent Walk-in Visits: Members with non-urgent care needs should be seen within two (2) hours of arrival of an unscheduled appointment, or scheduled for an appointment in a timeframe consistent with the Healthfirst scheduling guidelines. Providers must have policies and procedures which adequately address enrollees who present for unscheduled, non-urgent care, with the aim of promoting enrollee access to appropriate care.

**Missed Appointments**

Healthfirst 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.

**3.5 Provider Application Process**

Participating hospitals, hospital-sponsored practices, treatment centers, community-based groups, and individual providers should call 1-888-801-1660 to notify Healthfirst about new providers joining an existing practice or to inquire about how to become a participating provider. If the provider is determined to be a desirable candidate he or she will then be required to complete an application package and submit the appropriate credentialing information and required documentation based on their level of participation (e.g., Level III).

**3.6 Credentialing, Recredentialing Requirements & Provisional Credentialing**

Healthfirst is committed to providing healthcare services to its members through a high quality provider network that meets the guidelines set by the NYSDOH. Providers are initially credentialed and biannually recredentialed through approved delegation agreements with participating hospitals, or every three (3) years through a rigorous credentialing review conducted by Healthfirst. Providers have the right to review their Healthfirst credentialing file (with the exception of peer review references or recommendations) and may contact Healthfirst if they wish to make arrangements to do so.

**Provisional Credentialing**

Newly licensed providers and providers relocating from other states can apply for provisional credentialing if Healthfirst is unable to credential providers within 90 days after the receipt of a completed application.

Providers are eligible to apply for provisional credentialing only after 90 days have passed since Healthfirst has received a completed application and the following two requirements are met:

- Provider(s) must be newly licensed in the State of New York or relocating from other state(s)
- Provider group has notified Healthfirst that the group and the provider will comply with the statutory requirements concerning refunds and holding members harmless

Providers who are provisionally credentialed are allowed to participate in the Healthfirst network and given provisional participation status so that claims can be processed, however, they cannot be assigned a panel. The provisional participation status for providers will continue until Healthfirst fully credentials the provider or disapproves the provider for network participation.

Healthfirst will notify providers as soon as possible within 90 days of receipt of a completed application as to
whether the provider has been credentialed, whether the application has been denied, or if additional information is needed to complete the credentialing process.

**The Credentialing Subcommittee**

The Credentialing Subcommittee is a multi-disciplinary committee of clinical practitioners from Healthfirst participating hospitals, as well as the Healthfirst Chief Medical Officer, Vice President of Quality Improvement and Director of Credentialing (without vote). The Subcommittee is charged with the credentialing and recredentialing function and, through the review of credentialing and recredentialing materials, has the authority to make recommendations and decisions regarding credentialing, recredentialing and termination of providers. The Subcommittee meets quarterly and is responsible, through a peer review process, for the following functions:

- Review and approve credentialing policies and procedures
- Review practitioner credentials and make recommendations with respect to provider applications for membership in the Healthfirst Network
- Review practitioner recredentialing documents and make recommendations with respect to practitioner continuation in Healthfirst Network
- Review facility and vendor credentials and recredentials, and make recommendations with respect to participation and/or continuation in the Healthfirst Network
- Review and approve the Standards for Delegated Credentialing
- Review practitioner sanctions and make recommendations as to practitioners’ ability to deliver care and remain in the Healthfirst Network
- Review and approve the Delegated Credentialing File Audit Results of each member hospital’s Level I and Level II practitioners credential files
- Review and approve Level I and Level II practitioners in the network on a quarterly basis
- Review Provider Quality of Care issues that meet Healthfirst’s policy and threshold for Credentialing Subcommittee Review
- Review and approve minutes of Credentials Subcommittee Meetings
- Review recommendations made by the Fraud, Waste and Abuse Review Committee concerning alleged improper billing practices and suspected fraud and/or abuse committed by a provider. If the Credentialing Subcommittee determines that formal termination of a provider is warranted, the Subcommittee will submit its recommendations to the Health Care Quality Council in this regard for final determination
- Provide a summary report of findings and submit to Healthfirst Quality Improvement Committee (QIC) on a quarterly basis or more frequently as required

Please refer to Appendix II for a complete list of credentialing requirements.

**3.7 Provider Profiling**

Healthfirst monitors the performance of its provider network to ensure the quality and appropriate use of healthcare services and to identify opportunities for provider improvement and the management of medical costs. Healthfirst has developed criteria and methodologies to collect and analyze profiling data to evaluate a provider’s practice patterns and performance. Areas evaluated include but are not limited to billing and coding patterns; inpatient, outpatient, ancillary, and pharmacy utilization trends; and specialty costs.

All providers are measured against an appropriate group of healthcare providers using similar treatment modalities and servicing a comparable member population. On a periodic basis and upon the request of a provider, Healthfirst will provide a copy of the provider profile, data, and analysis used to evaluate the
requesting provider’s performance. Providers shall be afforded the opportunity to meet with Healthfirst to discuss the information reported in the provider profile and the unique nature of the provider’s member population, which may have a bearing on the provider’s profile. Providers will also be afforded the opportunity to work cooperatively with Healthfirst to improve performance.

All provider profiling evaluations comply with Section 4406 D(4) of the New York State Public Health Law.

### 3.8 Termination of Provider Agreements

Healthfirst or its participating providers may decide to terminate or elect not to renew a provider agreement. Termination procedures are subject to the provisions of the provider agreement. If conflicts between the provisions in this Provider Manual and any provider agreement exist, the terms of the provider agreement will apply.

#### Withdrawing from the Network

Providers who wish to withdraw from the Healthfirst network may request to do so by contacting their Healthfirst Network Management representative. Healthfirst will consider these requests on a case-by-case basis. Unless otherwise stated in the provider’s contract with Healthfirst, Healthfirst must agree to allow the provider to withdraw from the Healthfirst network. If Healthfirst agrees, we will confirm our agreement in writing which will include the effective date that the provider will no longer participate in the Healthfirst network. Both Healthfirst and the provider must comply with the applicable transitional care requirements for members following the effective withdrawal date. If Healthfirst does not agree to the withdrawal, providers may non-renew their provider agreement as explained below.

#### Non-Renewals

Healthfirst or its participating providers may elect not to renew a provider agreement. Exercising the option of non-renewal is not considered a termination of a provider agreement under Public Health Law Section 4406-d. A non-renewal decision made by either Healthfirst or a participating provider requires at least 60 days written notice to the other party prior to the expiration date of the provider agreement or written notice as set forth in the provider’s agreement with Healthfirst.

#### Immediate Termination

Consistent with Public Health Law Section 4406-d, Healthfirst reserves the right to terminate a provider contract immediately, based on the following:

- Final disciplinary action is taken by a state licensing board or governmental regulatory agency that impairs the provider’s ability to practice
- There is a determination of fraud on the part of the provider made either by the Healthfirst Credentialing Subcommittee or another appropriate body
- Continuation of the provider’s participation may cause imminent harm to members

Healthfirst may, at the sole discretion of the Healthfirst Medical Director, thereafter afford the provider an opportunity for a hearing in accordance with the procedures outlined below in the Section entitled “Termination for Cause.”

All provider requests for a discretionary appeal must be in writing, submitted no less than 30 days after the date of the termination notice, and sent to the Legal Department’s attention who will then deliver the request to the Medical Director. Best efforts will be used to by the Medical Director to make a determination and communicate this determination to the provider via letter within 30 days of receipt of the request.

In cases of immediate termination, Healthfirst will immediately close a provider’s panel to new members. In addition, Healthfirst is not required to, and may not arrange for, post-termination continuation of care from any provider who is subject to immediate termination pending the outcome of a hearing, if one is so afforded to the provider.

#### Termination for Cause
Healthfirst reserves the right to terminate a provider’s contract for cause upon 60 days prior written notice to the provider, or upon notice as set forth in the provider’s agreement with Healthfirst, in the event of:

- Repeated failure to comply with quality assurance, peer review and utilization management procedures
- Unprofessional conduct as determined by the appropriate state professional licensing agency
- Conviction for a criminal offense related to the practice of medicine or any felony unrelated to such practice, or any activity that would cause imminent harm or danger to a Healthfirst member
- Failure to comply with Healthfirst credentialing standards and procedures
- Revocation, reduction or suspension of privileges at any participating hospital or any hospital where the provider conducts his or her primary practice
- Discrimination against Healthfirst members as outlined in the Provider Agreement
- Engaging in abusive or improper billing practices

The Healthfirst Credentialing Subcommittee shall review all proposed provider terminations for cause. If the Credentialing Subcommittee’s recommendation is to terminate a Provider Agreement, the provider shall receive a written Notice of Proposed Adverse Action which shall include the following information:

- The reason for the proposed termination
- Information about the provider’s right to request a hearing before a panel appointed by Healthfirst
- A statement that the provider has 30 days to request a hearing from the date that Healthfirst mailed the Notice of Proposed Adverse Action
- A statement that Healthfirst will schedule a hearing within 30 days from the receipt of a provider’s request for a hearing
- A summary of the provider’s hearing rights

All terminations for cause shall be done in accordance with Public Health Law Section 4406-d(2). Under no circumstances will Healthfirst initiate termination or non-renewal actions against a provider solely because he/she has:

- Advocated on behalf of a member
-Filed a complaint against Healthfirst with state or federal regulatory bodies
-Appealed a decision made by Healthfirst
-Provided information, filed a report or requested a hearing or review

Please note: At any point the contractor may receive notice from the New York State Department of Health to terminate a provider contract. The provider will be subjected to the provisions outlined above.

Provider Hearings

Providers who receive a Notice of Proposed Adverse Action from Healthfirst recommending contract termination have the right to appeal the decision and request a hearing. All requests for a hearing must be made in writing within thirty (30) days from the date the provider received the Notice of Proposed Adverse Action. Please note: At any point the contractor may receive notice from the New York State Department of Health to terminate a provider contract. The provider will be subjected to the provisions outlined above.

Provider Hearings

Providers who receive a Notice of Proposed Adverse Action from Healthfirst recommending contract termination have the right to appeal the decision and request a hearing. All requests for a hearing must be made in writing within thirty (30) days from the date the provider received the Notice of Proposed Adverse Action.

Healthfirst Medical Director
100 Church Street
New York, New York 10007
A provider’s failure to submit a request for a hearing within thirty (30) days will be deemed a waiver of any appeal rights. The proposed termination will become final and the provider will not be afforded additional appeal rights.

Providers are encouraged to submit any additional documentation about his/her case together with the request for a hearing. If a hearing request is received, Healthfirst will schedule a hearing within thirty (30) days of the provider’s written request for a hearing. The provider shall be further apprised, in writing, of the date, time and place of the hearing, and a list of witnesses, if applicable, that are expected to testify at the hearing on behalf of Healthfirst. Healthfirst will consider any reasonable requests to reschedule a hearing other than the date originally scheduled; however, repeated requests to reschedule a hearing will lead to a waiver of appeal rights. In addition, Healthfirst reserves the right to be represented by outside counsel at the hearing.

The hearing panel shall consist of three (3) individuals appointed by Healthfirst. Specifically, the hearing panel shall include the Healthfirst Medical Director, a provider in the same or similar medical specialty as the provider under review (“clinical peer”), and a third individual selected by Healthfirst. If Healthfirst selects a hearing panel that is larger than three (3) individuals, at least one-third of the panel’s membership will be clinical peers. In addition, if the provider participates in Healthfirst’s Medicare Advantage programs, the majority of the hearing panel members shall be clinical peers.

At least ten (10) days prior to the scheduled hearing, a provider should submit to Healthfirst a written summary of his/her position and a copy of any exhibits or additional evidence that will be presented at the hearing.

At the hearing, a provider will be afforded the following rights:

- To be present at the hearing and represented by legal counsel
- To present any additional evidence that is relevant to the provider’s case without regard to its admissibility in a court of law
- To call, examine, or cross-examine any witnesses, all of whom will testify under oath
- To submit a written statement at the close of the hearing
- To have a copy of the record of the proceedings (at the provider’s expense)

The hearing panel shall render a final decision either on the day of the hearing or within ten (10) business days. The hearing panel may uphold or reverse the underlying determination made by the Healthfirst Credentialing Subcommittee, or may conditionally reinstate the provider subject to certain conditions determined by the hearing panel. The provider shall be notified in writing of the hearing panel’s decision within fifteen (15) business days from the date of the decision.

If termination is recommended, a provider’s termination shall be effective no less than thirty (30) days after the provider’s receipt of the hearing panel’s decision. In no event shall termination be effective earlier than sixty (60) days from the provider’s receipt of the initial notice of proposed termination.

**Continuity of Care If a Provider Leaves the Healthfirst Network**

Terminated or non-renewed providers are required under New York State law to continue a course of treatment until arrangements are made to transition the member’s care to another provider. Specifically, providers are required to continue providing services to Healthfirst members for a period of ninety (90) days from the date of the contract termination or nonrenewal in accordance with Public Health Law Section 4403(6)(e). In the case of providers caring for members in the second trimester of pregnancy, the continuity of care/transition period extends through post-partum care directly related to the delivery. **Providers must continue to accept the Healthfirst reimbursement rates set forth in the provider agreement and to comply with Healthfirst policies and procedures during the continuity of care period.** Additional information on continuity of care is found in Section 12.

**Notification to Members in Cases of Provider Termination**
Healthfirst sends written notice to members of provider termination in accordance with applicable law. The notice will inform the member of the effective date of the provider’s termination and advises members of procedures for selecting a new PCP within Healthfirst’s network. When a PCP leaves the network, Healthfirst reassigns the provider’s members to another PCP. Members have the option to change the new provider assignment by calling the Member Services Department and selecting a provider of their choice.

**Healthfirst’s Duty to Report**

Healthfirst is legally obligated to report to the appropriate state professional disciplinary agencies as well as the National Practitioner Data Bank under the following circumstances:

- The termination of a provider’s contract for reasons related to alleged mental or physical impairment, misconduct or impairment of a member’s safety or welfare
- The voluntary or involuntary termination of a provider’s contract or employment to avoid the imposition of disciplinary action or investigation by Healthfirst
- The termination of a provider’s contract in the case of a determination of fraud or of imminent harm to a member’s health
- Any disciplinary action based upon reasons related to professional competence or conduct that would adversely affect the clinical privileges of a provider for longer than thirty (30) days.

**Reporting Suspected Fraudulent Conduct**

Healthfirst is required by the New York State Department of Financial Services to report any suspected healthcare insurance fraud to the New York State Department of Financial Services Frauds Bureau whether or not Healthfirst elects to terminate a Provider Agreement.

To report suspected fraud or abuse an anonymous phone line is in place at 1 (877) 879-9137
4. Eligibility and Membership

4.1 Introduction

Healthfirst Medicaid Managed Care Plan

Members who are eligible for New York State Medicaid programs including TANF, SNA, Medicaid and SSI, and immigrants who are qualified aliens or fall under one of the permanent residence under color of law (PRUCOL) classifications, are also eligible for Healthfirst Medicaid. Coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, and Suffolk counties.

To be eligible for the Medicaid program, a potential member must meet criteria which include household income, residency, citizenship, and alien status requirements.

Enrollment in a Medicaid Managed Care Plan is now mandatory for the Medicaid-eligible population living in New York City and in Nassau and Suffolk counties. Those individuals who do not voluntarily select a plan will be assigned to a participating managed care plan by the New York State enrollment broker, New York Medicaid CHOICE, which is responsible for managing the mandatory enrollment process. However, there are certain categories of Medicaid recipients who are either excluded from the Medicaid managed care program or are exempt from mandatory enrollment. If you are treating members who qualify for an exemption, you may be required to complete an exemption form. This form must be submitted to New York Medicaid CHOICE for State Department of Health approval of the exemption. Exempt individuals have the option of choosing to join a managed care plan. Please contact Healthfirst if you have questions regarding managed care exemptions. See Appendix III for a complete list of the Medicaid Managed Care excluded and exempt population groups.

To obtain exemption forms, please call the New York Medicaid CHOICE helpline at 1-800-505-5678.

Individuals who have access to healthcare coverage through their own or a family member’s employment with the federal, state, or county government, a municipality or a school district are not eligible to enroll in the Medicaid managed care program. Coverage for individuals meeting such criteria will end upon their next annual renewal date occurring after the effective date of implementation.

Medicaid Recertification

Medicaid members must recertify their eligibility for the program on an annual basis. Members will receive notice to recertify from their local district of Social Services. Notification will be received via mail reminding a member to renew their coverage. A member will be able to send their renewal form through the mail or renew online (for NYC members only).

Child Health Plus (CHP)

CHP provides reasonably priced or no-cost healthcare coverage for children under the age of 19 for families who do not qualify for Medicaid and for whom the price of commercial health insurance is prohibitive. Those who qualify for Medicaid must pursue an application to participate in that program initially or upon recertification. The children are eligible for CHP regardless of immigration status, even if undocumented. Their families must be income-eligible to qualify for coverage under the New York State-sponsored CHP initiative that provides varying levels of subsidization for the insurance premium, depending on the family’s income level. Coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, and Suffolk counties.

The application for CHP requires supporting documentation for income, identity/date of birth, and residency (must reside in New York State). CHP members who are pregnant should be referred to Medicaid. They will remain in CHP until their Medicaid eligibility determination is made. Prospective members’ eligibility will be determined by the contractor upon receipt of the application and required supporting documentation. If all requirements are not met, there is potential for a prospect to become a member with the plan and receive 60 days of temporary coverage—this is referred to as presumptive eligibility.

CHP Recertification

CHP members must recertify their eligibility for the program annually. An abbreviated application form, called
the CHP Renewal Form, must be completed with new supporting documentation. The form is sent to a CHP member 90 days prior to the member’s anniversary date. It must be completed and submitted no later than 30 days before the anniversary date to ensure continuation of benefits. If it is determined that a member is Medicaid eligible, the member’s eligibility will be electronically submitted to HRA (NYC). For LI, the CHP Renewal Form will be submitted to the local district Social Services. If additional documentation is needed to properly process the recertification, a member may receive 60 days of presumptive coverage.

Providers are asked to note on the monthly enrollment roster which children are scheduled for annual renewal of eligibility and to communicate the importance of recertification to their families. This will avoid any lapse in coverage.

It may take up to 60 days to obtain documentation and verify eligibility for CHP. Therefore, applications are processed and members are considered presumptively eligible for 60 days while all documents are reviewed. Members will select PCPs and may access services during this period; providers will be compensated for services rendered. If, at the end of the 60 days, it is determined that the member is not eligible, he/she will be disenrolled.

Medicare

Our Medicare programs are offered by Managed Health, Inc./Healthfirst Medicare Plan. There are a variety of HMO products available to individual members who are eligible for Medicare Part A and B and who will continue to pay their Medicare Part B premium. Some plans have additional eligibility criteria. Coverage is available in Bronx, Kings, Nassau, New York, Queens, Richmond, and Westchester counties. Our 65+, IBP, and CBP plans are available in Bronx, Kings, New York, Queens, Richmond, and Nassau counties, and the LIP, CCP, and MAX plans are also available in Westchester county. Our JBP plan is available in New York, Kings, and Queens counties. Our CC plan is available in New York, Bronx, Kings, Queens, and Richmond counties.

Commercial/QHP

Our commercial programs are called Healthfirst Healthy NY, Healthfirst Leaf Plans, Healthfirst HMO A-D plans, and Healthfirst small group plans. Members are covered through individual contracts. New York State’s Healthy NY program no longer offers coverage for individuals and sole proprietors, as of December 31, 2013. Healthfirst Leaf Plans, Healthfirst Leaf Premier Plans, and Healthfirst HMO A-D plans for individuals and families are available in Bronx, Kings, New York, Richmond, Queens, Suffolk, and Nassau Counties. Healthfirst Healthy NY for small group coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, and Suffolk counties.

4.2 Marketing, Advertising, Outreach and Enrollment

Healthfirst has implemented advertising, enrollment, and outreach/education guidelines and policies to govern the outreach/education of its government-sponsored programs such as Medicare, Medicaid, CHP, and by
healthcare providers. These guidelines and policies are based on requirements set by CMS and the New York State Department of Health. The goal of these guidelines is to ensure that advertising, enrollment, and outreach/education activities by all parties involved in Healthfirst programs are conducted in a responsible manner so that potential members receive the most accurate and complete information possible. Providers may advise their members of managed care plans with which they participate, but they must list all plans and cannot promote one plan over another.

Under its contracts with CMS and the New York State Department of Health, Healthfirst is held responsible for advertising, enrollment, and outreach/education activities undertaken by any individual or entity involved in advertising, enrollment, and outreach for, or on behalf of, Healthfirst. This applies regardless of whether Healthfirst directly employs the involved party or whether that party is affiliated with Healthfirst by subcontract or through a participating provider agreement. Hospitals, clinics, physicians, and other providers belonging to the provider network are considered subcontractors and are subject to the marketing guidelines. Violations of the marketing guidelines may lead to a suspension of marketing activities at Healthfirst facilities or regulatory sanctions affecting the provider or Healthfirst. All Healthfirst marketing activities are conducted in strict compliance with CMS and/or NYSDOH guidelines (see Appendix IV). These policies are followed throughout the Healthfirst service area.

Healthfirst does not discriminate against prospective members based on age, gender, race, national origin, sexual orientation, or medical/mental condition. Written advertising, enrollment, and outreach/education materials developed by Healthfirst, as well as those produced independently by Healthfirst providers, must be pre-approved by regulatory authorities. Healthfirst providers who wish to contact their members to apprise them of managed care plan affiliations have the option of using a model letter prepared by the appropriate regulatory agency. This letter is available from Healthfirst upon request. Any modifications to this letter, and newly developed materials prepared by Healthfirst providers that advertise Healthfirst, must be submitted to regulators for pre-approval through Healthfirst.

Please note: Marketing correspondence should not be sent to members who are in an exclusion category for Medicaid and cannot join a managed care plan (see Appendix III).

If you have members in your practice who are interested in or eligible for one of the Healthfirst programs, you may refer them to Healthfirst Member Services. Healthfirst representatives will assist these individuals with the applicable enrollment or application process and will function as the liaison with Maximus, the Medicaid managed care enrollment office, for potential Medicaid members or as the liaison with NY State of Health—the New York health insurance marketplace—for those potential members who may be eligible for a Healthfirst commercial plan.

For providers interested in on-site marketing, Healthfirst will schedule time for a representative to be available at your office or facility for the convenience of your members. Please call 1-888-801-1660 for more information.

All providers participating in Medicaid or Medicare managed care plans are bound by the requirements of Healthfirst contracts with CMS and the New York State Department of Health, which include the MCO Advertising and Outreach Guidelines prepared by the New York State Department of Health (see Appendix IV).

### 4.3 PHSP Enrollment and Disenrollment

#### Mandatory Medicaid Managed Care

Medicaid recipients will have 30 days from notification that they must select a managed care plan to enroll in the plan of their choice. Family members may be enrolled into different plans and are no longer required to have one plan per family. Medicaid eligibles who do not select a managed care plan within the allotted time period will be “auto-assigned” to a plan by Maximus, the enrollment broker charged with managing all mandatory Medicaid managed care enrollments and disenrollments.

Once enrolled in a managed care plan, members will have 90 days to change plans, regardless of whether the selection was through choice or auto-assignment. After this period expires, members will be “locked in” to
the plan for a period of nine months following the effective date of enrollment. If a member loses and regains Medicaid eligibility within three months, he/she will be automatically re-enrolled with Healthfirst.

Healthfirst will assign a maximum of 1,500 members to a Physician and 1,000 members to a Nurse Practitioner based on a 40-hour FTE. Panel sizes will be prorated when providers carry less than 40 hours at a practice site.

Child Health Plus (CHPlus)

Members will enroll in Healthfirst through the application process outlined in Section 4.1. The advertising/outreach guidelines and enrollment process described above also applies to the CHPlus Program.

**Member Enrollment Rosters**

Members are enrolled monthly into the Healthfirst programs. Each month, Healthfirst will provide PCPs with an enrollment roster for each program that identifies new members in the provider’s panel as well as those members who have left the practice. Providers may use these rosters to verify eligibility, however, if a member is not listed on the roster and says that he/she belongs to the provider’s panel, the provider should verify eligibility by accessing the Member Eligibility section of our web site or by calling Member Services. Member Enrollment Rosters are available on our web site at [www.healthfirst.org/providers](http://www.healthfirst.org/providers).

**Newborns**

When a Healthfirst member is pregnant, the PCP should notify Member Services and Medical Management as soon as the pregnancy is confirmed. The mother’s name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided at this time. Hospitals must notify Medical Management of all deliveries within one (1) business day of the child’s birth. Hospitals must also provide Healthfirst with the newborn’s Client Identification Number (CIN).

All newborns of Medicaid-eligible mothers are automatically assigned to the mother’s managed care plan at birth. Healthfirst Providers are required to accept a mother’s Healthfirst enrollment as sufficient proof of the newborn’s enrollment in the mother’s plan. The mother does not have to produce a Medicaid or Healthfirst ID for the infant.

Early notification of the pregnancy enables Healthfirst staff to ensure that a PCP is selected for the infant before the actual delivery takes place and that the member is offered Care Management prenatally and postpartum. The only exceptions to this policy are newborns that meet the exclusion criteria listed in the Medicaid Managed Care Exclusions table (see Appendix III). These infants are excluded from enrollment in any Medicaid managed care plan.

**PCP Selection**

Healthfirst members select a PCP upon enrollment. If no PCP is indicated on the enrollment form, Healthfirst will assign a PCP and issue notice to the member. Healthfirst Member Services staff provides assistance with PCP selection and changes. PCP changes are effective immediately.

**Involuntary Change of PCP (Requesting Member Transfer)**

PCPs may wish to arrange the transfer of a member to another provider. The provider may request a transfer of a member when the following situations exist:

- Member is persistently noncompliant with a therapeutic regime
- Member is verbally abusive to provider or staff
- Member makes medically inappropriate demands or unreasonably refuses the provider’s recommendations

Providers should initially speak with the member to try to resolve the issue(s). If that cannot be done or is not successful, the following steps should be followed:

- The member must receive a letter informing him/her that the PCP cannot remain his/her provider and
the reason for this change

- The letter must indicate that the member will have thirty (30) days from receipt of the letter to select another PCP and must inform the member that he/she should contact Healthfirst Member Services for assistance, if necessary
- The member must be informed that the PCP will provide any needed care, medical services and/or prescriptions during the 30 day period
- The member must be informed that the PCP will provide the member’s medical records to the new PCP if requested
- The letter to the member should be sent certified mail, return receipt requested in order to ensure that the member receives the letter
- A copy of the letter must be placed in the member’s medical record
- A copy of the letter must be sent to the Provider Services Department
- The provider should contact Healthfirst Member Services, provide the member’s name and Healthfirst ID number and inform them that the member requires assistance in selecting a new PCP

All of the above situations should be clearly documented in the medical record. For more information, please call Member Services at 1-866-463-6743.

**Continuity of Care for New Members**

In some situations, members enrolling with Healthfirst may continue care with their existing healthcare provider for a 60-day transitional period when there is a life-threatening, degenerative or disabling disease or condition under treatment. New members in the second trimester of pregnancy at the effective date of enrollment will be allowed to continue with their existing provider through the post-partum care associated with the delivery. Services received during this period must be consistent with the scope of benefits available to Medicare or Medicaid recipients, or those covered under the CHPlus program.

Non-participating providers who care for Healthfirst members during a transition period must adhere to the Healthfirst quality assurance protocols, policies and procedures and must accept Healthfirst reimbursement rates. Further, the practitioner will provide Healthfirst and the member’s new Healthfirst provider with medical information relevant to the member’s care.

New members may have preexisting appointments arranged for specialty care that were scheduled before their Healthfirst membership became active and the appropriate Healthfirst referral generated. If a new Healthfirst member presents in your office under these circumstances and does not have a referral from their Healthfirst PCP, please call Medical Management for assistance.

**Disenrollment**

There are two (2) types of disenrollment processes: voluntary and involuntary. Members may elect to disenroll from Healthfirst or Healthfirst may disenroll members for a variety of reasons.

**Voluntary Disenrollment**

Medicaid members may disenroll or transfer from Healthfirst after the 90-day grace period or for a “good cause” reason during the nine-month lock-in period. To disenroll from a Healthfirst program, such as CHPlus, members may contact the Member Services Department. For the Medicaid managed care program, members should contact New York Medicaid CHOICE at 1-800-505-5678. New York Medicaid CHOICE now processes all plan disenrollments. Medicare members should contact Medicare at 1-800-633-4227 or TTY 1-877-486-2048 for the hearing and speech impaired. Please note that there are restrictions on when and how Medicare beneficiaries can disenroll from Medicare plans. PCPs will be notified of all member disenrollments affecting their panels through the monthly enrollment rosters.

**Involuntary Disenrollment**
Healthfirst will not, either verbally or in writing, or by any action or inaction, request or encourage a member to disenroll from a Healthfirst program. However, there may be circumstances that require Healthfirst to involuntarily disenroll a member. These are as follows:

- The member moves out of the Healthfirst service area
- The member loses Medicare or Medicaid eligibility or is no longer eligible for CHPlus coverage
- A member supplies fraudulent information or makes misrepresentations on the enrollment application that materially affects his or her eligibility to enroll in Healthfirst
- A member’s behavior is disruptive, unruly, abusive or uncooperative to the extent that the Healthfirst practitioner's ability to provide services is impaired (except where such behavior is related to an underlying physical and/or mental condition such as Tourette’s Syndrome)
- A member knowingly permits abuse or misuse of the Healthfirst membership card
- A member who is enrolled in CHPlus, Increased Benefits Plan, Life Improvement Plan, Maximum Plan or a commercial plan that has premium obligations fails to pay premiums. Reasonable efforts will be made to secure receipt of delinquent premiums; however, Healthfirst reserves the right to disenroll members under these circumstances if acceptable mitigating circumstances are not demonstrated

**Commercial Plans Enrollment and Disenrollment**

**Enrollment**

Individuals and families can enroll in Healthfirst Leaf plans through the NY State of Health website or in HMO A-D plans directly through Healthfirst. The following individuals are eligible to sign up for a Healthfirst Leaf Plan:

- Are under 65, are uninsured, and can’t get health insurance through their job.
- Don’t currently have health insurance.
- Are underinsured. People are considered underinsured if their insurance plan does not cover the Essential Health Benefits required by the ACA.
- Live within the five boroughs of New York City or Nassau County.

Members must pay their monthly premiums to maintain enrollment in the health plan. Members who receive federal premium subsidies have a 90 day ‘grace period’ to pay their premium, and members who do not receive subsidies have a 30 day grace period to pay their premium in full, should they miss a payment. Members may enroll in a health plan during Open Enrollment. The open enrollment period for 2015 when members can choose and enroll in a plan is 11/15/2014 – 1/15/2015.

**Newborns**

When a Healthfirst member is pregnant, the PCP should notify Member Services and Medical Management as soon as the pregnancy is confirmed. The mother’s name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided at this time. Hospitals must notify Medical Management of all deliveries within one (1) business day of the child’s birth. Hospitals must also provide Healthfirst with the newborn’s Client Identification Number (CIN).

**PCP Selection**

Healthfirst members select a PCP upon enrollment. If no PCP is indicated on the enrollment form, Healthfirst will assign a PCP and issue notice to the member. Healthfirst Member Services staff provides assistance with PCP selection and changes. PCP changes are effective immediately.
Voluntary Disenrollment

Healthfirst Leaf Plan members may disenroll or transfer from Healthfirst during the open enrollment period or after a qualifying event. A qualifying event is any event that results in a change of income or family size such as marriage, divorce, birth of a child, loss of job. To disenroll from a Healthfirst program, members may contact the NY State of Health website or the Member Services Department.

Involuntary Disenrollment

Healthfirst will not, either verbally or in writing, or by any action or inaction, request or encourage a member to disenroll from a Healthfirst program. However, there may be circumstances that require Healthfirst to involuntarily disenroll a member. These are as follows:

- The member moves out of the Healthfirst service area
- The member gains Medicaid eligibility
- A member supplies fraudulent information or makes misrepresentations on the enrollment application that materially affects his or her eligibility to enroll in Healthfirst
- A member’s behavior is disruptive, unruly, abusive or uncooperative to the extent that the Healthfirst practitioner’s ability to provide services is impaired (except where such behavior is related to an underlying physical and/or mental condition such as Tourette’s Syndrome)
- A member knowingly permits abuse or misuse of the Healthfirst membership card
- A member who is enrolled a commercial plan that has premium obligations fails to pay premiums. Reasonable efforts will be made to secure receipt of delinquent premiums; however, Healthfirst reserves the right to disenroll members under these circumstances if acceptable mitigating circumstances are not demonstrated

4.5 Member Rights and Responsibilities

A member’s relationship with Healthfirst guarantees a number of basic rights, including entitlement to high-quality, accessible, responsive and responsible healthcare; respectful and confidential treatment; and avenues to express dissatisfaction or receive assistance. In return, members are responsible for taking charge of their healthcare needs, using services appropriately, complying with member policies and procedures, and requesting assistance from Healthfirst to ensure that they are utilizing and receiving services appropriately.

Healthfirst member rights and responsibilities are outlined below. This information is provided to all new members as part of their orientation package. Providers participating with Healthfirst are expected to make every effort to support member rights.

Members Have the RIGHT to:

- High-quality healthcare services provided in a professional and responsible way
- Choose a PCP
- Complete and current information about available treatments, including diagnosis and prognosis as applicable, in terms the member can be expected to understand
- Have information provided to an appropriate person acting on the member’s behalf when it is not appropriate to give such information directly to the enrollee
- Access to assistance for medical care through the PCP’s office by telephone 24 hours a day, 7 days a week
- Privacy and confidentiality of their healthcare records, except as otherwise provided for by law
Refuse treatment, as far as the law allows, and to understand the consequences of refusing treatment.

Receive information as necessary to give informed consent before the start of any procedure.

Express their concerns or complaints to Healthfirst and receive a timely response.

Receive considerate and respectful medical care and treatment from Healthfirst staff and providers without discrimination due to race, color, sex, age, national origin, sexual orientation, and/or physical or mental condition.

Accept or refuse medical treatment, including life-support treatment.

Information regarding advance directives.

Members Have the RESPONSIBILITY to:

- Enter into this agreement with the intent to follow the rules and procedures outlined in the Member Handbook, Summary of Benefits, or Subscriber Contract.
- Meet with their PCP and get a baseline physical exam.
- Receive all covered healthcare services through the PCP, except in true emergencies; self-referral services, including OB/GYN, diagnosis, and treatment of TB by public health agency facilities, or as otherwise described in their Healthfirst Member Handbook, Subscriber Contract, or Evidence of Coverage (EOC); and to follow recommended treatments.
- Use the emergency room only in the event of a true emergency.
- Treat Healthfirst staff and providers with common courtesy and consideration.
- Keep scheduled appointments or, if this is not possible, call in advance to cancel.
- Call Member Services if they need information or have any questions about the benefits, rules, or procedures described in their Healthfirst Member Handbook, Subscriber Contract, or EOC.

Commercial Members

In addition to the above rights and responsibilities, many members in Healthfirst Leaf Plans or HMO A–D plans will have monthly premium responsibilities. Members will have to pay their premiums on time in order to maintain their insurance coverage. Members who receive no federal subsidies will have a 30-day grace period in which to pay their premium. Members who receive federal subsidies will have a 90-day grace period to pay their premium. If members fail to pay their premium at the end of their grace period, they will be disenrolled.

4.6 Member Services and Education

The Member Services department provides members with an extensive array of customer service, outreach, orientation, and educational programs, including translation services to assist members who do not understand English.

New Member Outreach and Orientation

All new Healthfirst members are contacted and invited to attend monthly orientations, which are also open to existing members. These sessions are conducted at selected participating hospitals, at community-based organizations, and in Healthfirst's offices. They reinforce and supplement the information provided in Healthfirst marketing presentations. Orientations focus on explaining the enrollment process, benefits, and rights and responsibilities to new members. Member orientations include presentations on covered benefits and services, the role of the PCP, free access services, and access to “carved out” services.

All members receive a new member enrollment kit and Provider Directory that lists primary care, OB/GYN,
specialists, and ancillary service providers. The new member enrollment kit contains a member handbook and subscriber contract or EOC, depending on which product the member enrolls in. Members also receive copies of our member newsletter and health education materials.

As part of the mandatory Medicaid managed care program, Maximus, the enrollment broker, issues health risk assessment questionnaires to newly enrolled individuals and families as part of the enrollment process. Healthfirst also sends health risk assessment forms to new members and once annually to all existing Medicare Special Needs Plan (SNP) members (e.g., members in Healthfirst’s Maximum, CompleteCare, and Life Improvement Plans). Healthfirst uses these self-reported health assessment tools to better understand the member’s health and lifestyle, their wellness, or specific service needs. Healthfirst encourages these members to visit their PCP as soon as possible to obtain services. In addition, Healthfirst Case Managers call members with complex medical needs to ensure that they receive appropriate attention and care.

**Special Outreach and Care Management**

Healthfirst sponsors special outreach programs to encourage appropriate preventive care and to provide care management services for selected conditions. Outreach programs include Quality Improvement initiatives that remind members to seek preventive care services such as well-child care, immunizations, and screening tests such as mammograms and regular Pap smears.

Healthfirst’s Care Management includes Asthma, Healthy Mom/Healthy Baby (for normal and high-risk pregnancies), Congestive Heart Failure, HIV, Behavioral Healthcare, Diabetes, Domestic Violence, Health Buddy (CHF and Diabetes), and the Coordinated Care Program.

**Commercial Plans**

Members new to Healthfirst Leaf, Healthfirst Leaf Premier, or HMO A-D plans will receive the following new member material:

- A letter with their assigned Primary Care Physician (or PCP) and their Healthfirst Member ID number
- A New Member Welcome Kit including the Healthfirst Member Handbook
- A member ID Card

These members will all receive a welcome call which will explain plan benefits, inform members of their PCP selection; offer members the opportunity to change their PCP; explain their financial responsibilities, such as deductibles, maximum-out-of-pocket, copay, and coinsurance; and cover the definition of emergency services. Additionally, these members will be asked to complete a health questionnaire to assess their baseline health status. The health questionnaire will be available on the member portal at [www.myhfny.org](http://www.myhfny.org). Healthfirst will also follow up with members who do not fill out the health questionnaire to ask them to complete the questionnaire by phone.
5.2 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.

Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical-record information with other network providers.

Periodically, Healthfirst requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. In many instances such reviews are required under the Medicaid, CHPlus, or Medicare Advantage programs. Clinical professionals conduct all Healthfirst medical-record reviews, and all information in the records is kept strictly confidential. Providers must make medical records available upon request by Healthfirst or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid, CHPlus, or Medicare Advantage programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the member’s explicit consent is not required for the release of such records and information to Healthfirst. In addition, at enrollment Healthfirst obtains the member’s authorization to review records.

Healthfirst 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 and HEDIS®/QARR measure compliance
- Monitoring of provider compliance with public-health regulations on reporting requirements
- Monitoring for compliance with Healthfirst 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.

Medical records must be maintained by practitioners who are providing primary care and referral services. They must be maintained for a period of ten (10) years after the last visit date or, in the case of minor children, for ten (10) years from the age of majority.

Transfer of Medical Records

When transferring medical records from one participating PCP to another, a release of information form is not required. However, a release form must be signed when the member requests records to be sent to other entities outside of Healthfirst, such as other insurance companies. When a member transfers PCPs, providers must facilitate the transfer of medical records in a timely manner.
5.3 Confidentiality

A member’s protected health information (PHI) is protected under the contractual relationships between Healthfirst and the member and between Healthfirst and the provider. PHI encompasses enrollment data with Healthfirst, medical records, treatment documentation and information, and/or payment for the provision of health services that are derived in whole or in part using personally identifiable information that is not otherwise publicly available. Such PHI must be safeguarded and held in strict confidence in order to comply with applicable privacy provisions of state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), specifically, 45 C.F.R. parts 160 and 164, Subpart E (the “Privacy Rule”), and Subpart C (the “Security Rule”), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (“HITECH”) (collectively hereinafter referred to as “HIPAA Rules”).

Upon enrollment, Healthfirst members authorize Healthfirst to review, release, and use their respective PHI. A member’s written acknowledgment—to be maintained in the provider’s records and subject to periodic audit by Healthfirst—is required upon receipt of the Privacy Notice. Providers should take all reasonable measures to protect the privacy and confidentiality of members’ nonpublic personal information and PHI at all times and to prevent the unauthorized use or disclosure to any unaffiliated third party.

All of Healthfirst’s contracted providers agree and understand that a member’s protected health information and records for quality assurance/utilization review pursuant to Section 2.5 and encounter data pursuant to Section 2.6 are healthcare operations pursuant to 45 CFR 501, and therefore the enrollee’s consent is not required for the release of such records and information to Healthfirst.

All providers should remain aware that PHI related to behavioral health and/or substance abuse services and PHI that identifies the presence of behavioral health, substance use disorders, and/or HIV-related illness are governed by a special set of confidentiality rules. Without a special individualized authorization these records and data should be released to no one but the member except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of a Healthfirst member’s information, please call 1-888-801-1660.

All Medicaid providers are required to develop policies and procedures to assure the confidentiality of behavioral health, substance abuse, and HIV-related information, including the following information:

• Initial and annual in-service education of staff, contractors
• Identification of staff allowed access, and limits of access
• Procedure to limit access to trained staff (including contractors)
• Protocol for secure storage (including electronic storage)
• Procedures for handling requests for behavioral health, substance abuse, and HIV-related information
• Protocols to protect from discrimination persons with, or suspected of having, behavioral health, substance use disorders, and/or HIV infection

5.4 Advance Directives/Health Care Proxy

All members, including Healthfirst members, have the right to make decisions about the amount and type of care that they will receive, including care if they are terminally ill. A terminal illness is defined as any illness that is likely to result in the death of a person within six months. Through the use of written Advance Directives, a Healthfirst member can ensure their wishes are known and followed in the event that they cannot make decisions for themselves.

Healthfirst members have the right to appoint a healthcare agent through a Health Care Proxy (Appendix VI). A Health Care Proxy is a formal document enabling a member to designate a trusted individual to make healthcare decisions on his/her behalf if the member is unable to make decisions themselves. All competent adults can appoint a healthcare agent by signing a Health Care Proxy form. A lawyer is not required, but two witnesses must be present and must also sign the form. Members who have questions or would like
additional information on these issues should be directed to the Member Services department.

A Living Will allows the member to define his/her wishes about the type and amount of care that will be provided or withheld at the end of life. Examples of the types of care that may be addressed in a Living Will include the use of ventilators, intubations, and other life-saving procedures, as well as the areas of nutrition and hydration therapy.

Inpatient facilities must determine if a member has executed an Advance Directive or that the member is aware of the possibility of doing so. If the member has completed a Health Care Proxy, a copy should be kept in the member’s inpatient chart or medical record, or the name, address, and phone number of the healthcare agent should be documented in the member’s inpatient medical records. It must be clearly documented in the inpatient medical record that the member has executed an Advance Directive.

Copies of both forms can be found in the Member Handbook.

Providers must document in all Healthfirst Medicare member medical records that there was a discussion about Advance Directives and a Health Care Proxy, and the documentation must be updated annually. If the member is hospitalized at the time, the documentation can include that the member was given the information about Advance Directives in the hospital.

If the facility feels that it is unable to adhere to the member’s wishes, the hospital should notify the member of this fact and recommend that he/she contact the Member Services department. Otherwise, Healthfirst expects the facility to adhere to the member’s wishes as determined by the chosen healthcare agent.

5.5 Disclosure Restrictions for Services Paid Out-of-Pocket

If at the time service is rendered, a Healthfirst member (or their representative) pays for services out of pocket, in full, and they request to restrict the disclosure of their PHI to Healthfirst, participating provider must comply with this request. Participating provider should employ a method to flag or notate the participating provider record with respect to the PHI that has been restricted. This will ensure that the PHI is not inadvertently sent to or made accessible to Healthfirst for payment or healthcare operations purposes, such as audits conducted by Healthfirst.

5.6 Critical Incident Reporting

Effective Date: November 1, 2012

Pursuant to Special Terms & Conditions, #28, c) ii), the State, through its contracts with MCOs, shall ensure that a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This includes critical incident monitoring and reporting to the State and investigations of incidents.

General Definition—A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or, well-being of a Nursing Home, LTSS, Home Health, Adult Home, and Home- and Community-Based Service participant.

Reportable Critical Incidents Defined

- Abuse
- Neglect
- Mistreatment
- Injuries of unknown origin
- Sexual abuse
- Verbal abuse
- Misappropriation of resident property has occurred
Critical Incident Management and Reporting: Provider Responsibilities

As a participating Healthfirst provider, you will be required to report all allegations of abuse, neglect, and exploitation of a member, as defined in the Critical Incident Manual. Take immediate action to assure the member is protected from further harm and respond to emergency needs of the member.

Who is supposed to report a critical incident? Facility/staff member who becomes aware of a critical incident as defined on this form. Qualified Service Providers that are enrolled with the Department of Human Services, Transition Coordinators, and Case Managers are required to report incidents.

Incident Reporting Procedure

How do you report a critical incident? Complete the Critical Incident Report form on the HCS Internet Portal https://commerce.health.state.ny.us within 24 hours of knowledge of the incident, any day of the week or time of day.

Using your username and password, log on to the HCS Internet Portal and proceed to the Nursing Home Surveillance and Reporting System to enter information on the electronic Incident Form. Instructions for the Incident Form can be found either by clicking on the Instruction link found on the left-hand side of the form, or through the Instruction link found within the Dear Administrator Letter section.

The Incident Reporting Line phone number, 1-888-201-4563, may be used in case of an emergency such as loss of Internet or computer service. If circumstances dictate reporting via the hotline, that contact will be sufficient and there will be no need to report online. If a provider continues to report via the hotline, they will be redirected to the website.

PLEASE NOTE:

For purposes of facility reported incidents, long-term care facilities must report abuse, neglect, and misappropriation within 24 hours after the reasonable cause threshold is concluded. All other reportable incidents are to be communicated to the NYSDOH by the next business day.

Detailed information and general Q&A on critical incident reporting can be found in the New York State Department of Health Nursing Home Incident Reporting Manual.
6. Primary Care

6.1 Responsibilities of a Primary Care Provider (PCP)

All Healthfirst members select a PCP at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to members, including primary and specialty care, hospital care, diagnostic testing, and therapeutic care. Healthfirst defines the following clinical specialty areas and practitioners as primary care providers.

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<tr>
<th>Physicians</th>
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<td>- General Practice</td>
<td>- Pediatrics</td>
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<td>- Geriatrics (Medicare and Commercial only)</td>
<td>- Women’s Health</td>
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<td>- Infectious Disease (HIV Specialist PCP)</td>
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Healthfirst PCP’s are evaluated on an annual basis in areas of quality and satisfaction such as:

- Wellness and Preventive Care
- Chronic Care Management
- Enrollee Experience and Satisfaction with Care
- Medication Adherence and High-Risk Medications

The ratings for each measure are combined to generate an overall quality rating for the provider. More information on this can be found in Section 14.6 of our Provider Manual.

PCPs are the first points of entry into the Healthfirst delivery system. PCPs also play essential clinical and oversight roles in managing the care of Healthfirst members. Healthfirst has identified the following scope of activities and responsibilities as key expectations for participating PCPs.

Access

For participation in the Medicaid, Child Health Plus, HARP, and Essential Plan programs, the PCP must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care office site.

For participation in the Medicare, Qualified Health Plan and Commercial programs, the PCP must maintain a minimum of 10 (ten) office hours per week at each primary care office site.

Maintain access 24 hours a day, 7 days a week either directly or through arrangements with other Healthfirst providers for back-up coverage. See Section 3 for additional information on access and coverage requirements.

Clinical Care

Provide first-line primary, preventive, inpatient, and urgent care, or arrange for care, as appropriate, to manage conditions outside of the scope of primary care.

Identify Healthfirst members with complex or serious medical conditions—assessing those conditions through appropriate diagnostic procedures—and contact the Healthfirst Care Management staff to collaborate on
treatment plans and follow-up.

Provide Healthfirst members with education on the appropriate use of healthcare services, personal health behavior, health risks, preventing STDs, preventing HIV/AIDS, and achieving and maintaining optimal physical and mental health.

**Preventive Care**

Provide or arrange for all appropriate screenings and preventive care, including immunizations and well-child visits; tuberculosis screening, diagnosis, and treatment; lead screening for children and appropriate dental care; HIV testing and counseling; mammography screening, colorectal cancer screening, cervical cancer screening, and HbA1c testing (Appendix VII).

Maintain compliance with established preventive care standards (Appendix VII-A) and clinical practice guidelines (Appendix XIII) adopted by Healthfirst.

Adhere to the New York State C/THP Guidelines (Appendix VII-B) and Guidelines for Adolescent Preventive Services (GAPS) (Appendix VII-C).

Participate in the Healthfirst Clinical Quality programs designed to improve care for members.

**Behavioral Health Screening**

Healthfirst promotes the use of the Patient Health Questionnaire (PHQ-9) as a screening tool (Appendix VII-D) to assist its PCPs in identifying Healthfirst members with symptoms of depression who are appropriate candidates for referral to the Healthfirst Behavioral Health (BH) Care Management Unit or delegated organization. The PHQ-9 should be used at the baseline appointment, at the annual preventive care visit, and at any point where the member's condition indicates that a behavioral health issue may be present. A copy of the questionnaire should be kept in the member’s medical record. This tool is not intended to replace a complete mental health evaluation and assessment.

Before asking a Healthfirst representative or a behavioral health provider to try contacting a member to arrange for an evaluation of the member’s needs regarding mental health or alcohol/substance abuse services, a PCP must get the permission of the member in question to do so.

Healthfirst makes every effort to partner with providers to promote the integration of Behavioral Health and medical-service delivery to adults and children. To this end, primary care and other medical providers will be routinely engaged in dialogue with Healthfirst clinical management teams and are invited to participate in ongoing education, trainings and seminars, access to rapid consultation from child and adolescent psychiatrists, and referral and linkage to appropriate Behavioral Health providers for our most at-risk child, adolescent, and adult members.

**Long-Term Services and Supports (LTSS)**

- PCPs may identify that their members require long-term services and support (LTSS). Some ways to identify this are: If a member already receives home care, adult day care, or other home care services, and if they already have both Medicaid and Medicare
- If a member requests a Home Health Aide, Personal Care Assistant Services, or non-skilled needs with a deficit in their Activities of Daily Living
- If a member is in need of Adult Day Health Care (ADHC) services
- If a SNF member is receiving short-term rehab or nursing care and is qualified to return to the community with home care
- If a member has dementia, confusion, Alzheimer’s, psych conditions, and/or other cognitive deficits with a deficit in their Activities of Daily Living, with someone to direct their care in the community
- If a member requests a power wheelchair or a hospital bed with a deficit in their Activities of Daily Living
- If a member has a history of falling and a deficit in their Activities of Daily Living
• Please note some programs require members to be over age 21

Any members that meet these needs and are identified as having a need for LTSS should be referred to the Healthfirst Care Management team or a participating LTSS provider as classified in the online Healthfirst Provider directory.

**Coordination of Care and Services**

Coordinate primary and specialty care, ancillary services, and other covered healthcare services and collaborate with Healthfirst case managers and other providers involved in the member’s care.

Arrange for behavioral health services through the Healthfirst Behavioral Health Care Management Unit or the member’s designated behavioral health care management organization.

Arrange for transportation services, as needed, to ensure that members are able to access healthcare services.

PCPs, as well as all members of the Interdisciplinary Team (IDT) of Healthfirst special needs plans, coordinate primary and specialty care, ancillary services, long-term services and support (LTSS), and other covered healthcare services.

PCPs, as well as all members of the care planning team (some Healthfirst plans call this the Interdisciplinary Team (IDT)), arrange for behavioral health services through the Healthfirst Behavioral Care Management Unit or the member’s designated behavioral health care management organization.

PCPs, as well as all members of the care planning team (some Healthfirst plans call this the Interdisciplinary Team (IDT)), arrange for transportation services, as needed, to ensure that members are able to access healthcare services.

**Administrative Responsibilities**

Verify member eligibility at every visit by logging into the Healthfirst secure Provider Portal at www.healthfirst.org/providerservices or by calling Member Services at 1-866-463-6743 to ensure that members are still active and enrolled in Healthfirst.

Provide comprehensive, accurate, and reliable encounter data with CMS HCFA 1500 or UB-04 claim forms sent to Healthfirst on a timely basis.

**6.2 Primary Care Panels and Member Enrollment Rosters**

Healthfirst members select a Primary Care Physician (PCP) at the time of enrollment. PCPs can receive enrollment rosters indicating the Healthfirst members assigned to their panel each month by logging into the secure Healthfirst Provider Portal online at www.healthfirst.org/providers and requesting access under the Healthfirst Reports section. The enrollment roster contains demographic information for each member in the provider’s panel and also reflects the Healthfirst product the member is enrolled in. Each time a Healthfirst member visits their PCP, the eligibility verification steps outlined in Section 4 should be followed.

**6.3 Preventive Care Standards**

Healthfirst provides its members with access to routine and preventive healthcare services; these services are provided and/or 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: Healthfirst Medicare Plan 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.

Providers wishing to file claims for vaccinations under Part D MUST submit these claims through the TransactRx Vaccine Manager at www.TransactRx.com. The TransactRx Vaccine Manager is a website that gives providers the ability to process the Part D vaccine and/or the administrative vaccine electronically. Member
obligation is calculated in a matter of seconds, and assures that you have the member TrOO
(pocket cost) at the point of service. There is no cost to providers to process claims through Vaccine Manager.

Healthfirst expects participating PCPs to adhere to established preventive care standards and schedules in
effect in New York State. These include New York State Vaccines for Children Program (VFC), which
supplies selected vaccines to providers caring for Healthfirst PHSP members at no cost. In addition, providers
may order vaccines for Medicaid and CHPlus members at no cost through the VFC program.

For additional information on the VFC or Immunization Program or to order vaccines for Healthfirst Medicaid
or CHPlus members, call:

- New York State Department of Health Bureau of Immunization: 1-518-473-4437
- New York City Department of Health and Mental Hygiene Immunization Hotline: 1-347-396-2400
- New York State Vaccines for Children Program: 1-800-KIDSHOT (1-800-543-7468)

To encourage compliance with timely and appropriate preventive care, Healthfirst has developed The
Healthfirst Quality Incentive Program (HQIP) for Healthfirst providers. Under this program,
eligible PCPs caring for Medicaid, CHP, BHP, QHP, Medicare, Complete Care, and FIDA members can
receive additional compensation for their efforts in promoting and documenting the provision of selected
preventive care services.

Additionally, Healthfirst provides preventive care screenings and immunization guidelines (Appendix VII) for
the pediatric population.

**USPSTF Recommendations for Children and Adolescents**

The health needs of children and adolescents differ from those of adults. In particular, preventive health care
for children must consider the "sensitive" windows during which the course of growth and development may
be influenced, and the long span of time over which health outcomes will be affected. The U.S. Preventive
Services Task Force (USPSTF) makes evidence-based recommendations for children and adolescents,
develops new approaches to assess evidence on child health, and convenes a workgroup dedicated to child
health. The USPSTF recommendations about clinical preventive services, including screenings, counseling,
and preventive medications for children and adolescents are located at:

**Depression**

Prevention is a key in quality clinical care provided to our members. Mental health diagnoses have historically
been and continue to be included in the Healthfirst top ten (10) inpatient and outpatient diagnoses. It is
extremely important to ensure that our members receive evaluations and get help as soon as possible if they
have any symptoms of depression. It is a requirement for Healthfirst providers to include this information in
the member’s chart and to refer the member to an appropriate mental health professional, if necessary.

If a member is given a prescription for any antidepressant medication, he/she should be given an appointment
to return to their PCP every four (4) weeks for a minimum of three (3) visits within 84 days of receiving the
prescription and then return for follow-up visits every three (3) months for at least one (1) year.
7. Obstetrics and Gynecology

7.1 Definition of Services

All female members have access to Obstetrician/Gynecologist (OB/GYN) care from any in-network provider without referral from their assigned PCP. An OB/GYN is responsible for providing and managing medical care for obstetrical and gynecological conditions.

In addition, Medicaid members may choose to receive Family Planning and Reproductive Health services from a nonparticipating provider who accepts Medicaid for these services (also known as “Free Access Policy”). Family Planning and Reproductive Health services mean the offering, arranging, and furnishing of those health services that enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. This DOES NOT include obstetrical care for pregnancy. All members, including Medicaid members, MUST use an in-network provider for obstetrical care for pregnancy.

The following medically necessary services are subject to “free access” for Medicaid female members and include related drugs and supplies that are furnished or administered under the supervision of a provider, licensed midwife, or certified nurse practitioner during the course of a Family Planning and Reproductive Health visit:

- Family Planning and Reproductive Health services which include those education and counseling services necessary to effectively render the services
- Contraception, including all FDA-approved birth control methods and devices, including diaphragms, insertion/removal of an intrauterine device (IUD) or insertion/removal of contraceptive implants and injection procedures involving pharmaceuticals such as Depo-Provera (FHPlus does not cover OTC products such as condoms and contraceptive foam)
- Emergency contraception and follow-up
- Sterilization*  
  * requires sterilization consent and hysterectomy consent form as applicable.
- Screening, related diagnosis, and referral to a participating provider for pregnancy
- Medically necessary induced abortions, which are procedures—either medical or surgical—that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration

When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visit:

- Screening, related diagnosis, ambulatory treatment, and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology
- Screening, related diagnosis, and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension, and breast disease
- Screening and treatment for sexually transmissible disease
- HIV testing and pre- and post-test counseling

Specialty Areas under OB/GYN

Healthfirst includes the following seven (7) specialty areas in its definition of obstetrics and gynecology. Practitioners in the specialties will be referred to as OB/GYN providers in this Provider Manual unless otherwise indicated:

- Gynecology
- Gynecology (Nurse Practitioner)
- Midwifery
- Obstetrics
- Obstetrics and Gynecology
- Obstetrics and Gynecology (Nurse Practitioner)
- Women’s Health (Nurse Practitioner)
Maternal and Fetal Medicine
Obstetrics and Gynecology – High-Risk

PCP and OB/GYN Care

In certain circumstances, a member may choose the same provider to serve as both her PCP and OB/GYN. This might occur if a member selects a family practitioner as her PCP or HIV Specialist PCP who also provides routine OB/GYN services.

Healthfirst members may access OB/GYN services directly, without a referral from a PCP, for routine care. The PCP, however, may refer a member to an OB/GYN for consultation. Reports of all diagnostic tests must be forwarded to the PCP for inclusion in the member's medical record. See Section 7.2 for additional details.

7.2 Diagnostic Testing

All testing, procedures, and consultations related to pregnancy and OB/GYN conditions may be performed or ordered directly by the participating OB/GYN without consulting the PCP, including:

- Sonograms performed during pregnancy
- Cervical biopsy
- Cesarean section
- Referral to a cardiologist for evaluation of heart murmur/dyspnea during pregnancy
- Referral to an endocrinologist for evaluation of metabolic disorders during pregnancy

When a PCP refers a member to the OB/GYN for consultation, the OB/GYN may order or perform certain diagnostic tests. The OB/GYN must communicate all test results to the PCP.

OB/GYN providers should not order tests or consultations for the evaluation of any condition that is not obstetric or gynecological. For example, if a member expresses concern about knee pain during a routine exam and requests referral to an orthopedist, the OB/GYN may not provide such a referral. The member must be referred back to her PCP for follow-up on this condition.

7.3 Consent Requirements for Hysterectomy – Medicaid, CHPlus, FHPlus, and Leaf Plans

Hysterectomy and other sterilization procedures are subject to special informed consent guidelines for members receiving Medicaid benefits as well as for members covered under the CHPlus, FHPlus, and Leaf Plan programs. Medical necessity and informed consent for hysterectomy are discussed in this section; information on family planning and sterilization procedures follows.

Before a hysterectomy is performed on a Healthfirst member, an adequately documented informed consent procedure must be completed. In addition, the hysterectomy will only be authorized if it is not being performed solely for the purpose of rendering the member incapable of reproduction and there are clinical indications for performing the hysterectomy—these cannot include rendering the individual permanently incapable of reproducing.

Informed consent policies and procedures for hysterectomy are strictly regulated. Providers must ensure that they are in full compliance with appropriate documentation standards to be reimbursed for performing these procedures. Providers must comply with the Informed Consent Procedures for Hysterectomy and Sterilization specified in 42CFR, Part 441, sub-part F, and 18NYCRR 505.13, and with applicable EPSDT requirements specified in 42CFR, part 441, sub-part B, 18NYCRR, 508, the NYSDOH C/THP Manual and all applicable public health laws.
All women undergoing hysterectomies must be informed, verbally and in writing, prior to surgery, that the procedure will render them permanently incapable of reproducing. Members or authorized representatives must sign Part 1 of the DSS-3113 Acknowledgment of Receipt of Hysterectomy Information Form. This documents that the member received all pertinent information or certifies that there are reasons to waive the receipt of information. It also contains the surgeon’s statement that the hysterectomy is not being performed for the purpose of sterilization.

Copies of the DSS-3113 and associated instructions may be obtained by contacting:

New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
Re: Hysterectomy Information Forms

The requirement that the member sign Part 1 of the form may be waived under certain circumstances, such as evidence that the woman was sterile prior to the hysterectomy and the hysterectomy was performed in a life-threatening emergency situation in which prior receipt of hysterectomy information was not possible.

In either of these situations, the surgeon performing the hysterectomy must certify in writing on a DSS-3113 form that one (1) of these two (2) conditions existed. He/she must attest to the reason for the member’s sterility or indicate the nature of the emergency that precluded transmittal of the Receipt of Hysterectomy Information Form. For example, the member may already be post-menopausal at the time of the hysterectomy, or she may have been admitted to the hospital via the emergency room requiring immediate surgery.

In certain situations, a member may not have been a Medicaid recipient at the time of her hysterectomy, but if she subsequently applied for Medicaid and was determined to qualify for retroactive eligibility, the surgeon might receive payment from Medicaid for this procedure. He/she must certify in writing that the woman received information prior to surgery indicating that the hysterectomy would make her permanently incapable of reproducing, or that one (1) of the extenuating circumstances existed allowing waiver of Part 1 of DSS-3113. **Providers must submit the DSS-3113 form to Medical Management before prior authorization for the procedure will be provided.**

### 7.4 Family Planning and Reproductive Health

#### Scope of Services

Family planning and reproductive health services comprise diagnostic, educational, counseling, and medically necessary treatments, medication, and supplies furnished or prescribed by, or under the supervision of, a provider or nurse practitioner for the purposes of:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera
- Screening and treatment for STDs
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy, and pelvic abnormality/pathology
- Termination of pregnancy services (provider must document the duration of the pregnancy)

HIV testing and pre- and post-test counseling (when performed within the context of a family planning encounter) is considered a free access service. HIV blood testing and counseling may also be obtained from Healthfirst PCPs, by referral from a PCP to a participating specialist, or by anonymous counseling and testing programs operated by New York State and New York City. Providers of family planning and reproductive healthcare services shall comply with all of the requirements set forth in Section 7 of the NYS Public Health Law, and 20 NYCRR, Section 751.9 and Part 753 relating to informed consent and confidentiality.

#### Consent Requirements for Sterilization – Medicaid, CHP, FHP, and Leaf Plans

Family planning and reproductive health services include sterilization. Sterilization is defined as any medical
procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing, or performed for other reasons, but which renders the individual permanently incapable of reproducing. Medicaid reimbursement is available for sterilization only if informed consent guidelines are met. The consent requirements for voluntary sterilization are described in this section. General requirements are summarized below, followed by specific disclosures that must be made to the member prior to the procedure.

**General Requirements**

*Minimum Age*

Members undergoing sterilization must be at least 21 years of age at the time of giving voluntary, informed consent to sterilization.

*Restrictions:*

The member undergoing sterilization must not be a mentally incompetent individual. For the purpose of this restriction, the term “mentally incompetent individual” refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

The member undergoing a sterilization procedure must not be an institutionalized person. For the purposes of this restriction, “institutionalized individual” refers to an individual who is (a) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or (b) confined under a voluntary commitment, in a mental hospital or other facility for the cure and treatment of mental illness.

Informed consent to sterilization may not be obtained while the member is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the member’s state of awareness.

*Translation Services*

An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

*Disabled Persons*

Suitable arrangements must be made to ensure that the sterilization consent information is effectively communicated to deaf, blind, or otherwise disabled individuals.

*Presence of Witnesses*

The presence of a witness is optional when informed consent is obtained, except in New York City, where the presence of a witness is mandated by New York City Local Law No. 37 of 1977.

*Waiting Period*

Voluntary informed consent to sterilization must be given not less than 30 days or not more than 180 days prior to the sterilization procedure. When computing the number of days in this waiting period, the day the recipient signs the form is not included.

*Waiver of Waiting Period*

Waiver of the thirty (30)-day waiting period may occur only in cases of premature delivery, when the sterilization was scheduled for the expected delivery date or when there is emergency abdominal surgery. Since premature deliveries and emergency abdominal surgeries are unexpected, medically necessary procedures may be performed during the same hospitalization, as long as seventy-two (72) hours have passed between the original signing of the informed consent document and the sterilization procedure.

*Reaffirmation Statement*
In New York City, a statement signed by the member upon admission for sterilization, acknowledging again an understanding of the consequences of sterilization and his or her desire to be sterilized, is mandatory. New York City Local Law No. 37 of 1977 establishes guidelines to ensure appropriate informed consent for sterilization procedures performed in New York City. Medicaid will not pay for services that are rendered illegally; therefore, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City.

**Consent Form**

A copy of the New York State Sterilization Consent Form DSS-3134 must be given to the member undergoing the procedure. Completed copies of the form must be submitted to Medical Management before prior authorization for the procedure is provided.

To obtain the New York State Sterilization Consent Form (DSS-3134) and the associated instructions in English and Spanish, contact: New York State Department of Social Services, 40 North Pearl Street, Albany, New York 12243, Re: Sterilization Consent Forms.

**Specific Disclosures**

The individual obtaining informed consent for a sterilization procedure must offer to answer any questions concerning the procedure, must provide a copy of the Medicaid Sterilization Consent Form (DSS-3134) for signature, and must verbally provide all of the following information or advice to the individual electing to undergo the procedure. In addition, the provider who performs the sterilization procedure must discuss the following points with the member at least thirty (30) days before the procedure, usually during the preparation examination:

- Advise that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.
- Advice that the sterilization will not be performed for at least thirty (30) days except under the circumstances specified under the “Waiver of 30-Day Waiting Period.”
8. Specialty Care

8.1 Definition of Specialty Care

Healthfirst has contracted with specialist providers and other specialty care professionals to provide healthcare services beyond the scope of primary care. Healthfirst Medicaid, CHP, and Medicare members can access these services in accordance with Healthfirst's prior authorization policies. Healthfirst commercial members can access these services in accordance with Healthfirst's commercial referral and prior authorization policies.

Specialty care practitioners provide medically necessary care within the scope of their practice. They are responsible for the following four (4) activities:

Identifying individuals with complex or serious medical conditions, assessing and diagnosing those conditions, and working with the member, as well as the PCP and Medical Management team, to provide effective, coordinated medical care

Collaborating with PCPs to provide coordinated clinical care and to enhance continuity of care for Healthfirst members. Specialists are responsible for contacting the PCP to request information where needed

Following up with PCPs in writing to apprise them of consultation results, diagnostic testing results, and treatment plans

Assisting members in accessing required services such as diagnostic tests, acute rehabilitation, home care, DME, and transportation

A complete listing of participating specialty providers can be found at www.hfdocfinder.org. A directory can also be created and printed or emailed, based on the search criteria entered, such as zip code and provider specialty.

Specialists as PCPs

Under certain circumstances, Healthfirst may authorize a specialist to serve as a member’s PCP. This may occur when a member has a life-threatening, degenerative or disabling condition, or a disease that requires prolonged specialized medical care through a specialty provider or at a specialty care center. In these situations, Healthfirst arranges for the specialist to take on primary care responsibilities in caring for the member. The member’s PCP must be part of this decision process, and the Healthfirst Medical Management department must authorize the transfer of primary care responsibilities to the specialist. The specialist will then be accountable for coordinating care, referring the member to sub-specialty providers as appropriate, managing health education and preventive care activities, and complying with all guidelines, reporting requirements, and medical and Care Management policies.

For HIV members: If the PCP does not meet the qualifications of an HIV specialist, an HIV specialist will be assigned to assist the PCP in an ongoing consultative relationship as part of the member’s routine care.

The following situations illustrate examples of cases when it would be acceptable and beneficial for a specialty care provider or specialty care center to take on the primary management of care for a Healthfirst member:

- HIV-positive members may select an HIV specialist to serve as their PCP
- Members with multiple traumas who require prolonged complex rehabilitative management
- Members with cancer who require a complex, ongoing course of treatment

The following procedures are applicable under these circumstances. Additional information on this subject also appears in Sections 3 and 12 of this Provider Manual.

If the PCP or specialist believes that it is in the member’s best interest to assign primary care responsibilities to the specialist, or if the member requests this arrangement, the PCP will discuss this option with the member.
The PCP or specialist will contact Medical Management with information about the member’s condition, course of treatment, and the name of the treating specialist. If all parties agree, the PCP, the specialist, and Medical Management will coordinate a plan to transfer care.

If a member has requested the transfer and the PCP or the specialist disagrees with the request, the member may contact Medical Management directly. In these cases, the Medical Director will make a final determination.

**Specialty Care Centers**

In some situations, a member may be best served by receiving care for a complex condition through a team of providers affiliated with an accredited or designated Specialty Care Center with experience in treating their life-threatening or degenerative and disabling disease or condition. For example, an HIV-infected mother with an HIV-infected and/or HIV-exposed child may be appropriately served by a Maternal/Pediatric HIV Specialized Care Center. The member, his/her PCP, or a specialty provider may initiate a request for this service. When a member makes the request, the PCP and Medical Management will evaluate the situation, and the following procedures will be followed:

The member, or the PCP on behalf of a member, should contact Medical Management to request care at a Specialty Care Center if he or she believes that this is the most appropriate resource.

If there is a Specialty Care Center in the Healthfirst network that provides the same or substantially similar services to those requested, the member will be directed for in-network care.

If it is determined that an out-of-network Specialty Care Center is the most appropriate provider of care for an individual member, Ancillary Services will contact the out-of-network Specialty Care Center to negotiate an arrangement. *(Healthfirst is financially responsible for all authorized out-of-network medical expenses.)*
9. Behavioral Health Services

9.1 Description of the Network

Healthfirst has participation agreements with a broad network of providers and other licensed professionals, community agencies, and inpatient and outpatient facilities that specialize in the treatment and management of mental health and substance use disorders (together referred to as “Behavioral Health”).

Healthfirst manages the Behavioral Health services for most of its members. However, some Healthfirst members receive Behavioral Health services based on the hospital system they have selected as their provider of choice, and Healthfirst has contracted with a third party that maintains their provider network, processes referrals, performs medical/utilization/case management, quality management, billing and claims payment. Regardless of who provides these services, Healthfirst retains programmatic and quality oversight of these delegated arrangements to ensure that members are being served appropriately.

Providers should use the phone numbers below for Behavioral Health services:

<table>
<thead>
<tr>
<th>Behavioral Health/Chemical Dependency Affiliate</th>
<th>Provider</th>
<th>Healthfirst Plans Accepted</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Behavioral Health Associates (UBA)</td>
<td>Montefiore Medical Center</td>
<td>• Healthfirst members have Primary Care Provider through Montefiore</td>
<td>1-800-401-4822</td>
</tr>
<tr>
<td>The Care Management Organization (CMO)</td>
<td>Sound Shore Medical Center</td>
<td>• Healthfirst PHSP Members with Elmhurst providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Mount Vernon Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elmhurst Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthfirst Clinical Services / Behavioral Health Department</td>
<td>Elmhurst Hospital</td>
<td>• Elmhurst (Medicare and Leaf Plan members only)</td>
<td>1-888-394-4327</td>
</tr>
<tr>
<td></td>
<td>Healthfirst Participating Providers (excluding Montefiore affiliation)</td>
<td>• Healthfirst members have non-Montefiore Primary Care Provider</td>
<td></td>
</tr>
</tbody>
</table>

Providers may call the behavioral healthcare management systems for the hospitals listed above to obtain services at 1-800-401-4822 or they may contact the Healthfirst Clinical Services Department at 1-888-394-4327 to facilitate access to services. Providers may also fax authorization requests to 646 313-4612 for services that require Prior Authorization. Providers may contact Member Services at the phone numbers listed in Section 1 to determine a member’s hospital affiliation or to obtain information about participating behavioral health providers.

**Behavioral Health Provider Responsibilities**

Healthfirst expects Mental Health, Substance Use, and Home and Community Based Service (HCBS) providers to assume the following set of responsibilities:

- Contact the Healthfirst Behavioral Health Department to verify member eligibility and to receive authorization for admissions and selected outpatient services as outlined in Appendix XI. The same authorization requirements will apply for all products. The authorization requirements are listed on the Healthfirst Provider Portal and at [www.mctac.org](http://www.mctac.org).

- Maintain contact with the Healthfirst Behavioral Health Department as treatment progresses to receive continuing authorization for additional services.
Comply with the established policies and procedures of the Healthfirst Behavioral Health and Quality Improvement Programs

Adhere to recovery-oriented principles, including provision of person centered services

Coordinate with the Behavioral Health Department when necessary to ensure appropriate integration of services

**Level of Care (LOC) covered for Medicaid Mainstream services and Health and Recovery Health Plan (HARP):**

- Inpatient—SUD and MH
- Clinic – SUD and MH
- Personalized Recovery Oriented Services (PROS)
- Intensive Psychiatric Rehabilitation Treatment Program (IPRT)
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Partial Hospitalization
- Comprehensive Psychiatric Emergency Program (CPEP)
- Opioid Treatment Programs
- Outpatient Chemical Dependence Rehabilitation
- Rehabilitation Services for Residential SUD treatment support
- Rehabilitation Supports for Community Residences
- Buprenorphine prescribers
- Ambulatory Detox
- Inpatient and Outpatient ECT
- Mobile Mental Health
- Mobile Crisis Intervention
- Home and Community Based Services (HCBS)*

*Only HARP members (age 21 and over) and specially identified children (ages 0-20) will be eligible for HCBS pending an approved eligibility assessment.

Mental Health and Substance Use billing guidelines are available on the Healthfirst secure Provider Portal and in Appendix XV-D of Healthfirst Provider Manual. Providers should refer to Section 9.4 "Utilization and Medical Management Guidelines" for additional guidance on Level of Care screening tools such as InterQual, Milliman Criteria Guidelines (MCG) and evidence based Healthfirst policies for Mental Health treatment and Locator 3.0 for Substance Use Disorder treatment.

Healthfirst Provider Portal is available [www.healthfirst.org](http://www.healthfirst.org) to all participating providers to verify member eligibility, view claims and authorization status. Providers may contact Provider Services at 1-888-801-1660 for further assistance.

**9.2 Benefits and Access to Care**

**Benefits Overview**

All Healthfirst Medicaid adult members (age 21 and over) have access to Behavioral Health services,
including mental health and substance use disorder treatment. Services which were previously carved out of the managed care benefit package for adults became available to all Healthfirst adult Medicaid members residing in New York City on October 1, 2015, and to adult Medicaid members residing on Long Island on July 1, 2016.

Beginning July 1, 2019, children ages 0–21 enrolled in Medicaid Managed Care will also have access to Behavioral Health services.

**Behavioral Health services include:**

- Inpatient – Substance Use and Mental Health
- Outpatient Clinic – Substance Use and Mental Health
- Personalized Recovery Oriented Services (PROS)
- Intensive Psychiatric Rehabilitation Treatment (IPRT) Program
- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Partial Hospitalization
- Comprehensive Psychiatric Emergency Program (CPEP)
- Crisis Intervention
- Opioid Treatment Programs
- Outpatient Chemical Dependence Rehabilitation
- Rehabilitation Services for Residential Substance Use Disorder Treatment Support

As of January 1, 2016, an additional array of Adult Home and Community Based Services (HCBS) became available to members (age 21 and over) who meet specific eligibility criteria, as defined by New York State. These services are designed to provide opportunities for Medicaid beneficiaries with serious mental illness and/or chronic substance use disorders to receive person-centered, recovery-oriented services in their own community. On or after October 1, 2019, children ages 0–21 who are deemed eligible via an assessment will also have access to a children's array of HCBS.

**Adult HCBS include:**

- Rehabilitation Services such as: Psychosocial Rehabilitation and Community Psychiatric Support and Treatment (CPST)
- Habilitation
- Crisis Intervention Services such as: Short-term Crisis Respite and Intensive Crisis Intervention
- Educational Support Services
  - Individual Employment Support Services such as: Prevocational, Transitional Employment Support, Intensive Supported Employment, and Ongoing Supported Employment
- Peer Supports
- Support Services such as: Family Support and Training and Non-medical Transportation

**Access to Care and Authorizations**

Members in need of services, or providers wishing to arrange services on behalf of a Healthfirst member, may call Member Services for information about network providers.

Healthfirst offers Behavioral Health Care Management by telephone for at-risk or high-risk members at no
additional cost. Members who are receiving intensive outpatient services and those who are transitioning to lower levels of care may benefit from this program. In addition, our Clinical Services department can provide referral or assignment to Health Home Care Management for those members who meet eligibility criteria. For further information, or to refer a member for Healthfirst Behavioral Health Care Management or Health Home Services, please contact our Clinical Services department at 1-888-394-4327, or the delegated Behavioral Health Care management organization (as noted in the chart in Section 9.1).

Authorization for traditional in-network outpatient Behavioral Health services delivered by Healthfirst providers is not required. Traditional outpatient Behavioral Health services, as defined by Healthfirst for this purpose, include individual, group, and family therapy and medication management, provided alone or in any combination, to treat a behavioral health condition in a manner consistent with established clinical guidelines and provided at a frequency not exceeding five (5) hours a week.

Authorization is required for admissions, all out-of-network care, and select outpatient services such as ECT, neuropsychological testing, and others. Members in need of care, or providers wishing to arrange these services for Healthfirst members, should call the Healthfirst Clinical Services department at 1-888-394-4327 for assistance.

Commercial Plans
Healthfirst Leaf and HMO A–D plans include the following mental health and substance abuse benefits:

**Mental Health Care**
• Outpatient services relating to the diagnosis and treatment of mental health disorders are covered, including:
  o Unlimited outpatient visits
  o Partial hospitalization program services
  o Intensive outpatient program services
  o Services must be provided by a psychologist, a psychiatrist, a Psychiatric NP, or a clinical social worker
  o Inpatient services relating to the diagnosis and treatment of mental health disorders

**Substance Use Services**
• Inpatient services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency are covered. These include:
  o Detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use
  o Outpatient services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency
  o 20 outpatient visits for family counseling. A family member will be covered, so long as that family member (i) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and (ii) is covered under the same family contract that covers the person receiving treatment for substance use and/or dependency.

Depending on the plan, the member may have a copayment or coinsurance, which will be applied towards his/her deductible.
9.3 Program Overview
The Behavioral Health Care Management Program is designed to maximize quality of care while providing services in a cost-effective manner. The program focuses on assisting providers in planning for, organizing, and managing the behavioral health services provided to Healthfirst members. Behavioral Health Care Management staff collaborate with network providers, community-based organizations and service agencies, contracted vendor organizations, and other Healthfirst staff to ensure that high-quality care is provided at the most appropriate level by the most qualified mix of providers.

The Healthfirst Behavioral Health Unit is responsible for the following areas:

• Notification process
• Authorization review
• Concurrent review
• Continuity of care
• Care coordination

Healthfirst offers a transitional care management program to members returning to the community from inpatient mental health treatment settings. This program provides enhanced care coordination and community-based support at no cost to our members.

For additional information about program components, please refer to Subsections 12.3–12.6. The Care Management Program is described in Section 13.

9.4 Utilization and Medical Management Guidelines
Authorization of Services
Authorization for traditional in-network outpatient behavioral health services provided by Healthfirst providers is not required.

Traditional outpatient Behavioral Health Services, as defined by Healthfirst for this purpose, include individual, group, and family therapy and medication management, provided alone or in any combination, to treat a behavioral health condition in a manner consistent with established clinical guidelines and provided at a frequency not exceeding five (5) hours a week.

Admissions and the following outpatient services: ECT, neuropsychological testing, partial hospital program, intensive outpatient treatment, and day treatment, are subject to utilization and medical-necessity review to ensure that the most appropriate treatment and level of care is being provided. Authorization from the Healthfirst Behavioral Health Unit or the delegated Behavioral Health care management organization as outlined in Section 9.1 is required. Providers affiliated with the Behavioral Health care management organization operate under a delegated arrangement with Healthfirst and must comply with that organization’s authorization policies and procedures, as well as with those of Healthfirst.

General Requirements
Providers must obtain authorization for all admissions, selected outpatient services, and out-of-network care. The following information must be supplied when requesting authorization of services:

• Healthfirst Provider ID number
• Member’s name and Healthfirst ID number
• Attending/requesting provider’s name and telephone number
• PCP’s name (if not the attending/requesting provider)
• Diagnosis and ICD-10 Code
• Procedure(s) and CPT-4 Code(s) and procedure date(s)
• Services requested and proposed treatment plan
• Clinical documentation to demonstrate medical necessity
• For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay

Please be sure that ALL the above information is available when calling in the request.

Authorization of Services When Care Is Managed by Healthfirst

Providers must contact the Healthfirst Behavioral Health Unit at 1-888-394-4327 to speak with a Clinical Intake Coordinator to ensure that all care is appropriately authorized.

Authorization status may be checked on our website at www.healthfirst.org. After requesting an authorization, providers are given a notification number that can be used to obtain authorization status. This notification number can be used within two (2) to three (3) business days after Healthfirst has received all the medical-necessity information.

Healthfirst Treatment Principles

Healthfirst has developed eight (8) general treatment principles and guidelines for outpatient behavioral health services. They are consistent with established clinical practice and standards for behavioral health treatment. The principles are as follows:

• Therapeutic Environment: An appropriate therapeutic environment must include face-to-face, in-person contact between the therapist and the member.

• Duration of Therapy Sessions: Individual therapy sessions should ordinarily be a minimum of thirty (30) minutes, customarily forty-five (45) minutes, unless they are only for medication management by a psychiatrist. Group/family/couple therapy sessions are usually required to run between forty-five (45) and ninety (90) minutes, unless they are for crisis intervention. Crisis intervention sessions ordinarily should not exceed two (2) hours per day for individual therapy or three (3) hours per day for family therapy.

• Individual Psychotherapy: Only one (1) therapist may provide individual psychotherapy to a member; therefore, separate claims should not be submitted when two (2) or more therapists are treating the same member concurrently. Ordinarily, no more than two (2) family members should receive individual therapy from the same provider. When more than two (2) family members require treatment, the provider would be expected to use family therapy as the treatment of choice.

• Composition of Therapy Group: Group therapy sessions usually consist of four (4) to 10 (ten) members, unless they are multifamily or multicouple groups.

• Electroconvulsive Therapy (ECT): Psychotherapy should not be rendered within 24 hours of ECT. Conventional practice does not recognize more than one (1) ECT treatment per day or more than 12 (twelve) ECT treatments in a 30 (thirty)-day period. Indications for a greater number of treatments should be discussed with a Healthfirst psychiatrist.

• Pharmaceuticals: The use of prescription medications should follow national professional standards.

• Contraindications for Psychotherapy: Psychodynamic psychotherapy is generally considered inappropriate for members with a sole diagnosis of organic brain syndrome, substance abuse or chemical dependence, or developmental disorders.

• Documentation: Documentation regarding the member’s progress should reflect movement toward defined treatment goals with measurable objectives. When a member’s diagnosis or treatment plan is changed, the documentation should include clinical information substantiating the reasons for the change.
10. Ancillary and Other Special Services

10.1 Overview of Services and the Provider Network

Healthfirst has arrangements in place to provide a full range of ancillary and other special services to its members, depending on the program in which they are enrolled. These services include:

- Adult and Social Day Care
- Ambulatory Surgery Center
- Audiology and Hearing Services
- Cardiac Monitoring
- Community Care Management (AIDS Institute–defined)
- Chiropractic Services (Medicare and Commercial)
- Dental Care
- Diagnostic Imaging Services
- Dialysis
- Durable Medical Equipment (DME)
- Home Healthcare and Home Infusion Therapy
- Hospice
- Laboratory Services
- Mental Health
- Orthotics and Prosthetics
- Outpatient Rehabilitation
- Personal Care Services
- Physical/Occupational/Speech Therapy
- Routine Vision Care
- Nursing Home and Custodial Care
- Substance Use Disorders
- Transportation

This section of the Provider Manual describes the scope of services and network arrangements in place for selected ancillary and special services covered by Healthfirst. Please refer to Appendix XI for additional instructions on referral and prior authorization guidelines for Ancillary Services.

Ancillary Services Provider Responsibilities

Healthfirst expects participating ancillary service providers to adhere to the following service guidelines:

When ordering services for a member, identify the member as a Healthfirst member and provide the member’s Healthfirst ID number as well as his or her own Healthfirst provider ID number.

Promptly report all findings, clinical reports, test results, and recommendations to the PCP and/or ordering
provider in writing, by mail or fax.

Consult the Healthfirst 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 integration of services.

10.2 Laboratory

Laboratory services are provided by Healthfirst Preferred Laboratory network of Clinical Diagnostic Laboratories including Healthfirst participating hospitals and several Specialty Laboratories in Genetics, Pathology, Dialysis Testing and Toxicology. Providers must comply with service delivery system guidelines for referring members to laboratories. Please note that services sent to out-of-network laboratories will not be paid, and the members will be held harmless. Refer to the Provider Directory for a complete list of laboratories and drawing stations.

10.3 Pharmacy

Programs and Covered Services

As of 10/1/11, pharmacy services are a covered benefit for Managed Care Healthfirst identification. A comprehensive formulary is available on the Healthfirst website. Pharmacy services are provided by the Healthfirst pharmacy benefit manager (PBM), CVS Caremark, and its network of participating pharmacy providers. If there are any questions, you may call Healthfirst Provider Services at 1-888-801-1660 for Medicaid, CHPlus program, Commercial, Leaf Plans, and Medicare. A list of participating pharmacies is available from Member Services at 1-866-463-6743 for Medicaid, CHPlus program, and Commercial; 1-888-250-2220 for Healthfirst Leaf Plans; and 1-888-260-1010 for Medicare.

Pharmacy services are a covered benefit in the Medicaid, CHPlus program and Leaf Plans. Medicaid, CHPlus and Leaf Plan members should present their Healthfirst identification cards to pharmacy staff when accessing pharmacy services. A comprehensive formulary is available on the Healthfirst website. Pharmacy services are provided by the Healthfirst pharmacy benefit manager (PBM), CVS Caremark, and its network of participating pharmacy providers. If there are any questions, you may call Healthfirst Provider Services at 1-888-801-1660 for Medicaid, CHPlus program, Commercial, Leaf Plans, and Medicare. Healthfirst will not cover prescription drugs or biologicals that are used for mercy killings. Please note, members who participate in the Restricted Recipient Program will be restricted to a pharmacy chosen by Healthfirst.

Medicare 65+, IBP, LIP, CC, AC and Commercial: Healthfirst provides coverage for prescription drugs for many of its products. Please refer to the member ID card to determine if a member has pharmacy coverage.

Medicare CBP: Healthfirst does not provide coverage for pharmacy services for CBP members. These members may obtain their prescription coverage from a retiree health plan, the Veterans Administration, or other creditable coverage they may have.

All prescriptions must be filled at a Healthfirst participating pharmacy. Healthfirst may require prior authorization of certain pharmaceuticals. To help your members maximize their pharmacy benefit, consider the following:

Prescription Formulary

Healthfirst plans with drug coverage have a restricted formulary. Providers are encouraged to consider the comparative cost and efficacy of pharmaceutical alternatives when prescribing medication for Healthfirst members. As a part of the Healthfirst prescription drug plan, pharmacists may contact providers to discuss whether an alternative drug might be appropriate for the member. A provider can assist a member in filing a request for an exception to cover a nonformulary prescription. All prescription coverage exception determinations are made by CVS Caremark, Healthfirst’s pharmacy benefits manager (PBM).

All of the formularies for our HF Leaf Plans, Medicare, Medicaid, CompleteCare and CHPlus are available on our website at www.healthfirst.org.
Generic Drugs

Healthfirst strongly encourages the use of generic drugs when clinically appropriate. The member’s copayment will be less if a generic equivalent is prescribed. Please note the following maximum days’ supply:

- Commercial [Healthy NY Small Group; Healthfirst HMO B Small Group] – 30 days
- HF Leaf Plans – 90 days Leaf Plans – 90 days
- Medicaid and CHPlus – 30 days
- CHPlus – 30 days
- Medicare – 90 days
- Mail order for Commercial, HF Leaf Plans, and Medicare – 90 days
- Over-the-Counter (OTC) Benefits (Medicare)

Eligible Medicare plan members can obtain OTC or nonprescription drugs and health-related items without a prescription at any OTC network pharmacy location. Eligible members will receive a Healthfirst OTC Card with a prefunded monthly benefit allowance upon enrollment. With this allowance, the member may purchase eligible OTC and health-related items (i.e., aspirin, cold & flu relief medications, and adhesive bandages) at any participating OTC network pharmacy, including any Rite Aid, Duane Reade, Walgreens, CVS, or Family Dollar location. In addition, the Healthfirst OTC card can be used at many neighborhood pharmacies.

To purchase items, members will take their eligible items to the front checkout lanes of a participating store and swipe the card at any register. Purchases for eligible items are automatically deducted from the OTC card balance. Any remaining balance will carry over until the next purchase. Any unused balances automatically expire at the end of the calendar year on December 31st or upon disenrollment from the plan.

If a member makes purchases of eligible OTC items at a store without the product-linked OTC card technology or from a store where the product-linked OTC card technology failed or was unavailable, he/she may submit an Over-The-Counter (OTC) Reimbursement Claim Form. This form is available at www.healthfirst.org or by calling Member Services.

For a complete list of covered OTC items, please visit www.healthfirst.org.

Specialty Medications

Healthfirst uses a pharmacy vendor to help manage the care members receive and who need oral and injectable specialty medications. The vendor verifies eligibility, submits requests for prior authorization, and bills the member-appropriate copayments or coinsurance for medications. Providers must order specialty medications directly through the delegated vendor. Providers will not be reimbursed for specialty medication claims submitted to Healthfirst.

The following items are not covered, or are covered as noted:

- Needles or syringes (except for diabetes)
- Appetite suppressants
- Erectile dysfunction medication
- Growth hormones are covered under a member’s medical benefit when medically necessary
- Prescription vitamins
- Cosmetic drugs, Rogaine (Minoxidil)
- Anabolic steroids
- Fertility agents
10.4 Durable Medical Equipment (DME), Orthotics and Prosthetics, and Medical Supplies

DME, orthotics and prosthetics are covered benefits for Healthfirst members who require such services to aid in the treatment of illness or injury or to improve bodily function. The provider must document in the member’s medical record that these items are medically necessary.

DME may be obtained through a participating DME provider with a provider’s written order and the appropriate authorization from Healthfirst.

If a member is receiving home healthcare services, DME is obtained from the home healthcare provider. This may be a hospital-owned or hospital-operated certified home health agency (CHHA) or another contracted home health agency or home infusion therapy provider. Members who are not receiving home healthcare services may be referred to or may have their provider order directly from DME and/or orthotic and prosthetic vendors that participate with Healthfirst. Healthfirst follows CMS guidelines as it relates to rental periods for all contracted providers.

DME and orthotic and prosthetic vendors must call to obtain prior authorization from Medical Management for all items. Diabetic supplies are limited to Bayer, Healthfirst's exclusive, preferred manufacturer.

10.5 Home Healthcare

Healthfirst members are eligible to receive medically necessary home healthcare services provided by a Certified Home Health Agency (CHHA). Home care providers participating with Healthfirst include CHHAs maintained by member hospitals, and other contracted CHHAs. For a listing of participating CHHAs, see the Provider Directory.

Services and Eligibility

The services listed below comprise the scope of covered home healthcare benefits:

- Intermittent or part-time nursing visits rendered by a registered nurse
- Intravenous therapy as ordered by a provider
- Home health aide services provided under the direction and supervision of a registered nurse. Other services to be delivered in the home setting as requested by the PCP or attending specialist and approved by Medical Management
- DME, oxygen, respiratory devices, and other equipment and supplies required to care for the member in the home
- Treatment adherence home assessments for some members on Highly Active Anti-Retroviral Therapy (HAART) treatment adherence home assessments for some members on Highly Active Anti-Retroviral Therapy (HAART)
- In order to be eligible to receive home healthcare services, members must meet all of the following criteria:
  - be confined to the home
  - be under a plan of treatment established and periodically reviewed by a provider
  - be in need of intermittent skilled nursing care, physical therapy, speech therapy, or, in certain situations, occupational therapy

Responsibilities of Certified Home Health Agencies

All participating CHHAs must complete the following steps when providing care for Healthfirst members.

- Verify member eligibility through eMedNY for Medicaid members or by calling Member Services at
1-866-463-6743

- Develop a treatment plan based on an assessment of the member’s physical, psychological, and social needs
- Obtain the signature of the provider who initially recommended home healthcare services on the treatment plan
- Call Medical Management at 1-888-394-4327 for prior authorization of services
- If changes to the treatment plan are required within the period for which home health services have been approved, the CHHA will notify the PCP or specialist and will contact Medical Management to obtain further authorization
- If the duration of the home healthcare service period needs to be extended, the CHHA shall notify the treating provider and shall obtain authorization from Healthfirst for the extension. Healthfirst will also notify the PCP or specialist of authorized changes
- If DME is required as part of the approved treatment plan, the CHHA shall request separate and simultaneous prior authorization of the home healthcare treatment plan and associated DME and/or home infusion therapy from Healthfirst
- Issue the Healthfirst Notice of Noncoverage to Medicare members two (2) days prior to end of services and retain a signed copy of the notice. CHHA must provide Healthfirst with notice by close of business when requested for QIO appeal. The provider shall be responsible for those services in which the Notice of Noncoverage is not issued to the member with the appropriate signatures within the required time frames.

Prior Authorization Process: General Guidelines

Home healthcare providers are responsible for obtaining authorization from Medical Management before providing services. Home healthcare services must be coordinated with the member’s PCP or attending specialist in accordance with the prescribed plan of care. It is expected that home care providers will 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. Medical necessity guidelines are used to determine the appropriateness of setting for home healthcare. Home healthcare services requested solely for convenience, for activities of daily living, or that are custodial in nature are not a covered benefit.

Please note: If the only service required is venipuncture, it will not qualify for the Healthfirst Medicare Plan home health benefit. Insulin shots for members who are incapable of self-administration are a covered benefit in the home.

Healthfirst members may be referred for home healthcare services by PCPs, specialists, or hospital discharge planners by one of the following methods:

Referrals to Hospital-Owned or Hospital-Operated Home Health Agencies

When a Healthfirst member is referred to a participating hospital-operated home health agency for home care services, the referral must be made by the member’s PCP, the attending specialist, or a hospital discharge planner with approval from the appropriate provider. Referral policies and procedures are based on the current home healthcare referral process of the participating hospital. Home care services must be pre-authorized by Healthfirst.

Referrals to Other Contracted Certified Home Health Agencies

When a Healthfirst member in Nassau or Suffolk County is referred for home healthcare or home infusion services to a contracted CHHA other than a hospital-owned or operated agency, the referring provider must contact Medical Management at 1-888-394-4327 to pre-authorize services through a participating home health agency. Medical Management staff will work with the referring provider to confirm the agency’s participation status with Healthfirst and to direct the referral to the appropriate individual responsible for
developing a plan of care and initiating services.

**Personal Care Services—Medicaid, CompleteCare and AbsoluteCare**

Healthfirst Personal Care Services provides qualified members with partial or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the member’s health and safety within his or her own home, as determined by Healthfirst in accordance with the regulations of DOH; ordered by the attending provider based on an assessment of the beneficiary’s needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

There are two levels of personal care services:

- Level I services are limited to the performance of environmental and nutritional functions, including dusting, vacuuming, dishwashing, shopping, laundry, and meal preparation and Healthfirst confidential and proprietary information. Unauthorized use, disclosure or reproduction is strictly prohibited.

- Level II services include Level I services and personal care functions such as assisting members with bathing, grooming, bathroom and/or bedpan routines, walking, transferring from bed to chair or wheelchair, and assistance with self-administration of medications.

**10.6 Dental**

Dental services for Healthfirst members are provided and managed by DentaQuest, a delegated vendor that maintains a comprehensive network of dental providers. Healthfirst Medicare members should refer to their Evidence of Coverage (EOC) to determine the extent of their dental benefit. Members may access any network dental provider without a referral. To assist a member in obtaining dental services, please contact Healthfirst Member Services at 1-866-463-6743. Members may contact Healthfirst Member Services or DentaQuest Member Services at 1-800-508-2047 if they have questions regarding dental benefits.

In addition to providing primary care dental services, the network includes specialty care dental providers such as orthodontists, endodontists, and oral surgeons. These providers see Healthfirst members without a referral but with approvals obtained from the delegated vendor. In general, the oral surgery performed by these providers is done in the provider’s office and involves procedures such as the extraction of impacted wisdom teeth; however, there may be oral surgery cases involving small children that must be performed under general anesthesia in a hospital setting. In these situations, the delegated vendor authorizes the oral surgery and reimburses the surgeon, but the hospital and anesthesia service component of the treatment must be pre-authorized by Healthfirst. This may be handled through communication initiated by either the hospital or the member’s PCP.

In situations when oral surgery is required to treat medical problems such as head and neck cancers, a referral from the member’s PCP to the oral surgeon is required, and all required prior authorization must be obtained from the Healthfirst Medical Management department. In these cases, all services are authorized and reimbursed by Healthfirst.

HIV-positive members may select an HIV specialist dentist by contacting the DentaQuest Dental Member Service Department at 1-800-508-2047.

Members may call Healthfirst Member Services with any questions at 1-866-463-6743.

**10.7 Routine Vision**

Healthfirst Medicaid and Medicare members are entitled to routine eye examinations and eyeglasses provided through Davis Vision, a delegated vendor. Members may access these services without a referral from the PCP by making an appointment and presenting their Healthfirst identification card at the office of the appropriate vision care provider. Information on the vision care benefits and the vision care network is provided in the Member Handbook and in the Provider Directories.

Healthfirst Leaf Premier members are entitled to routine eye examinations and eyeglasses provided through
Davis Vision. Members may access these services without a referral from the PCP by making an appointment and presenting their Healthfirst identification card at the office of the appropriate vision care provider. Healthfirst Leaf members ages 19 and under (pediatric) are entitled to routine eye examinations and eyeglasses provided through Davis Vision. Pediatric members may access these services without a referral from the PCP by making an appointment and presenting their Healthfirst identification card at the office of the appropriate vision care provider.

Information on vision care benefits and the vision care network is provided in the Member Handbook and in the Provider Directories. Members may contact Davis Vision at 1-800-753-3311.

10.8 Hospice – Medicaid, Personal Wellness Plan, CHPlus, Leaf Plans, Commercial, and Medicare

Hospice care requires prior authorization and is covered by Healthfirst for Medicaid, Personal Wellness Plan, CHPlus, Leaf Plans, and Commercial members. Hospice is not covered under our Medicare product offerings. Hospice is a coordinated program that is designed to provide comfort and alleviate the pain of symptoms connected with a terminal illness. This benefit is covered directly by Medicare fee-for-service for Healthfirst Medicare members and must be elected by qualifying individuals. Prior authorization is required from fee-for-service Medicare. Since the hospice benefit is covered directly by Medicare for Healthfirst Medicare members, these members will continue to be covered through Healthfirst for treatment for conditions other than the terminal illness.

The hospice benefit covers provider services; nursing care; pain and symptom management; physical, occupational, and/or speech therapy; home health aide services; homemaker services; counseling; short term inpatient care; and respite care.

Under the Medicare Hospice Benefit, “terminally ill” means that the individual has a medical prognosis of six months or less if the illness runs its normal course. The beneficiary (or his or her representative) must file and sign an election statement with the particular hospice. Additionally, the Social Security Act requires that the individual or representative electing hospice must acknowledge that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual’s terminal prognosis; and must acknowledge that he/she waives the right to payment of standard Medicare benefits for treatment of the terminal illness and related conditions. If a Healthfirst Medicare member meets the following criteria, he or she should consider electing Medicare’s hospice services:

- Member must be entitled to Medicare Part A
- Member must have a terminal illness as certified by their PCP
- Member must have a life expectancy of less than six (6) months
- Member must waive the right to receive treatment for the terminal condition from any provider other than the hospice and attending providers

Hospice service for a Healthfirst Medicare member is covered under Original Medicare, not under the Healthfirst Medicare Plan.

10.9 Transportation

Emergency Transportation

All Healthfirst members are eligible for emergency transportation benefits. To obtain emergency transportation to the nearest emergency facility when there is a life-threatening situation, dial 911.

Transportation for Newborns (Medicaid)

Healthfirst covers transportation of newborns from the birth hospital to a Regional Perinatal Care Center (RPCC) for neonatal services. RPCCs directly arrange for one-way transport of newborns to the RPCC, and this service should be billed as rate code A0225 for an enrolled newborn or the newborn of an enrolled mother. Transport from the RPCC to the hospital is arranged by Healthfirst’s transportation vendor, not by the
RPCC, and is billed by the transportation vendor as a routine transportation service.

**Public Transportation**

Participating PCPs, OB/GYNs, behavioral health providers, dental providers, and hospital facilities are responsible for distributing a round-trip MetroCard, or its equivalent, for each verifiable visit for Medicaid services. PCPs, OB/GYNs, and hospital facilities are also responsible for distributing a round-trip MetroCard, or its equivalent, for specialty care services. If services are provided at a hospital, the member must present his/her Healthfirst card and proof of an encounter/visit to the hospital’s transportation coordinator before reimbursement is given. Reimbursement for public transportation is available (in MetroCards) regardless of the member’s proximity to the service site.

If it is essential that an escort(s) accompany the member in need of care or if a child accompanies a parent/guardian, a round-trip MetroCard will be provided for each escort. There is no limit to the number of escorts who may accompany a member.

All provider MetroCard transportation forms should be mailed to LogistiCare for reimbursement. Providers should call LogistiCare at 1-877-564-5925 for details and instructions for reimbursement deliveries.

**Special Program for Medicaid Members**

This program offers free car service to qualified Healthfirst Medicaid members who need the following services:

- **Prenatal visits** – Only if in the first trimester of pregnancy (0 to 3 months) or first prenatal visit within forty-two (42) days, or six (6) weeks, of enrollment with Healthfirst
- **Postpartum visit** – Only if within 21 (twenty-one) to 56 (fifty-six days), or three (3) to eight (8) weeks, after delivery

**Well-child visits and immunizations:**

- Offered for members up to 24 (twenty-four) months old (total of six [6] round trips)
- Two (2) weeks after birth
- Six (6) weeks after birth
- One (1) round trip every two (2) months thereafter for a maximum of six (6) round trips

To access this service, members in Nassau, Suffolk, and Westchester should call Member Services at 1-866-463-6743. Members in the New York City area should contact LogistiCare at 1-877-564-5925.

**Nonpublic, Non-emergency Transportation**

If a member has a non-emergent medical condition but requires an ambulance, ambulette, stretcher ambulette, or livery service to access medical care, the PCP, OB/GYN, behavioral healthcare, or dental provider must notify Member Services (for all Medicare and Medicaid members outside New York City) or LogistiCare (for Medicaid and Essential Plan members in New York City) 48 hours before the transportation is required. Member Services will arrange for appropriate transportation based on the member’s medical needs. Member Services is staffed Monday to Friday, 9am to 6pm, and can be reached by calling 1-866-463-6743. The after-hours service maintained by Healthfirst has instructions for assistance with transportation needs. LogistiCare can be reached at 1-877-564-5925 to schedule transportation for Medicaid members in New York City.

**Ambulance, Ambulette, and Livery Providers**

Transportation providers who wish to have written confirmation that transportation was approved and arranged by Healthfirst have the option to request documentation on a Transportation Arrangement Form. To receive this form on a regular basis, transportation providers should contact their Network Representatives.

See Appendix IX for copies of all transportation forms.
10.10 Custodial Long-Term Care Placement

If a Healthfirst member is enrolled with Community Medicaid and is being placed for custodial services, the Nursing Home must contact Healthfirst immediately to obtain authorization.

Healthfirst will provide the authorization for custodial care and the MAP 2159i form.

As per the DOH guidelines, The Nursing Home is responsible for compiling all required documentation, as part of the request for custodial eligibility and application, and submission to LDSS/HRA within 90 days from the start date the member is authorized for custodial care including the following documents:

- 2159i – Notice of Permanent Placement Medicaid Managed Care
- MAP 648P – Receipt for Submission of “Request” from Residential Health Care Facilities (RHCF), submit 2 copies – 1 copy will be returned to the RHCF as a receipt
- DOH 4220 – Access NY Health Care
- DOH 4495A – Supplement A
- MAP 2123 - Statement in support of claim
- MAP 3043 – Authorization to Apply for Medicaid on My Behalf
- MAP 3044 – Facility Submission of Application on Behalf of Consumer
- MAP 258M - Medicare Buy-In
- OCA-960 – Authorization for release of Health Information Pursuant to HIPAA
- Patient Review Instrument (PRI) – Pages 1-4
- Must submit a New Application for active in NYSOH (Health Benefits Exchange) clients

If applicable:

- LDSS 486T - Medical Report Form
- LDSS 1151 - Disability Interview Form
- Signed HIPAA Releases (3 blank copies)
- MAP 252F - AIDS Medical Form
- MAP 259D - Discharge Alert & MAP 259H – Intent to Return Home

You may submit completed applications online through the Eligibility Data and Image Transfer System (EDITS) by registering with the MAP Authorized Resource Center (MARC).

If your facility is located in New York City, you can also mail applications to:

Medical Assistance Program
Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, New York 11202-9810

If your facility is located in Westchester, Nassau, or Suffolk counties, you may mail applications to your Local Department of Social Services. For your local department of services address please visit www.health.ny.gov/health_care/medicaid/ldss.htm.

Note: The nursing home facility must provide proof (see section below) to Healthfirst that the application was submitted to HRA/LDSS. Please note, Healthfirst may recoup reimbursement made for any period of
eligibility.

**Proof of Submission Requirements**

**Paper Submitters:** Nursing homes must send two copies of the MAP-648P form to LDSS/HRA. LDSS/HRA will return a copy to the nursing home as proof of submission. The nursing home must email a copy of this form to: NursingHomeHF@Healthfirst.org.
EDITS Submitters: Submitters using EDITS will receive and electronic notification “EASYng Case Status History” response form EDITS. The nursing home must email a copy of this response to: NursingHomeHF@Healthfirst.org.

LDSS/HRA has forty-five (45) days from the date of application to complete the eligibility determination, including 60 months and look-back period and transfer of asset rules.

For SSI individuals, if a disability determination is required, the district has 90 days from the date of application or request for an increase in coverage to determine Medicaid eligibility. The district may exceed these time periods if it is documented that additional time is needed for a consumer, to obtain and submit required documentation.

**NAMI Member Billing**

If applicable, the net available monthly income (NAMI) that an institutionalized individual must contribute toward the cost of nursing home care will be billed to the member at the member's residence. For questions pertaining to collection of NAMI, call the appropriate Member Services number as listed in this ORG.

Once HRA/LDSS approve eligibility and determine NAMI amount it will be documented on monthly Nursing Home Report (specialty) file.

**Authorization Requirements**

Nursing Home facilities must obtain authorization from Healthfirst before providing nursing facility services to an eligible Healthfirst member.

Authorization may be requested by contacting Healthfirst’s Care Management Team

Healthfirst must be informed when any change to an authorized admission occurs

**Important Contact Information**

<table>
<thead>
<tr>
<th>PROVIDER SERVICES</th>
<th>AUTHORIZATIONS</th>
<th>MEMBER SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 5168 New York, NY 10274-5168 1-888-801-1660 Fax: 1-646-313-4634 Monday through Friday 9am to 5pm <a href="mailto:hfprovsrvs@healthfirst.org">hfprovsrvs@healthfirst.org</a></td>
<td>P.O. Box 5166 New York, NY 10274-5166 Medicaid 1-888-394-4327, option 5 Monday through Friday 8:30am to 5:30pm Medicare/LIP 1-866-463-6743 CompleteCare (CC) 1-866-237-0997 Senior Health Partners (SHP) 1-800-633-9717 Monday through Friday 8am to 6pm TTY: 1-888-542-3821 TTY (Spanish): 1-888-867-4132</td>
<td>P.O. Box 5165 New York, NY 10274-5165 Medicaid 1-866-463-6743 Monday through Friday 8am to 6pm Medicare AssuredCare (AC) CompleteCare (CC) Life Improvement Plan (LIP) 1-888-260-1010 7 days a week, 6am to 8pm P.O. Box 5165 New York, NY 10274-5165 Medicaid/Medicare TTY: 1-888-542-3821 TTY (Spanish): 1-888-867-4132 Senior Health Partners 1-800-633-9717 TTY: 1-888-542-3821 TTY (Spanish): 1-888-867-4132 Monday through Friday 8am to 6pm</td>
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**Bed Hold Authorization**

The nursing home must notify Healthfirst when a bed hold authorization is required.

Reserved bed days related to leaves of absence for temporary hospitalizations shall be made at 50% of the
Medicaid FFS rate for a maximum of 14 days in a 12 month period.

Reserved beds related to non-hospitalization leave of absence (therapeutic leave) shall be at 95% of the Medicaid rate for a maximum of 10 days in a 12 month period.

**Access to Care and Quality**

Healthfirst closely monitors and coordinates the care for members who are typically frail and have multiple, chronic conditions that reside in nursing facilities that require long term care.

**Patient care after placement:**

- **Person Centered Care Plan**
  - Healthfirst arranges for UAS-NY assessment every 6 months or when enrollee condition changes
  - Coordinates with NH to share assessment data
  - Healthfirst may review for service coverage and medical necessity
  - Healthfirst reauthorizes stay under concurrent review at identified intervals
  - Healthfirst ensures enrollee has a PCP
  - Healthfirst arranges for other covered services enrollee needs

**Communication and Coordination of Care:**

- The nursing facility must inform Healthfirst care management of a change in member Status and Sentinel Event in order to assure UAS assessment.
- The nursing facility must inform the Healthfirst care management of member discharge to the community
- For any issues regarding the MAP 2195i form please contact the Healthfirst at NursingHomeHF@Healthfirst.org

**Discharge Planning**

If a member chooses to transition back to the community, the Care Management team will work to assure the following:

- Coordinate a formal patient centered discharge plan involving the member, the member’s family, and nursing facility to develop and ensure a safe and appropriate discharge plan back into the community.
- Nursing Facility must work with Healthfirst to reinstate community LDSS coverage
- Ensure that appropriate community supports are in place prior to discharge.

**Billing Guidelines**

The Billing Guidelines are located online at our website, www.healthfirst.org.
11. EMERGENCY CARE

11.1 Emergent Care

Healthfirst members are covered for inpatient and outpatient emergency care services within the Healthfirst geographic service area and also when members are traveling in or visiting out-of-area locations.

Emergency services are reimbursed when an emergency medical condition exists or when a Healthfirst provider instructs the member to seek emergency care either in- or out-of-network as is appropriate to the member’s situation. Services must be provided by facilities or healthcare professionals qualified to render emergency medical care.

PRIOR AUTHORIZATION FROM HEALTHFIRST IS NEVER REQUIRED FOR REIMBURSEMENT OF AN EMERGENT MEDICAL CONDITION.

Definition of an Emergency Medical Condition

As set forth in Section 4900(3) of the New York State Public Health Law, an “emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
- Serious impairment to such person’s bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Emergency Guidelines

When a Healthfirst member presents in the emergency room for care, the hospital is responsible for providing medically necessary and appropriate treatment. The hospital must contact the PCP as soon as possible to obtain clinical information that may be necessary to provide appropriate treatment.

If a member presents in the emergency room with a non-emergent condition, the hospital should contact the PCP and document that contact. The hospital is then responsible for deciding and carrying out the necessary and appropriate course of action. Referral to the PCP for non-emergency treatment may be arranged.

If the PCP is referring the member for emergency care, the PCP should send the member to his or her assigned hospital whenever possible or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information.

Members should be instructed to return to the PCP’s office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency care and the follow-up care cannot be safely postponed until the member returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

Emergency Inpatient Admissions

For emergency admissions, prior authorization is not required, but the treating facility or physician must contact Healthfirst within 48 hours of the admission or as soon as possible to ensure proper post-stabilization care and discharge planning. Providers should contact Utilization Management via the telephone and fax numbers listed in Section 1 or through the Healthfirst Information Exchange.

In addition, hospitals are responsible for contacting the member’s PCP to advise of the proposed admission and to obtain any relevant information regarding the member’s condition, past medical history, and other relevant information. Healthfirst PCPs who practice in private, community-based settings and do not have admitting privileges at Healthfirst hospitals (Level III providers) should contact their hospital liaison to arrange
for admission to the appropriate participating hospital in emergency situations as well as in elective cases.

If a Healthfirst member is hospitalized for emergency care in a nonparticipating institution, Healthfirst will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely transported to a participating facility. Healthfirst’s Utilization staff will work with staff at both hospitals to arrange the transfer when the member’s attending provider judges it to be safe.

### 11.2 Urgent Care

**Definition of Urgent Medical Condition**

Urgent medical conditions are defined as those illnesses and injuries of a less serious nature than emergencies but that require services to prevent a serious deterioration of a member’s health which cannot be delayed without imposing undue risk to the member’s well-being, or until the member either returns to the Healthfirst service area or until the member can secure services from his or her regular provider.

If the member is within the Healthfirst geographic service area and an urgent medical situation arises, he or she should contact the PCP for to obtain care on an urgent basis. The PCP may have the member seen in his or her office or may refer the member for treatment of an urgent, but non-emergent condition in an Urgent Care Center. If the PCP refers the member to a nonparticipating urgent care center or provider, an authorization from Healthfirst is required. The PCP should document this contact with the member as well as the recommended course of action in the member’s medical record. If the member is out-of-area at the time urgent care services are required, the PCP should be contacted as soon as possible for direction, but the member should seek appropriate care in the immediate location.

Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition are not subject to prior authorization. If a member believes that a medical emergency exists, he/she should go the nearest emergency room or call 911 for assistance.
12. Medical Management

12.1 Program Overview

The Healthfirst Medical Management Program has been designed to maximize the quality care delivered to Healthfirst members. The program focuses on assisting providers in collaboration with members/caregivers in planning for, organizing, and managing the healthcare services provided to Healthfirst 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 program emphasizes collaboration with network providers, contracted vendor organizations, and other Healthfirst 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:

- Authorization and Notification Processes
- Continuity of Care
- Concurrent and Retrospective Review
- Care/Disease Management

Each of these program components, with the exception of Care/Disease Management, is discussed in detail in the following subsections of Section 12. The Healthfirst Care/Disease Management Program is described in Section 13 of the Healthfirst Provider Manual.

12.2 PCP-Directed Care

For Medicaid, Medicare, and CHP members, providers do not need to submit referrals to Healthfirst for approval when referring to participating providers in the Healthfirst network.

For members enrolled under the Healthfirst Leaf Plans, the PCP or OB/GYN provider must submit electronic referrals for all specialist visits. There are some exceptions to the referral requirements for Leaf Plan members. See subsection 12.3 for a list of referral requirements and exceptions.

However, there are no non-emergent, out-of-network benefits for any plan, and the provider must obtain approval from Healthfirst's Medical Management department if the provider wishes to refer a member to a nonparticipating provider. See subsection 12.5 on how to refer members out of network.

General Guidelines

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

Members should be referred to 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 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. Or you may contact Medical Management for assistance.

Specialists may assume primary care responsibility for members with life-threatening, degenerative, or disabling conditions requiring prolonged specialty care services. In certain cases, it is more effective for a specialist or specialty care center to manage the full spectrum of care for a particular member. Under these circumstances, the member’s PCP should contact Medical Management to arrange for the member’s primary and specialty care services to be coordinated and managed by a designated specialty care provider with expertise in the member’s condition.

If possible, the PCP, OB/GYN, or the office staff should assist the member in making appointments with 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. Medicaid members and certain Medicare members are entitled to transportation assistance. Please see Section 10 for additional details.

Ancillary Services

The PCP or specialty care provider may refer a member for ancillary services, such as laboratory or routine x-ray services, by filling out a prescription to order these services.

Prior authorization from Healthfirst-delegated entities including, but not limited to, radiology, dental, vision care is required. Refer to Section 10 and Appendix XI for additional information on this process. Please refer to Appendix XI-B for Leaf Plan provider authorization requirements.

Behavioral Health and Chemical Dependency Services

Members may self-refer to a participating Behavioral Health Specialist for assessment or treatment of a mental health or substance use disorder. Healthfirst members may obtain assistance regarding behavioral health services by contacting the Behavioral Health Unit at 1-888-394-4327.

Authorization for routine in-network outpatient behavioral health services is not required. Please note that admissions and the following outpatient services: ECT, neuropsychological testing, partial hospital program, intensive outpatient treatment, and day treatment, are subject to utilization and medical-necessity review to ensure that the most appropriate treatment and level of care is being provided. Authorization from the Healthfirst Behavioral Health Unit or the delegated behavioral care management organization is required.

Obstetrical Services

Healthfirst does not require female members to obtain referrals before accessing routine gynecological care. In accordance with NYS prenatal care regulations (10 NYCRR Part 85.40), Healthfirst provides comprehensive prenatal care services to its members, including but not limited to prenatal risk assessment, health education, mental health and related social services, labor and delivery, and post-partum care.

During pregnancy, the obstetrician assumes the responsibility for coordinating and managing the member’s care. The OB/GYN may treat and/or make specialty referrals for any medical conditions arising during pregnancy without referring the member back to her PCP; however, if illness or injury occurs that is unrelated to the pregnancy, the OB/GYN should refer the member to her PCP for further evaluation and treatment. In addition, when caring for a high-risk pregnant member, the provider should register the member in the Obstetric Care Management Program by calling the Obstetric Care Manager at 1-888-394-4327.

12.3 Authorization of Services

General Requirements

Other than for emergency care, providers must obtain prior authorization from Healthfirst’s Utilization Management department 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. These requirements apply to all Healthfirst benefit plans.

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

• Member’s name and Healthfirst ID number
• Attending/requesting provider’s name and telephone number
• PCP’s name (if not the attending/requesting provider)
• Diagnosis and ICD-10 Codes
• Procedure(s) and CPT Code(s) and procedure date(s)
• Services requested and proposed treatment plan
• Medical documentation to demonstrate medical necessity

• For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay.

Please be sure that ALL of the above information is included when you submit a request for prior authorization. If you are calling in the request, please have the information available when you call Utilization Management.

Healthfirst Level III PCPs who do not have admitting privileges at a Healthfirst hospital must contact Healthfirst’s Utilization Management department to arrange for elective admissions. In these situations, the PCP, not the admitting liaison, is responsible for obtaining prior authorization.

Please note that adverse determinations will be made by a clinical peer reviewer.

**Standard Timeframes for Prior Authorization Determinations**

Utilization Management will make a preauthorization determination within three (3) business days of receipt of all necessary information to make the determination. Providers may take up to fourteen (14) calendar days to provide this necessary information for Medicare and Medicaid member request for prior authorization. For Healthfirst Commercial Leaf Plan members, providers have forty-five (45) calendar days from the request for information to provide the necessary information. If, after review of the requested information, the request does not meet medical necessity criteria or meet benefit coverage limits, the request is forwarded to the Clinical Peer Reviewer for an adverse determination. If the requested information needed to make a determination has not been received by the plan, the request will be forwarded to the Clinical Peer Reviewer for an adverse determination. The provider will have the opportunity to request an informal reconsideration of the adverse determination for Medicaid and Commercial Leaf and formal appeal of the adverse determination for Medicare.

If Healthfirst fails to reach a determination within the Service Authorization Determination timeframes noted in this section, it is considered an adverse determination subject to appeal., Healthfirst will send notice of the Adverse Determination to the enrollee. Notices of determination decisions are issued to the requesting provider, the member, or the member’s representative and the PCP, as appropriate. Authorization for services is valid for 90 (ninety) days from the date of issue for most medical/surgical services.

After requesting an authorization, providers are given a notification number that can be used to obtain authorization status. Authorization status may be checked at www.healthfirst.org/providers. Please allow up to 24 (twenty-four) hours after the authorization is issued for it to be posted on the website.

**Expedited Determinations**

A Healthfirst member or provider may request an expedited determination regarding service authorization under the following circumstances:

• The request is for healthcare services or additional services for a member undergoing a continued course of treatment.

• The standard process would cause a delay that poses a serious or imminent threat to the member’s health.

• The provider believes an immediate determination is warranted.

All requests for expedited determinations must be made by contacting Utilization Management at 1-888-394-4327 and faxing documentation containing support for the expedited determination to 1-646-313-4603.

If Healthfirst determines that a member’s request does not meet the criteria for an expedited determination, the request will be processed automatically under the standard timeframes indicated above, and the member will be notified verbally and in writing of this decision. If a provider requests or supports the member’s request for an expedited determination, Healthfirst must expedite the process. The provider/member requesting the expedited organization determination request will be notified as to Healthfirst’s decision orally within 72 (seventy-two) hours of receipt of the request, and written notice will follow for Healthfirst Commercial and Medicare plan members and within 72 (seventy-two) hours for all other Healthfirst plans.
Authorization of Inpatient Admissions: Elective Admissions

All elective inpatient admissions require prior authorization. This applies to hospital admissions for medical/surgical services, as well as to facility admissions for inpatient behavioral healthcare and substance abuse services, as well as to Skilled Nursing Facility and Acute Rehab admissions. The prior authorization process allows for pre-admission review of the proposed hospitalization.

Elective admissions must be scheduled in advance of the hospitalization. The admitting provider must contact Utilization Management at 1-888-394-4327 for prior authorization no later than seven (7) days before admission. The admitting provider must obtain an authorization number from Utilization Management for an approved admission. This number must be included on all claims submitted in relation to the admission. If questions arise during the prior authorization review as to the appropriateness of the admission, the case will be referred to the Healthfirst Clinical Peer Reviewer for determination. If the requested admission is not approved, the provider may work with Utilization Management to initiate an appeal. The appeal process is discussed in Section 15 of the Healthfirst Provider Manual.

Emergency Admissions

All emergency admissions, including admissions in which the member proceeds directly from the provider’s office to the hospital for immediate admission, require notification to Healthfirst. Hospital staff must contact Utilization Management within 48 hours of the admission or on the next business day following a weekend admission. However, prior authorization from Healthfirst is never required for emergency admissions. The staff must provide Utilization Management with details regarding the admission, including the same data elements required for prior authorization of inpatient care as listed in this section. Notification from the member’s PCP or admitting provider is also acceptable. Providers may call Utilization Management at 1-888-394-4327 or fax information to 1-646-313-4603.

12.4 Out-of-Network Services

At times, a Healthfirst member may require healthcare services from a nonparticipating provider. These situations may arise for reasons of medical necessity or because a particular service or specialty is not available within the Healthfirst network. When this occurs, our Utilization Management department should be contacted at 1-888-394-4327, Monday through Friday, 8am–5:30pm. Our staff will obtain the clinical information needed to address the member’s specific health condition. A determination will be made regarding whether or not out-of-network care can be supplied by an in-network provider and whether the requested service(s) are medically necessary. Healthfirst will inform you of its decision within three (3) business days of receiving all the information needed to make a decision. Out-of-network care for all plans must be approved by Utilization Management, which evaluates the case in conjunction with the attending practitioner and the member’s PCP.

When a Healthfirst member is referred for out-of-network inpatient hospitalization, the hospital must:

- Verify the member’s eligibility at the time of admission;
- Contact Utilization Management to verify that the member’s scheduled admission has been preauthorized and to obtain the authorization number for submission with the claim.

Out-of-network services will not be covered in any Healthfirst plan except for emergency services or services authorized by Healthfirst. Healthfirst members who opt to receive elective out-of-network services without authorization will be held liable for the cost of those services.

Participating providers who knowingly and routinely refer Healthfirst members to nonparticipating providers for non-emergent services may be determined to be in breach of their participation agreement and be subject to termination.

If a Medicare member is referred to an out-of-network provider by an in-network provider, this is considered plan-directed care, and the member will be held harmless except for any copayment responsibility.

Healthfirst members enrolled in Healthfirst’s Medicaid, Child Health Plus, Essential Plan, or Commercial plans who receive unauthorized care or emergency services from a nonparticipating provider and receive a
“surprise bill,” as defined in the New York Financial Services Law, may assign their benefits to the nonparticipating provider and be held harmless for any cost in excess of the amount they would have paid for services if they had been provided by a participating provider.

12.5 Continuity of Care

Healthfirst has policies to address transition periods when a new member is undergoing a course of treatment prior to enrollment with Healthfirst. This would include treatment with a nonparticipating provider or a member’s provider leaves the Healthfirst network. These policies are required both in Healthfirst’s provider agreements as well as in Section 4403 of the New York State Public Health Law, and are described below.

In all cases, continuation of care with a nonparticipating provider depends upon the provider’s acceptance of Healthfirst’s reimbursement rates as payment in full. The provider must also agree to do the following:

- Adhere to Healthfirst’s quality assurance requirements
- Abide by all Healthfirst policies and procedures
- Provide Healthfirst with medical information related to the member’s care
- Obtain prior authorization from Utilization Management for applicable services
- Agree not to “balance-bill” the member for services provided (for Healthfirst Medicaid, CHP, Medicare [all plans] members only). Healthfirst Leaf Plan members may be liable for the cost-sharing amounts and may be responsible for the cost of noncovered care).

Continuity of Care Guidelines

<table>
<thead>
<tr>
<th>LOB</th>
<th>New Enrollee</th>
<th>Provider Leaves Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid to include HARP</td>
<td>If a new enrollee has an existing relationship with a healthcare provider who is not a member of the contractor’s provider network, the contractor shall permit the enrollee to continue an ongoing course of treatment by the nonparticipating provider during a transitional period of up to sixty (60) days from the effective date of enrollment if the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to 60 (sixty) days after the delivery. Ninety (90) days or until the Patient Centered Service Plan (PCSP) is in place, whichever is later, for Long-Term Social Services at the same level, scope, and amount as you were receiving Ninety (90) days for the current care plan or until an alternate care plan is authorized, whichever is later, for new enrollees receiving Adult Day Health Care (ADHC) or AIDS ADHC services. Can keep their service with existing provider for up to one year, unless the enrollee elects to change.</td>
<td>The transitional period shall continue up to 90 (ninety) days from the date the provider’s contractual obligation to provide services to the contractor’s enrollees terminates; or, if the enrollee has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery through 60 (sixty) days postpartum. Ninety (90) days or until the Patient Centered Service Plan (PCSP) is in place, whichever is later, for Long-Term Social Services at the same level, scope, and amount as you were receiving Ninety (90) days for the current care plan or until an alternate care plan is authorized, whichever is later, for new enrollees receiving Adult Day Health Care (ADHC) or AIDS ADHC services. Can keep their service with existing provider for up to one year, unless the enrollee elects to change.</td>
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<tr>
<td>Medicare</td>
<td>For medically necessary treatment associated with a chronic or serious condition, or other Medicare covered services, will provide a limited number of visits with enrollee’s current provider or caregiver at the same level, scope, and amount that they were receiving. Will work with enrollee and their Primary Care Provider (PCP) to find an in-network provider that can meet the enrollee’s medical needs. For the rest of the pregnancy, if the member has entered</td>
<td>If you are undergoing a specified course of treatment with a provider who leaves our network, we will authorize a transitional period of up to 90 days from the date the provider leaves Healthfirst to ensure continuity of your care and prevent any disruptions in your treatment plan. In addition, if you are in your second trimester of pregnancy (more than three [3] months pregnant) when your provider leaves our network, we will authorize a transitional period of up to 60 days postpartum (after the baby is born) to...</td>
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<tr>
<td><strong>Complete Care</strong></td>
<td>If the service is regarding a Medicaid-only benefit, the Medicaid rules apply; otherwise, Medicare rules apply.</td>
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<td>If the enrollee is in an ongoing course of treatment with a non-participating provider when their coverage under this certificate becomes effective, they may be able to receive covered services for the ongoing treatment from the non-participating provider for up to 60 days from the effective date of their coverage under this certificate. This course of treatment must be for a life-threatening disease or condition or for a degenerative and disabling condition or disease. If the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to 60 (sixty) days after the delivery.</td>
<td>If the enrollee is in an ongoing course of treatment when their provider leaves the network, then the enrollee may be able to continue to receive covered services for the ongoing treatment from the former participating provider for up to 90 days from the date their provider’s contractual obligation to provide services to them terminates.</td>
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<tr>
<td><strong>FIDA</strong></td>
<td>The FIDA Plan allows Participants receiving any covered item or service at the time of the effective date of enrollment other than nursing facility services or behavioral health services to maintain current providers, including providers who are currently out of the FIDA Plan’s provider network (i.e., non-participating providers), and service levels, including prescription drugs, until the later of: For at least 90 (ninety) calendar days after the effective date of enrollment or Until the PCSP is finalized and implemented.</td>
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<tr>
<td>The FIDA Plan allows Participants who reside in a nursing facility to maintain current nursing facility providers for the duration of the Demonstration. The FIDA Plan shall allow Participants who are receiving behavioral health services to maintain current behavioral health service providers (i.e., participating and non-participating) for the current episode of care. The IDT may review a current episode of care to determine whether it needs to be continued with the behavioral health service provider that was providing services before the Participant’s enrollment in the FIDA Plan. This requirement will be in place for a period not to exceed two (2) years from the date of a Participant’s effective date of enrollment and applies only to episodes of care that were ongoing during the transition period from Medicaid Fee-For-Service (FFS) to enrollment in a FIDA Plan.</td>
<td>Providers are required to continue a course of treatment until arrangements are made to transition the member’s care to another provider. Specifically, providers are required to continue providing services to Healthfirst members for a period of 90 (ninety) days from the date that they leave our plan. The FIDA Plan allows Participants who reside in a nursing facility to maintain current nursing facility providers for the duration of the Demonstration.</td>
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**Standing Authorizations**

Healthfirst allows standing authorizations for out-of-network specialty care in cases in which the member’s diagnosis or condition requires ongoing care from a specialist, specialty center, or specialty institution. In these situations, the PCP or requesting provider must coordinate a standing authorization with the member, the specialist and Healthfirst.

To arrange this authorization, the requesting provider must call Utilization Management to discuss the treatment plan and the need for the extended authorization. When appropriate, Utilization Management, in consultation with the requesting provider/PCP and the specialist, will issue an authorization designating the approved number of visits, the services to be rendered, and the time period covered by the standing authorization.
In-network specialty care does not require prior authorization when a standing referral is requested by the member’s requesting provider/PCP.

**Medical Records**

When a member selects a new PCP, upon his/her request the former PCP should transfer the member’s records to the new provider in a timely manner, thereby ensuring continuity of care.

**12.6 Concurrent Review**

Healthfirst has implemented a concurrent review program to monitor the allocation of resources during an episode of care. The program uses evidence-based criteria including, but not limited to; InterQual (IQ)/Milliman Care Guidelines (MCG) and Healthfirst Medical Policies to review services provided to members. These criteria are available to providers upon request.

**Inpatient Concurrent Review**

The inpatient concurrent review program comprises three (3) basic components. They are:

Admission Review: Admission review is based on clinical information provided to verify the appropriateness and medical necessity of the hospitalization. Emergency admissions that occur during weekends or holidays, when Healthfirst is closed, will be reviewed when the office reopens, and a medical-necessity determination will be made, provided that the hospital has complied with the Healthfirst notification policy. Please refer to Section 12 for more information on this policy.

Continued Stay Review: Continued stay review is conducted to re-establish that inpatient hospitalization continues to be appropriate and medically necessary. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

Discharge Planning: Discharge planning begins prior to admission for elective admissions. For an emergency admission, the process begins with the first review of the case. The goal of discharge planning is to move members efficiently and effectively through the different levels of care required to manage and treat their medical condition.

**Outpatient Concurrent Review**

**Medical/Surgical/Behavioral Health Services**: Outpatient concurrent review focuses on the effective allocation of resources during an episode of care to ensure that care is provided at the most appropriate level is coordinated among all disciplines, that continued benefits exist for the service, and that problematic cases and quality issues have been identified. Providers must furnish clinical information to Utilization Management to support continued authorization of services before the expiration of the authorized treatment period. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

**Community-Based Services Concurrent Review**

**Community-Based Services**: These services, which include Long Term Services and Supports (LTSS), are typically ongoing services in the home, with a special focus on either rehabilitation or helping an LTSS-eligible beneficiary remain in their home. Concurrent review of these services is defined as a request for continued services, or a request for change in the level of care. Providers must furnish required information, which may include clinical information from a treating physician or primary care provider, as well as progress notes or status reports from an agency providing the services. Some community-based services may be terminated in accordance with state requirements if necessary documentation is not received in time to perform a concurrent review.
12.7 Retrospective Review

Retrospective reviews are performed after healthcare services have been provided. Healthfirst conducts retrospective reviews to evaluate the medical necessity for services that were not preauthorized or reviewed concurrently. Healthfirst will make retrospective determinations within 30 (thirty) days of Healthfirst receiving the necessary information.

We may reverse a preauthorized treatment, service, or procedure on retrospective review only when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;

- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;

- We were not aware of the existence of such information at the time of the preauthorization review;

- The treatment, service, or procedure being requested would not have been authorized had we been aware of such information;

- The determination is made using the same specific standards, criteria, or procedures as used during the preauthorization review.
13. Care Management

13.1 Overview for all Healthfirst Members

Medical Management brings added value to our members by providing proactive and comprehensive care management and outreach for those diagnosed with high-risk conditions, illnesses, and special situations and needs. Our collaborative process of assessment, planning, facilitation, and advocacy—coupled with a comprehensive portfolio of programs—helps our members better manage their overall health and well-being and navigate the complexities of the healthcare system.

Care Management encompasses a variety of clinical, outreach, and educational programs that cover:

- Complex Care Management Program
- Care Coordination Programs
- HIV
- Healthy Mom/Healthy Baby
- OB High Risk Program

Members may self-refer or be referred from provider referrals such as their PCP or from utilization data sources for Care Management. Members are screened for care management to receive case management and/or care coordination by the Healthfirst interdisciplinary care team. Care Managers and Care Coordinators will work with members and their families, PCPs, other attending providers, facilities, and other service providers to assess, plan, coordinate, monitor, and evaluate the member’s level of function and to support and empower the member in their healthcare decisions to improve their quality of life. After an initial assessment, care plans are developed that include interventions to educate, monitor, and evaluate both the member’s and the caregiver’s ability to maintain their optimal level of function and wellness in the community. These Care Management programs are member-centric and are focused on the most efficient and effective way to support the member’s goals. The member's care plan is an organized map of problems, goals, and interventions that are managed proactively with the member and their interdisciplinary care team to meet the individual needs of the member. The Healthfirst Care Management Team provides ongoing care management services when there is an identified need for case management and/or care coordination.

Healthfirst is committed to increasing the quality of life and decreasing mortality and morbidity in all members through a dedicated care/case management approach.

Healthfirst Model of Care (MOC) for Medicare Special Needs Plans

The Healthfirst Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve, and sustain member health outcomes across the care continuum in accordance with the requirements set forth by the Centers for Medicare & Medicaid Services. The program provides primary, specialty, and acute medical care services and Medicaid-covered long term care services where applicable. It coordinates these services to address acute medical needs and to manage chronic conditions while allowing members to remain safe and secure in their own homes. The goals of the Model of Care consist of:

- Improving access to essential medical, mental health, long term care, and social services
- Improving access to affordable care
- Ensuring coordination of care through an identified point of contact
- Ensuring seamless transitions of care across healthcare settings, providers, and health services
Enhancing access to preventive health services
Assuring appropriate utilization of healthcare services
Improving beneficiary health outcomes across the continuum of care
Maintaining member at home at the highest functional level possible for as long as possible

These goals are accomplished via:

The administration of an initial and annual comprehensive health-risk assessment and the development of an individualized care plan;

Assignment of members with complex medical and psychosocial needs to a case manager; provision of an adequate network of providers who can meet the special needs of the membership;

Effective collaboration with an interdisciplinary care team; training of stakeholders on the MOC effective analysis of data toward meeting goals; and ongoing identification of process improvements with designated stakeholders, as well as communication of the results to same.

Interdisciplinary Care Team

Healthfirst assigns an interdisciplinary care team to each member in care management which plays an important role in the development and implementation of a comprehensive individualized plan of care for each member. Members of the interdisciplinary care team may include some or all of the following:

- Primary care physician
- Nurse practitioner, physician’s assistant, mid-level provider
- Social worker, community resources specialist
- Registered nurse
- Restorative health specialist (physical, occupational, speech, recreation)
- Behavioral and/or mental health specialist (psychiatrist, psychologist, licensed social worker, drug or alcohol therapist)
- Board-certified physician
- Dietitian, nutritionist
- Pharmacist, clinical pharmacist
- Disease management specialist
- Nurse educator
- Pastoral specialists
- Caregiver/family member
- Preventive health/health promotion specialist

The interdisciplinary care team works together to manage each member’s care by performing duties including some or all of the following:

- Develop and implement an individualized care plan with the member/caregiver
- Conduct care coordination meetings on a regular schedule
- Conduct face-to-face meetings
- Maintain a web-based meeting interface
• Maintain web-based electronic health information
• Conduct case rounds on a regular schedule
• Maintain a call line or other mechanism for beneficiary inquiries and input
• Conduct conference calls among plan, providers, and beneficiaries
• Develop and disseminate newsletters or bulletins
• Maintain a mechanism for beneficiary complaints and grievances
• Use email, fax, and written correspondence to communicate

Initial and annual assessments are analyzed to determine the need for add-on services and benefits. These needs are incorporated into the individualized care plan for each member.

**Complex Care Management Programs**

Complex Care Management Programs target members diagnosed with high-risk conditions, illnesses, special situations or needs and emphasize outreach, education, and intervention through collaboration with each member’s healthcare team, including PCPs, hospitals, specialists, home care, DME companies, etc. Our highly trained team of nurses works by telephone with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options.

**Care Coordination Management Programs**

Care Coordination Management Programs target members requiring assistance, synchronization, and support in obtaining care and emphasize outreach and education in handling and dealing with chronic conditions or sudden unexpected acute illness. Care management is effectuated by collaborating with each member’s healthcare team, including PCPs, hospitals, clinics, specialists, home care, DME companies, etc. Our highly trained team of nurses works by telephone in clinics, in emergency rooms, and on units at several of our participating hospitals in collaboration with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options.

**HIV**

Healthfirst is committed to increasing the quality of life and to decreasing mortality and morbidity in the HIV/AIDS population. Emphasis of the program is based on member assessment and coordination of care with the PCP, infectious disease clinic, immunologist, or HIV specialist provider. The goal is member education, coordination of medical care to help prevent opportunistic infections, and early identification of behavioral health and/or community resource needs. This program was developed in accordance with HIV/AIDS clinical practice guidelines published by the AIDS Institute, New York State.

**Healthy Mom/Healthy Baby**

Healthfirst has implemented member education programs and care management programs focused on pregnancy and newborn care. All pregnant women enrolled in these programs are sent educational materials endorsed by the American Congress of Obstetricians and Gynecologists (ACOG). These include information about prenatal care, fetal development, nutrition, preterm labor, and vaccinations. Members identified as “high-risk” are followed by a registered nurse for education, outreach, and prenatal and post-natal care. Healthfirst offers an incentive program to encourage prenatal care. Please see Section 14 for details.

Healthy Mom/Healthy Baby provides outreach services for all obstetrical members. The program is designed to improve outcomes for mothers and newborns (with an emphasis on member outreach and education) and links the member and her family with appropriate providers and community resources to ensure that she receives needed services and to identify any obstacles to care. Part of the Healthy Mom/Healthy Baby program is that staff proactively contacts identified members to perform initial and ongoing comprehensive risk assessments, to encourage early and continuous prenatal care, to develop a prenatal
plan of care and to coordinate that care, to encourage and/or provide HIV testing and counseling with clinical recommendation, and to coordinate post-partum and newborn care. The standard of care for Healthy Mom/Healthy Baby follows the New York State Law 85.40, PCAP Guidelines.

Specific program components include:

- Identifying pregnant members
- Assessment of members to identify high-risk pregnant members
- Providing community outreach services through affiliated hospitals and clinics
- Educating members by telephone and through literature mailed out to members
- Assessing pregnant members for risk factors and complications
- Coordinating care in collaboration with the member’s obstetrical provider for high-risk pregnancies

Important: Please refer pregnant women under your care who meet these diagnostic criteria, as well as any other high-risk Healthfirst obstetrical members, to the Care Management program by calling 1-888-394-4327 or faxing a referral to 1-646-313-4603.
14. Clinical Performance Management

14.1 Overview and Philosophy

The Clinical Performance Management Program and Integrated Quality Plan is an organization-wide commitment that supports processes designed to improve the quality and safety of clinical care and the quality of service provided to our members. The Program utilizes clinical and service indicators to plan, implement, monitor, and improve the organization’s commitment to improve quality, maximize safe clinical practices, and enhance service delivery to our members.

**Key Objectives of the Healthfirst Clinical Performance Management:**

1. To establish and maintain a Clinical Performance Management Program and Integrated Quality Plan that demonstrates a commitment from the highest governing body of Healthfirst to every employee of the organization and to provide the highest possible quality in clinical care and service delivery to our members.

2. To share with its participating providers clinical and service performance indicators by which care and member satisfaction are measured and to hold those accountable in the implementation of actions designed to improve performance.

3. To establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring, and evaluating performance to improve desired outcomes.

4. To demonstrate a quality process that ensures compliance with all rules and regulations set forth by local and federal regulatory agencies that affect all aspects of the organization’s business, service, and clinical operations.

5. To implement and monitor educational materials and programs designed to empower members to take better care of themselves.

**Scope of the Integrated Quality Plan/CPM Program**

The Integrated Quality Plan/CPM Program is applicable to all Healthfirst products. All aspects of the organization participate in every facet of the Plan’s overall quality improvement efforts. The overall goal of this program is to include both administrative and clinical initiatives that are monitored regularly and evaluated annually. All clinical performance activities, when applicable, shall be conducted in accordance with the National Committee for Quality Assurance (NCQA) Standards for the Accreditation of Managed Care Organizations and/or other reporting requirements as promulgated by the different regulatory agencies that oversee the organization, such as the New York State Department of Health (NYSDOH), New York City Department of Health and Mental Hygiene (NYC DOHMH), and the Centers for Medicare & Medicaid Services (CMS). Activities fall into two (2) major categories: activities that improve the quality and safety of clinical care, and activities that improve the quality of service provided to its membership.

14.2 Reporting Requirements and Quality Programs

Healthfirst is required to report to federal, New York State, and New York City regulatory authorities on a variety of data elements, including clinical studies and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst relies upon its provider network to supply it with comprehensive, accurate, and timely information. Healthfirst also expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets.

This section of the Provider Manual describes the range of regulatory reporting requirements and provider data requirements mandated by CMS, the NYSDOH, the NYC DOHMH, and Healthfirst. It also describes the Quality Program’s tools, support, and educational initiatives that Healthfirst has implemented to help providers meet and satisfy these regulatory requirements.
Risk Adjustment: Member Diagnosis Information and Coding Requirements

Medicare, NYS-Medicaid, and Health Exchange Programs utilize ICD-9-CM as the official diagnosis code set for each respective risk-adjustment model. Accordingly, ICD-9 diagnosis codes are required in the determination of risk-adjustment factors. Accurate and appropriate ICD-9 codes must be submitted for each beneficiary. As of 10/1/2015, ICD-9 codes will no longer be accepted by Healthfirst and will be replaced with the ICD-10 code set.

Coding and Medical Record Documentation:

- As a standard policy, Medicare, Health Exchange, and NYS-Medicaid programs require accuracy and specificity in diagnostic coding
- Use current ICD-9-CM diagnostic coding conventions through 9/30/2015 and ICD-10 coding conventions beginning 10/1/2015
- Ensure office staff is up to date on the basics of ICD-9-CM and ICD-10 coding
- Code in the highest level of specificity known
- Clinical specificity of a disease/condition can be expressed through the fourth (4th) and/or fifth (5th) digit of some ICD-9CM diagnostic codes (ending 9/30/2015)
- Clinical specificity of a disease/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/or 7th (seventh) digit of some ICD-10CM diagnostic codes (beginning 10/1/2015)
- Specificity of coding is based on the accuracy of information written in the medical records
- Medical records are the source of all codes
- Verify that codes are supported by the medical record
- All claims submitted that do not have the appropriate fourth (4th) and/or fifth (5th) digit in the ICD-9CM diagnostic codes will be denied by Healthfirst

Guidelines when managing medical records:

- As per provider and member agreement with Healthfirst, access to medical records must be available for verification of diagnosis (please refer to your agreement)
- Include the member’s identification on each page of the medical record and date of service. Include the signature of the person(s) doing the treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records
- Documentation in the medical record of encounters with members must include all conditions and comorbidities being treated and managed
- Include the provider’s credentials on the medical record, either next to his/her signature or preprinted with the provider’s name on the practice’s letterhead
- Report and submit all diagnoses that impact the member’s evaluation, care and treatment; reason for the visit; co-existing acute conditions; chronic conditions or relevant past conditions
- Medical records must reflect the codes submitted
- For more information on Medicare program: [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/)
- For more information on Medicaid program: [www.health.state.ny.us](http://www.health.state.ny.us)
- For more information on the Health Exchange program: [www.hhs.gov/](http://www.hhs.gov/)
Quality Assurance Reporting Requirements (QARR)

QARR are a series of measures designed to examine managed care plan performance in several key areas. These measures are largely adopted from the NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®), with additional New York State–specific measures added to address public health issues of particular significance in New York.

HEDIS consists of eighty-three (83) measures and QARR has three (3) NYS-specific measures across five (5) domains of care. Highlights of the four (4) domains from HEDIS/QARR that are greatly impacted by the performance of a Plan’s participating providers are presented here.

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>Adult BMI Assessment</td>
</tr>
<tr>
<td></td>
<td>Weight Assessment &amp; Counseling for Nutrition &amp; Physical Activity for Children / Adolescents</td>
</tr>
<tr>
<td></td>
<td>Childhood Immunization Status</td>
</tr>
<tr>
<td></td>
<td>Immunizations for Adolescents</td>
</tr>
<tr>
<td></td>
<td>Human Papilloma Vaccine for Female Adolescents</td>
</tr>
<tr>
<td></td>
<td>Lead Screening in Children</td>
</tr>
<tr>
<td></td>
<td>Adolescent Preventive Care</td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Non-Recommended Cervical Cancer Screening in Adolescent Females</td>
</tr>
<tr>
<td></td>
<td>Chlamydia Screening in Women</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Non-Recommended PSA-Based Screening in Older Men</td>
</tr>
<tr>
<td></td>
<td>Care for Older Adults</td>
</tr>
<tr>
<td></td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td></td>
<td>Appropriate Testing for Children with Upper Respiratory Infection</td>
</tr>
<tr>
<td></td>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
</tr>
<tr>
<td></td>
<td>Use of Spirometry Testing in the Assessment &amp; Diagnosis of COPD</td>
</tr>
<tr>
<td></td>
<td>Pharmacotherapy Management of COPD Exacerbation</td>
</tr>
<tr>
<td></td>
<td>Use of Appropriate Medications for People with Asthma</td>
</tr>
<tr>
<td></td>
<td>Medication Management for People with Asthma</td>
</tr>
<tr>
<td></td>
<td>Asthma Medication Ratio</td>
</tr>
<tr>
<td></td>
<td>Cholesterol Management for Members with Cardiovascular Conditions</td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td></td>
<td>Persistence of Beta-Blocker Treatment After a Heart Attack</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care</td>
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<td></td>
<td>HIV/AIDS Comprehensive Care</td>
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<tr>
<td></td>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
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<tr>
<td></td>
<td>Osteoporosis Management in Women who had a Fracture</td>
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<tr>
<td></td>
<td>Use of Imaging Studies for Low Back Pain</td>
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<td></td>
<td>Antidepressant Medication Management</td>
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<tr>
<td></td>
<td>Follow-up Care for Children Prescribed ADHD Medication</td>
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<td></td>
<td>Follow-Up After Hospitalization for Mental Illness</td>
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<tr>
<td></td>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications</td>
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<td></td>
<td>Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia</td>
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<tr>
<td></td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</td>
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<tr>
<td></td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation Post-Discharge</td>
</tr>
<tr>
<td></td>
<td>Potentially Harmful Drug-Disease Interactions in the Elderly</td>
</tr>
</tbody>
</table>
Performance in the HEDIS/QARR data sets is one (1) of the core indicators on which Healthfirst plan-wide quality improvement efforts have been focused. It is extremely important to note the following:

HEDIS/QARR measures are primarily based on preventive health standards and clinical practice guidelines issued by expert panels and community respected organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), American Diabetes Association (ADA), American College of Obstetrics and Gynecology (ACOG), and the American College of Cardiology (ACC).

HEDIS/QARR requires specific technical specifications on how data is reported for each measure (see Appendix XVI).

Documentation is key – starting from the medical records (members’ charts) to the business office submission of encounter and claims data. There are measures such as well-child visits in the Medicaid product that can only be reported through claims and encounter data, but only if the appropriate coding and timing of service was submitted to the plan.

To assist providers, the Clinical Performance Management department will periodically prepare and forward listings of members to the appropriate providers indicating services that were not reflected on the encounter and claims data submitted. Providers are asked to review their records to see whether these services were rendered but not reported to Healthfirst. If the services were rendered, providers are asked to submit the claims/encounter data to Healthfirst as soon as they are identified. If they were not but would be beneficial to the member, the provider is asked to reach out to the member to offer the service. Staff from the Clinical Performance Management department will work with providers closely to monitor provider specific initiatives and performance rates.

**Provider Network Reports**
On a quarterly basis, Healthfirst submits its Health Provider Network (HPN) report to the State, listing all participating providers. This submission includes provider license numbers, Medicaid provider numbers, office locations and hours, provider types and specialties, etc. Healthfirst must attest to the accuracy of this provider information with a notarized affidavit. It is imperative that the information you give us about your practice—such as office address and office hours, your credentials and license/provider numbers—be accurate at the time and be updated promptly whenever there is a change. To submit any change in your information, fill out the Demographic Change Form on our website at www.healthfirst.org or call Provider Services at 1-888-801-1660.

**Reporting Requirements for the New York State Cancer Registry (NYSCR)**

The Cancer Research Improvement Act of 1997 amended section 2401 of the Public Health Law. Under this law, all managed care organizations certified pursuant to Article 44 are required to report cancer cases to the NYSCR. A prescribed list of data elements to track cancer incidence has been developed. Data is collected from the encounter forms submitted to Healthfirst by providers. Healthfirst providers must submit encounter forms to document services rendered and may be requested to forward additional information to support the reporting requirements of the NYSCR.

**Public Health and Communicable Disease Reporting**

Public health law requires that confirmed diagnoses of specific communicable diseases must be reported to the NYSDOH. Diseases relating to the potential for bioterrorism attacks are included on the mandatory reporting list. For a copy of the complete set of mandatory reporting lists, please refer to Appendix XV, check the NYSDOH website at www.health.ny.gov/professionals/diseases/reporting/communicable, or call the NYSDOH at 1-518-474-0548.

In addition to providers, all laboratories must submit a report to the NYSDOH when a communicable disease is identified. However, even though a laboratory may report the disease, providers are also required to submit a report once the diagnosis is confirmed.

Reports may be submitted by mail, fax, or telephone, and specific forms must be used in certain cases. If you file a report by telephone, please remember to document this in the member’s medical record, being sure to include the date reported, the telephone number, and the name of the person taking the report. The following telephone list contains important numbers for you to have available to report communicable and other reportable diseases.

**Telephone Guide for Communicable and Reportable Diseases**

<table>
<thead>
<tr>
<th>New York City</th>
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</thead>
<tbody>
<tr>
<td>NYC AIDS Reporting</td>
<td>1-212-442-3388</td>
</tr>
<tr>
<td>NYC Communicable Disease Bureau</td>
<td>1-212-788-9830</td>
</tr>
<tr>
<td>Lead Poisoning</td>
<td>1-212-676-6158</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>1-212-788-4444</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1-212-788-4162</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Nassau County</th>
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</thead>
<tbody>
<tr>
<td>Communicable Disease Control</td>
<td>1-516-227-9496</td>
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<tr>
<th>Suffolk County</th>
<th></th>
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<tbody>
<tr>
<td>Bureau of Epidemiology &amp; Disease Control</td>
<td>1-631-787-2200</td>
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</tbody>
</table>

**Additional Information Regarding Public Health Reporting**

Providers must cooperate with local department of health efforts to address and identify community health problems and gaps in service.

**HIV/AIDS Comprehensive Care**

Report new cases of HIV infection and HIV illnesses, along with AIDS cases, to the NYC DOHMH on a timely
basis. Cases of HIV infection, HIV-related illness, and AIDS are reportable by telephone to 1-212-442-3388.

Please ensure that HIV-positive Healthfirst members receive necessary preventive care services and that appropriate documentation is found in the member’s medical records.

Encounter data/claims should contain the following appropriate coding:

<table>
<thead>
<tr>
<th>Two outpatient visits for primary care or HIV related care - 1 in the first 6 months of the year; 1 in the second 6 months of the year (ages 2 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429</td>
</tr>
<tr>
<td>ICD-9 Diagnosis: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
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</table>

<table>
<thead>
<tr>
<th>Two viral load tests - 1 in the first 6 months of the year; 1 in the second 6 months of the year (ages 2 years and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4: 87534-87536, 87537-87539</td>
</tr>
<tr>
<td>One syphilis test (age 19 and older only)</td>
</tr>
<tr>
<td>CPT-4: 86592-86593, 86780</td>
</tr>
</tbody>
</table>

If your patient does not have private health insurance or Medicaid, he/she can get HIV care and medication from the AIDS Drug Assistance Program (ADAP) at no cost. For more information, call 1-800-542-2437.

The HIV/AIDS practice guidelines are downloadable at www.hivguidelines.org/clinical-guidelines/. For additional information, visit www.health.state.ny.us/diseases/aids/index.htm.

Encourage members to get tested for HIV infection, especially populations at risk, such as drug users, homosexual males, bisexual males/females, sexually active teenagers, etc.

Provide members with the toll-free numbers 1-800-541-AIDS (1-800-541-2437) and 1-800-233-SIDA (Spanish) for HIV testing and counseling.

Today's test technologies afford individuals the ability to receive an HIV test result in a single visit. If your office or organization offers HIV counseling and testing and has not yet adopted rapid testing, you should consider doing so.

Detailed guidance for implementing rapid testing for HIV is available at www.health.ny.gov/diseases/aids/testing/#rapid.

Sexually Transmitted Diseases (STDs)

Disease surveillance indicates that over fifty (50) percent of all infections reported on a national level are sexually transmitted. STDs represent the most commonly reported infectious diseases among sexually active adolescents. It is extremely important that both the healthcare provider and the health plan from which a young person may seek help and advice regarding these diseases are sensitive to the issues and challenges that face this population. Suggestions to improve performance:

- Be sure encounter data/claims contain appropriate coding.
- Encourage members to get tested for STDs, especially members of high-risk populations and populations at risk, such as drug users, homosexual males, bisexual males/females, sexually active teenagers, etc. For additional information, visit www.health.state.ny.us/diseases/communicable/std/index.htm.
- Provide members with the following STD hotlines for information and testing sites:
• Remind Healthfirst members that confidential STD services are available at the NYCDOH clinics for non-Healthfirst sexual and needle sharing partners for no charge

• Document all care and services rendered in the member’s chart and submit claims and encounter forms using the above appropriate codes

**Tuberculosis (TB) Control**

Healthfirst has adopted the clinical practice guidelines for the diagnosis and treatment of tuberculosis from the Clinical Policies and Protocols Manual, Bureau of Tuberculosis Control, New York City Department of Health, Third Edition, June 1999; Updated Fall, 2006. All Healthfirst providers should use these guidelines in the care and treatment of Healthfirst members with TB. These guidelines contain important information about counseling TB members and their families and about household precautions that are necessary to avoid spreading the disease.

A copy of these guidelines can be ordered from the NYC DOHMH Bureau of Tuberculosis Control by calling 1-212-788-4162. Directly Observed Treatment (DOT) programs are available at various locations throughout New York City, and referrals can be made for members who are not compliant with their medication regimen or do not keep follow-up visits. To enroll/refer a Healthfirst member to the DOT program, call 311.

The New York City health code mandates the reporting of children aged younger than five (5) years with a positive tuberculin skin test (TST) to the Department of Health and Mental Hygiene. Medical providers and infection control practitioners are now required to report on these children, in accordance with Article 11. Treatment for latent TB infection is recommended in all children as soon as active TB is ruled out. For all DOH-reported cases, children younger than five (5) years are assigned a Case Manager to follow up on their evaluation and treatment.

**Child Abuse and Domestic Violence**

It is important that providers and their staff be alert to potential cases of child abuse, domestic violence, and adult and elder abuse. An assessment screening is recommended for all new members during annual follow-ups and when child abuse/domestic violence is suspected (including in same-sex relationships). Reporting of child abuse or maltreatment is mandatory for all healthcare professionals. The Injury Prevention Program (TIPP) can be used as a reference guide to help prevent/minimize injury and violence. Your local department of health is also a resource for additional information and referral resources for domestic violence and abuse. The telephone numbers listed below provide resources for information and reporting of child abuse and domestic violence:

• New York State Child Abuse or Maltreatment Registry: 1-800-635-1522
• General Information on Child Abuse: 1-877-543-7692
• General Information on Domestic Violence: 1-800-942-6906
• General Information on Social Services: 1-800-342-3009

**Hepatitis B Screening**

All pregnant women must be screened for Hepatitis B, with a follow-up vaccination when indicated. If applicable, infants and close contacts of the women must also be tested. Members with positive Hepatitis B findings must be reported to the local department of health.

**Smoking Cessation**

Tobacco has been linked to lung cancer and other deadly chronic diseases. We urge providers to help your
members fight tobacco addiction as part of your standard of care rendered to your members. For every member at every clinic visit, the healthcare provider should:

- Identify whether a member is a smoker
- Document smoker status in the member’s chart as a vital sign
- Provide smoking cessation resources, such as:
  - NY State Smoker’s Quitline – 1-866-NY-QUITS or 1-866-697-8487
- Treat by introducing pharmacological counseling therapies

Healthfirst Medicaid programs provide smoking cessation counseling coverage for eligible members. Nonprescription medications must have “over the counter” written on the order. Healthcare providers can call the NY State Quitline to obtain concise, up-to-date information on stop-smoking techniques and medications, or to order office materials that can be shared with their members.

Member Incentive Program

Through Healthfirst’s Health Promotion Programs, members may be entitled to the following incentives:

The Healthfirst Wellness Reward Card Program is a way for Healthfirst members to earn rewards for taking care of themselves:

The program is available to Healthfirst Medicaid, Child Health Plus and Medicare members. Members can qualify for reward cards by completing selected preventive screenings and health initiatives, such as well child visits, completion of health risk assessments, mammograms, medication adherence and colorectal screenings. Reward card forms can be found on the Provider Portal, at http://healthfirst.org/providers/. Members can fill out a form and mail or fax the form back to Healthfirst. Providers must submit the correct claims in order for the members to be approved for a reward card.

Free car service – Available to qualified Medicaid members who need prenatal and/or post-partum visits, well-child visits, and immunizations within the required time frames. Members should contact Member Services at 1-866-463-6743 to arrange for their free transportation.

14.3 Clinical Practice Guidelines

Clinical practice guidelines (Appendix XII) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH, and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst.

Healthfirst has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two (2) years unless otherwise specified. Healthfirst adopts guidelines upon the recommendation and approval of the Healthfirst Quality Improvement Committee (QIC). They are communicated to providers—including performance indicators chosen by the clinical members of the Committee—through the Provider Manual, annual mailings, newsletters, and the Healthfirst website. Performance against chosen indicators is measured annually—preventive guidelines are measured utilizing HEDIS/QARR measurement tools and clinical guidelines are measured using focused studies methodologies.

Please note: Healthfirst disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our members. These guidelines provide a tool for objective comparison of clinical practices among network providers.
providers and ensure appropriateness of care to our members. These guidelines are readily available by virtue of their already broad publication and distribution.

To obtain a copy of the list of guidelines required by the NYSDOH and the list of guidelines adopted by Healthfirst, visit http://healthfirst.org/providers/provider-resources/

### 14.4 Studies, Surveys, and Investigations

**Studies - Medicaid and Managed Long Term Care (MLTC)**

Every two years, the Managed Care Organizations (MCOs) participating with Medicaid and Managed Long Term Care (MLTC) programs are required by the NYSDOH to conduct a Performance Improvement Project (PIP) in a priority topic area or a topic relevant to the MCO’s population demographics. A PIP, as defined by the NYSDOH, is a methodology for facilitating MCO and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through the PIPs MCOs and providers determine what processes need to be improved and how they should be improved. Providers are strongly encouraged to participate in the conduct of these studies, as well as in the implementation of action plans to improve performance. Participation can be accomplished by becoming a member of Healthfirst’s quality improvement committees.

We are also mandated to participate in the NYSDOH’s focused clinical studies on an annual basis. The NYSDOH determines the topic of focus. Participating providers are expected to cooperate with medical record reviews necessary to conduct these studies, comply with medical records standards, and meet required performance thresholds established for the project. The projects, their results, and updates are published in The Source, our provider newsletter, and/or on the Healthfirst website, at www.healthfirst.org as well as reported quarterly at the Quality Improvement Committee and the Board Meetings. For information on how to become a member of Healthfirst’s Quality Committee, or to obtain copies of the projects, please contact the Clinical Performance Management department.

<table>
<thead>
<tr>
<th>Contract Period</th>
<th>Study Topic</th>
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<tbody>
<tr>
<td>2015</td>
<td>Improving the Identification of Smokers in the Adult 18-64 y.o. Medicaid Population and Increasing the Utilization of Smoking Cessation Benefits (PIP)</td>
</tr>
<tr>
<td>2015</td>
<td>NY Depression Screening Validation Study (Focused Clinical Study)</td>
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<tr>
<td>2015</td>
<td>Reduce the number of falls requiring medical intervention (MLTC PIP)</td>
</tr>
</tbody>
</table>

**Studies – Medicare, Special Needs Plans (SNP), and Fully Integrated Duals Advantage (FIDA)**

Each year, Managed Care Organizations (MCOs) participating with Medicare, Special Needs Plans (SNPs), and Fully Integrated Duals Advantage (FIDA) programs are required by CMS to conduct a Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) for a topic that is relevant to these member populations. The CCIP is a five year study and the QIP is a three year study.

<table>
<thead>
<tr>
<th>Contract Period</th>
<th>Study Topic</th>
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<tbody>
<tr>
<td>2012</td>
<td>Improve Medication Adherence for Medicare Members with Cardiovascular Disease on Statins and/or ACEI/ARB (CCIP)</td>
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<tr>
<td>2013</td>
<td>Improving Cardiovascular Disease Outcomes through Medication Management (iSNP CCIP)</td>
</tr>
</tbody>
</table>
Reduction of All Cause Hospital Readmission for Healthfirst iSNP Members through Use of Continuity of Care Medication Reconciliation Tools (iSNP QIP)

Improving the health outcomes of our members with COPD through increased pharmacotherapy compliance after an acute exacerbation and Spirometry testing to monitor the efficacy of treatment and disease severity (QIP)

Reduce the number of falls requiring medical intervention (FIDA QIP)

Improving the rates of dilated retinal exams among our members with diabetes (FIDA CCIP)

The topic of cardiovascular disease was selected by CMS for the 2012 CCIP and 2013 iSNP CCIP. CMS selected this health issue to support the Million Hearts Initiative. Additional information on this campaign can be found at the following website: http://millionhearts.hhs.gov/about_mh.html. The 2013 QIP focuses on the reduction of 30-day, all-cause hospital readmissions. The 2016 QIP will strive to improve the health outcomes of Medicare members with COPD while the 2016 FIDA QIP addresses fall prevention and the FIDA CCIP aims to increase dilated retinal exam screenings among our diabetic FIDA population.

**Member Satisfaction Surveys**

The NYSDOH and CMS conduct annual member satisfaction surveys which are administered by third party survey vendors and provide the plans with their individual results. The NYSDOH and CMS use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys as well as the Qualified Health Plan Enrollee Experience Survey (QHPEES) as its survey tools. The CAHPS surveys & QHPEES are a set of standardized questions that assess member satisfaction with the experience of care. The surveys are based on randomly selected samples of members from the MCO and summarize satisfaction with the experience of care through ratings and composites. The members’ perception and experience with their providers impact a major portion of these ratings and composites. It is important that providers participating with Healthfirst conduct the delivery of services in their offices and facilities at the highest quality level, ensuring that the needs of their patients (our members) are met to their satisfaction. Results of these surveys are communicated to providers through newsletters, our website, and/or special mailings. If you need more information about the CAHPS surveys, please visit the NCQA website, www.ncqa.org. If you need more information about the QHPEES, please visit www.CMS.gov.

**Quality-of-Care Investigations**

To ensure the quality and safety of the services provided to its members, as well as to improve member satisfaction, Healthfirst responds to any identified concerns or issues regarding provider performance through a quality review process. Review of quality-of-care referrals can include, but is not limited to, medical record review, provider contact, member contact, referral for peer review, interdepartmental review, review by the Medical Director, and review by the clinical members of the Healthfirst Quality Committee. All clinical quality-of-care referrals are trended and tracked to identify patterns. When the inquiry/review has been completed and a final disposition is assigned to the referral, the outcome/recommendation is communicated to the referring and concerned parties, as appropriate. Information about the inquiry and review is forwarded to the Credentialing department for inclusion in the provider’s files.

**14.5 Quality Improvement – Medicare**

Healthfirst’s participation in the Medicare Advantage Program requires additional reporting requirements. The Program incorporates the mandatory quality standards for the Medicare program. The Medicare program is operated under the auspices of the U.S. Department of Health and Human Services – Centers for Medicare & Medicaid Services (CMS). It is expected that providers comply with the requirements of Healthfirst, CMS, and the Quality Improvement Organization (QIO) designated as the review agent for CMS, in order to meet these requirements.
important initiatives that ensure our Medicare members receive the highest quality of care possible. The Medicare Star Rating system, a program administered by the Centers for Medicare & Medicaid Services (CMS), measures the quality of Medicare Advantage plans and supports CMS efforts to drive improvements in Medicare quality and improve the level of accountability for the care provided by physicians, hospitals, and other providers. CMS publishes the Star Ratings each year to assist beneficiaries in finding the best plan for them and to determine MA Quality Bonus Payments. The Star Ratings system is consistent with CMS’ Three Aims (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

| 1. Outcomes | Outcome measures focus on improvements to a beneficiary’s health as a result of the care that is provided. |
| 2. Intermediate Outcomes | Intermediate outcome measures help move closer to true outcome measures. |
| 3. Patient Experience | Patient experience measures represent beneficiaries’ perspectives about the care they have received. |
| 4. Access | Access measures reflect issues that may create barriers to receiving needed care. |
| 5. Process | Process measures capture the method by which health care is provided. |

Medicare members may be asked to provide feedback by answering up to three surveys per year. Not all Medicare members receive these three annual surveys:

1. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey:** Provided to Medicare members to rate their satisfaction with their doctors and the plan. Members may be asked questions like:
   - In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment as soon as you thought you needed one?
   - In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
   - How often did your health plan’s customer service give you the information or help you needed?

2. **Health Outcomes Survey (HOS):** Provided to Medicare members to rate their physical and mental health. Members may be asked questions like:
   - In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity?
   - Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?
   - Have you ever talked with a doctor, nurse, or other healthcare provider about leaking of urine?

3. **Health Risk Assessment (HRA) Survey:** The HRA survey is given to all plan members enrolled in a Special Needs Plan (SNP) once a year. Members are to complete the HRA survey within 90 days of enrolling in a SNP plan, and once a year after that. This survey asks about health status and to identify any health conditions or concerns a member may have.

The following measures are the standard reporting requirements for the Medicare products:

<table>
<thead>
<tr>
<th>Domain/Category</th>
<th>Measure/Description</th>
</tr>
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<tbody>
<tr>
<td>Access/Availability of Care</td>
<td>Access to Primary Care Doctor Visits</td>
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<tr>
<td></td>
<td>Appeals Auto-Forward</td>
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<td>Appeals Upheld</td>
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<td></td>
<td>Beneficiary Access and Performance Problems</td>
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<td>Call Answer Timeliness</td>
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<tr>
<td></td>
<td>Disenrollment Reasons - Financial Reasons for Disenrollment</td>
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<tr>
<td></td>
<td>Disenrollment Reasons - Problems Getting Information about Prescription Drugs</td>
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<tr>
<td></td>
<td>Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Info</td>
</tr>
<tr>
<td></td>
<td>Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals</td>
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<tr>
<td>Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage</td>
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<tr>
<td>Drug Plan Provides Current Information on Costs and Coverage for Medicare’s Website</td>
<td></td>
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<tr>
<td>Engagement of Alcohol or other Drug Treatment</td>
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<tr>
<td>Enrollment Timeliness</td>
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<td>Foreign Language Interpreter and TTY Availability</td>
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<td>Grievance Rate</td>
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<tr>
<td>Initiation of Alcohol or other Drug Treatment</td>
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<tr>
<td>Medicare Plan Finder – Stability</td>
<td></td>
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<tr>
<td>Plan Makes Timely Decisions about Appeals</td>
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<tr>
<td>Plan Submitted Higher Prices for Display on MPF</td>
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<tr>
<td>Reviewing Appeals Decisions</td>
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<td>Timely Effectuation of Appeals</td>
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<td>Timely Receipt of Case Files for Appeals</td>
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<tr>
<td>Transition monitoring - failure rate for all other drugs</td>
<td></td>
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<tr>
<td>Transition monitoring - failure rate for drugs within classes of clinical concern</td>
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| Aspirin Use and Discussion |
| Care Coordination |
| Complaints about the Health Plan |
| Computer Use Made Talking with Doctor Easier |
| Computer Used during Office Visits |
| Computer User by Doctor Helpful |
| Customer Service |
| Doctors who Communicate Well |
| Getting Appointments and Care Quickly |
| Getting Information from Drug Plan |
| Getting Needed Care |
| Getting Needed Prescription Drugs |
| Medical Assistance With Smoking and Tobacco Use Cessation |
| Members Choosing to Leave the Plan |
| Rating of Drug Plan |
| Rating of Health Care Quality |
| Rating of Health Plan |
| Reminders for Appointments |
| Reminders for Immunizations |
| Reminders for Screening Tests |
| Reminders to Fill prescriptions |
| Reminders to Take Medications |

| Process |
| Medicare Plan Finder Price Composite |
| Medication Therapy Management Program Completion Rate for Comprehensive Medication Review |
| SNP Care Management |

<p>| Process/Effectiveness of Care |
| Adult BMI Assessment |
| Annual Flu Vaccine |
| Annual Monitoring for Patients on Persistent Medications |
| Antidepressant Medication Management |
| Breast Cancer Screening |
| Care for Older Adults: Medication Review |
| Care for Older Adults: Functional Status Assessment |
| Care for Older Adults: Pain Screening |</p>
<table>
<thead>
<tr>
<th>Intermediate Outcome/Effectiveness of Care</th>
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### 14.6 Quality Evaluation of Providers

Healthfirst uses standardized and evidence-based tools to evaluate the quality of providers acting as Primary Care Physicians for our members. Healthfirst evaluates the quality of providers using their Overall Quality Rating (OQR), a numerical score on a scale of 1.0 to 5.0 that summarizes the provider’s weighted average performance on select quality measures. The quality measures used to determine OQR (as well as their cut points and target rates) are informed by Medicare STARS and the New York State Department of Health Medicaid Incentive Program which are updated on a yearly basis. Healthfirst’s detailed methodology for calculating OQR is available upon request. A list of the quality measures commonly used for OQR calculation(s) is available in Appendix XVII.

Providers are evaluated on the following domains for quality:

- Adult and Pediatric Preventive Care, including measures related to well-care visits, screenings and immunizations
- Chronic Care Management, including measures related to asthma, diabetes and HIV treatment
- Acute Care Management, including measures related to pharyngitis and bronchitis
- Efficiency of Care, including measures related to hospital utilization rates and medication adherence
Enrollee Experience and Satisfaction with Care

Providers’ OQRs are calculated by line of business. Providers will have access to their quality data and OQRs through Healthfirst reporting tools. Healthfirst will review Providers’ OQRs throughout the calendar year (January-December). Healthfirst will calculate and share Final OQRs with Providers included in the evaluation by late Q2 or early Q3 of the following year.

Healthfirst will engage Providers falling at or below the Minimum Quality Rating (MQR) for the Provider network. Each MQR will be no higher than 3.0 and Providers will only be evaluated against the MQR if they have at least ten valid quality measures they can be evaluated on. Providers will be notified if they are at or below the MQR throughout the year via engagement with Network Management or Clinical Quality Managers. Providers whose Final OQR is at or below the MQR will receive a formal notification letter from Healthfirst. This letter will include an offer to furnish Providers with additional support and resources to improve their OQRs.

For Providers consistently falling below the MQR, Healthfirst may take other actions deemed necessary, including but not limited to:

- Suppression of the Provider’s information from the Healthfirst Directory
- Reduction or discontinuation of quality incentive bonus payments/deductions
- Suppression from Healthfirst’s Enrollee/PCP auto-assignment process
- Removal from the Healthfirst network

Providers can appeal their Overall Quality Rating. Providers may appeal by following the guidelines briefly described in Section 16.3 of this Provider Manual. Healthfirst reserves the right to deny or disqualify appeals as applicable.

For additional information, please email HQIP@Healthfirst.org.
15. Appeals and Grievances

Please note:
Medicare-related information can be found in Sections 15.1 through 15.7.
Medicaid/CHPlus/Commercial-related information can be found in Sections 15.8 through 15.18.

15.1 Provider Notice Requirements – Medicare

Because Healthfirst serves various types of members who are covered under a variety of commercial and governmental contracts, the requirements for appeals and grievances may differ among the different products offered. The title bar above each section indicates the program(s) for which the information applies. The sections within Appendix XIII contain copies of all forms, notifications, and documents referenced in this section.

Member Dissatisfaction with Specialist Providers

Members who are not satisfied with the care provided by a particular specialist provider have the option of switching to an alternative in-network provider of the same specialty if a suitable alternative exists. The member’s PCP must be involved in the transition of the member to an appropriate specialist and should discuss the issue with the member. The PCP may also suggest that the member obtain a second opinion prior to changing a specialist altogether.

If the PCP feels strongly that the specialist with whom the member is dissatisfied is uniquely qualified to deal with the member’s medical needs, the PCP should discuss this with the member, in an attempt to continue the existing relationship. If the member still wants to change specialists, the PCP should refer the member to a new specialist and inform him/her to contact Member Services to file a grievance against the initial specialist.

Noncovered Benefits

If the provider recommends a course of treatment or service that is a noncovered benefit, the provider must:

- Inform the member, in writing, that the service or item may not be covered by Healthfirst and that the member will be responsible for payment of those services
- OR

If the provider is willing to waive payment, inform the member that he or she will be held harmless for payment if Healthfirst determines that the treatment or service is not covered. Where a provider has not been given a list of covered services by Healthfirst or the provider is uncertain as to whether a service is covered, the provider should make reasonable efforts to contact Healthfirst to obtain a coverage determination prior to advising a member about coverage and liability for payment and prior to providing the service.

15.2 SNF/HHA/CORF Provider Service Terminations – Medicare

Grijalva Decision

For Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers, Healthfirst would like to advise you of some important changes that have taken place with respect to the appeals process and delivery of the notification of termination of covered services.

As part of a settlement agreement between CMS and Medicare beneficiaries, the federal rules governing Medicare appeals were recently revised. Specifically, pursuant to 42 CFR Section 422.624, the provider of services is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to Medicare managed care members prior to the cessation of services for medical necessity determinations. For denials of SNF
day Benefit Exhaustion, admission to SNF, Home Care or CORF that is Not Covered, or when single service ends but skilled stay continues, the Notice of Denial of Medical Coverage (NDMC) will be issued. The delivery must be made to the managed care member two (2) days prior to the termination of the covered services and will not be considered valid until the member 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 legally 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). If the member has no legally authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

The Notice of Medicare Non-Coverage will be faxed to you, along with every preauthorization and concurrent authorization approval letter issued on behalf of Healthfirst members. It is imperative that you keep this form on file until it is time to present it two (2) days prior to discharge or within the last two sessions of home health services or therapy/rehabilitation. In addition, it is important that you understand that Healthfirst will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and secure a member’s signature.

**Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF**

**Provider Service Terminations**

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

**When to Issue Detailed Explanation of Non-Coverage**

Once the QIO receives an appeal, it must issue a notice to Healthfirst that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, Healthfirst is responsible for issuing the Detailed Explanation of Non-Coverage – a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA, or CORF care. (See Appendix XIII).

Healthfirst must issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the member no later than the close of business when the QIO notifies Healthfirst that a member has requested an appeal.

Healthfirst 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 Healthfirst.

**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 Healthfirst 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, by fax, or in writing by the close of the business day of the appeal request date.

Healthfirst must supply a copy of the Notice of Medicare Non-Coverage, Detailed Explanation of Non-Coverage, and any medical information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day that the QIO notifies Healthfirst of an appeal. If a member requests an appeal on the same day the member receives the Notice of Medicare Non-Coverage, then Healthfirst 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 Healthfirst by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, Healthfirst, or both. If the QIO does not receive the information it needs to sustain the Healthfirst decision to terminate services, then the QIO may make a decision 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 Healthfirst 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 noon (12pm) of the next day after receiving the notice;

Healthfirst meets its time-frame obligations to deliver medical information and a Detailed Explanation of Non-Coverage to the QIO; and

the QIO either reverses the Healthfirst 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 (1) day** of financial liability if the QIO upholds the Healthfirst 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 Healthfirst 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 appeal with Healthfirst. Healthfirst will expedite the request for an expedited appeal if the QIO receives a request for an immediate QIO review beyond the noon (12pm) filing deadline and forwards that request to Healthfirst. Healthfirst would generally make an expedited decision about the services within seventy-two (72) hours. Financial liability applies in both the immediate QIO review and Healthfirst expedited review situations.

If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or SNF/HHA/CORF administrator on duty to facilitate the delivery of the Detailed Explanation of Non-Coverage.

### 15.3 Notification to Members of Non-Coverage of Inpatient Hospital Care – Medicare

Where Healthfirst has authorized coverage of the inpatient hospital admission of a Medicare member, either directly or by delegation (or the admission constitutes emergency or urgently needed care), Healthfirst is required to issue the member a written notice of non-coverage only under the circumstances described below.

**Hospital Discharge Notification Process**

Healthfirst delegates the issuance of discharge notices to all its participating hospitals.

Specifically, participating hospitals must:

- **Issue the Important Message from Medicare About Your Rights (IM)** (see Appendix XIII) and explain discharge rights to beneficiaries within two (2) calendar days of admission. They must also obtain the signature of the beneficiary or his/her representative’s. If a member refuses to sign the notice, the hospital must annotate the refusal.

- **Deliver a copy of the signed notice not more than two (2) calendar days prior to discharge.** In short-stay situations, when inpatient stays are five (5) days or fewer, hospitals are not required to deliver a follow-up notice as long as the initial notice was delivered within two (2) calendar days of discharge.

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

If an appeal occurs during a weekend, a Healthfirst Care Manager 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 process are available on the CMS website at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

For additional information, please visit our website at www.healthfirst.org/providerservices.

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

A member remaining in the hospital who wishes to appeal the Healthfirst discharge decision that inpatient care is no longer medically 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 by fax; and
- Makes the request before the end of the day of discharge.

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 Healthfirst that the member has filed a request for immediate review.

- Healthfirst and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, by 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 Healthfirst, 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 Healthfirst 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 Healthfirst by close of business of the first working day after it receives all necessary information from the hospital, Healthfirst, or both.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst is encouraged to expedite the request for an expedited appeal. Likewise, the QIO is encouraged to expedite a request for immediate QIO review if received beyond the noon (12pm) filing deadline and to forward that request to Healthfirst. Thus, Healthfirst would generally make an expedited decision about the services within 72 (seventy-two) hours; however, the financial liability rules governing immediate QIO review do not apply in an expedited review situation. This means that the member could be financially liable if the discharge decision is upheld.

**Liability for Hospital Costs**

The presence of a timely appeal for an immediate QIO review as filed by the member or member representative in accordance with this section entitles the member to automatic financial protection by Healthfirst. This means that if Healthfirst authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, Healthfirst continues to be financially responsible for the costs of the hospital stay (less any member copayments, coinsurance, or deductibles) until noon (12pm) of the calendar day following the day the QIO notifies the member of its review determination.
15.5 Organization Determinations and Reconsiderations (Appeals) – Medicare

When Healthfirst receives a request for payment or to provide services to a member, it must make an organization determination on whether or not payment and/or coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member 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 organization determination from Healthfirst. The member should be referred to their EOC or should contact Healthfirst Member Services for additional information.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Definitions</th>
<th>Stakeholders Who Can Submit</th>
<th>Who Can Submit</th>
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<tr>
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<td>Member (Includes AOR)</td>
<td>Contracted Provider (INN)</td>
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<td>Appeal (Pre-Payment)</td>
<td>The review of adverse organization determinations on the healthcare services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service.</td>
<td>Yes</td>
<td>Yes</td>
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<td>Appeal (Post-Payment)</td>
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<td>Yes</td>
<td>No</td>
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<td>Coverage Request (OD/CD)</td>
<td>Request for a decision made by or on behalf of a plan regarding payment or benefits to which an enrollee believes he or she is entitled. OD = Organization Determination (Part C) CD = Coverage Determination (Part D)</td>
<td>Yes</td>
<td>Yes</td>
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Healthfirst is required to make organization determinations and process appeals as expeditiously as the member’s health status requires, but no later than indicated in the following chart:

### Time Frames for Organization Determinations and Reconsiderations (Appeals)

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<tr>
<th>Organization Determinations</th>
<th>Reconsiderations (Appeals)</th>
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<td>Standard – Not to exceed 14 calendar days. (The 14-day deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)</td>
<td>Standard (Service-Related) – Not to exceed 30 calendar days. (The 30-day deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)</td>
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<td>Expedited – Not to exceed 72 hours. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)</td>
<td>Expedited – Not to exceed 72 hours. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.)</td>
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<td>Standard Only – Payment/Claims-Related Not to exceed 60 calendar days.</td>
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A member has a right to appeal if the member believes that:

- Healthfirst has not paid for emergency, post-stabilization, or urgently needed services
- Healthfirst has not paid a bill in full
Health services have been furnished by a noncontracting medical provider or facility or supplier that the member believes should have been provided by, arranged for, or reimbursed by Healthfirst.

Services that the member feels are the responsibility of Healthfirst to provide or pay for have not been received or paid for.

Previously authorized ongoing course of treatment that has been reduced or prematurely discontinued and member believes the services are still medically necessary.

An organization determination has not been made within the appropriate time frames.

Noncovered services that the member believes should be provided, arranged, or reimbursed have not been provided, arranged, or reimbursed.

**Time Frames and Methods for Submitting Standard Appeals**

Appeal requests can be made in writing or orally within 60 (sixty) calendar days from the date of the notice of organization determination. Healthfirst may extend the time frame for filing a request for reconsideration for good cause. Appeals received after the 60-day timeframe must be in writing and state why the request for an appeal was not filed on time.

A member or a member’s representative may also request a standard appeal request of an organization determination in writing or orally. A member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases, others authorized under state law may act on behalf of the member. Providers and/or member advocate acting on behalf of a member must complete an Appointment of Representative Statement (Appendix XIII-E) for the services in question.

**Requests for Additional Medical Documentation**

Healthfirst will make reasonable efforts to request clinical documentation to substantiate services in a timely manner in the event the information is not submitted with the initial request. Providers should understand that delays or failures to submit necessary clinical information may put member’s health in jeopardy.

If further information about the member’s appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner to allow for resolution within regulatory time frames.

For Expedited Reconsiderations:

When participating providers submit requests for expedited considerations of an appeal, they should submit all supporting clinical information with the expedited appeal. If additional information is needed to help resolve the submitted appeal, Healthfirst will make reasonable efforts to contact the provider to request such information. Any additional Clinical documents should be submitted within 24 hours and can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

For Standard Reconsiderations:

If additional information is needed to help resolve the submitted standard appeal, Healthfirst will make reasonable efforts to contact the provider to request such information. Any additional information requested should be submitted within 10 calendar days and can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

**Appeal Determinations**

If Healthfirst reverses an initial adverse organization determination, then services will be authorized or provided as expeditiously as the member’s health condition requires, but no later than 30 (thirty) calendar days from the date the request for standard appeal was received or no later than upon expiration of an extension; and within 72 hours from the date the request for expedited appeal was received or no later than upon expiration of an extension. For payment-related requests, payment will be made no later than 60 (sixty) calendar days after the appeal request was received.

If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review.
If CMS’ contractor upholds the Healthfirst adverse organization determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS’ contractor reverses the Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed within 14 (fourteen) calendar days of receipt of the IRE’s notice, and if the member’s condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notice. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that are reversed by the IRE will be effectuated within 30 calendar days of receipt of the IRE’s notice.

If Healthfirst does not complete an expedited appeal process within 72 (seventy-two) hours or a standard appeals process within 30 (thirty) calendar days or payment related within 60 (sixty) calendar days, the case will be automatically referred to CMS’ contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to 1-877-779-2959.

Please Note: Dual-eligible members only

CompleteCare members have both Medicaid and Medicare benefits and have different options when filing an appeal for services covered under the benefit package. For Healthfirst services funded by the state contract, members must follow Medicaid appeal rules. For services funded through the Medicare program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules. If a member chooses to pursue Medicaid appeal rules to challenge an organizational determination or action, he/she has 60 (sixty) calendar days from the date on the Notice of Denial of Coverage issued by Healthfirst to also pursue a Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue a Medicare appeal, he or she may not file an appeal under Medicaid. Healthfirst determines whether Medicaid, Medicare, or both cover a particular service.

15.6 Expedited Organizational Determinations and Appeals

If a Healthfirst member, appointed representative, or member’s provider believes an expedited organizational determination is required because a delay would significantly increase risk to the member’s health, the Healthfirst member, their appointed representative, or the provider may request an expedited organizational determination by calling Healthfirst at 1-888-394-4327. If Healthfirst denies the request for an expedited organizational determination, Healthfirst will notify the member or the member’s representative and the provider in writing within three (3) calendar days (Medicare and Leaf Plans) or 3 business days (Medicaid) and include the member’s right to an expedited grievance. Healthfirst will then process the organizational determination using the standard determination time frames.

If a provider requests or supports the member’s request for an expedited organizational determination, Healthfirst must automatically expedite the organizational determination. We will make a determination and provide the member, the member’s designee, and the provider by telephone within seventy-two (72) hours (Medicare and Leaf Plans) or 3 business days (Medicaid) of receipt of the request. Written notice will follow within one (1) calendar day of the determination. If the member requests an extension or Healthfirst needs additional information, we will extend the timeframe up to fourteen (14) calendar days. The member, the member’s designee, and provider will be notified in writing of the extension and will be provided with the right to file an expedited grievance if he or she disagrees with Healthfirst’s decision to grant an extension.

If a Healthfirst member or that member’s provider believes an expedited appeal is required because a delay would significantly increase risk to the member’s health, the member or the member’s appointed representative may request an expedited appeal by calling Healthfirst at 1-877-779-2959. If Healthfirst denies the request for an expedited appeal, Healthfirst will notify the member and/or the member’s representative and review the appeal using the standard appeal process. If a provider requests or supports the member’s request for an expedited determination or appeal, Healthfirst must automatically expedite the review.

The member’s provider can also request an expedited appeal if the denial was made during concurrent
review (request for extension of services beyond the time period or quantity currently authorized).

In addition, the member or the member’s designee may provide additional information to Healthfirst, either in person or in writing, including evidence and allegations of fact or law related to the issue in dispute. If further information regarding the member’s appeal is required to render the reconsideration decision, providers must submit the additional information in a timely manner. For an expedited appeal, the additional information must be provided within three (3) business days from the date of Healthfirst receipt of the appeal.

The time frame for appeal resolution may be extended up to fourteen (14) days if the member, the member’s designee, or the member’s provider requests an extension orally or in writing. The expedited appeal may be extended by Healthfirst for up to fourteen (14) days if Healthfirst justifies the need for more information and believes the extension is in the best interest of the member.

Oral appeals may be requested by calling 1-888-260-1010. Any oral appeal can be followed up with a written submission for the request. Please send such requests to our Appeals and Grievances department at:

Healthfirst
Appeals and Grievances Department
P.O. Box 5166
New York, NY 10274

Appeal Determinations
Healthfirst will make a determination with regard to a STANDARD appeal within thirty (30) calendar days from the date we received the appeal.

Healthfirst will make a determination with regard to an EXPEDITED (fast-track) appeal within the lesser of 72 hours of receipt of the request (Healthfirst Leaf Plan and Medicare Plan members)/3 business days from receipt of request (Medicaid members) or two (2) business days of receipt of the necessary information to conduct the appeal for all members.

If Healthfirst reverses an initial adverse organizational determination, then services will be authorized or provided as expeditiously as the member’s health condition requires, but no later than thirty (30) calendar days from the date the request for standard appeal was received or no later than upon expiration of an extension; and within 72 hours from the date the request for expedited appeal was received or no later than upon expiration of an extension. For payment-related requests, payment will be made no later than sixty (60) calendar days after the appeal request was received.

If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review.

If CMS’s contractor upholds the Healthfirst adverse organizational determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS’s contractor reverses Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed within fourteen (14) calendar days of receipt of the IRE’s notice, and if the member’s condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notice. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that are reversed by the IRE will be effectuated within 30 calendar days of receipt of the IRE’s notice.

If Healthfirst does not complete an expedited appeal process within seventy-two (72) hours or a standard appeals process within thirty (30) calendar days, the case will be automatically referred to CMS’s contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to 1-877-779-2959.

Please Note: Dual-eligible members only
CompleteCare members have both Medicaid and Medicare benefits and have different options when filing an appeal for services covered under the benefit package. For Healthfirst services funded by the state contract, members must follow Medicaid appeal rules. For services funded through the Medicare program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules. If a member chooses to pursue Medicaid appeal rules to challenge an organizational determination or action, he/she has sixty (60) calendar days from the date on the Notice of Denial of Coverage issued by Healthfirst to also pursue a Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue a Medicare appeal, he or she may not file an appeal under Medicaid. Healthfirst determines whether Medicaid, Medicare, or both cover a particular service.

15.7 Coverage Determinations for Part D Prescription Drugs – Medicare

Most Healthfirst Medicare plans offer Medicare prescription drug coverage (Part D). Generally, the members must share costs for their prescription drugs. Drugs on the formulary are grouped into four (4) tiers with the lowest cost share being Tier 1 and the highest being Tier 4:

- Tier 1: Generic
- Tier 2: Preferred Brand
- Tier 3: Non-Preferred Brand
- Tier 4: Specialty

Healthfirst 65 Plus Plan however is designed to be the preferred plan for Medicare beneficiaries who do not qualify for “Extra Help,” either in the form of Low Income Subsidy (LIS) for Part D or Medicare Savings Programs (MSP) for Medical benefits. As such, this plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, but at a $0 monthly premium, making it a high-value yet affordable choice. Healthfirst 65 Plus Plan has a 5 tier prescription drug formulary.

- Tier 1: Generic
- Tier 1: Non-Preferred Generic Drugs
- Tier 3: Preferred Brand Drugs
- Tier 4: Non-Preferred Brand Drugs
- Tier 5: Specialty Tier Drugs

Coverage determinations include exception requests. An exception request is the way a member can exercise his or her right to ask for an “exception” to the formulary. In other words, to request lower cost-sharing. An exception request must be accompanied by a supporting statement from the prescribing provider.

Healthfirst strongly encourages and recommends that a prescribing provider review the current Medicare Part D formulary to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics (P&T) Committee comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider’s treatment criteria.
Prior Authorization (PA)

Healthfirst Medicare Plan requires a member or his or her provider to request prior authorization for certain drugs. This means the member must obtain prior approval for a prescription from Healthfirst Medicare Plan before the prescription is filled. If you do not obtain approval, Healthfirst Medicare Plan may not cover the drug.

- **Quantity Limit (QL):** For certain drugs, Healthfirst Medicare Plan limits the amount of the drug that Healthfirst Medicare Plan will cover.
- **Step Therapy (ST):** In some cases, Healthfirst Medicare Plan requires the member first try certain drugs to treat their medical condition before we will cover another drug for that condition.

Healthfirst’s Medicare formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QL) criteria listings, can be found on Healthfirst’s public website: [www.healthfirst.org/formulary.html](http://www.healthfirst.org/formulary.html).

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department, 7:00am to 5:30pm MST, Monday–Friday, in one of the following ways:

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **WRITE** CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

Medicare Part D Appeals

A member’s appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A member may appeal an adverse coverage determination; however, if an exception request for a non-formulary drug is approved, the member cannot request an exception to the copayment they are required to pay for the drug.

A member has a right to appeal if he or she believes that Healthfirst/CVS Caremark, Inc. did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit,
- Decided not to reimburse a member for a part D drug that he/she paid for,
- Asked for payment or provided reimbursement with which a member disagrees,
- Denied the member’s exception request,
- Made a coverage determination with which the member disagrees.

Appeals for Part D Prescription Drugs

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **TTY** Number: 1-866-236-1069
### Write

CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

**Complaints About Part D Prescription Drugs**

**Write to:**

CVS Caremark

Attn: Grievance Department

MC 121

P.O. Box 53991

Phoenix, AZ 85072-3991

If CVS Caremark fails to meet coverage determination or redetermination time frames, it must automatically forward the member’s request(s) to the Independent Review Entity (IRE) contracted by CMS.

If the IRE upholds the Healthfirst adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

### Time Frames for Coverage Determinations and Appeals

CVS Caremark is required to make coverage determinations and to process appeals as expeditiously as the member’s health status requires but no later than is indicated in the following chart:

**Medicare Prescription Drug (Part D) Time Frames for Appeals**

<table>
<thead>
<tr>
<th>Pharmacy Coverage Determinations (Initial Decision)</th>
<th><strong>STANDARD</strong></th>
<th><strong>EXPEDITED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>72-hour time limit</td>
<td>24-hour time limit</td>
<td></td>
</tr>
</tbody>
</table>

**APPEAL PROCESSES**

| **FIRST LEVEL OF APPEAL** (Internal) | **MAPD/PDP** Standard Redetermination 7-day time limit | **MAPD/PDP** Expedited Redetermination 72-hour time limit |
| **SECOND LEVEL OF APPEAL** (Independent Review Entity – IRE) | **Independent Review Entity** Standard Redetermination 7-day time limit | **Independent Review Entity** Expedited Redetermination 72-hour time limit |
| **THIRD LEVEL OF APPEAL** (Office of Medicaid Hearings and Appeals) | **Administrative Law Judge** Standard Decision 90-day time limit | **Administrative Law Judge** Expedited Decision 10-day time limit |
| For amounts in controversy ≥ $150.00 | **FOURTH LEVEL OF APPEAL** (Medicare Appeals Council – MAC) | **FINAL LEVEL OF APPEAL – JUDICIAL REVIEW** (Federal District Court) |
| **STANDARD** | **STANDARD** | **Federal District Court** |
| **EXPEDITED** | **EXPEDITED** |

**Note:** Each appeal level requires member or member’s representative to file the appeal within 60 days of previous determination.
A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the member, by the member’s appointed representative, or by the member’s provider or other prescriber.

† The adjudication time frames generally begin when the request is received by CVS Caremark/Healthfirst. However, if the request involves an exception request, the adjudication time frame begins when CVS Caremark/Healthfirst receives the provider’s supporting statement.

‡ The amount in controversy requirement for an Administrative Law Judge hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2015.

15.8 Coverage Determinations for Prescription Drugs – Medicaid, CHPlus and Leaf Plans

The formulary outlining the Medicaid, Child Health Plus, and Leaf Plans pharmacy benefits can be found on the Healthfirst website www.healthfirst.org/formulary.html.

Coverage determinations include requests for prior authorization or formulary exceptions.

Healthfirst strongly encourages/recommends that a prescribing provider review the current Medicaid, CHPlus, and Leaf Plan formularies to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. In addition, the formulary can help a provider identify the drugs and therapies that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics Committee (P&T) comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider’s treatment criteria.

Some covered drugs may have additional requirements or limits on coverage. These requirements or limits may include:

- **Prior Authorization:** Healthfirst requires prior authorization for certain drugs. This means that approval from Healthfirst must be obtained before the prescription is filled. If approval is not obtained, Healthfirst may not cover the drug.

  In order to obtain prior authorization, prescribers should contact CVS Caremark at 1-877-433-7643 and be prepared to provide relevant clinical information that supports the medical necessity of the required medication. A comprehensive formulary is also available on the Healthfirst website www.healthfirst.org or by contacting the Member Services department at 1-866-463-6743.

- **Quantity Limits:** For certain drugs, Healthfirst limits the amount of the drug that is covered.

- **Step Therapy:** In some cases, Healthfirst requires a member to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the medical condition, Healthfirst may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, Healthfirst will then cover Drug B. However, if it is a new member who has already tried Drug A before taking Drug B, Healthfirst will not require the member to try Drug A again. You should notify us if this is the case.

You can ask Healthfirst to make an exception to these restrictions or limits. Please contact CVS Caremark at 1-877-433-7643 for information about how to request an exception.

To initiate a coverage determination request, including a request for a drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department in any of the following ways:

**Coverage determinations for Medicaid and CHPlus**

- **CALL** CVS Caremark at 1-877-433-7643
Calls to this number are free, 8:00am–6:00pm CST

- **FAX** 1-866-848-5088

While no specific form is required, the NY State Medicaid Standard Global Prior Authorization form can be found at the website: [www.healthfirst.org/providerforms](http://www.healthfirst.org/providerforms).

**WRITE**: CVS Caremark

Attn: Healthfirst NY Medicaid Prior Authorization

1300 E. Campbell Road

Richardson, TX 75081

Healthfirst’s Medicaid and CHPlus formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QLL) criteria listings, can be found on Healthfirst’s public website: [www.healthfirst.org/formulary.html](http://www.healthfirst.org/formulary.html).

**Coverage determinations for Leaf Plans**

- **CALL** CVS Caremark at 1-800-294-5979
- **FAX** 1-888-836-0730

Calls to these numbers are free, 8:00am–6:00pm CST.

- **WRITE**

  CVS Caremark
  
  Attn: Healthfirst NY Exchange Prior Authorization
  
  1300 E. Campbell Road
  
  Richardson, TX 75081

Healthfirst’s Exchange formulary, as well as Prior Authorization (PA), Step Therapy (ST) and Quantity Limit (QLL) criteria listings, can be found on Healthfirst’s public website [www.healthfirst.org/formulary.html](http://www.healthfirst.org/formulary.html).

15.9 Action Denial Notice – Medicaid/CHPlus

An action can be considered any of the following activities of the Plan or its delegated entities that results in:

- The denial or limited authorization of a Service Authorization Request, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner, as defined by applicable state law and regulation.
- Failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals provided in Section 15.6 of this manual.
- The restriction of an enrollee to certain network providers under the Contractor’s Recipient Restriction Program.

15.10 Action Appeals – Medicaid, and Medicaid Advantage Plus

An Action Appeal is a request for a review of an Action (see Glossary of Terms, Section 18 of Manual). A member or a member’s designee shall have no more than 60 (sixty) calendar days after receipt of the notice of the Action determination for MMC, and 45 (forty-five) calendar days for Medicaid Advantage Plus, to file an appeal, which may be submitted orally by calling Member Services or by submitting a written request.
An oral Action Appeal can be filed by calling the Healthfirst Member Services toll-free telephone during normal business hours, as well as via a telephone system available to take calls during other hours. If the request is made by a member’s designee, the plan may ask for the enrollee’s written consent for representatives to request a plan appeal, grievance, or fair hearing on their behalf. Providers may request an appeal, a grievance, or a fair hearing but may not request Aid Continuing.

Providers should submit supporting clinical information along with the request for appeal, and in any event, within 10 calendar days of the request. Clinical documentation can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

Healthfirst will request any clinical documentation required to substantiate services. However, failure to provide requested clinical information in a timely manner may put a member's health in jeopardy.

Within 15 (fifteen) calendar days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the Action Appeal, including the name, address, and telephone number of the individual designated by Healthfirst to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

Healthfirst shall designate one or more qualified personnel to review the Action Appeal, provided that when the Action Appeal pertains to clinical matters, the personnel shall include licensed, certified, or registered healthcare professionals.

Healthfirst must allow the member or his/her designee, both before and during the Action Appeals process, the opportunity/ability to examine the member’s case file, including medical records and any other documents and records considered during the Action Appeals process. The member or his/her designee is subject to the Release of Information process.

Clinical Matters

The determination of an appeal on a clinical matter is made by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in Article 49 of the NYS Public Health Law.

Nonclinical Matters

The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the Action determination.

Timeliness of Action Appeals Determination

Healthfirst shall seek to resolve all appeals in the most expeditious manner.

Healthfirst must resolve an Action Appeal as fast as the member’s condition requires and no later than 30 (thirty) calendar days from the date of receipt of the Action Appeal.

Healthfirst must resolve Expedited Action Appeals as fast as the member's condition requires but within 72 hours of the date of the receipt of the Action Appeal.

Time frames for Action Appeal resolution may be extended for up to 14 (fourteen) calendar days if requested by Healthfirst, the member, his or her designee, or the provider if it is in the best interest of the member. We will make reasonable efforts to give prompt oral notice of an extension and written notice within two calendar days.

In the event Healthfirst requires additional information to process the appeal, Healthfirst shall request the additional information in writing.

If Healthfirst does not make a determination within the time frames specified, as applicable, this shall be deemed to be a reversal of the UR agent's adverse determination.
15.11 Expedited Appeals – Medicaid, Medicaid Advantage Plus, and AbsoluteCare

A Healthfirst member, his or her representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Expedited appeals are processed within 72 hours. Time frames for Action Appeal resolution may be extended for up to 14 (fourteen) calendar days if requested by Healthfirst, the member, his or her designee, or the provider if it is in the best interest of the member. Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within two calendar days.

If the member’s designee makes the request, the plan may ask for the enrollee’s written consent for representatives to request a plan appeal, grievance, or fair hearing on their behalf. Providers may request an appeal, grievance, or fair hearing but may not request Aid Continuing.

Providers should submit supporting clinical information along with the expedited appeal request, and in any event, within 24 hours of the expedited request. Clinical documentation can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

Healthfirst will request any clinical documentation required to substantiate services. However, failure to provide requested clinical information in a timely manner may put a member’s health in jeopardy.

Notice of an Action Appeal Determination

The notice of a determination on an appeal shall include the detailed reasons for the determination and, in cases where the determination has a clinical basis, the clinical rationale for the determination.

Medicaid and Medicaid Advantage Plan

Healthfirst will promptly notify by phone, and send written notice to, the member, his or her designee, and the provider (where appropriate) within two (2) business days of the Action Appeal determination.

AbsoluteCare

Healthfirst will promptly notify by phone, and send written notice to, the member, his or her designee, and the provider (where appropriate) within two (2) calendar days of Action Appeal determination.

Healthfirst shall not retaliate nor take any discriminatory action against a member because a member or a member’s representative has filed an Action Appeal.

15.12 Member Rights to a Fair Hearing – Medicaid, Medicaid Advantage Plus

Medicaid and Medicaid Advantage Plus members may request a Fair Hearing regarding adverse determinations concerning:

- Enrollment, disenrollment, eligibility
- Denial, termination, suspension, or reduction of a clinical treatment or other benefit package services by Healthfirst that is covered under the Medicaid benefit
- Healthfirst’s lack of reasonable promptness to act regarding these services

The Medical Management department will issue the Managed Care Action Taken Form, which contains the member’s Fair Hearing Rights with instructions on how to request a Fair Hearing, along with its initial adverse determination when Healthfirst has denied a request to approve a benefit package service ordered by a participating provider. For Medicaid Advantage Plus members, the Appeals and Grievances department will issue the Managed Care Action Taken Form with the final adverse determination on an Action Appeal of the denial of Medicaid-only services. If you have questions about the Fair Hearing process or would like additional information, please call 1-888-801-1660.

External Appeal

In connection with a concurrent or retrospective review, members and a member’s healthcare provider are able to request an external appeal for the three (3) types of adverse determinations – not medically necessary services, experimental or investigational, or clinical trial or treatment of rare disease or when out-of-network services are denied as not materially different from services available in-network or when services are denied because they are considered treatment for a rare disease.

If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of when the member made the agreement from the date of the denial determination. If this occurs, Healthfirst will provide a written letter with information regarding filing an external appeal to the member within twenty-four (24) hours of agreement to waive the internal appeal process.

Providers may elect an external appeal on behalf of the member within four (4) months of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS), including an application and instructions to members or providers regarding how to request an external appeal.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider’s request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member’s external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member’s healthcare provider can request an expedited external appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member’s external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.

15.14 Member-Initiated Complaints – Medicaid

If a member has a problem, he/she can speak with his/her PCP or call or write to Member Services. Most problems can be resolved right away. If a member has a problem or dispute with the care he/she is receiving, he/she can file a complaint with Healthfirst. Problems that are not resolved right away over the phone, and
any complaint received via mail, will be handled according to our complaint procedure described below.

Members can ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint for them. If a member’s designee makes a request, the plan may ask for the enrollee’s written consent for representatives to request plan appeal, grievance, or fair hearing on their behalf. Providers may request appeal, grievance, or fair hearing but may not request Aid Continuing.

A member also has the right to file a complaint with the local area office of the New York State Department of Health or local Department of Social Services. To file with the New York State Department of Health, members may call 1-800-206-8125 or write to NYSDOH Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Corning Tower ESP Room 1911, Albany, NY 12237.

To file with the City of New York, members may call the Human Resources Administration, Medicaid Assistance Program Helpline at 1-800-505-5678.

A member may also contact their local Department of Social Services with their complaint at any time. A member may call the State Department of Financial Services at 1-800-342-3736 if their complaint involves a billing problem.

If a member needs help because of a hearing or vision impairment or if he/she needs translation services or help filing the forms, we can help. Healthfirst will not take any action against the member for filing a complaint.

**How to File a Complaint with the Plan**

To file by phone, a member can call Member Services at 1-866-463-6743. If a member calls Healthfirst after hours, they can leave a message and Healthfirst will return the call the next working day. If we need more information to make a decision, we will inform the member.

A member can write to us with a complaint or call the Member Services number and request a complaint form, which should be mailed to Healthfirst Appeals and Grievances Department, P.O. Box 5166, New York, NY 10274-5166 or faxed to 1-646-313-4618.

**What Happens Next?**

If we don’t solve the member’s problem right away over the phone, we will send him/her a letter within 15 (fifteen) business days. The letter will tell the member who is working on the complaint, how to contact this individual, and whether more information is needed.

A member’s complaint will be reviewed by one or more qualified people. If the complaint involves clinical matters, the case will be reviewed by one or more qualified healthcare professionals.

If additional information is needed from the provider to help resolve the submitted complaint, Healthfirst will make reasonable efforts to contact the provider. Additional informational documents should be submitted within 10 calendar days and can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

**After We Review the Complaint**

We will let the member know our decision within 45 (forty-five) calendar days of when we have all the information we need to answer the complaint, but the member will hear from us within no more than 60 (sixty) calendar days from the day we get the original complaint. We will write the member and tell him/her the reasons for our decision.

When a delay would risk the member’s health, we will let the member know of our decision within 48 (forty-eight) hours of when we have all the information we need to answer the complaint, and in any event, within seven (7) days from the day we receive the original complaint. We will call the member with our decision. The member will also receive a letter within three (3) business days from oral notification.

We will inform the member how to appeal our decision if he/she is not satisfied, and we will include any forms needed. If we are unable to make a decision about a member’s complaint because we don’t have enough information, we will send a letter to let the member know.

**Appeal of Complaints**
If a member disagrees with a decision we made about his/her complaint, he/she can make a complaint appeal personally or ask someone he/she trusts to file the appeal. If a member is not satisfied with what we decide, the member has 60 (sixty) business days to file an appeal in writing after receiving our decision. If a member submits an oral appeal of a complaint decision via phone, we will send a form containing a summary of their appeal which must be signed and returned.

**What Happens After We Receive the Member’s Complaint Appeal?**

After we get a member’s complaint appeal, we will send him/her a letter within 15 (fifteen) business days. The letter will tell him/her who is working on the complaint, how to contact this individual, and whether more information is needed.

The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer who was not involved in making the first decision about the complaint.

If we have all the information we need, the member will receive our decision in 30 (thirty) business days. If a delay would risk his/her health, he/she will received our decision within two (2) working days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, he/she or someone on their behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

**15.15 Standard Appeals – Commercial, CHPlus**

A CHPlus or Commercial member or a member’s designee shall have 45 (forty-five) or 180 days, respectively, from the date an adverse determination notice is received to file a standard appeal. Healthfirst will accept an oral or written standard appeal. An oral appeal can be filed by calling our toll-free Member Services number, Monday to Friday, 8am–8pm.

We will send a notice that the appeal has been received for review within 15 (fifteen) calendar days of our receiving the request. The appeal will then be investigated and a decision made within 60 (sixty) calendar days for standard CHP appeals.

Appeals for Commercial members are conducted according to the following timelines. Appeals related to a preauthorization request will be decided within 30 (thirty) calendar days of receipt of the appeal request. Appeals related to a retrospective appeal will be decided within 60 (sixty) calendar days of receipt of the appeal request. Expedited appeals will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

Healthfirst’s failure to render a determination of an appeal within 60 (sixty) calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

Once we make a decision for all types of appeals, the member or member’s designee, as appropriate, will be notified within two (2) business days of our reaching a decision. This notice will include the reasons (and any related medical information) for our decision and further appeal rights.

Providers should submit clinical information along with the request for an appeal, and in any event, within 10 calendar days of the request. Clinical documentation can be faxed to the Appeals and Grievances department, fax # 1-646-313-1618.

Healthfirst will request any clinical documentation required to substantiate services. However, failure to provide requested clinical information in a timely manner may put member’s health in jeopardy.

**15.16 Appealing the Grievance – CHPlus, Commercial (Small Group)**

A member or a member’s designee shall 60 (sixty) business days after receipt of notice of the grievance determination to file an appeal.
Within 15 (fifteen) business days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the appeal, including the name, address, and telephone number of the individual designated by Healthfirst to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

**Clinical Matters:** The determination of an appeal on a clinical matter is made by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in Article 49 of the NYS Public Health Law.

**Nonclinical Matters:** The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

Healthfirst individual market commercial members do not have grievance appeal rights. If a Healthfirst Leaf Plan member is dissatisfied with the grievance determination, they may call the New York State Department of Health at 1-800-206-8125 or write to them at New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

**Timeliness of Appeals Determination**
Healthfirst shall seek to resolve all appeals of grievances in the most expeditious manner and shall make a determination and provide notice no more than two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a member's health. Grievance appeals for pre-service grievances will be decided within 15 calendar days of receipt of the appeal. Post-service grievance appeals will be decided within 30 calendar days of receipt of the appeal. All other grievance appeals (e.g., for issues not in relation to a claim or request for a service or treatment) will be decided within 30 (thirty) business days after the receipt of all necessary information.

**Notice of Appeals Determination**
The notice of a determination on an appeal shall include the detailed reasons for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

Healthfirst shall not retaliate or take any discriminatory action against a member because a member has filed an appeal or grievance.

**15.17 Expedited Appeals – Commercial, CHPlus**
A Healthfirst member, the member’s representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Expedited appeals are processed within two (2) business days of receipt of requested information and within no more than 72 hours of receipt of the request. The notice of determination regarding the appeal will include the reason(s) for a Healthfirst decision, including any clinical factors. Appeals for services previously provided are not eligible for an expedited appeal. Appeal of claims determinations are also not eligible for an expedited appeal.

**15.18 External Review – Commercial, CHPlus**

**External Appeal**
In connection with a concurrent or retrospective review, members and a members' healthcare providers are able to request an external appeal for four (4) types of adverse determinations: 1) services deemed not medically necessary, 2) services deemed experimental or investigational (include clinical trials and treatments for rare diseases), 3) services denied because they are not materially different from services available in-network, 4) or in the instance of a denied referral to an out-of-network non-participating provider.

A member may elect to file an external appeal at the time of the initial adverse determination if s/he and Healthfirst both agree to waive Healthfirst's internal appeals process. If both the member and Healthfirst
agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of the date of the denial determination. Providers may elect an external appeal on behalf of the member within sixty (60) days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS) including an application and instructions to members or providers to request an external appeal.

Members must file their external appeal with the DFS within four (4) months of the time that Healthfirst gave the notice of final adverse determination from the appeals process.

**For Providers**

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider’s request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member’s external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member’s healthcare provider can request an expedited appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member’s external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.
16. Provider Compensation

Billing and reimbursement policies serve as a supplement to the Provider Compensation section of the Provider Manual. Please refer to Appendix XIV-A for a complete list of coding requirements.

16.1 Payees

As detailed in Section 3.1 of this manual, Healthfirst contracts with providers through participating hospitals (Level I providers) or directly with individual providers or provider groups (Level II and Level III providers). For all Level I providers who are covered by the hospital agreement with Healthfirst and who practice in hospital outpatient departments or hospital-owned community-based sites, payment is made directly to the hospital. Level II and Level III providers and provider groups receive payment from Healthfirst directly.

16.2 Primary Care Services/Primary Care Providers

Healthfirst has established a set of healthcare services which Healthfirst considers to be Primary Care Services and which are to be rendered by Primary Care Providers (PCPs) within the Healthfirst provider network. These services support the member’s primary care needs in both an ambulatory (office or clinic) and an inpatient setting and include the following:

- Early and periodic screening, diagnostic and treatment (EPSDT) services, including preventive office visits and immunizations
- Primary care office visits for urgent conditions
- Primary care inpatient visits
- Basic hearing and vision screenings
- Urgent laboratory services for diagnosis and/or treatment of members with acute conditions
- Dual-energy X-ray absorptiometry, chest X-rays, and ultrasounds for the diagnosis and/or treatment of members with acute conditions
- Other basic diagnostic tests and simple treatments of urgent and chronic conditions

A complete list of reimbursable services for primary care physicians is detailed in Appendix XIV-B and listed by CPT code.

Given the important role that PCPs play in the Healthfirst network and in providing primary care services to members, PCPs are not expected to provide specialty or other healthcare services which are not primary care services as described in this Provider Manual. As explained more fully in Section 3.1, PCPs are responsible for coordinating all of the care a member receives and are expected to refer members to in-network specialists for care that is outside the scope of primary care.

With regard to Healthfirst commercial Leaf Plan products and Leaf Premier Plan products, when a member needs elective care that a PCP or OB/GYN (women can choose either an OB/GYN or PCP) cannot generally provide within the scope of his/her practice, a referral to an in-network Leaf Plan or Leaf Premier Plan provider who can perform these services will be required. Consistent with this requirement, Healthfirst will not reimburse PCPs for services other than the listed primary care services unless the PCP is also credentialed and designated by Healthfirst as a specialist. Note, however, that family practice providers who provide minor surgery, obstetrical, or gynecological care for members will also be reimbursed for those services.

Referrals are not required for the following services, among others:

- Emergency services
- Primary and preventive obstetric and gynecological services (OB/GYN), including annual examinations
- Care resulting from such annual examinations
- Treatment of acute gynecological conditions, or for any care related to a pregnancy from a qualified contracted provider of such services

If you are not yet credentialed as a specialist and wish to be credentialed by Healthfirst as a Specialist in addition to being a PCP, please speak to your Network Representative or contact Healthfirst Provider Services at 1-888-801-1660 for assistance in the application process.

To also ensure that PCPs are able to coordinate member care, Healthfirst members seeking primary care from your clinic or practice that are not assigned to your member panel must be directed back to their assigned PCP for care or referred within their PCP’s own network, as appropriate. Claims submitted for primary care services rendered by a provider other than the member’s assigned PCP will be denied. These claims will be denied for “Intra-Network Primary Care – Not Member’s PCP.” Members, however, are free to change their PCP. If the member is in need of an appointment immediately and wishes to switch to your panel, Member Services can make the appropriate changes right away. Members should call Member Services at 1-866-463-6743 for assistance in switching PCPs.

PCPs may be reimbursed either through monthly capitation or on a fee-for-service basis, depending on the terms and conditions of their provider agreement with Healthfirst.

Regardless of whether reimbursement is via capitation or fee-for-service, all PCPs must submit claims for all services, including capitated services, in order to provide encounter data. Healthfirst uses encounter data to verify the types and level of services provided and for mandatory reporting to federal and state regulatory agencies. See Section 14 for reporting requirements.

For more information on payments to providers who receive a monthly capitation for each member on their panel, see Appendix XIV-B.

16.3 The Healthfirst Quality Incentive Program (HQIP)

Healthfirst’s mission is to provide the best possible quality and experience of care to our members. We recognize the importance of the relationships providers have with their patients in achieving this goal. To support providers in their efforts, Healthfirst established the Healthfirst Quality Incentive Program (HQIP), an annual program that incentivizes superior performance on select measures which are consistent with national and state-level benchmarks for quality of care. By achieving or surpassing the clinical performance goals set in HQIP, providers can earn quality incentive payments based on their Overall Quality Rating (OQR) and/or measure-specific rates/ratings.

Participation in HQIP is limited to providers that take risk on Healthfirst members and/or meet membership thresholds determined by Healthfirst. Healthfirst PCPs participating in our Medicaid, CHP, QHP, HARP, Medicare, Complete Care, and FIDA Plans may be eligible to earn quality incentive payments while delivering the superior healthcare and satisfaction to Healthfirst members that we all strive for. Healthfirst will share quality data and scoring, including OQR, with providers participating in HQIP on a monthly and quarterly basis. If a provider participating in HQIP believes there are discrepancies or inaccuracies with their quality scoring, they may communicate this to Healthfirst through their Network Management Representative or Clinical Quality Manager. If a provider would like to contest their Final HQIP results and/or OQR, they may do so by filing an appeal with Healthfirst. To briefly summarize:

- Healthfirst will accept appeals after HQIP Final Preview results are shared with providers.
- Providers must notify Healthfirst of their intention to appeal by sending an email to HQIP@healthfirst.org briefly outlining on what grounds they plan to appeal within ten (10) business days of Final Preview results being released by Healthfirst. Providers must also (securely) provide any and all documentation supporting their appeal to HQIP@healthfirst.org within 10 business days of their initial written notification.
- Healthfirst will strive to make a formal decision within 45 business days of receiving a complete appeal proposal. All appeal decisions will be reviewed and approved by Healthfirst’s Executive Team, including the Chief Medical Officer. Any decisions made by Healthfirst will be considered final and adjustments to final quality scoring and incentive earnings, if any, will be made accordingly.
- Not all measures will be eligible for appeal and some appeals may be denied if the basis of the appeal
does not meet the criteria outlined by Healthfirst. For more information about the Healthfirst Quality Incentive Program, email HQIP@healthfirst.org.

16.4 Specialty Care and Specialists

Specialty care providers, including HIV specialist PCPs, are compensated on a fee-for-service basis. Mental Health providers are reimbursed at the APG rate for services to Medicaid and Leaf Plan members, and are reimbursed according to a set fee schedule for Healthfirst Medicare members. Substance Use Disorder (SUD) providers are reimbursed according to a set fee schedule.

16.5 Obstetrical Care

Healthfirst reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and post-partum visits, as well as for delivery. Cases requiring more than seven (7) prenatal visits or more than one (1) post-partum visit may be subject to retrospective medical record review by the Healthfirst Medical Management department.

16.6 Family Planning Services

Healthfirst reimburses for family planning services provided to Healthfirst members. Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers. CHP, Leaf Plan, and Leaf Premier Plan members may obtain family planning and reproductive health services through any in-network CHP, Leaf Plan, or Leaf Premier Plan provider without approval from or notification to Healthfirst or their PCP. Healthfirst will not pay claims for Healthfirst CHP, Leaf Plan, or Leaf Premier Plan members seeking family planning and reproductive health services from out-of-network providers.

16.7 Healthfirst Consultation Payment Policy

In 2010, Medicare implemented a policy to no longer reimburse for consultation services. However, Healthfirst will pay for consultation services. Reimbursement for these services will be based on a new member visit or the hospital case rate. The consultation code mapping for Medicare-based contracts is listed below:

<table>
<thead>
<tr>
<th>Billed Service Code</th>
<th>Billed Service Code Description</th>
<th>Paid Service Code</th>
<th>Paid at Rate Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient; physicians typically spend 15 minutes face-to-face with the patient and/or family.</td>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient; physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 20 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99243</td>
<td>Office consultation for a new or established patient; physicians typically spend 40 minutes face-to-face with the patient and/or family.</td>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
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<tr>
<td>99244</td>
<td>Office consultation for a new or established patient; physicians typically spend 60 minutes face-to-face with the patient and/or family.</td>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 45 minutes face-to-face with the patient and/or family.</td>
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<tr>
<td>99245</td>
<td>Office consultation for a new or established patient; physicians typically spend 80 minutes face-to-face with the</td>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 60 minutes face-to-face with the</td>
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<td>Code</td>
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<td>99251</td>
<td>Inpatient consultation for a new or established patient; physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.</td>
<td>99221</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient consultation for a new or established patient; physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.</td>
<td>99221</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient consultation for a new or established patient; physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.</td>
<td>99222</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient consultation for a new or established patient; physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.</td>
<td>99223</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.</td>
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<tr>
<td>99255</td>
<td>Inpatient consultation for a new or established patient; physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.</td>
<td>99223</td>
<td>Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.</td>
</tr>
</tbody>
</table>

### 16.8 Healthfirst Payment in Full/Member Hold Harmless

Pursuant to their provider contract, participating providers are prohibited from seeking payment, from billing, or from accepting payment from any member for fees that are the legal obligation of Healthfirst, even if Healthfirst becomes insolvent or denies payment on a claim, regardless of the reason. Participating providers must refund all amounts incorrectly collected from Healthfirst members or from others on behalf of the member. As permitted by a provider’s contract with Healthfirst and by applicable law, Healthfirst will recoup payments inappropriately made by a member from a provider’s future claims payments and will remit the amount to the member.

Healthfirst is not financially responsible for reimbursing non-covered services provided to members. Please see Section 2 for additional information on the procedure to be followed in order to bill and collect from members for non-covered services.

With the exceptions of deductibles, copayments, or coinsurance, all payments for services provided to Healthfirst members constitute payment in full, and providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts. Any such billing is a violation of the provider’s contract with Healthfirst and of applicable New York State law. Where appropriate, Healthfirst will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Additionally, per requirements set forth by the Centers for Medicare & Medicaid Services (CMS), dual-eligible members will not be held responsible for any cost-sharing for Medicare services when the state is responsible for paying those amounts. Providers must accept Healthfirst’s payment as payment in full or bill the appropriate state source (i.e., Medicaid FFS). This requirement applies to all dual-eligible individuals and not just to those members enrolled in a Medicare Advantage Dual Eligible Special Needs Plan (SNP) or Medicare-Medicaid Plan (MMP).
17. Billing & Claims Processing

Billing and reimbursement policies serve as a supplement to the Provider Compensation section of the Provider Manual. Please refer to Appendix XIV for a complete list of coding requirements.

17.1 Member Eligibility

Payment for services rendered is subject to verification that the member was enrolled in Healthfirst at the time the service was provided and to the provider’s compliance with the Healthfirst Medical Management and prior authorization policies at the time of service.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in Healthfirst. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with Healthfirst after the date of service. Therefore, verification of eligibility is not a guarantee of payment by Healthfirst. Please contact Overpayment Recovery at 1-866-635-1520 in cases where members retroactively lose coverage so that you can obtain further information, including any other payor that may be billed.

Claims submitted for services rendered without proper authorization will be denied for “failure to obtain authorization.” No payment will be made.

In certain cases, a managed care plan member, including Healthfirst members, may change health plans during the course of 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.

17.2 General Billing and Claim Submission Requirements

Submitting Claims Electronically

For all electronic claims, Healthfirst utilizes the Emdeon clearinghouse and MD On-line, a free online service for providers who do not have claims submission software. Claims submitted electronically receive a status report indicating the claims accepted, rejected, and/or pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

- Healthfirst Payer ID Number 80141 on each claim.
- Complete Healthfirst Member ID Numbers (see member ID card or monthly enrollment roster).
- A National Provider Identifier (NPI) should reside in:
  - 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI);
  - 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI).

To sign up for electronic billing with Emdeon, providers must contact their software vendor and request that their Healthfirst claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Please call Healthfirst at 1-888-801-1660 to set up electronic billing. To sign up for electronic billing with MD On-line or for more information, visit www.healthfirstmdol.com or call 1-888-499-5465. Providers who sign up for electronic billing may also sign up for electronic fund transfer/electric remittance advice (EFT/ERA). See Section 17.5 for more information.

Reports are available through billing software vendors to review electronic submission of claims and rejection errors. Although this may be an optional feature, providers are encouraged to obtain this reporting tool to better manage their submissions. The following are two (2) report options providers should review for claim submission activity:

- The Initial Acceptance Report (R022/RPT-05)
The R022 report shows that the clearinghouse accepted the claim submission and routed it to the designated insurance carrier. Acceptance of a claim on the R022 report is acceptance by the clearinghouse and not by the Plan.

Providers should wait until they receive confirmation on the Insurance Carrier Rejection Report (R059).

**Insurance Carrier Rejection Report (R059/RPT-11)**

The R059 report consists of two (2) summaries. The first section confirms that the claims were accepted by Healthfirst.

The second section lists the claims rejected and the reason(s) for each rejection. This report may be used to substantiate timely filing to Healthfirst.

Note: In 2009, both the R022 and R059 reports were discontinued and replaced with the RPT reports.

**Submitting Claims on Paper**

All paper claims should be submitted to:

Healthfirst Claims Department

P.O. Box 958438

Lake Mary, FL 32795-8438

All paper claims should include the National Provider Identifier (NPI) and well as the Healthfirst-assigned Provider ID Number (the latter is not required for electronic claims). The Healthfirst Provider ID is a unique provider number for each practice site and hospital affiliation he/she has and must be included with paper claims.

The letter after the hyphen—A, B, C, D, etc.—corresponds to one (1) of the provider’s practice sites. The two (2) digits at the end of the provider number correspond to the provider’s hospital affiliation. The following table illustrates the potential provider numbers an individual practitioner may have:

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<th>Number of Practice Sites</th>
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processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State, and other governmental and regulatory agencies. Further, for some Healthfirst providers, it will impact the provider’s eligibility for bonuses paid for certain preventive care services. It is essential that this information be submitted in a timely and accurate manner.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data Healthfirst requires. In addition, participating Healthfirst providers reimbursed on a capitated basis are still required to submit claims so that encounter data is reported to Healthfirst.

Healthfirst submits encounter and claims data monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate, and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, including capitated services. MEDS is the standard by which the performance of Healthfirst and other managed care organizations is measured. To meet the state mandate, Healthfirst requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section (see Section 17) for the specific requirements when submitting claims or encounters. Please refer to each reporting measure as described in this section for specific measure requirements.

**Present on Admission (POA)**

The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission. Healthfirst requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes, regardless of the manner in which claims are submitted (i.e., paper or electronic). Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 Institutional (837I) forms.

**Requirements for Billing by Facilities**

Facilities, including hospitals, must submit inpatient and outpatient facility claims on the UB-04 or on electronic media:

- Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).
- Include the Healthfirst authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in the Healthfirst system and processed in accordance with applicable Healthfirst policies and procedures.

Professional services that are not part of the facility claim should be billed on a CMS 1500 form.

Facilities billing on behalf of employed providers must submit claim reporting data on the UB-04 for outpatient services or directly to Healthfirst via electronic claim submission. Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).

**Required Data Elements and Claim Forms**

Prior to being adjudicated, all claims are reviewed within the Healthfirst Claims department for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the Healthfirst utilization systems. If the following information is missing from the claim, the claim is not “clean” and will be rejected:

<table>
<thead>
<tr>
<th>Data Element</th>
<th>CMS 1500</th>
<th>UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
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<td>Patient Sex</td>
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<td>Item</td>
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<tr>
<td>Subscriber (Member) Name/Address</td>
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<tr>
<td>Healthfirst Member ID Number (including Client Identification Number [CIN] for all newborn babies, when applicable)</td>
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</tr>
<tr>
<td>Coordination of Benefits (COB)/other insured’s information</td>
<td></td>
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<tr>
<td>Date(s) of Service</td>
<td></td>
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<tr>
<td>ICD-9 Diagnosis Code(s), including 4th and 5th Digit when Required (ending 9/30/2015)</td>
<td></td>
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<tr>
<td>ICD-10 Diagnosis Code(s), including 4th, 5th, 6th, and 7th Digit when Required (beginning 10/1/2015)</td>
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<tr>
<td>CPT-4 Procedure Code(s)</td>
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<td></td>
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<tr>
<td>HCPCS Code(s)</td>
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<tr>
<td>Service Code Modifier (if applicable)</td>
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<tr>
<td>Place of Service</td>
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<tr>
<td>Service Units</td>
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<tr>
<td>Charges per Service and Total Charges</td>
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<tr>
<td>Provider Name</td>
<td></td>
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<tr>
<td>Provider Address/Phone Number</td>
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<tr>
<td>National Provider Identifier – NPI (Healthfirst does not accept legacy provider ID numbers submitted on HIPAA standard transactions)</td>
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<tr>
<td>Tax ID Number</td>
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<tr>
<td>Healthfirst Provider Number – For Paper Claims Only</td>
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<tr>
<td>Healthfirst Payer ID Number 80141 – For EDI Claims Only (refer to Section 17.2)</td>
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<tr>
<td>Hospital/Facility Name and Address</td>
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<tr>
<td>Type of Bill</td>
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<tr>
<td>Admission Date and Type</td>
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<tr>
<td>Patient Discharge Status Code</td>
<td></td>
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<tr>
<td>Condition Code(s)</td>
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<tr>
<td>Occurrence Codes and Dates</td>
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<tr>
<td>Value Code(s)</td>
<td></td>
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<tr>
<td>Revenue Code(s) and corresponding CPT/HCPCS Codes when billing outpatient services</td>
<td></td>
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<tr>
<td>Principal, Admitting, and Other ICD-9 (ending 9/30/2015); ICD-10 (beginning 10/1/2015) Diagnosis Codes</td>
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</tr>
<tr>
<td>Present on Admission (POA) Indicator (if applicable)</td>
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<tr>
<td>Attending Physician Name and NPI</td>
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<tr>
<td>Healthfirst Authorization Number</td>
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</tbody>
</table>

CMS 1500 forms and UB-04s can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and by facilities billing on behalf of employed providers.

### 17.3 Time Frames for Claim Submission, Adjudication, and Payment

#### Timely Claim Submission

Providers should submit all claims within 30 (thirty) days of the date of service for prompt adjudication and payment. However, claims for services that are submitted later than the time period set forth in the provider’s agreement with Healthfirst will not be paid except under certain circumstances. In no event will Healthfirst pay claims submitted more than 180 (one hundred eighty) days after the date of service. Please refer to Section 17.2 for electronic and paper submission of claims.

#### Late Claim Submission
In certain circumstances, Healthfirst will process claims submitted after the time period required under the provider’s agreement with Healthfirst. 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 period 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.

<table>
<thead>
<tr>
<th>Reason for Delay</th>
<th>Time Frame for Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Litigation involving payment of the claim</td>
<td>Within 60 (sixty) calendar days from the time the submission came within the provider’s control</td>
</tr>
<tr>
<td>Medicare or other third-party processing delays affecting the claim</td>
<td>Within 60 (sixty) calendar days from the time the submission came within the provider’s control</td>
</tr>
<tr>
<td>Original claim rejected or denied due to a reason unrelated to the 180-day rule</td>
<td>Within 60 (sixty) calendar days of the date of notification (submit with original EOP)</td>
</tr>
<tr>
<td>Administrative delay (enrollment process, rate changes) by NYSDOH or other State agencies</td>
<td>No time frame</td>
</tr>
<tr>
<td>Delay in member eligibility determination</td>
<td>Within 60 (sixty) days from the time of notification of eligibility (submit with documentation substantiating the delay)</td>
</tr>
<tr>
<td>PRO denial/reversal</td>
<td>No time frame</td>
</tr>
<tr>
<td>Member’s enrollment with Healthfirst was not known on the date of service</td>
<td>Within 60 (sixty) days from the time the member’s enrollment is verified. Providers must make diligent attempts to determine the member’s coverage with Healthfirst</td>
</tr>
</tbody>
</table>

The Insurance Carrier Rejection Report—R059/RPT-11 (refer to Section 17.2)—may be used to substantiate timely filing to Healthfirst.

Healthfirst adjudicates and pays all claims for its Medicaid, FHP, CHP, and commercial plans according to Section 3224-a of the New York State Insurance Law, also known as New York’s “prompt pay” law. Healthfirst adjudicates and pays all claims for its Medicare lines of business pursuant to Section 3224-a of the New York State Insurance Law, except that the applicable prompt-pay interest rate shall be that applicable to Medicare fee-for-service interest rate. Out-of-network Medicare claims are adjudicated pursuant to the applicable regulations governing Medicare Advantage Plans.

**Grace Period Impact to Commercial and Leaf Plan Providers**

Provider payment is subject to member’s insurance coverage status; refer to Section 4.4: Eligibility Verification. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during days 31–90 of the member’s grace period will not be subject to prompt-pay provisions until the member pays their premium in full. Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member’s premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied. (The Grace Period model is now “pay and pursue” – discuss with DSE the desired communication to providers).

**17.4 Coordination of Benefits (COB)**

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help hold down copayments and premiums. Healthfirst follows all standard guidelines for COB. Members are asked to provide information about other insurance plans under which they are covered.
Healthfirst is Always the Secondary Payer in the Following Circumstances

- Workers’ compensation.
- Automobile medical.
- No-fault or liability auto insurance.

Healthfirst Does Not Pay for Services Provided Under the Following Circumstances When There is COB

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services).
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider.

The Following Applies to Healthfirst Medicare Plan Only

Healthfirst will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, Healthfirst is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP).
- Most EGHPs for disabled members.

All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end-stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just to ESRD. If the individual entitlement changes from ESRD to over sixty-five [65] or disability, the coordination period will continue.)

17.5 Explanation of Payment (EOP)/Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

The EOP describes how claims for services rendered to Healthfirst members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim. There are separate EOPs for inpatient facility services and for outpatient services. The outpatient services EOP includes outpatient facility services, provider services, and ancillary services such as DME (see Appendix XIV-C). 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. Inpatient facility claims are sorted separately from all other claims. 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 (0), the claim was paid in the amount indicated.

• **Denied Claim Lines**: If the Not Covered field is greater than zero (0) 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 (0), 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.

Providers may request a copy of an EOP on our website at [www.healthfirst.org](http://www.healthfirst.org) or by calling 1-888-801-1660.

**Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)**

Healthfirst’s Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of Healthfirst claims.

**EFT** is the direct electronic deposit of claim reimbursements into your bank account, and **ERA** is the statement that allows you to reconcile these reimbursements to your member accounts. Advantages of these programs include:

• Prompt payment – no waiting for checks to clear.

• Reduced paperwork.

• No lost checks or mail delay.

• Savings of administrative and overhead costs.

• Simplified and organized recordkeeping.

• Improved cash flow.

You **must** be able to submit claims electronically to use EFT/ERA. When claims are submitted for payment, the payment is deposited electronically into your bank account. Capitation checks can also be deposited directly into your account. When you enroll in EFT/ERA, you will continue to receive an Explanation of Payment (EOP) for a sixty (60) day grace period. The EOP shows the member’s name, dates of service, services rendered, and amounts of Healthfirst payments. After the grace period, you will receive only the ERA. Bank statements will continue to reflect deposited amounts and dates of deposit. Your clearinghouse/software vendor **must** be able to accept the ERA file which is in the 835 HIPAA standard format.

Please refer to our website at [www.healthfirst.org](http://www.healthfirst.org) for information on how to enroll in EFT/ERA. You can also call Provider Services at 1-888-801-1660.
17.6 Claim Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process

Claim Inquiries

Providers can view claims status on our website at www.healthfirst.org. Providers may also call Provider Services at 1-888-801-1660, 24 hours a day, seven (7) days a week, to access claim status on a service line or service code basis instead of a claim’s total.

As described below, Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate. Please note that the provider appeal process described in this Section 17 does not apply to utilization management determinations concerning medical necessity. See Section 15 for information on medical necessity appeals.

Corrected Claims

Definitions

Rejected claim: A claim that was received by Healthfirst and determined to be unclean. The claim is never loaded to the adjudication system. The claim is returned to the provider along with the reason for the rejection.

Re-submission claim: Represents a claim that was rejected by Healthfirst. Once the provider makes the appropriate changes to the claim, the provider must re-submit the claim within timely filing guidelines for new claims. **Note: This re-submitted claim is always treated as a new claim.**

Accepted claim: A claim that was received by Healthfirst and passed all criteria. The claim was successfully loaded to the adjudication system. The system then makes a final determination of paid or denied.

Corrected claim: Represents a claim that was accepted by Healthfirst. The corrected claim has changed data elements that will potentially effect the payment of the claim.

EDI Corrected Claims:

When submitting an EDI “Corrected” Professional and/or Institutional claim to Healthfirst the following requirements must be met:

1) The claim type/frequency (CLM05-03) must be a 7.

   Ex. CLM*8084*96.98***11>B*7*Y*A*W*I*P~

2) The Healthfirst original claim ID must be sent in the REF*F8 segment in the 2300 loop. The Healthfirst claim ID is made up of a 2 digit branch code, 6 digit batch date, 3 digit batch sequence, and a 2 digit sequence ID. The Healthfirst claim ID can be found on the EOP and/or 835.

   Ex. REF*F8*04141539061~

Paper Corrected Claims:

When submitting a Paper “Corrected” Professional and/or Institutional claim to Healthfirst, the Providers should stamp or handwrite on the claim “CORRECTED” or “CORRECTED CLAIM” and must include the original claim number being corrected.
Note: Corrected Claims submission must follow timely filing guidelines for new claims (Refer to Section 17.3 for timely filing rules).

Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Healthfirst regarding a claim determination. Some of the common reasons include, but are not limited to:

- incorrectly processed or denied claims;
- the untimely submission of claims;
- a failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Healthfirst must submit a written request for review and reconsideration with all supporting documentation to Healthfirst within ninety (90) calendar days from the paid date on the provider’s Explanation of Payment (EOP). Written requests, including attachments, are accepted via the Healthfirst provider website at www.healthfirst.org or addressed to the following location:

Healthfirst Correspondence Unit
P.O. Box 958438,
Lake Mary, FL 32795-8438

All written requests for Review and Reconsideration via the provider website or P.O. Box 958438 should include the following information: a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Healthfirst’s determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- A written statement explaining why you disagree with Healthfirst’s claim determination.
- Provider’s name, address, and telephone number.
- Provider’s identification number.
- Member’s name and Healthfirst identification number.
- Date(s) of service.
- Healthfirst claim number.
- A copy of the original claim or corrected claim, if applicable.
- A copy of the Healthfirst EOP.
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity.
- Contract rate sheet to support payment rate or fee schedule.
- Evidence of eligibility verification (e.g., copy of Healthfirst member ID card).
- Evidence of timely filing:
  - Please note: Healthfirst does not accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.
• Copy of the approval number issued by Medical Management.

Healthfirst will investigate all written requests for Review and Reconsideration, and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld, within thirty (30) calendar days from the date of receipt of the provider’s request for Review and Reconsideration.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the ninety (90) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at 1-888-801-1660.

Claim Appeals Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a written request for a formal appeal within sixty (60) calendar days from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

Healthfirst Provider Claim Appeals
P.O. Box 958431
Lake Mary, FL 32795-8431

Providers should provide a written statement explaining why they disagree with Healthfirst’s decision regarding the review and reconsideration, a copy of that determination, and, if the provider submitted the request for Review and Reconsideration via the Healthfirst provider website, the specific Healthfirst tracking number. Providers should also specify the name, address, and telephone number of an individual who may be contacted regarding the appeal and include any additional relevant documentation to support the provider’s position (see above for examples of documentation). Healthfirst will not accept appeals from providers that are not made in writing and that fail to address the reason for the appeal.

For appeals on payment rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation, including, but not limited to, contract rate sheets or fee schedules.

Healthfirst will investigate all written requests for appeal and issue a written explanation stating that the claim has been either reprocessed or upheld, within thirty (30) calendar days from the date of receipt of the provider’s request for appeal.

Healthfirst will not consider appeals that are not submitted according to the procedures set forth above. If a provider submits a request for appeal after the sixty (60) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for appeal is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at 1-888-801-1660.

17.7 Overpayments, Duplicate Payments, and Underpayments

Healthfirst periodically reviews payments made to providers to ensure claims are paid accurately pursuant to the terms of the provider contract. If Healthfirst identifies that it has overpaid a provider for certain services, Healthfirst will notify the provider and recoup the overpayment amount according to the procedures detailed below, and any applicable requirements under Section 3224-b of the New York State Insurance Law or other applicable law or regulation.

Unless a shorter lookback period is specified in the provider’s contract, Healthfirst will not initiate overpayment
recovery efforts with respect to any claim more than twenty-four (24) months after the original payment date for the claim; provided, however, that any time limitation shall not apply to overpayments that are: (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, or (3) required or authorized by a state or federal government program. In the case of any Healthfirst plans offered through the Medicaid and/or Child Health Plus programs, Healthfirst may pursue recovery of any overpayment identified to provider within six (6) years of provider’s receipt of payment; provided however that the six-year limitation will not apply to overpayments in which fraud may be involved or in which the provider or an agent or the provider prevents or obstructs Healthfirst auditing and overpayment recovery efforts.

We Will Provide Notice of Overpayments Before Seeking Recovery

If Healthfirst determines that an overpayment has occurred, Healthfirst will provide sixty (60) days advance written notice to the provider of the overpayment before engaging in any overpayment recovery efforts. This notice will include the member’s name, service dates, payment amount(s), proposed adjustment, a reasonably specific explanation of the reason for the overpayment, and the proposed adjustment. In response to a notice of overpayment, the provider may either (1) dispute the finding or (2) remit payment to Healthfirst as outlined below.

If You Agree That We Have Overpaid You

If a provider agrees with Healthfirst’s overpayment determination as detailed in the overpayment notice, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc.) within sixty (60) days from the date the overpayment notice was mailed by Healthfirst. Providers should further include a statement in writing regarding the purpose of the refund check (e.g. payment of identified overpayment) and a copy of the overpayment notice to ensure the proper recording and timely processing of the refund. Refund checks should be mailed to: Healthfirst Finance Department, P.O. Box 5198, New York, NY 10275-0304, Attention: Overpayment Recovery.

If You Disagree That We Overpaid You

If a provider disagrees with Healthfirst’s overpayment determination as detailed in the overpayment notice, the provider must submit the following in accordance with the “Claims Appeals Process” as detailed in Section 17.6 within sixty (60) days from the date the overpayment notice was mailed: (1) a written request for an appeal, and (2) any supporting documentation. Upon making a determination on the provider’s appeal request and supporting documentation, Healthfirst will provide written notice of the appeal determination. If Healthfirst upholds the overpayment determination, providers may initiate arbitration, as provided pursuant to their provider agreement. Healthfirst will proceed to offset the amount of the overpayment prior to any final determination made pursuant to binding arbitration.

If You Fail to Respond to an Overpayment Notice

If a provider fails to dispute or otherwise respond to an overpayment notice within sixty (60) days from the date the overpayment notice was mailed by Healthfirst, the provider will be deemed to have acknowledged and accepted the overpayment amount demanded by Healthfirst and, subject to the provider’s right to arbitration pursuant to the provider agreement, Healthfirst will offset the overpayment amount against current and future claim remittance(s) until the full overpayment amount is recovered by Healthfirst.

If an Offset Results in a Negative Balance

If an overpayment offset results in a negative balance, the provider will receive a special Negative Balance Letter from Healthfirst while the offset amount is being recovered, in lieu of the standard Explanation of Payment (EOP). This letter will contain the current negative offset balance and any claim activity that has taken place since during the check cycle period to reduce the negative balance. Once the entire negative amount has been recovered, the provider will resume receiving standard EOPs.

Duplicate Payments
Healthfirst may also apply the procedures described in this section to recoup duplicate claims payments. However, in accordance with 3224-b of the New York State Insurance Law, Healthfirst reserves the right to use other available procedures to recoup duplicate claims payments.

**Underpayments**

After a provider has complied with the Review and Reconsideration Process and/or the Claims Appeals Process as detailed in Section 17.6, if Healthfirst agrees with the provider’s assertion that Healthfirst has underpaid any claim(s) to the provider, Healthfirst may offset such identified underpayments against any overpayments dating as far back as the claimed underpayment that have not yet been recouped. Prior to such offset, however, Healthfirst shall ensure compliance with the provisions in this Section 17.7 regarding notice of overpayments to the provider.

### 17.8 Avoidable Readmission Reimbursement Policy

Healthfirst’s Avoidable Readmission Reimbursement Policy is designed to reduce avoidable readmissions to improve quality of care. Healthfirst will deny any claim for an acute-care hospital admission that meets the criteria for an avoidable readmission, as defined in this policy. This policy applies to all inpatient claims across all lines of business.

An avoidable readmission is one that occurs within 30 days of discharge of the index (i.e., initial) admission from the same hospital or hospital system, for a condition with the same, a similar, and/or a related diagnosis group (same major diagnostic category (MDC)), provided that none of the exceptions listed below applies. Subsequent admissions will not be subject to denial under this policy if any of the following is true:

- Patient transferred from out of network (OON) to in network (INN),
- Patient transferred to an inpatient rehabilitation facility,
- Patient transferred to a skilled nursing facility (SNF)
- Patient transferred to receive care not available at the first facility,
- The subsequent admission was a planned readmission for repetitive treatments (e.g., chemotherapy for cancer),
- The subsequent admission was a scheduled readmission for elective procedures,
- Patient left Against Medical Advice (AMA) from the index admission,
- Patient expired during the subsequent admission,
- Patient was enrolled in hospice during the subsequent admission,
- The index admission and/or subsequent admission was for:
  - trauma, burns, malignancies, cystic fibrosis, eye, mental health, substance use disorders,
- The subsequent admission was to a psychiatric/substance abuse unit or facility
- The subsequent admission was related to treatment for pregnancy and/or newborns, or
- The subsequent admission occurred more than 30 days from discharge from the index admission.

If you feel a claim was denied in error or would like to dispute a denial, please follow the claim reconsideration and appeal process outlined in your Healthfirst Provider Manual.

**Review Process:**

1. If Healthfirst determines that the admission is a readmission of the index, the hospital will be notified of the claims denial.
2. The hospital has the right to a claims review and reconsideration (1st level) and to a claims appeal (2nd level) of the determination. Denial of payment for the claim will be upheld unless it can be shown that the admission does not meet the criteria for an avoidable readmission.
3. The claims review and reconsideration, and the claims appeal process, will follow the Healthfirst standard
claims reconsideration process as documented in Section 17.6 of this Provider Manual. If it is determined on appeal that the readmission did not meet the criteria for an avoidable readmission, the admission will be reimbursed in accordance with the terms of the applicable Participating Hospital Agreement.

4. Failure of the hospital to provide complete medical records from the index hospitalization and readmission hospitalization for review and reconsideration may result in an adverse determination under the reconsideration process.

5. Healthfirst reserves the right to look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be for an avoidable readmission.

6. Healthfirst reserves the right to deny the claim or to recoup and/or recover monies previously paid on a claim that is within the guidelines of this policy.

Members may not be charged for hospital admissions denied as avoidable readmissions under this policy.
18. Glossary of Terms

**Access to Care:** The extent to which a patient/member is able to obtain healthcare services at the time they are needed or within a preset time frame as established by Healthfirst or by regulatory agencies. Access, including telephone access, is defined by the availability and acceptability of medical services to the member, the location of healthcare providers, transportation, hours of operation, the cost of care, and the ability to schedule appointments.

**Action:** A service authorization determination or other activity of Healthfirst or its subcontractor that results in the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; failure to provide services in a timely manner, as defined by applicable state law and regulation and Section 15 of the Medicaid Contract; or failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals.

**Additional Benefits:** Healthcare services not covered by original Medicare and reductions in premiums or cost-sharing for Medicare-covered services.

**Advance Directives:** Legal documents allowing competent adults to provide information regarding treatment should they become incapacitated and unable to speak for themselves.

**Ancillary Services/Providers:** A term used to describe the additional services and the providers/facilities of those services that are related to medical care. They include apnea or sleep study centers, fetal/uterine monitoring, audiology and hearing services; chiropractors, dental care; diagnostic imaging and radiology services; dentists, dialysis; durable medical equipment; home healthcare and home infusion therapy; hospice, laboratory services; orthotic and prosthetic equipment; outpatient rehabilitation; pharmacy services; physical, occupational, and speech therapy; skilled nursing facilities; and routine vision care.

**Appeal:** A formal request by a provider or member for review and reconsideration of a health-plan decision. An appeal request initiates a formal review process.

**Appropriate Transfer:** One in which the transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records to the receiving hospital, and uses qualified personnel and transportation equipment for the transfer.

**Authorization Number:** A unique number generated by the Medical Management department when a request for authorization of services has been approved. Authorization numbers are communicated to the provider of service; they should be referenced on all claims and correspondence related to those services.

**Authorized Services:** Medical, ancillary, or behavioral healthcare services that require authorization beyond a routine referral from the Medical Management department. Generally, authorization must be obtained in advance of services in order for the provider to receive reimbursement.

**Auto-Assignment:** A process by which an eligible person, mandated to enroll in managed care but who has not enrolled within sixty (60) days, is assigned to a Prepaid Health Services Plan (PHSP) or HMO contracted with a local Department of Social Services such as a Medicaid Managed Care Provider.

**Balance Billing:** A provider billing a member for the difference between the amount the provider charges for the services rendered and the amount the provider has been reimbursed for the health plan. Healthfirst providers are prohibited from balance-billing members for any covered services.

**Behavioral Health Services:** Services to address mental health disorders and/or chemical dependency.

**Beneficiary:** An eligible person is an individual who the Center for Medicaid Services (CMS) determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

**Benefits:** The services to which health plan members are entitled under their designated Healthfirst program.

**Capitation Payment:** A fixed amount of money paid to a provider, hospital, or other provider per-member-per-month to cover the cost of a specific scope of services which must be provided or arranged for by the
provider pursuant to the provider’s contract with Healthfirst.

**Care Management:** The process of planning for treatment and services, assessing the appropriateness of services, and following up to review the effectiveness of services to ensure that members receive efficient, effective, high-quality care that meets their healthcare needs in a cost-effective manner.

**Center for Health Dispute Resolution (CHDR):** An independent CMS contractor that reviews appeals by members of Medicare managed care plans.

**Centers of Medicare & Medicaid Services (CMS):** An organization within the United States Department of Health and Human Services that administers the Medicare program and certain aspects of State Medicaid programs; formerly known as the Healthcare Financing Administration.

**Chemical Dependence Services:** Examination, dependency, level-of-care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence; includes the provision of alcoholism and/or substance abuse services.

**Child/Teen Health Program (C/THP):** This is a program of early and periodic screening, including inter-periodic, diagnostic, and treatment services that New York State offers all Medicaid-eligible children younger than age 21. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the NYSDOH. The services include administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative care management, and transportation assistance to the extent that transportation is included in the benefit package.

**Claim Review/Reconsideration:** The process by which a claim is reviewed at the provider’s request to reconsider the payment determination made when the claim was processed.

**Clean Claim:** A claim for services that includes all required information and documentation, passes all system edits, and does not require any additional review to determine the medical necessity and appropriateness of services provided.

**Clinical Peer:** A provider having the same or a substantially similar specialty as the provider under review during the hearing process.

**Coinsurance:** A fixed percentage of the total amount paid for a healthcare service that can be charged to a member on a per-service basis.

**Concurrent Review:** An assessment of inpatient hospital care or ambulatory services by trained clinical review staff, during the period that those services are being provided, to assess the appropriateness and duration of care and treatment plans and to facilitate discharge planning.

**Coordination of Benefits (COB):** The process of assigning primary, secondary, and residual financial responsibility for coverage of healthcare services when an individual is eligible for benefits from more than one insurer or benefits program.

**Copayment:** A fixed amount that can be charged to a member on a per-service basis.

**Cost Sharing:** The amount of deductibles, coinsurance, and copayments that the member is responsible for paying on a per-service basis.

**Covered Services:** Services that must be furnished or paid for in accordance with the subscriber agreement or Evidence of Coverage between the health plan and the member, or covered by the applicable Medicaid, Medicare or CHP program.

**Current Procedural Terminology (CPT):** A recognized industry standard of descriptive terms and code identifiers for reporting medical services and procedures performed by physicians and other healthcare providers. CPT codes are used in conjunction with ICD-9 diagnostic codes for claims data and other reporting of services provided.

**Credentialing:** This process reviews and verifies a provider’s credentials and experience prior to said provider’s being approved for participation in a health plan. Specific review criteria are applied to ensure that
the provider’s credentials are appropriately verified initially and at ongoing intervals.

**Cultural Competence:** A provider’s effective method of communicating with members who have limited proficiency in English or limited reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities, in order to facilitate the member’s decision-making regarding medical treatment options. In addition, cultural competence includes offering the option of receiving no treatment.

**Custodial Care:** Care furnished for the purpose of meeting nonmedically necessary personal needs which could be provided by a person without professional skills or training. Custodial care is not covered unless provided in conjunction with Skilled Nursing Care.

**Detoxification Services:** Medically Managed Detoxification Services; and Medically Supervised Inpatient and Outpatient Withdrawal Services as defined in Appendix K – Prepaid Benefit Package Definitions of Covered and Noncovered Services of the Medicaid Managed Care Contract.

**Direct Access:** Access to specialty care services that do not require a referral from the member’s PCP. Members may access these services at their own discretion without prior approval.

**Direct Admission:** This is a situation in which a member has been seen in the provider’s office and the provider has made a determination that immediate admission to an inpatient hospital facility is medically necessary.

**Disenrollment:** Disenrollment is the process by which a member’s entitlement to receive services from a health plan is terminated and the member is removed from the plan. Reasons for disenrollment may include, but not be limited to, loss of eligibility as well as disenrollment “for cause.”

**Discharge Planning:** The planning and arranging for post-hospital services to ensure that members are discharged from inpatient care with timely arrangements in place for all necessary and appropriate post-hospital care.

**Drug Formulary:** A continuously updated list of preferred prescription medications. For Healthfirst, the formulary is developed by the Healthfirst Medical Affairs department and takes into consideration cost and efficiency. The formulary contains FDA-approved brand-name and generic drugs.

**Durable Medical Equipment (DME):** Equipment that can withstand repeated use by one (1) member, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the member’s home.

**Effective Date of Enrollment:** The date on which a health plan member can begin to receive services from the health plan.

**Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA):** A convenient service for the automatic reimbursement of Healthfirst claims. EFT is the direct electronic deposit of claim reimbursements into a provider’s bank account, and ERA is the statement that allows providers to reconcile these reimbursements to their member accounts.

**Eligible Person:** An individual who the local Department of Social Services or State authority determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

**Emergency Medical Condition – PHSP:** A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of that person or others in serious jeopardy; or (ii) serious impairment to such person’s bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her
unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

**Emergency Services:** Covered inpatient and outpatient services that are (i) furnished by a provider qualified to provide emergency services and (ii) needed to evaluate or stabilize an emergency medical condition.

**Enrollment Broker:** An agent or contractor of the state or county who assists in educating and enrolling potential managed care members, assists in explaining the differences between managed care and fee-for-service, and offers nonbiased enrollment counseling.

**Enrollment Roster:** A report circulated each month to participating primary care providers to identify and provide demographic information on the health plan members who are in that provider’s member panel for that month.

**Evidence of Coverage (EOC):** The contract between the member and Healthfirst Medicare putting forth the terms of the coverage for medically necessary healthcare services.

**Explanation of Payment (EOP):** A form or report that provides a detailed explanation of the payment or denial of payment in response to a provider’s claim for reimbursement of services.

**External Appeal:** A request to the state for an independent review of a health plan’s denial of services.

**Extra Help:** Medicare members with limited income and resources may qualify for financial assistance with paying for prescription drug costs (i.e., monthly premium, yearly deductible, and prescription coinsurance payments). The Centers for Medicare & Medicaid Services (CMS) provide (or pay for) extra help. The amount of extra help depends on the individual’s income and resources.

- **Please Note:** Medicare members who have lost their Medicaid status are required to reapply for Extra Help.

**Family Planning Services:** Offering, arranging, and furnishing of those health services which enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. Family planning and reproductive healthcare include the following medically necessary services and related drugs and supplies that are furnished or prescribed by or under the supervision of a physician or nurse practitioner:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera.
- Screening and treatment for STDs.
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy, and pelvic abnormality/pathology.
- Termination of pregnancy services (provider must document duration of pregnancy).

Such services include those education and counseling services needed to render the services effective.

**Fee-for-Service (FFS):** The traditional healthcare payment system under which providers receive a payment for each service provided based upon a contractually agreed-upon fee schedule.

**Grace Period:** A ‘grace period’ is a period of extra time that a member is given to pay their monthly premium should they miss a payment. The grace period provision for a Leaf Plan or Leaf Plan Premier member depends on the subsidy or tax credit that the member qualifies for. Members who receive no premium subsidies or federal tax credits have up to 30 days to pay their premium after their premium due date. Members who receive premium subsidies have up to 90 days to pay their premium after their premium due date.

**Grievance Process:** The formal process by which health plan members or providers can communicate complaints and seek remedies from the health plan.

**Guaranteed Eligibility:** The period beginning on the member’s effective date of enrollment with the health plan and ending six (6) months thereafter during which the enrollment of and capitation payments on behalf of
the member continue even if a change in the member’s financial or other circumstances ordinarily would have rendered him or her ineligible to receive any Medicaid-reimbursed services.

**Health Care Proxy:** A formal document that enables a health plan member to designate a trusted individual to make healthcare decisions on his or her behalf should the member lose the ability to make decisions on his or her own.

**Health Plan Employer Data and Information Set (HEDIS®):** HEDIS is a set of standardized performance measures designed to ensure that consumers, purchasers, and the general public can access information that allows for reliable comparison of the performance of different healthcare plans.

**Home Health Agency:** A licensed or certified agency under Part A of Medicare that provides intermittent skilled nursing care and other therapeutic services in the member’s home.

**Home Healthcare:** Services provided by a Home Health Agency. The services may consist of the following:

- intermittent or part-time nursing visits rendered by an RN;
- intravenous therapy as ordered by the provider;
- home health aid services under the direction and supervision of an RN;
- other health services to be delivered in the home setting as requested/approved by the PCP/specialist and authorized by Medical Management.
- Home Healthcare services may require the use of durable medical equipment, oxygen and respiratory equipment, and other medical supplies.

**Hospice:** An organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill members and their families.

**International Classification of Diseases, 9th Edition (Clinical Modification) (ICD9-CM):** This is an industry standard listing and coding system used by providers for reporting medical conditions and diagnoses. ICD-9 codes are used in conjunction with CPT-4 codes for claims data and other clinical data reporting.

**Informed Consent:** A legal concept requiring the member, the member’s guardian, or the member’s legal representative to be advised of and to understand the risks of a proposed medical procedure or treatment prior to approving such procedure or treatment. Informed consent is usually provided in writing.

**In-Network:** The designation given to medical care services provided by providers, hospitals, and other providers that have participation agreements with the health plan.

**Lock-in Period:** The time beginning 90 days after the effective date of enrollment in the health plan by a social services official and ending 12 months after the effective date of enrollment, during which the member may not dis-enroll from the health plan except for certain specified reasons.

**Low Income Subsidy (LIS):** See Extra Help.

**Marketing:** Any activity of the health plan by which information about the health plan is made known to eligible persons for the purpose of persuading them to enroll with the health plan.

**Managed Care:** A comprehensive, coordinated approach to the provision of healthcare services that combines medical services with administrative procedures to ensure timely access to high-quality, medically appropriate, and cost-effective care. Managed care emphasizes primary and preventive care and focuses on the appropriate utilization of specialty care, emergency room services, and inpatient hospital care.

**Medicare Advantage Organization:** A public or private entity organized and licensed by the state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage plan contract requirements. Formerly Medicare + Choice Organization.

**Medicare Advantage Plan:** Health benefits coverage offered under a policy or contract by a Medicare Advantage Organization that includes a specific set of benefits offered at a uniform premium and uniform level
of cost-sharing to all Medicare beneficiaries residing in the service area of the Medicare Advantage Organization. Formerly Medicare + Choice Plan.

**Medicaid**: A federal program created in 1965 under Title XIX—Medical Assistance of the Social Security Act. The program is administered and operated individually by participating state and local governments providing medical benefits and services to eligible persons who meet income or medical need criteria. The federal and state governments share Medicaid program costs.

**Medical Management**: The Healthfirst Medical Management department whose function it is to promote the efficient use of healthcare services and quality of care.

**Medical Management Program**: The program of utilization management, clinical review, and quality improvement established by Healthfirst to assure that the proper level and quality of care is provided to members.

**Medical Record**: A complete record that documents care received by the member, including inpatient, outpatient, and emergency care, in accordance with all applicable laws, rules, and regulations, which is signed by the medical professional rendering the services.

**Medically Necessary – PHSP**: Applies to healthcare and services that are necessary to prevent, diagnose, correct, or cure conditions in a person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.

**Medically Necessary**: Medical or hospital services which are determined by Healthfirst to be 1) rendered for the treatment or diagnosis of an illness or injury; 2) are appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; 3) are not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and 4) are furnished in the most economically efficient manner which may be provided safely and effectively to the member.

**Medical Staff**: A hospital’s or ambulatory surgery center’s medical staff, as that term is defined in the bylaws of the hospital or ambulatory surgery center.

**Medicare**: The federal government health insurance program established by Title XVIII of the Social Security Act.

**Medicare Part A**: Hospital insurance benefits, including inpatient hospital care, Skilled Nursing Facility Care, Home Health Agency Care, and Hospice care offered through Medicare.

**Medicare Part B**: Medical insurance benefits that are optional and require the payment of a premium. Covers provider and certain non-provider services.

**Medicare Part D**: Prescription drug insurance available to everyone with Medicare and provided by private companies.

- Effective January 1, 2006.

**Medicare Basic Benefits**: All healthcare services that are covered under Medicare Part A and Part B programs (except hospice services), additional services that are covered by Medicare funds, and other services for which a member is required to pay a premium.

**Medicare Benefit Period**: A period beginning with the first day of a Medicare-covered inpatient hospital stay and ending with the close of a period of 60 consecutive days during which the member was neither an inpatient of a hospital nor of a SNF.

**Member**: An individual who is covered by Healthfirst, including newborn children of persons who have enrolled in benefit programs offered by Healthfirst.

**Noncontracting Medical Provider or Facility**: Any professional, organization, or health facility licensed and/or certified by the state or Medicare to deliver or furnish healthcare services but not under contract with Healthfirst to provide such services.
Nonparticipating Provider: A provider of medical care and/or services with which the health plan has no provider agreement.

Nonprescription/Over-the-Counter (OTC) Drugs and Medical/Surgical Supplies: Nonprescription drugs and supplies listed on the New York State Fee schedule as listed in the MMIS pharmacy Provider Manual.

Notice of Discharge and Medicare Appeal Rights (NODMAR): A notice issued to Healthfirst Medicare Plan members receiving inpatient hospital care or to their representative when it is determined that the current care is no longer medically necessary or is custodial in nature.

Obstetric and Gynecologic (OB/GYN) Providers: A group of providers including obstetricians, gynecologists, certified nurse midwives, and nurse practitioners with training in obstetrics and/or gynecology that provide women’s healthcare services to Healthfirst members.

Optional Supplemental Benefits: Services not covered by Medicare that a member must purchase as a part of a Medicare Advantage plan that are paid for directly or on behalf of a member in the form of premiums or cost-sharing.

Organizational Determination: A decision whether or not coverage is necessary and appropriate.

Original Medicare: The payment system by which doctors, hospitals, and other providers are paid a specific amount for each service performed as it is rendered and identified by a claim for payment.

Participating Provider: A hospital, physician, ambulatory surgical center, home healthcare agency, pharmacy, multispecialty group practice, or other healthcare provider that has entered into an agreement to provide services covered under benefit plans marketed by Healthfirst.

Peer Review Organization (PRO): An independent contractor paid by CMS to review medical necessity, appropriateness, and quality of medical care and services provided to Medicare beneficiaries.

Premium: The amount that must be paid for your health insurance or plan on a monthly, quarterly, or yearly basis.

Prior Authorization: The process whereby a provider must receive approval from the Medical Management department prior to rendering services. Services are authorized in accordance with nationally recognized standards of medical care.

Prepaid Health Services Plan (PHSP): A public or private organization organized under the laws of the State of New York and certified by the State Department of Health under Section 4403-A of the New York State Public Health Law.

Prescription Drugs: Those drugs that are listed on the New York State List of Medicaid Reimbursable Drugs.

Primary Care Covered Services: Those provider services covered by Healthfirst as described in the PCP agreement.

Primary Care Provider (PCP): A qualified physician or nurse practitioner or team of no more than four (4) qualified physicians/nurse practitioners who provide all required primary care services contained in the benefit package to members. Medical residents may be used as part of the PCP delivery system under the supervision of a qualified attending physician. PCPs specialize in internal medicine, family practice, pediatrics, or general practice. For the Medicare and commercial programs, geriatricians may participate as PCPs.

Provider Agreement: Any written contract between the health plan and a participating provider to provide medical care and/or services under this agreement.

Prepaid Capitation Plan Roster: The monthly reporting mechanism by which all Medicaid Managed Care Plans currently enrolling recipients in New York State (and any county within which these plans operate) are informed of specifically which recipients a managed care plan will be servicing for the coming month.

Provider’s Members: Those members who have been assigned by Healthfirst to the provider, including newborn children of members who have been assigned to the provider, for the provision of medically
necessary covered services. These members comprise the participating provider’s panel.

**Provider Network:** The providers with whom Healthfirst contracts or makes arrangements to furnish covered healthcare services to Healthfirst members.

**Qualified Health Plan (QHP):** An insurance plan that is certified by the Federal or State Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements established by the Marketplace in which it is sold. Qualified health plans began coverage in 2014 under the Affordable Care Act. The QHPs offered by Healthfirst on the NY State of Health website are known as the Healthfirst Leaf Plans and Leaf Premier Plans.

**Quality Improvement Organization (QIO):** An independent organization under contract with the Centers for Medicare and Medicaid Services (CMS) for the purpose of improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund, and protecting Medicare beneficiaries by addressing individual cases such as beneficiary complaints.

**Quality Improvement Program (QIP):** A program for reviewing, assessing, ensuring, and making determinations regarding the quality of the healthcare delivery system serving Healthfirst members. This includes review of the timeliness, quality, and appropriateness of medical care by the Health Care Quality Council and external peer review bodies.

**Reconsideration:** An appeal of an initial determination that was not favorable.

**Referrals:** A health plan–approved recommendation given to one participating provider from another participating provider (usually from a PCP to a participating specialist) in order to arrange for certain medical services for a Member within the health plan’s active provider network. A referral facilitates a provider’s effort in coordinating a member’s healthcare needs. Leaf Plan and Leaf Premier Plan members must obtain referrals from their PCPs to arrange for certain specialist services in order to ensure the plan will cover these services.

**Service Area:** The specific geographic area where members reside and the health plan is authorized to operate. A geographic area approved by New York State and CMS within which an eligible individual may enroll in Healthfirst.

**Skilled Nursing Care:** Services that can only be performed by or under the supervision of licensed nursing personnel.

**Skilled Nursing Facility (SNF):** A facility that provides inpatient Skilled Nursing Care, rehabilitation services, or other related health services. This term does not apply to convalescent nursing homes, rest homes, or facilities for the aged that primarily furnish custodial care including training in routines of daily living.

**Specialty Care Provider:** A physician or other provider in a medical specialty (e.g., cardiology, dermatology, or orthopedics) who provides clinical services to a Healthfirst member upon referral by the member’s primary care provider.

**Sterilization:** Any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

**Urgent Medical Condition – PHSP:** A medical condition manifesting itself by acute symptoms of sufficient severity that, in the assessment of a prudent layperson possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ, body part, or mental ability, or any other condition that would place the health or safety of that person or another individual in serious jeopardy in the absence of medical or behavioral treatment within 24 hours.

**Urgently Needed Services:** Covered services provided when a member is temporarily absent from the plan’s service area (or, under unusual and extraordinary circumstances, provided when the member is in the service area but the plan’s provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the member’s PCP.
Appendix I — Appointment Availability and 24-Hour Access Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New York State regulations. Healthfirst and the NYSDOH actively monitor adherence to these standards. Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage. All participating providers are expected to provide care for their Healthfirst members within these access guidelines.

<table>
<thead>
<tr>
<th>Description of Level of Care or Type of Service</th>
<th>Standards</th>
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<tr>
<td><strong>Emergency Care:</strong> An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such condition in: a) serious jeopardy, impairment, dysfunction, or disfigurement, or b) placing the health of others in serious jeopardy, in the case of a behavioral condition.</td>
<td>Care must be provided immediately upon presentation at the service delivery site.</td>
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<td><strong>Urgent Care:</strong> Urgent conditions are defined as those illnesses and injuries, of a less serious nature than emergencies, that require services to prevent a serious deterioration of a member’s health and which cannot be delayed without imposing undue risk to the patient’s well-being, until the patient either returns to the Plan’s service area or until the patient can secure services from his or her primary care physician.</td>
<td>Urgent medical or behavioral problems must be seen within 24 hours of request.</td>
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<td><strong>Non-urgent “Sick” Visits:</strong> These are visits for symptomatic conditions which are neither an emergency nor of an urgent nature.</td>
<td>Visit must be scheduled within 48-72 hours of request as indicated by the nature of the clinical problem.</td>
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<td><strong>Routine Care:</strong> These visits are for routine management of clinical conditions or other follow-up care as is clinically appropriate.</td>
<td>Appointment must be scheduled within 4 weeks of request.</td>
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<td><strong>Adult Baseline and Routine Physicals</strong></td>
<td>Appointment must be scheduled within 12 weeks of enrollment.</td>
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<tr>
<td><strong>Well-Child Care Visits</strong></td>
<td>Appointment must be scheduled within 4 weeks of request.</td>
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<td><strong>Initial Prenatal Visits:</strong></td>
<td>Appointment must be scheduled within 3 weeks of request.</td>
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<td>– First Trimester</td>
<td>Appointment must be scheduled within 2 weeks of request.</td>
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<td>– Second Trimester</td>
<td>Appointment must be scheduled within 1 week of request.</td>
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<td>– Third Trimester</td>
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<td>Newborn Visits: Initial Visit to the PCP</td>
<td>Appointment must be scheduled within 2 weeks of hospital discharge.</td>
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<tr>
<td>Initial Family Planning Visits</td>
<td>Appointment must be scheduled within 2 weeks of request.</td>
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<tr>
<td>Non-urgent Referred Specialist Visits</td>
<td>Appointment must be scheduled within 4 to 6 weeks of request.</td>
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<tr>
<td>In-Plan Behavioral Health or Substance Abuse Follow-up Visits (subsequent to an emergency or inpatient stay)</td>
<td>Appointment must be scheduled within 5 days or as clinically indicated.</td>
</tr>
<tr>
<td>In-Plan, Non-urgent Behavioral Health or Substance Abuse Visits</td>
<td>Appointment must be scheduled within 2 weeks of request.</td>
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Appendix II Credentialing

Appendix II-A — Credentialing Requirements

All providers must meet the specific core criteria listed below as a condition for their participation in any of the Healthfirst provider networks.

A valid, current, unencumbered, and registered license for the state(s) in which the applicant will provide care. A license is “unencumbered” if it has not been the subject of any adverse action, including, but not limited to, probation, suspension, revocation, or imposition of conditions such as periodic reporting, restrictions on nature or scope of practice, or public or private censure.

Professional liability insurance in the amount of $1 million per incident/$3 million aggregate, per annum. The practitioner must maintain continuous malpractice coverage and must have no history of denial or cancellation of professional liability insurance, or exclusion of any specific procedures from coverage or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard performance.

No history of professional liability claims, including, but not limited to, lawsuits, arbitration, settlements, or judgments paid by, for, or on behalf of the practitioner or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.

Valid, current, unencumbered, and unrestricted participation in the Medicaid and Medicare programs or, in the case of a provider who does not participate in these programs, proof that such nonparticipation is entirely voluntary and not due to current or past debarment or disbarment from the programs.

No physical or mental impairment/condition, including, but not limited to, a communicable disease that makes the provider unable to perform the essential functions of a practitioner in the same area of practice or unable to perform such functions without causing a threat to the health or safety of others, except where the provider has submitted adequate evidence that a physical or mental impairment/condition does not render the provider unable to perform the essential functions of a practitioner in the same practice area or unable to perform such functions without causing a threat to the health or safety of others.

No present or past chemical dependency or substance abuse problem that might adversely affect the provider’s ability to competently and safely perform the essential functions of a practitioner in the same area of practice, except where the provider has submitted adequate evidence that a chemical dependency or substance abuse problem does not adversely affect the provider’s ability to competently and safely perform the essential functions of a practitioner in the same practice area.

No history of professional disciplinary actions or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.

No history of involuntary termination (including resignation to avoid dismissal) of professional employment or of a contract.

No history of felony criminal conviction or indictment or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.

No information to indicate a pattern of inappropriate utilization of medical resources.

No other information that might indicate provider is engaged in conduct unbecoming to a professional in any jurisdiction. “Conduct unbecoming” can be defined as, but not limited to, sexual misconduct (e.g., with patients), tax evasion, sexual harassment of his/her patients, fraudulent billing practices, etc.

No falsification of the credentialing application, requested documents, or material omission of information requested in the application.

No report history to the National Practitioner Data Bank.
No verified adverse reports from member satisfaction surveys or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.

Absence of inclusion on the Medicare Opt-Out List.

Specially Designated Nationals List (SDN).


Absence of inclusion on the U.S. Department of Justice, Drug Enforcement Administration (DEA), Case Against Doctors Listing.

Absence of inclusion on the CMS Preclusion List.

For Medicaid only, providers that are sanctioned by the NYS DOH’s Medicaid Program will be excluded from participation in the HMO’s Medicaid panel.

**Additional Requirements for MDs, DDSs, DMDs, DPMs, and Doctors of Osteopathy (DOs)**

Graduation from an accredited medical school, dental school, college of osteopathy, or a foreign medical school recognized by the World Health Organization, and completion of a residency program.

Evidence of a minimum of five (5) years of work history. If provider does not have five (5) years of work history, the time spent in training will be included in the five-year minimum.

Valid, current DEA registration (where applicable).

A review of the practitioner’s site of practice that meets Healthfirst standards for office environment assessments is required (where applicable).

**Additional Requirements for HIV Specialist Providers**

Direct clinical ambulatory care of HIV-infected persons, including management of antiretroviral therapy, in at least 20 patients during the past year AND ten (10) hours annually of continuing medical education (CME), including information on the use of antiretroviral therapy in the ambulatory care setting. Practitioners who have been accorded HIV Specialist status by the American Academy of HIV Medicine (AAHIVM) or who have met the HIV Medicine Association’s (HIVMA) definition of an HIV-experienced provider are eligible for designation as an HIV Specialist in New York State, provided that the requirements for management of antiretroviral therapy in HIV-infected patients have been fulfilled in the ambulatory care setting.

Nurse practitioners and licensed midwives who provide clinical care to HIV-infected individuals in collaboration with a physician may be considered HIV Specialists, provided that all other practice agreements are met (8 NYCRR 79-5.1; 10 NYCRR 85.36; 8 NYCRR 139-6900). Physician assistants who provide clinical care to HIV-infected individuals under the supervision of an HIV Specialist physician may also be considered HIV Specialists (10 NYCRR 94.2).

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

A provider must have appropriate on-call designees (covering providers) who are in compliance with the requirements of these credentialing criteria.

**Additional Requirements for Behavioral Health/Nurse Practitioner/NurseMidwife/AlliedHealthProviders**

Nurse Practitioners that have more than 3,600 hours of practices as a licensed or Certified NP may practice more autonomously by having a Collaborative Relationship with a Physician qualified to collaborate in the specialty he/she is involved in. The NP must sign the Collaborative Relationship Attestation Form; this form will be accepted in lieu of the Collaborative Agreement.

Completion of an accredited education program registered with the State Education Department or
program determined by the State Education Department to be equivalent to such a registered program which is designed to prepare graduates to practice in the specialty in which the applicant will provide care.

Valid, current DEA registration (where applicable).

Evidence of a minimum of five (5) years of work history. If provider does not have five (5) years of work history, the time spent after in training will be included in the five-year minimum.

A review of the practitioner’s site of practice that meets Healthfirst's standards for office environment assessments is required (where applicable).

Nurse Practitioners: Execution of a collaborative agreement and practice protocols with a physician, in accordance with the requirements of the New York State Department of Education. The collaborating physician must be a member of the Healthfirst provider network.

Nurse Midwives: A collaborative relationship with a physician in accordance with the requirements of the New York State Department of Education. The collaborative relationship must be with an OB/GYN provider in the Healthfirst network.

Appendix II-B — Healthfirst Office Site Evaluation Form

**PROVIDER NAME:** ___________________________ **SPECIALTY:** ___________________________

**ADDRESS:** _______________________________________________________

**PROVIDER ID:** ____________________________

**Office Hours:**

<table>
<thead>
<tr>
<th>SUNDAY</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
</tr>
</thead>
</table>

**Reason for Visit:**

- [ ] Initial Site Visit
- [ ] Recredentialing Visit
- [ ] Routine Visit
- [ ] Other ____________________________

**PHYSICAL ACCESSIBILITY**

<table>
<thead>
<tr>
<th>Clearly marked office sign</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handicapped parking available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entrance to facility handicapped accessible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam rooms handicapped accessible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient restrooms properly equipped and handicapped accessible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL APPEARANCE**

<table>
<thead>
<tr>
<th>Facility is clean and well maintained</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrooms AND exam rooms clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider hand washing area available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate patient seating available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate number of exam rooms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FIRE AND SAFETY ISSUES**

<table>
<thead>
<tr>
<th>Exits are clearly marked and accessible</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety equipment present (alarm/detector AND extinguisher)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazardous waste disposal process in place (“Red bag system”)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Impervious container for needle/syringe disposal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency kit available and includes Ambu bag/mask – Emergency drugs</td>
<td></td>
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</tbody>
</table>
### X-RAY / LABORATORY / PHARMACEUTICALS

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Current X-Ray/Radiological Equipment inspection certificate</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Current CLIA certificate or certificate of waiver</td>
<td></td>
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<td></td>
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<tr>
<td>Medication accessible only to authorized personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription pad, needles and syringes are inaccessible to patients</td>
<td></td>
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</table>

### MEDICAL RECORDKEEPING/CONFIDENTIALITY

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Current medical records are accessible only to authorized staff</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Medical records are kept in a secured location after hours</td>
<td></td>
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<tr>
<td>Private consultation space available</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Use of Mental Health Assessment Tool *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardized medical record format</td>
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</table>

*If the provider office is using a tool other than Healthfirst’s, please provide a copy.

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### Healthfirst Office Site Evaluation Form (continued)

<table>
<thead>
<tr>
<th>PROVIDER AVAILABILITY</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Maximum wait time for appointments – 1 hour for a scheduled visit</td>
<td></td>
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<tr>
<td>Medicare patients only – 30 minute or less wait-time</td>
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<tr>
<td>Maximum wait time for appointments – 2 hours for a walk-in (non-emergent condition)</td>
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<tr>
<td>Emergency Care: Immediately upon presentation</td>
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<tr>
<td>Urgent medical care appointment within 48 hours</td>
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<tr>
<td>Non-urgent “sick visits” within 48-72 hours</td>
<td></td>
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<tr>
<td>New patient appointments within 12 weeks (4 weeks for HIV positive members)</td>
<td></td>
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<tr>
<td>Pediatrics – well child care 4 weeks</td>
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<td></td>
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<tr>
<td>Routine appointments within 4 weeks</td>
<td></td>
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<tr>
<td>24 hour coverage available/7 days a week (list method)</td>
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<tr>
<td>Physician MUST be available minimum of 16 hours/week at each site</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(Medicare and Commercial only minimum of 10 hours/ 2 days)</td>
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Name and address of practitioner(s) providing coverage:

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</tbody>
</table>

Is the practitioner providing coverage a Healthfirst provider?  □ Yes  □ No

Comments:
Score: ________________

Healthfirst Representative: ___________________________________________ Date: ____________________________

I acknowledge that the above review has taken place and that I am not necessarily in agreement with the above listed responses.

Provider / Staff Acknowledgment Signature: ___________________________________ Date: ________________________________

Appendix II-C — Interpretative Guidelines for the Office Site Evaluation Form

Physical Accessibility

**Clearly marked office sign**: Sign identifying the practitioner/practice should be prominent and easy to read from the street or easy to find if the practitioner is housed in a building with other tenants.

**Handicapped parking available**: This standard is met if there are designated parking spaces available for the handicapped (exceptions are made for urban areas; i.e., Manhattan).

**Entrance to facility is handicapped accessible**: There must be an appropriate ramp for the building; an entrance large enough to accommodate a wheelchair or person using crutches; no barriers (i.e., curbsides).

**Exam rooms are handicapped accessible**: The entrance must be large enough to accommodate a wheelchair or person using crutches; no barriers.

**Patient restrooms are properly equipped and handicapped accessible**: At least one stall is equipped with a grab bar; no barriers; entrance is large enough to accommodate a wheelchair.

Physical Appearance

**Facility is clean and well maintained**: Reception, waiting area, and hallways are orderly, uncluttered, and clean. The carpet/floor is in good condition. There are clean wall coverings and furniture. Overall appearance is acceptable.

**Restrooms and exam rooms are clean**: There is no paper on the floor of the restroom; exam room is neat; proper care is taken to ensure that items used for a particular patient—such as gowns, instruments, and paper exam table covers—are not reused.

**Practitioner hand washing area is available**: There should be a sink, soap, and paper towels available in each exam room for practitioner use.

**Adequate patient seating is available**: There should be two (2) to three (3) chairs for patient seating for each practitioner in the office.

**Adequate number of exam rooms**: There should be two (2) exam rooms available per practitioner on duty.

Fire and Safety Issues

**Exits must be clearly marked and accessible**: Lighted exit signs should be posted on the doors.

**Fire safety equipment must be present**: This standard is met if there are both a working smoke alarm/smoke detector and fire extinguisher.

**Hazardous waste disposal process is in place**: The practitioner must have a mechanism in place for the proper disposal of body fluids and any other materials that may be soiled and/or considered hazardous.
Disposable equipment is readily available when necessary: There are disposable gloves within reach of the examination table and disposable masks and table covers inside the exam room.

Impervious container available for needle/syringe disposal: The standard is met if there is an impenetrable container for sharp objects located within reach of the point where the sharp object is being used.

Emergency kit available: This kit must include Ambu bag/mask and epinephrine; a crash cart should be accessible and conveniently located.

X-Ray/Laboratory/Pharmaceuticals

Current X-Ray and Radiology Equipment Inspection Certificate is available: A current or recently reviewed inspection certificate and performance summary-testing sheet must be on file.

Current CLIA Certificate: If laboratory services are performed in the provider’s office, the site must have a current CLIA (Clinical Laboratory Improvement Act) certificate or certificate of waiver.

Laboratory specimen storage: Laboratory specimens must be stored/shipped in puncture-proof containers.

Accessibility of medication: Medication is accessible only to authorized personnel; narcotics are kept in a locked and secure area.

Prescription pads, needles, syringes must not be accessible to patients: These supplies are to be kept in a secure location.

Medical Recordkeeping/Confidentiality - The site reviewer must physically examine at least one (1) actual medical record.

Current medical records should be accessible only to authorized staff: Medical records being utilized for the day must be inaccessible to patients.

Medical records are kept in a secured location after hours: Medical records should be kept in a locked cabinet or a locked file room after business hours.

Private consultation space is available: This standard is met if there is space available away from other patients and office staff to discuss patient information privately with the patient or with other clinical staff.

Standardized formats: There should be templates established and followed by the office staff regarding the order of each medical record for consistency. Templates must meet the medical records standards set by Healthfirst, as adopted from NCQA.

Provider Availability

Emergency Care: Patients presenting with an emergency condition such as severe chest pains must be seen immediately.

The maximum waiting time in the office for scheduled appointments is one (1) hour. Provider offices should not overbook appointments. The standard is met if the waiting time for a scheduled appointment is zero (0) to one (1) hour. For Medicare patients, the maximum waiting time for scheduled appointments is 30 minutes or less.

The maximum waiting time for a non-emergent walk-in patient (if the provider accepts walk-in patients) is two (2) hours. The standard is met if the waiting time to be seen is between zero (0) to two (2) hours.

Appointments for urgent medical care: Appointments for urgently required medical care must be scheduled to take place within 48 hours of request. Potentially life-threatening conditions require immediate attention.

Appointments for non-urgent “sick visits”: These appointments must be scheduled to take place within forty-eight (48) to seventy-two (72) hours of request.

Well-care appointments: Adult baseline physicals/new patient appointments are scheduled within twelve
(12) weeks; well-child/preventive care appointments are scheduled within four (4) weeks.

**Physician coverage:** The provider maintains coverage of the practice twenty-four (24) hours a day, seven (7) days a week. Reviewer must document (1) the type of coverage provided—live voice answering service, answering machine, or direct phone number—and (2) the coverage arrangements in place (e.g., shared coverage with other participating providers).

**Physician hours:** Providers must practice a minimum of sixteen (16) hours per week. To qualify as a primary care provider, the practitioner must be available a minimum of two (2) days or sixteen (16) hours per week at each practice site. For Medicare and commercial programs, the minimum is two (2) days or ten (10) hours per week at each practice site.
Appendix III — Healthfirst Commercial Plans and Medicaid Managed Care Exclusions and Exemptions

Medicaid Exclusions
The following persons are excluded from joining a managed care plan:

- Medicare/Medicaid Dual Eligibles.
- Individuals who became eligible for Medicaid only after spending down a portion of their income.
- Residents of State psychiatric facilities and residential treatment facilities for children and youth.
- Residents of residential healthcare facilities at the time of enrollment and persons who enter a residential healthcare facility subsequent to enrollment, except for short-term rehabilitative stays anticipated to be less than thirty (30) days.
- Participants in capitated long-term care demonstration projects, including beneficiaries with Medicare.
- Medicaid-eligible infants living with incarcerated mothers.
- Comprehensive private health insurance consumers if cost is lower than the State’s.
- All children in foster care. (Noninstitutional foster care children and institutional foster care children, children enrolled in Brides to Health waiver program – not excluded as of April 1, 2013).
- Certified blind or disabled children living or expected to live separate from their parents for thirty (30) days or more. (No longer excluded as of April 1, 2013.)
- Individuals expected to be Medicaid eligible for less than six (6) months (except for pregnant women).
- Individuals receiving (at the time of enrollment) institutional long-term care services through long-term home healthcare programs, or child care facilities (except ICF Services for the Developmentally Disabled).
- Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
- Individuals placed in OMH licensed family care homes.
- Individuals enrolled in the Restricted Recipient Program. (No longer excluded as of August 1, 2012.)
- Individuals receiving family planning services who are not otherwise eligible for medical assistance and whose net available income is 200% or less of the federal poverty line.
- Individuals receiving hospice services (at time of enrollment).
- Individuals eligible for Medicaid pursuant to the terms of the “Medicaid buy-in for the working disabled.” (No longer excluded as of April 1, 2013.)
- Individuals who are eligible for medical assistance.

Medicaid Exemptions
The following persons may voluntarily enroll, but are not required to enroll, in a Medicaid managed care plan.

- Individuals with chronic medical conditions who have been under active treatment for at least six (6)
months with a subspecialist who is not a network provider for any Medicaid managed care plan in the service area, or whose request has not been approved by the SDOH medical director because of unusually severe chronic care needs.

- Residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR). (No longer exempt as of April 1, 2013.)

- Individuals with characteristics and needs similar to those who are residents of an ICF/MR. (No longer exempt as of April 1, 2013.)

- Individuals previously scheduled for a major surgical procedure (within thirty [30]) days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid managed care plan in the service area.

- Persons with developmental or physical disability receiving services through a Medicaid Home- and Community-Based Services Waiver. (No longer excluded as of April 1, 2013.)

- Individuals whose needs are similar to participants receiving services through a Medicaid Home- and Community-Based Services Waiver.

- Participants in the Medicaid Model Waiver (Care-At-Home) Program. (No longer excluded as of April 1, 2013.)

- Individuals whose needs are similar to participants receiving services through the Medicaid Model Waiver (Care-At-Home) Programs. (No longer excluded as of April 1, 2013.)

- Residents of Alcohol/Substance Abuse Long-Term Residential Treatment Programs.

- Native Americans.

- Recipients with a "County of Fiscal Responsibility" Code of 98 (OMRDD in MMIS).

- Individuals eligible for Medicaid pursuant to the terms of the "Medicaid buy-in for the working disabled." (No longer excluded as of April 1, 2013.)

**Healthfirst Commercial Plan Exclusions**

The following persons are excluded from joining a Healthfirst Commercial plan:

- Individuals over 65 who are eligible for Medicare.

- Individuals who are eligible for Medicaid.

- Individuals who live outside of Bronx, New York, Queens, Kings, Richmond, Suffolk, and Nassau counties.

- Individuals who are already insured through an employer or through a spouse’s employer.

- Individuals who are incarcerated.
Appendix IV — Marketing Guidelines

Appendix IV-A — Medicaid Marketing Guidelines for Medical Service Providers

Definitions

“Providers” shall mean all physicians or medical facilities (hospitals, clinics, diagnostic and treatment centers, and physician group practices) that contract with one or more Medicaid managed care organizations.

“Marketing” shall mean all forms of communication, written or oral, used to encourage or induce Medicaid recipients to enroll in a managed care plan.

Appropriateness of Advertising and Outreach Materials

1. Advertising and outreach materials must be pre-approved by the State Department of Health (SDOH) or the Local Department of Social Services (LDSS) prior to distribution.

2. Providers shall not engage in marketing practices, nor distribute any advertising and outreach materials, that mislead, confuse, or defraud eligible persons, the public, or any government agency. Providers may not misrepresent the Medicaid program, the Medicaid managed care program, or the program or policy requirements of the LDSS or the SDOH.

Reminder: Medicaid recipients may never be told by their providers that they have to join a plan now—they will never have to make a selection until they receive their official notices.

3. Advertising and outreach materials must accurately reflect general information which is applicable to the average consumer of Medicaid managed care. Advertising and outreach materials must provide as much information as possible to allow consumers to choose the plan that best meets their needs.

4. Providers may not use any federal, state, or local government logos in their materials. Care should be taken to avoid the format and colors used in informational materials by these entities to ensure that there is not confusion about their sources.

Permitted/Impermissible Advertising and Outreach Activities

1. Advertising and outreach activities may not discriminate on the basis of a potential member’s health status, prior health service use, or need for future healthcare services.

2. Providers may not conduct “cold call” telephone solicitations.

3. Providers may not provide mailing lists of their patients to managed care organizations (MCO). Providers may not provide mailing lists of their patients to managed care organizations (MCO).

4. Providers may give permission to managed care organization marketing representatives to conduct advertising and outreach activities at their facility. If the providers are in multiple plans and allow one (1) plan to market in their facilities or want to let their patients know of their affiliation with one (1) or more MCOs, they must prominently display a list of all other managed care plans operating in the county or borough with which they are contracted.

5. Physicians may speak to their patients about their MCO affiliation and should encourage the patient to make their choice of plan based on the health needs of the patient and his/her family. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one (1) plan over another.

6. Neither the provider nor MCO-facilitated enrollment representatives may market in emergency room facilities, treatment rooms, or hospital patient rooms. MCOs may not require providers to distribute plan-prepared communications to their patients.
7. In the event a provider is no longer affiliated with a particular MCO but remains affiliated with other participant MCOs, the provider may notify his/her patients of the new status and the impact of such change on the patient.

8. All advertising and outreach activities shall be conducted in an orderly, nondisruptive manner and shall not interfere with the privacy of potential members or the general community.

9. Providers shall not target individuals and families who are already enrolled in other managed care plans.

**Inducements to Enroll**

1. Providers may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, providers may only:
   a. make reference in advertising and outreach materials and activities to benefits/services offered under the program; and
   b. offer only nominal gifts, with a fair market value of no more than $5, with such gifts being offered regardless of beneficiary's intent to enroll.

2. Providers shall not pay any individual, or accept payment from a Medicaid MCO, any commission, bonus, or similar compensation that uses numbers of Medicaid-eligible persons enrolled in the managed care plan as a factor in determining compensation.

**Appendix IV-B — Medicare Marketing Guidelines**

The term “provider” means all Medicare health plan-contracting healthcare delivery network members (e.g., physicians, hospitals, etc.) The purpose of this section is to specify what marketing practices in this area meet both CMS requirements and the needs of the Medicare health plans with respect to entities considered providers by Medicare health plans.

CMS holds health plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Therefore, Healthfirst must ensure that any providers contracted (and its subcontractors, including providers or agents) comply with the CMS marketing requirements.

Healthfirst (and subcontractors, including contracted providers or agents) is prohibited from steering or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, based on the financial interest of the provider or agent (or their subcontractors or agents).

Providers are limited to assisting beneficiaries with enrollment or education. Assisting with enrollment means discussing characteristics of various plans based solely on the potential enrollee’s needs. Plan sponsors are held responsible for comparative/descriptive materials developed and distributed on their behalf by providers.

CMS is concerned with provider marketing for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary’s provider.

A provider may face conflicting incentives when acting as a plan sponsor representative since he/she knows the patient's health status. The desire to either reduce out-of-pocket costs for their sickest patients or to gain financially by enrolling their healthy patients may result in recommendations that do not address all of the concerns or needs of a potential Medicare health plan member.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their healthcare options.

Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
• Accepting enrollment applications for Medicare Advantage (MA)/Medicare Advantage Part D (MA-PD) plans or Prescription Drug Plans (PDPs).

• Directing, urging, or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.

• Mailing marketing materials on behalf of plan sponsors.

• Offering anything of value to induce plan enrollees to select them as their provider.

• Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.

• Health screening and distributing information to patients are prohibited marketing activities.

Participating providers and contractors are permitted to do the following:

• Provide the names of plan sponsors with which they contract and/or participate.

• Provide information and assistance in applying for Medicare Extra Help, the Medicare Part D Low Income Subsidy program.

• Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contract all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, providers are permitted to:

  • Provide objective information on plan sponsors’ specific plan formularies, based on a particular patient’s medications and healthcare needs. Provide objective information on plan sponsors’ specific plan formularies, based on a particular patient’s medications and healthcare needs.

  • Provide objective information regarding plan sponsors’ plans, including information such as covered benefits, cost sharing, and utilization management tools.

  • Make available and/or distribute plan marketing materials, including PDP enrollment applications but not MA or MA-PD enrollment applications, for all plans with which the provider participates.

  • To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.

  • Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS’s website at www.medicare.gov or 1-800-MEDICARE.

  • Print out and share information with patients from CMS’s website.

The “Medicare and You” Handbook or “Medicare Options Compare” (www.medicare.gov) may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.

There are some permissible delegated provider marketing activities. The following are requirements associated with provider activities:
1. **Plan Activities and Materials in the Healthcare Setting** – While providers are prohibited from accepting enrollment applications in the healthcare setting, plans or plan agents may conduct sales presentations and distribute and accept enrollment applications in healthcare settings so long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

   a. Plans are prohibited from conducting sales presentations and distributing and accepting enrollment applications in areas where patients primarily intend to receive healthcare services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

   **Please note:** Upon request by the beneficiary, plans are permitted to schedule appointments with beneficiaries residing in long-term care facilities just as with other individuals.

2. **Provider Affiliation Information** – Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., publicity, radio, television). An announcement to patients of a new affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail and/or email. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located on the premises of the provider must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS.

   **Please note:** Materials that indicate the provider has an affiliation with certain plans and lists only plan names and/or contact information do not require CMS approval.

3. **Comparative and Descriptive Plan Information** – Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of different plans (all or a subset) with which they contract. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (i.e., these items are not subject to File & Use Certification). The plans must determine a lead plan to coordinate submission of these materials. CMS continues to hold the plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers may not health screen when distributing information to their patients, as health screening is a prohibited marketing activity.

   **Please note:** Plans may not use providers to distribute printed information comparing the benefits of different plans unless providers accept and display materials from all plans in the service area and contract with the provider.

4. **Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party** – Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party.

5. **Providers/Provider Group Websites** – Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative,
providers may include a link to the CMS Online Enrollment Center.

Medicare Marketing Guidelines for Medicare Advantage Plans Specific Guidance about Provider Promotional Activities (Sections 70.11.1; 70.11.2 and 70.11.5) July 2, 2015.

A full copy of the most current Medicare Marketing Guidelines is available on the Centers for Medicare & Medicaid Services (CMS) website at [www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html](http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html)
Appendix V — Medical Record Standards

Healthfirst providers are required to maintain member medical records in a manner that is current, detailed, organized, and comprehensive and that permits effective patient care and quality review. All medical records MUST include the following:

1. Patient’s name and ID number on each page.
2. Personal biographical data, including the patient’s date of birth, address, employer, home and work telephone numbers, and marital status.
3. A Problem List that is updated regularly to reflect current medications, significant illnesses, surgeries, and medical conditions.
4. Medication/food allergies and adverse reactions must be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this must be appropriately noted in the record.
5. Patient’s medical history (for patients seen three (3) or more times) must be easily identifiable and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), medical history relates to prenatal care, birth, operations, and childhood illnesses.
6. For patients 13 years and older, an appropriate notation concerning the use of cigarettes, alcohol, and illegal substances and a substance abuse history.
7. The history and physical exam identify appropriate subjective and objective information pertinent to the patient’s presenting complaints and must be updated annually.
8. Laboratory and other studies are ordered as appropriate and results are included with the chart.
9. Working diagnoses are consistent with findings, and treatment plans are consistent with diagnoses.
10. Encounter forms or notes have a notation regarding follow-up care, calls, or visits. The specific time of the return is noted in weeks, months, or as needed.
11. Unresolved problems from previous office visits are addressed in subsequent visits.
12. If a consultation is requested, there is a note or letter from the consultant in the medical record.
13. Consultation, lab, and imaging reports filed in the chart must be initialed by a physician to signify review. Review and signature by a professional other than a physician, such as a nurse or physician assistant (PA), does not meet this requirement. If the reports are presented electronically or by some other method, there must also be indication of physician review. Consultations, abnormal lab, and imaging study results must have an explanation in the record of follow-up plans.
14. There is an up-to-date immunization record for children (a note stating “immunizations up to date” is not acceptable). For adults, an appropriate history notation must be made in the medical record.
15. There is evidence that preventive services and risk screening are offered, in accordance with Healthfirst’s practice guidelines.
16. Evidence of reporting of public health cases (e.g., STDs, TB, lead poisoning, domestic violence, etc.) to appropriate public health agencies is documented in the record.
17. A record of all emergency room (ER) visits and hospitalizations should be maintained in the medical record. If the provider receives a written notice regarding a member’s ER visit/hospitalization from a Medical Management Care Manager, a copy of such notice should be made part of the member’s medical record and a note documenting the member’s present condition relative to the ER visit/hospitalization must be included on the Progress Note.
18. All entries are signed, stamped, or otherwise indicate the author’s identity. All entries by a resident or PA are cosigned by an attending physician.
19. All entries are dated.

20. The record is legible to someone other than the writer. (A second reviewer will examine any record judged to be illegible by the first reviewer.)

21. A Behavioral Health Screening Tool must be used to assess the mental health of PHSP Medicaid members, as appropriate.

22. The member’s written consent to disclose personal health information (PHI) to Healthfirst.

23. Documentation of the risks of treatment versus no treatment for specific problems has been explained to the member.

24. Evidence of continuity and coordination of care between primary and specialty providers.

25. Documentation of prescriptions given, including drug name, dose, and date of initial and refill prescription.

26. Documentation of a discussion about Advance Directives for HFHP Medicare members.
Appendix VI — Healthcare Proxy
Health Care Proxy Form Instructions

**Item (1)**
Write the name, home address and telephone number of the person you are selecting as your agent.

**Item (2)**
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

**Item (3)**
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

**Item (4)**
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent’s authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

*If I become terminally ill, I do/don’t want to receive the following types of treatments....*

*If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don’t want the following types of treatments....*

*If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don’t want the following types of treatments....*

*I have discussed with my agent my wishes about... and I want my agent to make all decisions about these measures.*

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

**Item (5)**
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

**Item (6)**
You may state wishes or instructions about organ and/or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent’s agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor’s death.

**Item (7)**
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.
Health Care Proxy

(1) I, ____________________________, hereby appoint ____________________________,
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint ____________________________,
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent’s authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.
(5) **Your Identification (please print)**

Your Name ____________________________________________________________

Your Signature ______________________________________ Date _____________

Your Address __________________________________________________________

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ______________________________________

☐ Limitations __________________________________________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ______________________________________ Date _____________

(7) **Statement by Witnesses** *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date ____________________________ Date ____________________________

Name of Witness 1
(print) __________________________ Name of Witness 2
(print) __________________________

Signature ________________________ Signature ________________________

Address __________________________ Address __________________________

_________________________________
## Appendix VII — Preventive Care

### Appendix VII-A — Preventive Care Standards and Required Documentation

<table>
<thead>
<tr>
<th>Preventive Care Service</th>
<th>Standard</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood and Adolescent Immunizations</strong></td>
<td>Complete immunizations on or before the child’s 2nd birthday: 4 – DTaP/DTP 3 – IPV 3 – Hib 3 – Hep B 4 – PCV 1 – MMR 1 – VZV 2 or 3 – Rotavirus 1 – Hep A 2 – Influenza</td>
<td>When information is obtained from the patient’s history, the medical record documentation must include: • Dated immunization history OR note indicating name of specific antigen and date of immunization When entries are made at the time of the immunization, documentation must include: • Name of specific antigen • Date of immunization(s) A certificate of immunization from an authorized provider or agency must include: • Specific date of immunization(s) • Type of immunization(s) given All entries must be dated by the child’s 2nd birthday. A note that the patient is up-to-date with all immunizations is not sufficient documentation.</td>
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<td></td>
<td>Complete immunizations on or before child’s 13th birthday: 1 – MCV4 or MPSV4 (on or between 11th and 13th birthdays) 1 – Tdap or Td (on or between 10th and 13th birthdays)</td>
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<td></td>
<td>Complete immunizations on or between the female adolescent’s 9th and 13th birthdays: 3 – HPV vaccinations</td>
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<td><strong>Lead Screening</strong></td>
<td>All children should have at least one lead capillary or venous blood test on or before the child’s second birthday.</td>
<td>Any medical record documentation, including lab slips, must include all of the following: • Child’s name • Child’s date of birth (age is not sufficient) • Date blood test was performed • Result of test Results of erythrocyte protoporphyrin testing are unacceptable.</td>
</tr>
<tr>
<td><strong>Well-Child Visits in the 1st 15 Months of Life</strong></td>
<td>Patients who turned 15 months during the reporting year should have at least six (6) well-child visits conducted during the first 15 months of life.</td>
<td>Documentation must include a note indicating a visit with a PCP, the date on which the well-child visit occurred, and evidence of all the following: • A health history</td>
</tr>
</tbody>
</table>
### Well-Child Visits in the 3rd, 4th, 5th, and 6th Year of Life

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation Must Include:</th>
</tr>
</thead>
</table>
| At least one (1) well-child visit with a PCP during the measurement year for all patients who were 3–6 years of age as of December 31st of the measurement year. | A note by the PCP  
• Date of the well-child visit  
• Health history  
• A physical developmental history  
• A mental developmental history  
• A physical exam  
• Health education/anticipatory guidance |

### Adolescent Well-Care Visits

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation Must Include:</th>
</tr>
</thead>
</table>
| At least one (1) comprehensive well-care visit with a PCP or OB/GYN for all patients 12–21 years old by December 31st of measurement year. | A note by the PCP  
• Date of the well-care visit  
• A health history  
• A physical developmental history  
• A mental developmental history  
• A physical exam  
• Health education/anticipatory guidance |

### Adolescent Screening & Counseling

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation in the Medical Record Must Include:</th>
</tr>
</thead>
</table>
| Adolescents 12–17 years old who receive comprehensive well-care visit with a PCP or OB/GYN should have the following seven components of preventive care during the measurement year:  
1. BMI screening/percentile  
2. Nutrition  
3. Physical activity/exercise  
4. Sexual activity & preventive actions  
5. Depression  
6. Risks of tobacco usage  
7. Risks of substance abuse (including alcohol and drugs) | BMI calculation/percentile or graph (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old)  
• Notation of assessment, counseling, or education on both nutrition & exercise  
• Notation of assessment, counseling, or education on physical activity/exercise  
• Notation of assessment, counseling, or education on preventive actions and risk behaviors associated with sexual activity  
• Notation of an assessment for depression  
• Notation of assessment, counseling, or education about the risks of tobacco use  
• Notation of assessment, counseling, or education about risk behaviors associated with substance abuse (including alcohol and drugs) |
| **Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents** | Children 3–17 years old who had an outpatient visit with a PCP or OB/GYN should have evidence of the following: 1. BMI screening/percentile 2. Nutrition counseling 3. Physical activity counseling | Documentation in the medical record must include:  
- BMI percentile documentation (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old)  
- Notation of counseling on nutrition  
- Notation of counseling on physical activity |

| **Annual Dental Visit** | Children 2-21 years of age should have at least one dental visit during the measurement year. 2. | Documentation in the medical record must include:  
- Oral health risk assessments to identify known risk factors |

| **Appropriate Testing for Children with Pharyngitis** | For children 2–18 years of age, a strep test/throat culture should be performed when a diagnosis of pharyngitis is made and antibiotics are prescribed. | Documentation in the medical record must include:  
- Date the strep test/throat culture was performed and the result  
- Additional diagnosis (if any) during the same date of service |

| **Appropriate Treatment for URI** | Antibiotics should not be prescribed for patients aged 3 months to 18 years with a diagnosis of URI. | Documentation in the medical record must include additional diagnosis (if any) during the same date of service |

| **Follow-Up Care for Children Prescribed ADHD Medication** | Children 6–12 years old who are prescribed ADHD medications should have at least 3 outpatient follow-up visits after the initial prescription: 1. 1 follow-up visit within 30 days 2. 2 follow-up visits within 2 to 9 months after the initial prescription (one can be a telephone visit) | Documentation in the medical record must include the date on which the follow-up care occurred |

| **Follow-up after Hospitalization for Mental Illness** | Patients 6 years of age and older who were hospitalized during the year for mental health disorders should have follow-up visits by a mental health provider within 7 and 30 days of hospital discharge. | Documentation in the medical record must include:  
- Date of follow-up visit  
- Documentation that visit was with a mental health provider |

| **Adult BMI Assessment** | Patients 18–74 years old who had an outpatient visit should have evidence of BMI screening performed | Documentation in the medical record must include the BMI value and weight for members 18 years and older |

<p>| <strong>Prenatal and Postpartum Care</strong> | Prenatal Care: initial visit must be | Documentation in the medical record must include: |</p>
<table>
<thead>
<tr>
<th>Type of Screening</th>
<th>Frequency of Screening</th>
<th>Medical Record Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Screening in Women</td>
<td>Sexually active women age 16–24 years old should be screened for chlamydia once a year.</td>
<td>Medical record documentation must include both:</td>
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<tr>
<td></td>
<td></td>
<td>• Date the test was performed</td>
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<td></td>
<td></td>
<td>• Result of test</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>For women age 21–64 years – 1 or more cervical cytology tests at least once every 3 years. For women age 30–64 years of age – 1 or more cervical cytology and HPV co-testing at least once every five years.</td>
<td>Medical record documentation must include both:</td>
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<td></td>
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<td>• Date cervical cytology and HPV test were performed</td>
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<tr>
<td></td>
<td></td>
<td>• Result of test(s)</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>Women age 50–74 should have a mammogram at least once every two years.</td>
<td>Medical record documentation must include both:</td>
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<tr>
<td></td>
<td></td>
<td>• Date the mammogram was performed</td>
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<td></td>
<td></td>
<td>• Results of procedure</td>
</tr>
<tr>
<td>Colorectal Screening</td>
<td>Patients age 50–75 should have 1 or more screening(s) done: 1. Fecal occult blood (FOB) in the year 2. Flexible sigmoidoscopy in the last 5 years 3. Colonoscopy in the last 10 years</td>
<td>Documentation in the medical record must include both:</td>
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<td>• A note indicating the date the colorectal cancer screening was performed; and</td>
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<td>• The results or finding</td>
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<tr>
<td>Comprehensive Diabetes Care</td>
<td>For patients age 18–75 with diabetes: 1. 1 or more HbA1c test(s) in the year. Result should be &lt; 7 % 2. A screening for diabetic retinal disease in the year for members with diabetic retinopathy and every 2 years for members without diabetic retinopathy by an optometrist or ophthalmologist 3. Annual nephropathy screening a. Therapy with ACE inhibitor/ARB b. A test for microalbuminuria or documentation of existing macroalbuminuria or nephropathy 4. Blood pressure control (&lt; 140/90</td>
<td>Medical record documentation must include all of the following:</td>
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<tr>
<td></td>
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<td>• Note that the HbA1c, nephropathy screening, dilated retinal eye exam, and BP check were performed</td>
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<td>• Date performed</td>
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<td></td>
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<td>• Result of the test</td>
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</table>
| **Controlling High Blood Pressure** | Document BP reading every visit for patients 18 years old and over. BP reading is considered controlled:  
- 18-59 years old whose BP was <140/90 mm Hg.  
- 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.  
- 60-85 years of age without a diagnosis of diabetes whose BP <150/90 | Documentation in the medical record must include both:  
- Date the visit occurred  
- BP reading |
| **Avoidance of Antibiotic in Acute Bronchitis** | Antibiotics should not be prescribed for patients ages 18–64 years with a diagnosis of acute bronchitis. | Documentation in the medical record must include additional diagnosis or comorbidities (if any) during the same date of service |
| **Antidepressant Medication Management** | Patients 18 years of age and older with a diagnosis of major depression must remain on medication for a minimum of 84 days and optimally at least 180 days. | Documentation in the medical record must include both:  
- Date of follow-up visit to a mental health provider  
- Name and dose of the prescribed antidepressant |
| **Care for Older Adults** | Patients 65 years old and older should receive the following:  
1. Advance care planning  
2. Medication review  
3. Functional status assessment  
4. Pain assessment | Documentation in the medical record must include evidence of:  
- Advance care planning  
- Medication list and review  
- Functional status assessment  
- Pain assessment |
| **Medication Reconciliation** | Patients 65 years old and older should have medication reconciled within 30 days of discharge. | Documentation in the medical record must include medications prescribed at discharge or a notation that no medications were prescribed. |
| **Influenza Vaccine** | Patients 18 years of age and over or those with chronic illnesses or weak immune systems should receive an annual flu vaccine during the months of July to December. | Medical record documentation must include both:  
- Date of administration  
- Specific antigen OR documentation of contraindication or patient refusal |
| **Pneumococcal vaccine** | Patients 65 years of age and over or those with chronic illnesses or weak immune systems should receive a pneumococcal vaccine at least once in their lifetime. | Medical record documentation must include both:  
- Date of administration  
- Specific antigen OR documentation of contraindication or patient refusal |
| HIV/AIDS Comprehensive Measures | All patients ages 2 and older with a diagnosis of HIV/AIDS should receive the following: 1. Engaged in Care – 2 outpatient visits for physician services of primary care or HIV-related care, on 2 different dates of service occurring at least 182 days (6 months) apart within the measurement year 2. Viral Load Monitoring – 2 viral load tests conducted on different dates of service at least 6 months apart within the measurement year 3. Syphilis Screening Rate – 1 syphilis screening test performed within the measurement year for members 19 years or older | Medical record documentation must include: • Date of outpatient visits for physician services • Date the test was performed for viral load monitoring and syphilis screening • Results of tests |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | Members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received spirometry testing to confirm the diagnosis. | Medical record documentation must include: • Date of test • Result of test |
| Osteoporosis Management in Women | Women 67-85 years of age who suffered a fracture and who had to either a bone mineral density test or prescription for a drug to treat osteoporosis in the six months after the fracture. | Medical record documentation must include: • Date of test and result or • Name of prescription to treat osteoporosis |
| DMARD for Rheumatoid Arthritis | Members who with a diagnosis of rheumatoid arthritis need to be on a disease-modifying anti-rheumatic drug (DMARD). | Medical record documentation must include: Name of prescription to treat rheumatoid arthritis. |

*Please refer to NYSDOH website for further info/additional requirements.

Appendix VII-B — Child/Teen Health Plan (C/THP) Guidelines and Immunization Schedule

The matrix displayed below generally follows recommendations of the Committee on Standards of Child Healthcare of the American Academy of Pediatrics. The contents of each exam are the recommended standards for the specific age of the child/teenager and do not preclude providers from performing additional tests if indicated. A star indicates the age at which each component of the exam should be performed.
<table>
<thead>
<tr>
<th>Section</th>
<th>s</th>
<th>4</th>
<th>5</th>
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<tr>
<td>HISTORY – Initial/Interval</td>
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<tr>
<td>COUNSELING and EDUCATION</td>
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<td>IMMUNIZATIONS (See Guidelines) (3)</td>
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<td>SCREENING – GENERAL</td>
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<td>Hereditary/Metabolic Screening</td>
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<td>HISTORY – Initial/Interval</td>
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<td>SENSORY SCREENING – Sight &amp; Hearing</td>
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<td>DEVELOPMENTAL &amp; BEHAVIORAL ASSESSMENT</td>
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<td>DENTAL CARE</td>
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<td>IMMUNIZATION (See Guidelines)</td>
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</table>
At each visit, a complete physical exam is essential, with infants totally unclothed, older children undressed or suitably dressed.

1. Scheduling a visit to the dentist is recommended within six (6) months of the eruption of the first tooth and no later than the child’s first (1st) birthday, then 2 times a year thereafter.

2. See guidelines for immunization.

3. At first encounter, obtain results of newborn screening tests for all children born in New York State.

4. Performed during the 9th- to 10th-month visit and then repeated during the 23rd- to 25th-month visit (2 tests by age 2 years). All menstruating adolescents should be screened annually.

5. Testing should be done upon recognition of high-risk factors.

6. Regardless of exposure risk, all children must be screened with a blood lead test at or around 12 months and 24 months of age. Elevated blood lead levels require evaluation and referral for appropriate follow-up services.

7. Performed if family history is positive for early cardiovascular disease or hyperlipidemia.

8. Conduct dipstick urinalysis for leukocytes for male and female adolescents.

9. Screen at least annually if sexually active.

10. Screen if high-risk for infection. Provide age and developmentally appropriate education/prevention, as well as confidential HIV counseling, testing, and supportive services.

11. Screen females annually if sexually active or if 18 years or older.

12. Should have physician exam with periodic health exam and be taught to do monthly breast self-examinations.

Sources: NYS Chapter 6 – Operational Protocol (Child/Teen Health Plan), Guidelines for Adolescent Preventive Services.

The U.S. Preventive Services Task Force, American Academy of Pediatrics and American Dental
Association, Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed.

Appendix VII-C — Guidelines for Adolescent Preventive Services (GAPS)

The recommendations for GAPS emphasize annual clinical preventive services visits that address both the developmental and psychosocial aspects of adolescent health, in addition to traditional biomedical conditions. These recommendations were developed by the AMA, with contributions from a Scientific Advisory Panel comprising national experts, as well as representatives of primary care medical organizations and the health insurance industry. The body of scientific evidence indicated that the periodicity and content of preventive services can be important in promoting the health and well-being of adolescents.

Preventive Health Service by Age and Procedure

<table>
<thead>
<tr>
<th>Age of Adolescent</th>
<th>Early</th>
<th>Middle</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
<td>11</td>
<td>12</td>
<td>13</td>
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<tr>
<td>Health guidance</td>
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<tr>
<td>Parenting***</td>
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<td>Development</td>
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<tr>
<td>Diet and physical activity</td>
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<tr>
<td>Healthy lifestyles**</td>
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<tr>
<td>Injury prevention</td>
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<tr>
<td>Screening history</td>
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<tr>
<td>Eating disorders</td>
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<tr>
<td>Sexual activity***</td>
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<td>*</td>
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<tr>
<td>Alcohol &amp; other drug use</td>
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<tr>
<td>Tobacco use</td>
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<td>Abuse</td>
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<td>School performance</td>
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<td>Depression</td>
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<td>Risk for suicide</td>
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<td>Physical Assessment</td>
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<td>Blood pressure</td>
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<td>TB</td>
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<td>Pap smear</td>
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<tr>
<td>Immunizations</td>
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</table>
1. Screening test performed once if family history is positive for early cardiovascular disease or hyperlipidemia

2. Screen if positive for exposure to active TB or lives/works in high-risk situation; e.g., homeless shelter, healthcare facility

3. Screen at least annually if sexually active

4. Screen if high risk for infection

5. Screen annually if sexually active or if 18 years or older.

6. Vaccinate if high risk for hepatitis B infection.

7. Vaccinate if at risk for hepatitis A infection.

8. Vaccinate if no reliable history of chicken pox.

9. * Adolescents should have a complete physical examination during three of these preventive services visits. One should be performed during early adolescence (age 11-14), one during middle adolescence (age 15-17), and one during late adolescence (age 18-21), unless more frequent examinations are warranted by clinical signs or symptoms.

10. ** Includes counseling regarding sexual behavior and avoidance of tobacco, alcohol, and other drug use.

11. *** Includes history of unintended pregnancy and STD.

12. **** A parent health guidance visit is recommended during early and middle adolescence.

13. -+- Do not give if administered in last five years.

**Appendix VII-D — Primary Care Provider Behavioral Health Screening Tool**

**This questionnaire is intended exclusively as a screening device and is NOT a substitute for a complete Behavioral Health evaluation and assessment. All answers will remain confidential.**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Over the past month, have you had decreased interest or pleasure in doing things that you usually enjoy?</td>
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</tbody>
</table>
2A. Over the past month, have you been feeling down or depressed?
2B. If yes, rate your mood most of the time over the past month, on a scale of 1 to 10 (1 = worst, 10 = best mood)
3. Over the past month, has there been a change in your sleeping or eating habits or energy level, without any obvious explanation?
4. Do you ever think about harming yourself or feel you might be better off dead?
5. Over the past month have you experienced feelings of helplessness, hopelessness, or worthlessness?

6A. Over the past month, have you often felt very nervous or anxious or have you been worrying about things for no good reason?
6B. If yes, rate how anxious or nervous you felt most of the time, on a scale of 1 to 10 (1 = highly anxious, 10 = relaxed).
7. In the past month, have you had an anxiety attack (suddenly felt fear or panic)?
8. Over the past month, have you ever had recurrent thoughts or rituals that interfere with your daily activities or make them difficult to complete?

9A. Have you ever felt you ought to cut down on your drinking?
9B. Have people annoyed you by criticizing your drinking?
9C. Have you ever felt bad or guilty about your drinking?
9D. Have you ever felt had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

10A. Do you ever use illegal drugs?
10B. Approximately how often?
10C. What kind of drugs do you use?
11. Has drinking or drug use ever interfered with work, home, school, or family responsibilities?

12A. In the last three months, have you done any of the following to avoid gaining weight?
12B. Intentionally made yourself vomit?
12C. Taken laxatives regularly or excessively?
12D. Fasted for over 24 hours, for no other reason?
12E. Exercised excessively, for more than an hour at a time?
13A. In the past three months, have you ever had an episode of binge eating?
13B. If yes, approximately how many episodes have you experienced?
13C. Approximately how often have you experienced them?

14. Over the past month, has there ever been a time when you heard voices when no one else was around or seen things that no one else saw?
15. During the past month, have you ever had thoughts or feelings that someone wanted to hurt you or is out to get you?
16. Do you believe that you have any special powers?
Primary Care Provider Behavioral Health Screening Tool Scoring Guide

Questions 4 and 14, if answered in the affirmative, require immediate referral for urgent or emergent evaluation.

Section I
Depression questions 1–5:

Any three (3) or more questions answered in the affirmative or any two (2) or more questions answered in the affirmative with a mood severity rating of < 4 should be referred for further evaluation.

Section II
Anxiety/Panic/OCD questions 6–8:

Any two (2) questions or more answered in the affirmative or any one (1) question answered in the affirmative with an anxiety severity rating of < 4 should be referred for further evaluation.

Section III
Substance & Alcohol Use/Abuse questions 9–11:

Any two (2) or more questioned answered in the affirmative should be referred for further evaluation. Referral should also be made based on the severity assessment screening questions.

Section IV
Eating Disorders questions 12–13:

Any three (3) or more questions (question 12 counts as 4 questions) answered in the affirmative should be referred for further evaluation. Referral should also be made based on the severity assessment screening questions.

Section V
Perceptual Abnormalities/Psychotic Symptoms questions 14–16*:

Any two (2) or more questions answered in the affirmative should be referred for further evaluation.

If the total number of questions answered in the affirmative is equal to or greater than 10, regardless of the distribution/specific question answered or the severity reported, the patient should be referred for further evaluation.

Appendix VII-E Healthfirst Wellness Reward Card - PHSP

The Healthfirst Wellness Reward Card Program is a way for Healthfirst members to earn rewards for taking care of themselves. The program is available to Healthfirst Medicaid and Child Health Plus members. Members can qualify for reward cards by completing selected preventive screenings and health initiatives, such as well child visits, health risk assessments, mammograms, medication adherence and colorectal screenings. Members can fill out a form and mail or fax the form back to Healthfirst. Providers must submit the correct claims in order for the members to be approved for a reward card.

Please click these links to download the Reward Card form -

2015 PHSP Reward Card Form_English.pdf
Appendix VII-F Healthfirst Wellness Reward Card - Medicare

The Healthfirst Wellness Reward Card Program is a way for Healthfirst members to earn rewards for taking care of themselves. The program is available to Healthfirst Medicare members. Members can qualify for reward cards by completing selected preventive screenings and health initiatives, such as health risk assessments, flu shot, medication adherence and colorectal screenings. Members can fill out a form and mail or fax the form back to Healthfirst. Providers must submit the correct claims in order for the members to be approved for a reward card.

Please click these links to download the Reward Card form -

2015 Medicare Reward Card Form_English.pdf
2015 Medicare Reward Card Form_Spanish.pdf
2015 Medicare Reward Card Form_Chinese.pdf
## Appendix VIII — Description of Skilled Nursing Services

### Units = 15 Minutes

<table>
<thead>
<tr>
<th>Level of Care/Bill Codes</th>
<th>Skilled Nursing</th>
<th>Rehabilitation</th>
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<tbody>
<tr>
<td><strong>1. Level 1</strong>&lt;br&gt;Skilled Nursing Care&lt;br&gt;Bill Code: 191</td>
<td>1–4 hours skilled nursing per day</td>
<td>Up to 1.5 hrs. multidiscipline therapies per day; min. 5 days per week</td>
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<tr>
<td><strong>2. Level 2</strong>&lt;br&gt;Rehabilitation Therapy&lt;br&gt;Bill Code: 192</td>
<td>Over 4 and up to 6 hours skilled nursing per day</td>
<td>Between 1.5–3 hrs. multidiscipline therapies per day; min. 5 days per week</td>
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<tr>
<td><strong>3. Level 3</strong>&lt;br&gt;Subacute Skilled Care Nonweanable Ventilator Management&lt;br&gt;Bill Code: 193</td>
<td>More than 6 hours of skilled nursing per day</td>
<td>Between 3-6 hrs. multidiscipline therapies per day; min 5 days per week</td>
</tr>
<tr>
<td><strong>4. Level 4</strong>&lt;br&gt;Weanable Ventilator Management&lt;br&gt;Bill Code: 194</td>
<td>3–6 hours skilled nursing per day</td>
<td>More than 6 hrs. multidiscipline therapies per day; min. 5 days per week</td>
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</table>

### Inclusions
- Semi-private room
- Administration of drugs and biologicals
- Routine medications, including intramuscular (IM) medications and supplies (see exclusions)
- Nutrition services, including enteral and parental supplies
- Registered nurse onsite availability 24 hours a day
- Nursing and personal care, including assistance in activities of daily living
- Rehabilitation services: physical, speech, and occupational therapy
- Attending physician services
- Routine admission diagnostic radiology
- Lab services based on medical necessity or diagnosis/physician plan care
- Basis equipment, medical supplies, and appliances
- Supervision of the use of durable medical equipment, assistive devices and, prescribed therapies
- Recreational therapies
- Social work and psychological services
- Routine dental services
- Maintenance of patient room cleanliness
- Other services or furnishings related to the basic room, board, and care of the patient
- Discharge planning

### Exclusions
- Specialty consults (except when consult is included in specific level of care)
- Hemo and peritoneal dialysis
- Blood and blood products
- Enteral and TPN solutions
- Transportation
- Specialty equipment, supplies, wheelchairs, appliances, and beds
- Nonroutine radiology (including MRI, CT scan, PET scan)
- All of the foregoing excluded services must be precertified by a case manager or designated representative. In the event that there is a question concerning the need for treatment, the matter shall be referred to the Managed Care Organization
- Drugs exceeding $50 per day on average are excluded from the per diem and must be purchased through the MCO’s designated pharmacy network or contracted provider(s) of infusion therapy services
Appendix IX — Healthfirst Transportation

Appendix IX-A — Provider Approval Form

Instruction: This form should be completed and signed by the provider responsible for the physical or behavioral health of the Healthfirst member indicated below. If the member requires medically necessary, non-emergency taxi, ambulette, or ambulance transportation to and from medical services, please fax a completed form to Member Services at 1-212-801-3250.

Date: ____________________  
Member Name: ____________________  CIN Number: ____________________  
Required Mode of Transportation:  Taxi/Livery ☐  Ambulette ☐  Ambulance ☐  Other: ____________________

Extent for Requirement: No. Trips: _______-and- From: ___________ Thru: ___________  
MM/DD/YY  MM/DD/YY

Medical Justification (please indicate diagnosis and why it prevents member from using public transportation):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other Assistance Required: ☐ Wheelchair  ☐ Stretcher  ☐ Other: ____________________

Comments: ____________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Provider Signature  
Phone Number  
Date

Provider Name (please print)  
Healthfirst ID #  
Hospital Affiliation

COMPLETED FORMS:  Healthfirst Member Services Transportation  
P.O. Box 5165  
New York, NY 10274  
Fax: 1-212-801-3250  
Phone: 1-866-463-6743

Appendix IX-B — Member Transportation

Non-emergency transportation is available by calling LogistiCare at 1-877-564-5922. If possible, you should call LogistiCare at least three days before your medical appointment and provide the appointment date, time,
address, and the provider’s name. Non-emergency transportation includes personal vehicle, bus, taxi, ambulette, and public transportation.

For Nassau and Suffolk County members: Non-emergency transportation arrangements can be provided and arranged by Healthfirst by calling Member Services at 1-866-463-6743.

Appendix IX-C — Non-emergent Transportation Services Policy – Livery and Ambulette

Healthfirst members must call LogistiCare to arrange taxi or ambulette transportation, see chart below for reference.

<table>
<thead>
<tr>
<th>NYC, Nassau and Suffolk Medicaid Members:</th>
<th>Medicare Members:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LogistiCare</td>
<td>Healthfirst Member Services</td>
</tr>
<tr>
<td>Monday through Friday</td>
<td>7 days a week</td>
</tr>
<tr>
<td>7am–6pm</td>
<td>8am–8pm</td>
</tr>
<tr>
<td>1-877-564-5922</td>
<td>1-888-260-1010</td>
</tr>
<tr>
<td></td>
<td>TTY English: 1-866-288-3133</td>
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<tr>
<td></td>
<td>TTY English: 1-888-542-3821</td>
</tr>
<tr>
<td></td>
<td>TTY Spanish: 1-888-867-4132</td>
</tr>
</tbody>
</table>

NYC, Nassau and Suffolk Medicaid and Essential Plan Members

Non-emergency transportation is now provided by LogistiCare. Transportation services can be scheduled by calling 1-877-564-5922. If possible, services should be scheduled three days before member’s medical appointment and provide the appointment date, time, address, and the provider name. Non-emergency transportation includes personal vehicle, bus, taxi, ambulette, and public transportation.

Who is eligible for transportation services?

Livery Service

- Medicaid members who lives in NYC and Long Island (Nassau and Suffolk counties).
- Medicare members receive limited routine transportation benefits as described in the Evidence of Coverage.

Ambulette Service

- All Medicaid members in NYC and Long Island (Nassau and Suffolk counties) are eligible for ambulette service if they have disabilities or medical conditions that prevent them utilizing public transportation or livery services. Approval from the member’s physician is required.

*Medicare members are NOT eligible for ambulette service.*

Special Program for Medicaid Members – Through LogistiCare

Free car service is available to qualified Healthfirst Medicaid members who need the following services:

- Prenatal visits (only if first trimester of pregnancy [0 to 3 months pregnant]; first prenatal visit within 42 days [6 weeks] of enrollment with Healthfirst).
- Postpartum visit; (only if within 21 to 56 days [3 to 8 weeks] after delivery).
- Well-child and immunizations
a. Offered for members from 0 to 24 months old (total of 6 round trips)
b. 2 weeks after birth
c. 6 weeks after birth
d. One (1) round trip every two (2) months thereafter for a maximum of six (6) round trips
Appendix X — Medicare Member Reimbursement Form
# Healthfirst Medicare Plan
## Member Reimbursement Form

Here are some helpful hints on how to complete this form:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1</strong></td>
<td>Member Information</td>
</tr>
<tr>
<td>-</td>
<td>Write your member ID# found on your ID card.</td>
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<tr>
<td>-</td>
<td>Write your name as shown on your ID card (First Name, Last Name).</td>
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<tr>
<td>-</td>
<td>Write your mailing address.</td>
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<tr>
<td>-</td>
<td>Write your telephone number in case we need to reach you to verify any information you have provided.</td>
</tr>
<tr>
<td><strong>Section 2</strong></td>
<td>Reimbursement Information</td>
</tr>
<tr>
<td>-</td>
<td>Write the amount to be reimbursed.</td>
</tr>
<tr>
<td><strong>Section 3</strong></td>
<td>Reason for Reimbursement Request</td>
</tr>
<tr>
<td>-</td>
<td>Select the reason for your reimbursement request. You may submit only one reimbursement request at a time.</td>
</tr>
<tr>
<td>-</td>
<td>If you do not see your type of request listed, please give us a detailed description in the box listed as “Other”.</td>
</tr>
<tr>
<td><strong>Section 4</strong></td>
<td>Attached Supporting Documentation</td>
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<td>-</td>
<td>Check the type of supporting documentation (receipt) you will be attaching with your form.</td>
</tr>
<tr>
<td><strong>Section 5</strong></td>
<td>Member Attestation</td>
</tr>
<tr>
<td>-</td>
<td>Sign and date your form to certify that the information on the form and that the documents attached are accurate and complete.</td>
</tr>
<tr>
<td>-</td>
<td>If you are not the member and are signing this form, we may request that you send us your contact information.</td>
</tr>
</tbody>
</table>

Don’t forget to attach your receipt when you submit this form. If you have any questions or need additional help with filling this form, please call our Member Services department at **1-888-260-1010**, Monday–Sunday, 8:00am–8:00pm. If you need an interpreter, please call our Member Services department at **1-888-260-1010**, Monday–Sunday, 8:00am–8:00pm, TDD/TTY English 1-888-542-3821, TDD/TTY Español 1-888-867-4132. If you require in-person assistance with filling out this form, you may contact Member Services for the nearest Community Office location.
Healthfirst Medicare Plan
Member Reimbursement Form

Here are some helpful hints on how to complete this form:

Section 1  Member Information

- Write your member ID# found on your ID card.
- Write your name as shown on your ID card (First Name, Last Name).
- Write your mailing address.
- Write your telephone number in case we need to reach you to verify any information you have provided.

Section 2  Reimbursement Information

- Write the amount to be reimbursed.

Section 3  Reason for Reimbursement Request

- Select the reason for your reimbursement request. You may submit only one reimbursement request at a time.
- If you do not see your type of request listed, please give us a detailed description in the box listed as “Other”.

Section 4  Attached Supporting Documentation

- Check the type of supporting documentation (receipt) you will be attaching with your form.

Section 5  Member Attestation

- Sign and date your form to certify that the information on the form and that the documents attached are accurate and complete.
- If you are not the member and are signing this form, we may request that you send us your contact information.

Don’t forget to attach your receipt when you submit this form. If you have any questions or need additional help with filling this form, please call our Member Services department at 1-888-260-1010, Monday–Sunday, 8:00am–8:00pm. If you need an interpreter, please call our Member Services department at 1-888-260-1010, Monday–Sunday, 8:00am–8:00pm, TDD/TTY English 1-888-542-3821, TDD/TTY Español 1-888-867-4132. If you require in-person assistance with filling out this form, you may contact Member Services for the nearest Community Office location.
Appendix XI — Preauthorization Guidelines by Service Type

Appendix XI-A — Preauthorization Guidelines for Healthfirst Medicaid, Child Health Plus, Medicare, and CompleteCare Plans

Preauthorization is not a guarantee of payment. The member’s eligibility determines benefits. Policies are subject to change. Written formal referrals are not required for all Healthfirst plan in-network providers. Members should always be referred and receive care from in-network specialists.

Please contact Medical Management for prior authorization questions at the number listed on the attached grids.
Pre-authorization guidelines by service type for Medicaid, CHP, FHP, and Medicare Plans – authorization requests should be made directly to Healthfirst Medical Management 1.888.394.4327.

<table>
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<th>Services That Require Prior Authorization</th>
<th>Medicaid</th>
<th>FHP</th>
<th>CHP</th>
<th>65 Plus Plan</th>
<th>Increased Benefits Plan</th>
<th>Coordinated Benefits Plan</th>
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Preauthorization is not a guarantee of payment. Payment by Healthfirst for services provided is contingent upon the member’s active membership in Healthfirst at the time of service or when treatment was rendered. Policies are subject to change.

For preauthorization for the services listed above or to notify Healthfirst of an admission, contact the Medical Management department at 1-888-394-4327.

For advance imaging and radiology preauthorization, please contact CareCore at 1-877-773-6964.

For preauthorization of surgical procedures of the eye, please contact Block Vision at 1-877-773-6964.

For information on chiropractic services, please contact ASH at 1-800-972-4226.

For pharmacy authorizations, please contact CVS Caremark at 1-800-294-5979.

Appendix XI-B — Preauthorization Guidelines – Leaf Plan

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<td>Dialysis</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>DME and Breast Pump Rental</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>EMG/Nerve Conduction Study</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Habilitation Services – Physical, Occupational, and Speech Therapy</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Hearing Aid and Cochlear Implants</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Hospice Care – Inpatient and Outpatient</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Inpatient Hospital Services and Facility</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Rehabilitation Services (Physical, Occupational, and Speech Therapy) – Inpatient and Outpatient</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Insulin Pump</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Interruption of Pregnancy (Abortion)</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Mental Health and Substance Use Services – Admissions and the following outpatient services:</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>ECT, Neuropsychological Testing, Partial Hospital Program, Intensive Outpatient Treatment, and Day Treatment require preauthorization. Authorization for traditional in-network outpatient behavioral health services provided by Healthfirst providers is not required.</td>
<td></td>
</tr>
<tr>
<td>Non-emergency Ambulance Services</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Outpatient Hospital Services and Surgery</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Prosthetic (External and Internal)</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Transplant</td>
<td>Preauthorization Required</td>
</tr>
</tbody>
</table>

Preauthorization is not a guarantee of payment. Payment by Healthfirst for services provided is contingent upon the member's active membership in Healthfirst at the time of service or when treatment was rendered. Policies are subject to change.

- For preauthorization for the services listed above or to notify Healthfirst of an admission, contact the Medical Management department at **1-888-394-4327**.
- For advance imaging and radiology preauthorization, please contact CareCore at **1-877-773-6964**.
- For preauthorization of surgical procedures of the eye, please contact Block Vision at **1-877-773-6964**.
- For information on chiropractic services, please contact ASH at **1-800-972-4226**.
- For pharmacy authorizations, please contact CVS Caremark at **1-800-294-5979**.
### Appendix XII — Clinical Practice Guidelines

#### 2015 Clinical Practice Guidelines and Protocols

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Clinical Practice Guideline</th>
<th>Source</th>
</tr>
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<tbody>
<tr>
<td><strong>Respiratory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
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</tr>
<tr>
<td>Chronic Stable Coronary Artery Disease</td>
<td>College of Cardiology Foundation for Health Care Improvement Partnership® (PCPI™) ACCF, AHA, PCPI Approved January 2011</td>
<td>American Medical Association <a href="http://www.ama-assn.org/ama1/pub/upload/mm/pfcci/pcpi/administerjune06.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/pfcci/pcpi/administerjune06.pdf</a></td>
</tr>
<tr>
<td>Condition</td>
<td>Reference</td>
<td>Organization</td>
</tr>
<tr>
<td>--------------------------------</td>
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<tr>
<td><strong>Coronary Heart Disease (CHD)</strong></td>
<td>CCF Secondary Prevention and Risk Management From the American Heart and American College of Cardiology</td>
<td>American Heart Association</td>
</tr>
<tr>
<td><strong>Hyperlipidemia</strong></td>
<td>C/AHA Guideline on the Treatment of Atherosclerotic Vascular Risk in Adults: A Report of the College of Cardiology/American Heart on Task Force on Practice Guidelines</td>
<td>American Heart Association</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>Evidence-Based Guideline for the Management of High Blood Pressure in Adults from the Panel Members Appointed to the Joint National Committee (JNC 8)</td>
<td>Journal of the American Medical Association</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>American Diabetes Association Standards of Care in Diabetes – 2015</td>
<td>American Diabetes Association</td>
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<tr>
<td><strong>Attention Deficit Hyperactivity Disorder (ADHD)</strong></td>
<td>American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td><strong>Depression</strong></td>
<td>American Psychiatric Association</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td>Reference</td>
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<tr>
<td><strong>Preventive and Screening Guidelines</strong></td>
<td></td>
<td><strong>Preventive and Screening Guidelines</strong></td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>New York State Department of Health Care Standard, March 2015</td>
<td><a href="http://www.health.state.ny.us/health_care/medicaid/standardsprenatal_care/">www.health.state.ny.us/health_care/medicaid/standardsprenatal_care/</a></td>
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**Antibiotic Use**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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<tr>
<td>Principles of Appropriate Antibiotic Use Summary: An Information Sheet</td>
<td><a href="http://www.cdc.gov/getsmart/campaign-materials/info-sheets/adult-approp-summary.pdf">Centers for Disease Control and Prevention</a></td>
<td></td>
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<tr>
<td>June 2012</td>
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**Sexually Transmitted Diseases**

|---|---|---|

**HIV**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Primary Care Approach To The HIV-Infected Patient; updated November 2014</td>
<td><a href="http://www.cdc.gov/std/tg2015/default.htm">New York City STD Treatment Guidelines Tables for Adults &amp; Adolescents, updated 2013</a></td>
<td></td>
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**Obesity**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Committee Recommendations on the Prevention, Prevention and Treatment of Childhood Overweight and Obesity: January 2013</td>
<td><a href="http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee">AHA/ACC/TOS</a></td>
<td></td>
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<tr>
<td>Adult</td>
<td><a href="http://circ.ahajournals.org/content/early/2013/11/11/01.cir.000437739.71477.ee">AHA/ACC/TOS</a></td>
<td></td>
</tr>
<tr>
<td>A/ACC/TOS Guideline for the Treatment of Overweight and Obesity in Adults</td>
<td></td>
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<tr>
<td>of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Guidelines Committee</td>
<td></td>
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</table>

**Low Back Pain**

<table>
<thead>
<tr>
<th>Low Back Pain</th>
<th><a href="http://annals.org/article.aspx?articleid=736814">American College of Physicians</a></th>
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<tbody>
<tr>
<td>Diagnosis and Treatment of Low Back Pain: A Clinical Practice Guideline from the American College of Physicians and the American Pain Society: October 2007</td>
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**Rheumatoid Arthritis**

<table>
<thead>
<tr>
<th>Rheumatoid Arthritis</th>
<th><a href="http://onlinelibrary.wiley.com/doi/10.1002/acr.21641/epdf">American College of Rheumatology</a></th>
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<tr>
<td>Date of the 2008 American College of Rheumatology Recommendations for the Use of modifying Antirheumatic Drugs and Agents in the Treatment of Rheumatoid Arthritis</td>
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</table>

**Long Term Care**

<table>
<thead>
<tr>
<th>Long Term Care</th>
<th><a href="http://www.amda.com/tools/clinical/toccpg.pdf">American Medical Directors Association</a></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions of Care in the Long-Term Care Setting, Clinical Practice Guideline. Columbia, MD 2010.</td>
<td></td>
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</tbody>
</table>

**Reference**

<table>
<thead>
<tr>
<th>Reference</th>
<th><a href="http://www.mckesson.com">McKesson</a></th>
<th></th>
</tr>
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<tr>
<td>Clinical Care Criteria for Payors</td>
<td></td>
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</tbody>
</table>
** New guideline for adoption
* Updated guidelines

QIC Approved 6.24.2015
Appendix XIII-A — Notice Of Medicare Noncoverage

Patient Name:

The Effective Date Coverage of Your Current Services Will End:

☐ • Your Medicare health plan and/or provider have determined that Medicare probably will not pay for your current services after the effective date indicated above.

☐ • You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

• You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.

• If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.

• If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

• If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  o Neither Medicare nor your plan will pay for these services after that date.

• If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

• You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.

• Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.

• The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.

• Call your QIO at: Livanta, 1-866-815-5440, TTD/TTY: 1-866-868-2289 to appeal, or if you have questions.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you have Original Medicare: Call the QIO listed on page 1.
If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Healthfirst Medicare Plan
Appeals & Grievances Unit
P.O. Box 5166
New York, NY 10274-5166T
Telephone: 1-877-779-2959
TDD/TTY: 1-888-542-3821

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative ________________________________ Date __________

Appendix XIII-B — Important Information for Healthfirst Medicare Plan Members’ Appeal Rights

Healthfirst Medicare Plan
100 Church Street,
New York, NY 10007

If a member does not agree with a decision made by Healthfirst Medicare Plan, the member or the member’s
representative has the right to request a reconsideration. If the member believes that his/her health or ability to function could be seriously harmed by waiting 30 days for a service-related standard appeal, he/she may request an expedited 72-hour appeal. Healthfirst will decide if your request meets the requirements under Medicare guidelines. If not, the appeal will be processed under the standard 30-day appeal process.

**To request an expedited 72-hour appeal (does not apply to denials of payment):**

<table>
<thead>
<tr>
<th>Telephone</th>
<th>1-877-779-2959</th>
<th>Fax</th>
<th>1-646-313-4618</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail</td>
<td>Healthfirst Appeals Unit P.O. Box 5166 New York, NY 10274</td>
<td>Visit</td>
<td>Healthfirst 100 Church Street New York, NY 10007</td>
</tr>
</tbody>
</table>

**To request a 30-day service-related appeal or a 60-day payment-related appeal:**

A member can file a service-related appeal, which will be processed within 30 days, or a payment-related appeal, which will be processed within 60 days. The appeal can be submitted verbally or in writing.

In addition, the member may also file such appeal with the Department of Health and Human Services or the Railroad Retirement Board if the member is a railroad annuitant. Your request will be transferred to Healthfirst for processing.

**Help With Your Appeal**

Assistance with an appeal request is available at the New York City Department for the Aging, Health Insurance Information, Counseling and Assistance Program (HIICAP) Helpline at 1-212-442-1382; the Medicare Rights Center at 1-888-466-9050 (1-888-HMO-9050); Elder Care Locator at 1-800-677-1116; or you can contact 1-800-633-4227 (1-800-MEDICARE), 24 hours/7 days. TTY/TDD users should call 1-877-486-2048.

**14-Day Extension**

An extension up to 14 calendar days is permissible for both 30-day and 72-hour appeals, if the extension of time benefits the member; for example, if the member needs time to provide Healthfirst with additional information or if Healthfirst needs to have additional diagnostic tests completed.

Healthfirst will make a decision on the appeal and notify the member of it within 30 days for a standard appeal or within 72-hours for an expedited appeal from the date it is received. However, if our decision is not fully favorable, we will automatically forward the member appeal request to the Centers for Medicare & Medicaid Services’ contractor, as well as the Center for Health Dispute Resolution (The Center), for an independent review. The Center will notify the member of its decision within the same time frames required of Healthfirst. An extension of up to 14 calendar days is also permitted under certain circumstances.

**Appendix XIII-C — Standard Description and Instructions for Healthcare Consumers to Request an External Appeal**

New York State law ensures you the right to an external appeal when healthcare services are denied by your HMO or insurer (health plan) on the basis that the services are not medically necessary or that the services are experimental or still under investigation by the AMA.

To request an external appeal you must complete the application form and send it to the Department of Financial Services within four (4) months of receipt of said notice of final adverse determination from your health plan in the first (1st) level of the plan’s internal appeal process or within four (4) months of receiving written confirmation from your health plan that the internal appeal process has been waived. If all applicable items have not been completed, your request will not be accepted.
What is an External Appeal?

An external appeal is a request that you make to the state for an independent review of a denial of services by your health plan.

Reviews are conducted by external appeal agents who are certified by the state and have a network of medical experts to review your health plan’s denial of services.

You must complete the attached application and submit the application to the Department of Financial Services to request an external appeal.

Eligibility for an External Appeal

To be eligible for an external appeal: You must have received a final adverse determination as a result of your health plan’s internal utilization review appeal process, or you and your health plan must have agreed to waive that appeal process. A final adverse determination is written notification from your health plan that your healthcare service has been denied through the plan’s appeal process. If your health plan offers two (2) levels of internal appeals, a final adverse determination is the determination of the first (1st) level appeal.

If you and your health plan agree to waive the internal appeal process, the health plan must confirm the agreement in writing. You must request an external appeal within four (4) months from receipt of a notice of final adverse determination from your health plan or within four (4) months of receiving written confirmation from your health plan that the internal appeal process has been waived. If your plan had two (2) levels of internal appeals, you must file a request for an external appeal within four (4) months of your receipt of the notice of final determination from the plan’s first (1st) level appeal process to be eligible for an external appeal.

If services are denied as experimental, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal, and your attending physician must complete the attached Attending Physician Attestation form and send the form to the Department of Financial Services.

You may only appeal a service or procedure that is a covered benefit under your contract. The external appeal process may not be used to expand the coverage of your contract.

Your health plan cannot be a self-insured plan. The state does not have jurisdiction over self-insured plans. Your employer can tell you if your plan is self-insured. The appeal cannot be for workers’ compensation claims or for claims under no-fault auto coverage.

What Happens if My Health Plan Offers a Second (2nd) Level of Internal Appeal?

You will not be required to seek a second level of internal appeal with your health plan in order to request an external appeal.

If you seek a second level of internal appeal with your health plan, you may not have time to request an external appeal. You must request an external appeal within 45 days of receiving the determination from your health plan’s first level of internal appeal.

Am I Eligible for an External Appeal if I am Covered by Medicare or Medicaid?

You are not eligible for this external appeal process when Medicare is your only source of health services. If you have coverage under Medicare, you must file a complaint with the federal government for denials of services. Questions concerning Medicare coverage should be directed to the Centers for Medicare & Medicaid Services at 1-800-MEDICARE (1-800-633-4227).

If you have coverage under Medicare and Medicaid, this external appeal process may be used solely to appeal denials of services or treatments covered by Medicaid.

If you have Medicaid coverage you may also request a fair hearing. If you have requested an external appeal and a fair hearing, the determination in the fair hearing process will be the one that applies. If
you have questions about the fair hearing process you should contact the New York State Department of Health at 1-800-774-4241.

Eligibility for an Expedited (fast-tracked) External Appeal

If your attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to your health, you may request an expedited appeal. When requesting an expedited appeal, make sure you give the attending physician an attestation from your primary care doctor to complete. Your appeal will not be forwarded to the external appeal agent until your physician sends this attestation to the Department of Financial Services.

How Long Will an External Appeal Take?

Expedited appeals: The external appeal agent must make a determination within three (3) days of receiving your request for an external review from the state.

Standard appeals: When your appeal is not expedited, the external appeals agent must make a determination within 30 (thirty) days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five (5) additional business days to make a determination.

The Cost to you for an External Appeal

Your health plan may charge you a fee of up to $50 for an external appeal.

If you have coverage under Medicaid, CHPlus, or your health plan determines that the fee will pose a hardship, you will not be required to pay a fee.

If your health plan does require a fee, you must submit the fee with your application for an external appeal. If you fax your application to the Department of Financial Services, you must send the fee within three (3) business days to the Department of Financial Services. If the fee is not sent to the Department of Financial Services within this timeframe, the external appeals agent will suspend review of your appeal until payment is received.

Only checks or money orders, made payable to your health plan, will be accepted.

If the external appeal agent overturns your health plan’s determination, the fee will be refunded to you.

When Information May Be Submitted to the External Appeals Agent

If your case is determined to be eligible for external review, you and your health plan will be notified of the certified external appeals agent assigned to review your case.

Your health plan must send your medical and treatment records to the external appeal agent.

When the external appeals agent reviews your case, the agent may request additional information from you or your doctor. This information should be sent to the external appeals agent immediately.

You and your doctor can submit information even when the external appeals agent has not requested specific information. You must submit this information within 45 days from when your health plan made a final adverse determination or from when you and your health plan agreed to waive the internal appeal process.

It is important to send this information immediately. Once the external appeals agent makes a determination or once your 45 days’ time period ends, you will be unable to submit additional information.

What Happens When an External Appeals Agent Makes a Decision?

Expedited appeals: If your appeal was expedited, you and your health plan will be notified immediately by telephone or fax of the external appeal agent’s decision. Written notification will follow.

Standard appeals: If your appeal was not expedited, you and your health plan will be notified in writing within two business days of the external appeals agent’s decision.
The decision of the external appeals agent is binding on you and your health plan.

If you have any questions, please contact the Department of Financial Services at 1-800-400-8882 or the New York State Department of Health at 1-800-774-4241, or visit http://www.dfs.ny.gov/insurance or www.health.state.ny.us.

Appendix XIII-D — Attending Physician’s Attestation for a Patient’s External Appeal

(To be completed by the attending physician.)

Right to an External Appeal:

Patients may request an external appeal when an HMO or insurer has denied healthcare services on the basis of medical necessity or because services were considered experimental or investigational. Patients must request an external appeal within four (4) months of receiving a final adverse determination. Providers must file an external appeal within 60 days of the initial adverse determination.

The attending physician must complete this attestation and immediately fax it to the Department of Financial Services, at 1-800-332-2729, in order for a patient to be eligible for an expedited or standard external appeal of an experimental or investigational determination or for an expedited external appeal of a medical necessity determination.

I Instructions

1. Items II, III, and V must be completed for all external appeal requests. In addition, item IV must be completed when services have been denied as being experimental or investigational.

II General Information

2. Name of attending physician completing this form:

   __________________________________________________________

   “Attending physician” is defined as a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's/insured's life-threatening or disabling condition or disease. This physician is the one who recommended the service or treatment that is the subject of this request. For members who have HMO coverage without an out-of-network option, the attending physician must either participate in the member's health plan or must be a provider to whom the member’s health plan referred the member.

3. Address: __________________________ (city) __________________________ (state) __________________________ (zip)

4. Contact Person: __________________________

5. Phone Number: (____)____________________ Fax Number: (____)____________________

6. Name of Patient: __________________________

7. Patient’s Health Plan Member ID Number: __________________________

III Expedited Request for an External Review

8. A delay in providing the recommended health service would pose an imminent or serious threat to the health of the patient; therefore, an expedited determination (within three [3] days of the request) is necessary (please check one):

   __________________________ YES             __________________________ NO

IV To Request External Review of Experimental or Investigational Treatment Determinations
9. I hereby attest that (select a or b):
   a. _____ The patient has a life-threatening condition or disease which has a high probability of causing death.
   OR
   b. _____ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or who, in case of a child under the age of eighteen (18), suffers from any medically determinable physical or mental impairment of comparable severity.

10. AND for which (please check one):

   [  ] Standard health services or procedures have been ineffective or would be medically inappropriate.

   [  ] There does not exist a more beneficial standard health service or procedure covered by the patient’s health plan.

   [  ] There exists a clinical trial that is open, that the patient is eligible to participate in, and into which the patient has been or will likely be accepted.

   (Please note: the clinical trial must be a peer-reviewed study plan which has been:
   (1) reviewed and approved by a qualified institutional review board; and
   (2) approved by either of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the Federal Department of Veterans Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has multiple project assurances approved by the Office of Protection from Research Risks of the National Institutes of Health. The term “cooperative groups” means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups; the NCI Community Clinical Oncology Program; the AIDS Clinical Trial Groups; and the Community Programs for Clinical Research in AIDS.)

11. AND (select a or b):

   a. __________ I have recommended a health service or procedure or a pharmaceutical product that, based on the following two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service or procedure.

      Citation #1 (Describe the medical and scientific evidence relied upon, as defined below, and include publication name, issue number, and date, if available.)
      Attach a copy of the document.

      Citation #2 (Describe the medical and scientific evidence relied upon, as defined below, and include publication name, issue number, and date, if available.)
      Attach a copy of the document.

   (Please note: medical and scientific evidence means the following sources: (a) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts
who are not part of the editorial staff; (b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board; biomedical compendia; and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research; (c) peer-reviewed abstracts accepted for presentation at major medical association meetings; (d) peer-reviewed literature does not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer; (e) medical journals recognized by the Secretary of Health and Human Services, under section 1861 (t) (2) of the federal Social Security Act; (f) the following standard reference compendia: (i) the American Hospital Formulary Service – Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia- Drug Information; (g) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Healthcare Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Healthcare Financing Administration, Congressional Office Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.)

OR

b. __________ I have recommended a clinical trial that is open, that the patient is eligible to participate in, and into which the patient has been or will likely be accepted.

V Attestation

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

________________________________________________________________________________
Attending Physician’s Name (please print clearly)

________________________________________________________________________________
Signature Date

This application should be faxed to the New York State Insurance Department at 1-800-332-2729. If you have any questions, please contact the Insurance Department at 1-800-400-8882.
Appendix XIII-E — Appointment of Representative Statement and Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0936-0550

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY

MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: ___________________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, ___________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an ___________________________ (PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE

DATE

STREET ADDRESS

PHONE NUMBER (AREA CODE)

CITY

STATE

ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue must complete this section.)

I waive my right to charge and collect a fee for representing ______________________ before the Secretary of the Department of Health and Human Services.

SIGNATURE

DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a providerupplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE

DATE

Form CMS-1096 (07/05)  EF (07/05)
CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE
THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection
with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ)
or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR
§405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is
considered to be before the Secretary after the remand by the court.

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be
completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before
DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the
Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount
must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1)
rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court
has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3)
in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she
may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the
form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed
before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In
approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the
case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the
results achieved, the level of administrative review to which the representative carried the appeal and the amount of the
fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers,
employees and former officers and employees of the United States to render certain services in matters affecting the
Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of
interest are excluded from being representatives of beneficiaries before DHHS.

Appendix XIII-F — Detailed Notice of Discharge

DETAILED NOTICE OF DISCHARGE

OMB Approval No. 0938-1019
DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____________________________. This is based on Medicare coverage policies listed below and your medical condition. This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k).)

  ___ Medicare Managed Care policies, if applicable (check below):

    ___ In response to your diagnosis, your physician developed a comprehensive care plan designed to specifically address your medical condition. Based on your progress and recovery thus far, your physician is confident that a sufficient level of inpatient services have been provided and has not requested additional inpatient days be added to your care plan.

    ___ Per Medicare guidelines, any additional inpatient days would need to be outlined under a plan of care and approved by a physician. As there is no current physician order for additional inpatient days, no additional services will be covered.

  ___ Other

    Specific information about your current medical condition:

    Some or all of the following factors no longer exist:

      ___ Severity of the signs and symptoms exhibited by the patient;

      ___ The medical predictability of something adverse happening to the patient;

      ___ The need for inpatient diagnostic studies;

      ___ Diagnostic and therapeutic services for medical diagnosis, treatment, and care are no longer medically necessary.

If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, or if you need help understanding the content of this notice, please call our Medical Management department at 1-888-394-4327 (TTY 1-800-662-1220), Monday–Friday, 8am–6pm.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Appendix XIII-G — Important Message from Medicare About Your Rights

Department of Health & Human Services
AN IMPORTANT MESSAGE FROM MEDICARE
ABOUT YOUR RIGHTS

As a Hospital Inpatient, you have the right to:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will be responsible for paying for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here {Insert Name and Telephone Number of the QIO}.

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:
Talk to the hospital staff, your doctor, and your managed care plan (if you belong to one) about your concerns.
You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
   If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
   If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
Step-by-step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call ______________________.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date

CMS-R-193 (approved 07/10)
1 of 3
Steps to Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

  Here is the contact information for the QIO:
  
  o QIO Name: ____________________________
  
  o Phone Number: _________________________
  
  o You can file a request for an appeal any day of the week. *Once you speak to someone or leave a message, your appeal has begun.*
  
  o Ask the hospital if you need help contacting the QIO.

  o The name of this hospital is:
    
    Hospital Name: ____________________________
    
    Provider ID Number: _________________________

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information. If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  
  If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon (12pm) of the day after the QIO notifies you of its decision.

If you miss the deadline to appeal, you have other appeal rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  
  If you have Original Medicare: Call the QIO listed above.
  
  If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

**Additional Information:**
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

2 of 3
Notice Instructions: The Important Message From Medicare

Completing the Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient’s full name.

Patient ID Number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the patient’s social security number.

Physician: Fill in the name of the patient’s physician.

B. Body of the Notice

Bullet # 3. Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _______________________.

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date and time to document delivery of the follow-up copy of the IM, or documentation of refusals.

3 of 3
Appendix XIV — Codes, Claims and Reimbursable Services

Appendix XIV-A — Appropriate Codes for Claims/Encounter Data

Reminder ICD10 is here and should be used for all dates of service from October 1, 2015 forward. Visit www.healthfirst.org/ICD10 for resources to ensure your practice is using the correct ICD-10 codes.

Providers should follow all guidelines outlined in Provider Manual Section 16 – Provider Compensation and the Billing and Reimbursement Policies. Adhering to these guidelines ensures prompt and accurate claims payments.

Obstetrical Care: Healthfirst reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and postpartum visits, as well as for delivery. The following CPT-4 codes should be used:

- 59409 – Vaginal Delivery Only
- 59514 – Cesarean Delivery Only
- 59612 – Vaginal Delivery after Previous Cesarean Delivery
- 59620 – Cesarean Delivery after Previous Cesarean Delivery
- 59430 – Postpartum Care (in conjunction with the appropriate pregnancy diagnosis ICD10 code; e.g., Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2)

Cases requiring more than seven (7) prenatal visits or more than one (1) postpartum visit may be subject to retrospective medical record review by the Healthfirst Medical Management department.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appropriate CPT-4 Codes</th>
<th>Appropriate ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRENATAL CARE (Initial visit must be</td>
<td>59425 and 59426 (itemize each date of service), 99201–99205,</td>
<td>Series 009-016, Series 020-026, Series 020-030, Series 040-048</td>
</tr>
<tr>
<td>made in the 1st trimester or within</td>
<td>99211–99215, 99241–99245 with a pregnancy-related diagnosis code</td>
<td>Z codes-Z33.2-Z34.93</td>
</tr>
<tr>
<td>42 days of enrollment with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthfirst)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POSTPARTUM VISITS (Visit must be</td>
<td>59430</td>
<td>Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2</td>
</tr>
<tr>
<td>made between 21 to 56 days after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>delivery)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please verify that the codes you are currently using match those shown above. If you have a billing service, please make them aware that they should use these codes to report prenatal and postpartum services. To report gestational diabetes, use the appropriate ICD10 codes O24.011- O24.919

Family Planning Services: Healthfirst reimburses for family planning services provided to Healthfirst members.

The following CPT/HCPCS/ICD9CM codes are acceptable for billing family planning services: A4260, 11975, 11976, 11977, 55450, 56301, 56302, 57170, 58300, 58301, 58600, 58605, 58611, 58700, 58770, 81025, 84703, 86406, Z30.02, Z31.61, J1050, J1055, J7300.

The following codes are likely to be deemed unacceptable according to New York State’s definition of family planning services: 84235, 89310, 54900, 54901, 55250, 55400, 57700, 57720, 58760, 58321,
58322, 58345, 58740, 58750, 59000, 59012, 59015, 59320, 59325, 74740, 74742, 76857, 84165 V26.0–V26.9.

Please note:

Healthfirst’s Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers.

Healthfirst’s CHPlus and members may obtain family planning and reproductive health services through any in-network CHPlus provider without approval from or notification to Healthfirst or their PCP.

Healthfirst will not pay claims for Healthfirst CHPlus members seeking family planning and reproductive health services from out-of-network providers.

Chlamydia Testing: In accordance with the requirements of the NYSDOH, tests for chlamydia must be coded according to the DNA tests specific for chlamydia. Healthfirst will deny all claims coded with -ICD 10 CM diagnostic code 87797 – DETECT AGENT NOS, DNA, DIR when used for chlamydia testing. Use CPT4 code 87491 for chlamydia screening using urine specimen.

Providers must use these codes for chlamydia testing:

87110 – Chlamydia culture

Chlamydia trachomatis detection by:

87270 – immunofluorescence microscopy
87320 – enzyme immunoassay technique

Chlamydia trachomatis detection by nucleic acid:

87490 – direct probe technique
87491 – amplified probe technique
87492 – quantification
87810 – Chlamydia trachomatis detection by immunoassay with direct optical observation

Venipuncture: Venipuncture for the collection of specimens is considered a bundled service and is NOT separately reimbursable. Venipuncture is the insertion of a needle into a vein in order to obtain a blood sample, start an intravenous infusion, or to give medication. A bundled service is any service essential to the primary procedure and is included in the fee for the primary procedure. Bundled services are not reimbursed separately.

Venipuncture for the collection of specimens shall NOT be reimbursed separately if submitted with a charge for an office visit, hospital or emergency room visit, or in addition to a laboratory test. The reimbursement is considered included in the office visit, or the surgical or laboratory procedure. Healthfirst will automatically deny payment for the venipuncture procedure codes listed below. “ZE”–“Procedure Rebundled” will appear on the EOP.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36400</td>
<td>Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; femoral or jugular vein</td>
</tr>
<tr>
<td>36405</td>
<td>Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; scalp vein</td>
</tr>
<tr>
<td>36406</td>
<td>Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; other vein</td>
</tr>
</tbody>
</table>
Modifier – 25: Modifier – 25 indicates that on the day a procedure or service was performed, the patient required a significant, separately identifiable evaluation and management (E&M) service. The service must have been above and beyond the initial service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

In these instances the provider should bill the E&M code with Modifier – 25. E&M codes should not be billed separately in addition to a CPT-4 procedure code that has been assigned a global period. Medical records should support the use of Modifier – 25. Healthfirst will review E&M codes and will deny such codes billed in addition to procedure codes assigned a global period.

ICD-10: The ICD-10-CM code set has expanded the length of characters (formerly referred to as “digits”) to a maximum of seven (7) characters, as opposed to five characters (digits) in ICD-9-CM. The code structure contains categories, subcategories and codes. All categories are three characters, and the first character of a category is a letter. The second and third characters may be either numbers or alpha categories. A three character category that has no further subdivision is equivalent to a code (I10 – Essential [primary] hypertension). Subcategories are either four (4) or five (5) characters. Subcategory characters may be either letters or numbers. Codes are four, five or six characters and the final character may be either a letter or number. The four (4) character subclass further defines the site, etiology, and manifestation(s) or state(s) of the disease or condition. The fifth (5th) or sixth (6th) character sub-classification represents the most precise level of specificity. Certain ICD-10-CM categories have applicable seven (7) characters. The seventh (7th) character must always be the 7th character in the data field. Example: T50.B96A – Underdosing of other viral vaccines, initial encounter

If a code that requires a 7th character is not 6 characters, a placeholder X (dummy placeholder) must be used to fill in the empty characters. Example: T15.12XS Foreign body in conjunctival sac, left eye, sequela.

As mentioned above, medical records must contain the information to substantiate and support the reported codes.

Sexually Transmitted Diseases

<table>
<thead>
<tr>
<th>STD</th>
<th>Minimum Required Visits</th>
<th>Appropriate CPT-4 Codes</th>
<th>Appropriate ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>Once per year</td>
<td>87110, 87270, 87320, 87490–87492, 87810</td>
<td>Z00.00, Z11.3, Z11.8, Z11.9, Z20.2</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Once per year</td>
<td>87590–87592, 87850</td>
<td>Z00.00, Z11.3, Z11.8, Z11.9, Z20.2</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Once per year</td>
<td>86592, 86593</td>
<td>Z11.3</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Once per year</td>
<td>88141–88158, 87177, 87210, 87211</td>
<td>Z00.00, Z11.3, Z11.8, Z11.9, Z20.2</td>
</tr>
</tbody>
</table>

Well-Child/Adolescent Care
### Required Visits

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>CPT Codes</th>
<th>ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 15 months</td>
<td>6 or more</td>
<td>99381, 99382, 99391, 99392, 99432, 99461, and one of the ICD-9 codes listed in the next column</td>
<td>Z00.00-Z02.9</td>
</tr>
<tr>
<td>3 to 6 years old</td>
<td>Once per year</td>
<td>99382, 99383, 99392, 99393, and one of the ICD-9 codes listed in the next column</td>
<td>Z00.00-Z02.9</td>
</tr>
<tr>
<td>12 to 21 years old</td>
<td>Once per year</td>
<td>99383–99385, 99393–99395, and one of the ICD-9 codes listed in the next column</td>
<td>Z00.00-Z02.9</td>
</tr>
</tbody>
</table>

**Childhood and Adolescent Immunizations**

<table>
<thead>
<tr>
<th>Required Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (4)</td>
<td>90700</td>
</tr>
<tr>
<td>Diphtheria and tetanus</td>
<td>90702</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>90719</td>
</tr>
<tr>
<td>Tdap</td>
<td>90715</td>
</tr>
<tr>
<td>Td</td>
<td>90714, 90718</td>
</tr>
<tr>
<td>Tetanus</td>
<td>90703</td>
</tr>
<tr>
<td>IPV (3)</td>
<td>90713</td>
</tr>
<tr>
<td>DTaP-Hib-IPV</td>
<td>90698</td>
</tr>
<tr>
<td>DtaP-HepB-IPV</td>
<td>90723</td>
</tr>
<tr>
<td>DtaP-Hib</td>
<td>90721</td>
</tr>
<tr>
<td>MMR (1)</td>
<td>90707</td>
</tr>
<tr>
<td>Measles</td>
<td>90705</td>
</tr>
<tr>
<td>Measles &amp; Rubella</td>
<td>90708</td>
</tr>
<tr>
<td>Mumps</td>
<td>90704</td>
</tr>
<tr>
<td>Rubella</td>
<td>90706</td>
</tr>
<tr>
<td>MMRV (Measles/Mumps/Rubella/Varicella)</td>
<td>90710</td>
</tr>
<tr>
<td>HiB (3)</td>
<td>90645, 90646, 90647, 90648</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>90633</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>90740, 90744, 90747</td>
</tr>
<tr>
<td>HepB-Hib</td>
<td>90748</td>
</tr>
<tr>
<td>VZV (1)</td>
<td>90716</td>
</tr>
<tr>
<td>Rotavirus (2 doses)</td>
<td>90681</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>90680</td>
</tr>
<tr>
<td>Human Pappilomavirus Vaccine (HPV)</td>
<td>90650</td>
</tr>
<tr>
<td>PCV Pneumococcal (4)</td>
<td>90669</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>90733, 90734</td>
</tr>
<tr>
<td>Influenza</td>
<td>90655, 90657, 90661, 90662</td>
</tr>
</tbody>
</table>

[Please click here for a complete list of HEDIS eligible codes](#)

### Appendix XIV-B — Reimbursable Services

**In Scope – Effective 01/01/2013.**

The following table lists the CPT-4 Codes and service descriptions that are reimbursable to Healthfirst NY PCPs/FPs and clarifies the reimbursement methodology for each CPT-4 code.
<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Capitated Provider Coverage</th>
<th>FFS Provider Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>INCISION AND DRAINAGE OF ABSCESS (E.G., CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); SIMPLE OR SINGLE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>10061</td>
<td>INCISION AND DRAINAGE OF ABSCESS (E.G., CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); COMPLICATED OR MULTIPLE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>10080</td>
<td>INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>10081</td>
<td>INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>10120</td>
<td>INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>10121</td>
<td>INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11000</td>
<td>DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11042</td>
<td>DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); FIRST 20 SQ CM OR LESS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11043</td>
<td>DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); FIRST 20 SQ CM OR LESS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11045</td>
<td>DEBRIDEMENT SUBCUTANEOUS TISSUE; EACH ADDTL 20 SQ CM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11046</td>
<td>DEBRIDEMENT SUBCUTANEOUS TISSUE &amp; MUSCLE; EACH ADDTL 20 SQ CM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11200</td>
<td>REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND INCLUDING 15 LESIONS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11201</td>
<td>REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL 10 LESIONS, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11300</td>
<td>SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.5 CM OR LESS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11305</td>
<td>SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>11400</td>
<td>EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 0.5 CM OR LESS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>11401</td>
<td>EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11975</td>
<td>INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>11976</td>
<td>REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>12001</td>
<td>SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP,</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Paid at FFS</td>
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<td></td>
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<tr>
<td>12002</td>
<td>SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK, AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.5 CM OR LESS</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>12004</td>
<td>SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK, AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.6 CM TO 7.5 CM</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>12011</td>
<td>SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS, AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS</td>
<td>Paid at FFS</td>
<td></td>
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<tr>
<td>12020</td>
<td>TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; SIMPLE CLOSURE</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>12021</td>
<td>TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; WITH PACKING</td>
<td>Paid at FFS</td>
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<tr>
<td>12031</td>
<td>REPAIR, INTERMEDIATE, WOUNDS OF SCALP, AXILLAE, TRUNK, AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.5 CM OR LESS</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>16000</td>
<td>INITIAL TREATMENT, FIRST DEGREE BURN, WHEN NO MORE THAN LOCAL TREATMENT IS REQUIRED</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>16020</td>
<td>DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT; SMALL (LESS THAN 5% TOTAL BODY SURFACE AREA)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>16025</td>
<td>DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT; MEDIUM (E.G., WHOLE FACE OR WHOLE EXTREMITY, OR 5% TO 10% TOTAL BODY SURFACE AREA)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>16030</td>
<td>DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT; LARGE (E.G., MORE THAN 1 EXTREMITY, OR GREATER THAN 10% TOTAL BODY SURFACE AREA)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>17000</td>
<td>DESTRUCTION (E.G., LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (E.G., ACTINIC KERATOSES); FIRST LESION</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>17003</td>
<td>DESTRUCTION (E.G., LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (E.G., ACTINIC KERATOSES); SECOND THROUGH 14 LESIONS, EACH (LIST SEPARATELY IN ADDITION TO CODE FOR FIRST LESION)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>17004</td>
<td>DESTRUCTION (E.G., LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (E.G., ACTINIC KERATOSES), 15 OR MORE LESIONS</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>17110</td>
<td>DESTRUCTION (E.G., LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT) OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; UP TO 14 LESIONS</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>17250</td>
<td>CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD FLESH, SINUS, OR FISTULA)</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
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<td>Paid at FFS</td>
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<td>-------------</td>
</tr>
<tr>
<td>20000</td>
<td>INCISION SOFT TISSUE ABSCESS SUPERFICIAL</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20550</td>
<td>INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (E.G., PLANTAR “FASCIA”)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20551</td>
<td>INJECTION(S); SINGLE TENDON ORIGIN/INSERTION</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20552</td>
<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20553</td>
<td>INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 3 OR MORE MUSCLE(S)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20600</td>
<td>ARTHROCENTESIS, ASPIRATION, AND/OR INJECTION; SMALL JOINT OR BURSA (E.G., FINGERS, TOES)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20605</td>
<td>ARTHROCENTESIS, ASPIRATION, AND/OR INJECTION; INTERMEDIATE JOINT OR BURSA (E.G., TEMPOROMANDIBULAR, ACROMIOCLAVICULAR, WRIST, ELBOW, OR ANKLE, OLECRANON BURSA)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>20610</td>
<td>ARTHROCENTESIS, ASPIRATION, AND/OR INJECTION; MAJOR JOINT OR BURSA (E.G., SHOULDER, HIP, KNEE JOINT, SUBACROMIAL BURSA)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>26010</td>
<td>DRAINAGE OF FINGER ABSCESS; SIMPLE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>26011</td>
<td>DRAINAGE OF FINGER ABSCESS; COMPLICATED (E.G., FELON)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>29130</td>
<td>APPLICATION OF FINGER SPLINT; STATIC</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>29131</td>
<td>APPLICATION OF FINGER SPLINT; DYNAMIC</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>29550</td>
<td>STRAPPING; TOES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>29580</td>
<td>STRAPPING; UNNA BOOT</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>30300</td>
<td>REMOVAL FOREIGN BODY, INTRANASAL; OFFICE TYPE PROCEDURE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>30901</td>
<td>CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED CAUTERY AND/OR PACKING) ANY METHOD</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>45330</td>
<td>SIGMOIDOSCOPY, FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>46600</td>
<td>ANOSCOPY; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>54150</td>
<td>CIRCUMCISION, USING Clamp OR OTHER DEVICE WITH REGIONAL DORSAL PENILE OR RING BLOCK</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>58300</td>
<td>INSERTION OF INTRAUTERINE DEVICE (IUD)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>58301</td>
<td>REMOVAL OF INTRAUTERINE DEVICE (IUD)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>62270</td>
<td>SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>69200</td>
<td>REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITHOUT GENERAL ANESTHESIA</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>71010</td>
<td>RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>71020</td>
<td>RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>77080</td>
<td>DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>77081</td>
<td>DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81000</td>
<td>URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Included in Cap</td>
<td>Paid at</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>81001</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis; qualitative or semiquantitative, except immunoassays</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis; bacteriuria screen, except by culture or dipstick</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82271</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82272</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1–3 simultaneous determinations, performed for other than colorectal neoplasm screening</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82274</td>
<td>Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1–3 simultaneous determinations</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82465</td>
<td>Cholesterol, serum or whole blood, total</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose; blood, reagent strip</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>83013</td>
<td>Helicobacter pylori (HP); breath test analysis for urease activity</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>83014</td>
<td>HP; drug admin</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>83655</td>
<td>Lead</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun microhematocrit</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>85014</td>
<td>Blood count; hematocrit (HCT)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>85018</td>
<td>Blood count; hemoglobin (HGB)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>85025</td>
<td>Blood count; complete (CBC), automated (HGB, HCT)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>85610</td>
<td>HCT, RBC, WBC AND PLATELET COUNT) AND AUTOMATED DIFFERENTIAL WBC COUNT</td>
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</tr>
<tr>
<td>86317</td>
<td>IMUINOASSAY FOR INFECTIOUS AGENT ANTIBODY, QUANTITATIVE, NOT OTHERWISE SPECIFIED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86403</td>
<td>PARTICLE AGGLUTINATION; SCREEN, EACH ANTIBODY</td>
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</tr>
<tr>
<td>86580</td>
<td>SKIN TEST; TUBERCULOSIS, INTRADERMAL</td>
<td></td>
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<tr>
<td>87110</td>
<td>CULTURE, CHLAMYDIA, ANY SOURCE</td>
<td></td>
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<tr>
<td>87210</td>
<td>SMOER, PRIMARY SOURCE WITH INTERPRETATION; WET MOUNT FOR INFECTIOUS AGENTS (E.G., SALINE, INDIA INK, KOH PREPS)</td>
<td>Included in Cap</td>
<td></td>
</tr>
<tr>
<td>87220</td>
<td>TISSUE EXAMINATION BY KOH SLIDE OF SAMPLES FROM SKIN, HAIR, OR NAILS FOR FUNGI OR ECTOPARASITE OVA OR MITES (E.G., SCABIES)</td>
<td>Included in Cap</td>
<td></td>
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<tr>
<td>87880</td>
<td>INFECTIOUS AGENT ANTIGEN DETECTION BY IMUINOASSAY WITH DIRECT OPTICAL OBSERVATION; STREPTOCOCCUS, GROUP A</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>90460</td>
<td>IMADM &lt;18YR PHYS CNSL1ST NJX PR D</td>
<td>Included in Cap</td>
<td></td>
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<tr>
<td>90461</td>
<td>IMADM &lt;18YR PHYS CNSL EA ADDTL NJX PR D</td>
<td>Included in Cap</td>
<td></td>
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<tr>
<td>90470</td>
<td>IMMUNE ADMIN H1N1 IM/NASAL INCL CNSL</td>
<td>Included in Cap</td>
<td></td>
</tr>
<tr>
<td>90471</td>
<td>IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)</td>
<td>Included in Cap</td>
<td></td>
</tr>
<tr>
<td>90472</td>
<td>IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Included in Cap</td>
<td></td>
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<tr>
<td>90473</td>
<td>IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)</td>
<td>Included in Cap</td>
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<tr>
<td>90474</td>
<td>IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Included in Cap</td>
<td></td>
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<tr>
<td>90476</td>
<td>ADENOVIRUS VACCINE, TYPE 4, LIVE, FOR ORAL USE</td>
<td>Included in Cap</td>
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<tr>
<td>90477</td>
<td>ADENOVIRUS VACCINE, TYPE 7, LIVE, FOR ORAL USE</td>
<td>Included in Cap</td>
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</tr>
<tr>
<td>90581</td>
<td>ANTHRAX VACCINE, FOR SUBCUTANEOUS OR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
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<tr>
<td>90585</td>
<td>BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR TUBERCULOSIS, LIVE, FOR PERCUTANEOUS USE</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>90632</td>
<td>HEPATITIS A VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>90633</td>
<td>HEPATITIS A VACCINE PEDIATRIC 2 DOSE SCHEDULE IM</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>90636</td>
<td>HEPATITIS A AND HEPATITIS B VACCINE (HEPA-HEPB), ADULT DOSAGE, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>90647</td>
<td>HEMOPHILUS INFLUENZA B VACCINE PRP-OMP 3 DOSE IM</td>
<td>Included in Cap</td>
<td></td>
</tr>
<tr>
<td>90648</td>
<td>HEMOPHILUS INFLUENZA B VACCINE PRP-T 4 DOSE IM</td>
<td>Included in Cap</td>
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</tr>
<tr>
<td>90649</td>
<td>HUMAN PAPILLOMA VIRUS VACCINE QUADRIV 3 DOSE IM</td>
<td>Paid at FFS</td>
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<tr>
<td>90650</td>
<td>HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 16,</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<tr>
<td>90655</td>
<td>INFLUENZA VIRUS VACC SPLIT VIRUS FREE 6-35 MO IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90656</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS AND OLDER, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90657</td>
<td>INFLUENZA VIRUS VACCINE SPLIT VIRUS 6-35 MO IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90658</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90660</td>
<td>INFLUENZA VIRUS VACCINE, LIVE, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90662</td>
<td>INFLUENZA VIRUS VACCINE, DERIVED FROM CELL CULTURES, SUBUNIT, PRESERVATIVE AND ANTIBIOTIC FREE, FOR INTRAMUSCULAR USE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90669</td>
<td>PNEUMOCOCCAL CONJ VACCINE 7 VALENT IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90670</td>
<td>PNEUMOCOCCAL CONJUGATE VACCINE, 13 VALENT, FOR INTRAMUSCULAR USE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90680</td>
<td>ROTAVIRUS VACCINE PENTAVALENT 3 DOSE LIVE ORAL</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90691</td>
<td>TYPHOID VACCINE, VI CAPSULAR POLYSACCHARIDE (VICPS), FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90696</td>
<td>DTAP-IPV INACTIVATED IF ADMIN PTS AGE 4–6 YRS IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90698</td>
<td>DTAP-HIB-IPV VACCINE IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90700</td>
<td>DTAP VACCINE &lt; 7 YR IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90702</td>
<td>DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO INDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90703</td>
<td>TETANUS TOXOID ADSORBED INTRAMUSCULAR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90704</td>
<td>MUMPS VIRUS VACCINE LIVE SUBCUTANEOUS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90705</td>
<td>MEASLES VIRUS VACCINE LIVE SUBCUTANEOUS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90706</td>
<td>RUBELLA VIRUS VACCINE LIVE SUBCUTANEOUS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90707</td>
<td>MEASLES MUMPS RUBELLA VIRUS VACCINE LIVE SUBQ</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90710</td>
<td>MEASLES MUMPS RUBELLA VARICELLA VACC LIVE SUBQ</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90713</td>
<td>POLIOVIRUS VACCINE INACTIVATED SUBQ/IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90714</td>
<td>TD TOXOIDS ADSORBED PRSRV FR 7 YR + IM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90715</td>
<td>TDAP VACCINE 7 YR + IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90716</td>
<td>VARICELLA VIRUS VACCINE LIVE SUBQ</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90718</td>
<td>TETANUS &amp; DIPHTHERIA TOXOIDS ADSORBED 7 YR + IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90721</td>
<td>DTAP-HIB VACCINE INTRAMUSCULAR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90723</td>
<td>DTAP-HEPB-IPV VACCINE INTRAMUSCULAR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90732</td>
<td>PNEUMOCOCCAL POLYSAC VACCINE 23-V 2 YR + SUBQ/IM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90733</td>
<td>MENINGOCOCCAL POLYSAC VACCINE SUBCUTANEOUS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90734</td>
<td>MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-135 (TETRAVALENT), FOR INTRAMUSCULAR USE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90736</td>
<td>ZOSTER (SHINGLES) VACCINE, LIVE, FOR SUBCUTANEOUS INJECTION</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90740</td>
<td>HEPATITIS B VACCINE DIALYSIS DOSAGE 3 DOSE IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90743</td>
<td>HEPATITIS B VACCINE, ADOLESCENT (2 DOSE SCHEDULE), FOR INTRAMUSCULAR USE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<tr>
<td>90744</td>
<td>HEPATITIS B VACCINE PEDIATRIC 3 DOSE IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90746</td>
<td>HEPATITIS B VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90747</td>
<td>HEPATITIS B VACCINE DIALYSIS DOSAGE 4 DOSE IM</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90748</td>
<td>HEPB-HIB VACCINE INTRAMUSCULAR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92081</td>
<td>VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; LIMITED EXAMINATION (E.G., TANGENT SCREEN, AUTOPILOT, ARC PERIMETER, OR SINGLE STIMULUS LEVEL AUTOMATED TEST, SUCH AS OCTOPUS 3 OR 7 EQUIVALENT)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92551</td>
<td>SCREENING TEST, PURE TONE, AIR ONLY</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92552</td>
<td>PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92553</td>
<td>PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92567</td>
<td>TYPANOMETRY (IMPEDEANCE TESTING)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92568</td>
<td>ACOUSTIC REFLEX TESTING, THRESHOLD</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>92587</td>
<td>DISTORTION PRODUCT EVOKED OTOACOUSTIC EMISSIONS; LIMITED EVALUATION (TO CONFIRM THE PRESENCE OR ABSENCE OF HEARING DISORDER, 3–6 FREQUENCIES) OR TRANSIENT EVOKED OTOACOUSTIC EMISSIONS, WITH INTERPRETATION AND REPORT</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>93000</td>
<td>ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; WITH INTERPRETATION AND REPORT</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>93005</td>
<td>ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>93010</td>
<td>ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; INTERPRETATION AND REPORT ONLY</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>93040</td>
<td>RHYTHM ECG, 1–3 LEADS; WITH INTERPRETATION AND REPORT</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>93224</td>
<td>EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT, PHYSICIAN REVIEW AND INTERPRETATION</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94010</td>
<td>SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY, EXPIRATORY FLOW RATE MEASUREMENT(S), WITH OR WITHOUT MAXIMAL VOLUNTARY VENTILATION</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94011</td>
<td>MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94012</td>
<td>MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94060</td>
<td>BRONCHODILATION RESPONSIVENESS, SPIROMETRY AS IN 94010, PRE- AND POST-BRONCHODILATOR ADMINISTRATION</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94375</td>
<td>RESPIRATORY FLOW VOLUME LOOP</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>94640</td>
<td>PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION OR FOR SPITUM INDUCTION FOR DIAGNOSTIC PURPOSES (E.G., WITH AN AEROSOL GENERATOR, NEBULIZER,)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Method</td>
<td>Payment Method</td>
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<tr>
<td>94664</td>
<td>DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER, OR IPPB DEVICE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96360</td>
<td>INTRAVENOUS INFUSION, HYDRATION; INITIAL, 31 MINUTES TO 1 HOUR</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96361</td>
<td>INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>96365</td>
<td>INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96366</td>
<td>INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96367</td>
<td>INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL SEQUENTIAL INFUSION OF A NEW DRUG/SUBSTANCE, UP TO 1 HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96372</td>
<td>THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96373</td>
<td>THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRARTERIAL</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96374</td>
<td>THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRAVENOUS PUSH, SINGLE OR INITIAL SUBSTANCE/DRUG</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>96375</td>
<td>THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF A NEW SUBSTANCE/DRUG (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>98925</td>
<td>OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 1–2 BODY REGIONS INVOLVED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>98926</td>
<td>OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 3–4 BODY REGIONS INVOLVED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>98927</td>
<td>OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 5–6 BODY REGIONS INVOLVED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>98928</td>
<td>OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 7–8 BODY REGIONS INVOLVED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>98929</td>
<td>OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 9–10 BODY REGIONS INVOLVED</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99201</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED HISTORY; A PROBLEM-FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
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<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
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<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.</td>
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<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.</td>
<td>Included in Cap</td>
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<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.</td>
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<td>99211</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99212</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED HISTORY; A PROBLEM-FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF-LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Included in Cap</td>
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<td>99213</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
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<td>99214</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
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<td>99215</td>
<td>OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR</td>
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<td>99217</td>
<td>OBSERVATION CARE DISCHARGE DAY MANAGEMENT (THIS CODE IS TO BE UTILIZED BY THE PHYSICIAN TO REPORT ALL SERVICES PROVIDED TO A PATIENT ON DISCHARGE FROM “OBSERVATION STATUS” IF THE DISCHARGE IS ON OTHER THAN THE INITIAL DATE OF “OBSERVATION STATUS.” TO REPORT SERVICES TO A PATIENT DESIGNATED AS “OBSERVATION STATUS” OR “INPATIENT STATUS” AND DISCHARGED ON THE SAME DATE, USE THE CODES FOR OBSERVATION OR INPATIENT CARE SERVICES, [INCLUDING ADMISSION AND DISCHARGE SERVICES, 99234–99236, AS APPROPRIATE.])</td>
<td>Paid at FFS</td>
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<td>99218</td>
<td>INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION TO “OBSERVATION STATUS” ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S HOSPITAL FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99219</td>
<td>INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION TO “OBSERVATION STATUS” ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 50 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S HOSPITAL FLOOR OR UNIT.</td>
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<td>99220</td>
<td>INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE</td>
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<td>99221</td>
<td>INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.</td>
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<td>99222</td>
<td>INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 50 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99223</td>
<td>INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 70 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99224</td>
<td>SBSQ OBS CARE PR D 15 MIN</td>
<td>Paid at FFS</td>
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<td>99225</td>
<td>SBSQ OBS CARE PR D 25 MIN</td>
<td>Paid at FFS</td>
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<td>99226</td>
<td>SBSQ OBS CARE PR D 35 MIN</td>
<td>Paid at FFS</td>
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<td>99231</td>
<td>SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS:</td>
<td>Paid at FFS</td>
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<td>99232</td>
<td>A PROBLEM-FOCUSED INTERVAL HISTORY; A PROBLEM-FOCUSED EXAMINATION; MEDICAL DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS STABLE, RECOVERING, OR IMPROVING. PHYSICIANS TYPICALLY SPEND 15 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99233</td>
<td>SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS RESPONDING INADEQUATELY TO THERAPY OR HAS DEVELOPED A MINOR COMPLICATION. PHYSICIANS TYPICALLY SPEND 25 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99234</td>
<td>OBSERVATION OR INPATIENT HOSPITAL CARE, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, INCLUDING ADMISSION AND DISCHARGE ON THE SAME DATE, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY THE PRESENTING PROBLEM(S) REQUIRING ADMISSION ARE OF LOW SEVERITY.</td>
<td>Paid at FFS</td>
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<td>99235</td>
<td>OBSERVATION OR INPATIENT HOSPITAL CARE, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT,</td>
<td>Paid at FFS</td>
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<td>99236</td>
<td>Observation or Inpatient Hospital Care, for the Evaluation and Management of a Patient, including admission and discharge on the same date, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) requiring admission are of high severity.</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<td>99238</td>
<td>Hospital Discharge Day Management; 30 Minutes or Less</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>99239</td>
<td>Hospital Discharge Day Management; More than 30 Minutes</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>99251</td>
<td>Inpatient Consultation for a New or Established Patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient’s hospital floor or unit.</td>
<td>Paid at FFS</td>
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<tr>
<td>99252</td>
<td>Inpatient Consultation for a New or Established Patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient’s hospital floor or unit.</td>
<td>Paid at FFS</td>
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<td>99253</td>
<td>Inpatient Consultation for a New or Established Patient</td>
<td>Paid at FFS</td>
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<td>99254</td>
<td>INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. Usually, the Presenting Problem(S) Are of Moderate to High Severity. Physicians Typically Spend 80 Minutes at the Bedside and on the Patient’s Hospital Floor or Unit.</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>99255</td>
<td>INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. Usually, the Presenting Problem(S) Are of Moderate to High Severity. Physicians Typically Spend 110 Minutes at the Bedside and on the Patient’s Hospital Floor or Unit.</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>99281</td>
<td>EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED HISTORY; A PROBLEM-FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. Usually, the Presenting Problem(S) Are Self-Limited or Minor.</td>
<td>Yes</td>
<td>Yes</td>
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<td>99282</td>
<td>EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR</td>
<td>Yes</td>
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<td>99283</td>
<td>EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY.</td>
<td>Paid at FFS</td>
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<td>99284</td>
<td>EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.</td>
<td>Paid at FFS</td>
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<td>99285</td>
<td>EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS WITHIN THE CONSTRAINTS IMPOSED BY THE URGENCY OF THE PATIENT’S CLINICAL CONDITION AND/OR MENTAL STATUS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY AND REQUIRE URGENT EVALUATION BY THE PHYSICIAN BUT DO NOT POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.</td>
<td>Paid at FFS</td>
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<tr>
<td>99291</td>
<td>CRITICAL CARE, EVALUATION, AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; FIRST 30–74 MINUTES</td>
<td>Paid at FFS</td>
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<td>99292</td>
<td>CRITICAL CARE, EVALUATION, AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)</td>
<td>Paid at FFS</td>
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<tr>
<td>99304</td>
<td>INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL</td>
<td>Paid at FFS</td>
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<td>99305</td>
<td>DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<tr>
<td>99306</td>
<td>INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 35 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99307</td>
<td>SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED INTERVAL HISTORY; A PROBLEM-FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PATIENT IS STABLE, RECOVERING, OR IMPROVING. PHYSICIANS TYPICALLY SPEND 10 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99308</td>
<td>SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED</td>
<td>Paid at FFS</td>
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<td>New York Provider Manual revision 5/14/19</td>
<td>Page 247</td>
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<td>INTERVAL HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PATIENT IS RESPONDING INADEQUATELY TO THERAPY OR HAS DEVELOPED A MINOR COMPLICATION. PHYSICIANS TYPICALLY SPEND 15 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
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<td>SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PATIENT HAS DEVELOPED A SIGNIFICANT COMPLICATION OR A SIGNIFICANT NEW PROBLEM. PHYSICIANS TYPICALLY SPEND 25 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
<td>Paid at FFS</td>
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<td>99309</td>
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<td>SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE INTERVAL HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. THE PATIENT MAY BE UNSTABLE OR MAY HAVE DEVELOPED A SIGNIFICANT NEW PROBLEM REQUIRING IMMEDIATE PHYSICIAN ATTENTION. PHYSICIANS TYPICALLY SPEND 35 MINUTES AT THE BEDSIDE AND ON THE PATIENT’S FACILITY FLOOR OR UNIT.</td>
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<td>99310</td>
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<tr>
<td>99315 NURSING FACILITY DISCHARGE DAY MANAGEMENT; 30 MINUTES OR LESS</td>
<td>Paid at FFS</td>
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<tr>
<td>99316 NURSING FACILITY DISCHARGE DAY MANAGEMENT; MORE THAN 30 MINUTES</td>
<td>Paid at FFS</td>
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<td>EVALUATION AND MANAGEMENT OF A PATIENT INVOLVING AN ANNUAL NURSING FACILITY ASSESSMENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS OF LOW TO MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PATIENT IS STABLE, RECOVERING, OR IMPROVING. PHYSICIANS TYPICALLY</td>
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<td>99324</td>
<td>DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED HISTORY; A PROBLEM-FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 20 MINUTES WITH THE PATIENT AND/OR FAMILY OR CAREGIVER.</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>99325</td>
<td>DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES WITH THE PATIENT AND/OR FAMILY OR CAREGIVER.</td>
<td>Paid at FFS</td>
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<tr>
<td>99326</td>
<td>DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES WITH THE PATIENT AND/OR FAMILY OR CAREGIVER.</td>
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<td>99327</td>
<td>DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 60 MINUTES WITH THE PATIENT AND/OR FAMILY OR CAREGIVER.</td>
<td>Paid at FFS</td>
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<td>99328</td>
<td>DOMICILIARY OR REST HOME VISIT FOR THE</td>
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<td>99334</td>
<td>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.</td>
<td>Paid at FFS</td>
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<td>99335</td>
<td>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>99336</td>
<td>Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.</td>
<td>Paid at FFS</td>
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<td>99337</td>
<td>Domiciliary or rest home visit for the</td>
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<td>99341</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED HISTORY; A PROBLEM-FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 20 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Paid at FFS</td>
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<td>99342</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Paid at FFS</td>
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<td>99343</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Paid at FFS</td>
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<td>99344</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A</td>
<td>Paid at FFS</td>
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<td>99345</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 75 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Paid at FFS</td>
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<td>99347</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM-FOCUSED INTERVAL HISTORY; A PROBLEM-FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF-LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
<td>Paid at FFS</td>
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<td>99348</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM-FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM-FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
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<td>99349</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 35 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
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<td>99350</td>
<td>HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A \n</td>
<td>COMPREHENSIVE INTERVAL HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE TO HIGH COMPLEXITY. COUNSELING AND/OR \n</td>
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<td>COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S \n</td>
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<td>NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 40 MINUTES FACE-TO-FACE WITH THE PATIENT \n</td>
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<td>AND/OR FAMILY.</td>
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<td>99381</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, \n</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT \n</td>
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<td>(AGE YOUNGER THAN 1 YEAR)</td>
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<td>99382</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, \n</td>
<td>Included in Cap</td>
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<td>COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; EARLY \n</td>
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<td>CHILDHOOD (AGE 1 THROUGH 4 YEARS)</td>
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<td>99383</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, \n</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; LATE \n</td>
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<td>CHILDHOOD (AGE 5 THROUGH 11 YEARS)</td>
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<td>99384</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, \n</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; ADOLESCENT \n</td>
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<td>(AGE 12 THROUGH 17 YEARS)</td>
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<td>99385</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 18–39 YEARS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99386</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 40–64 YEARS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99387</td>
<td>INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 65 YEARS AND OLDER</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99391</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE YOUNGER THAN 1 YEAR)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99392</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; EARLY CHILDHOOD (AGE 1 THROUGH 4 YEARS)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<td>99393</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; LATE CHILDHOOD (AGE 5 THROUGH 11 YEARS)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99394</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; ADOLESCENT (AGE 12 THROUGH 17 YEARS)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99395</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL,</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Included/Paid</td>
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<tr>
<td>99396</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; 18–39 YEARS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99397</td>
<td>PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL, INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; 40–64 YEARS</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99401</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99402</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99403</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 45 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99404</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99406</td>
<td>SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTERMEDIATE, GREATER THAN 3 MINUTES UP TO 10 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99407</td>
<td>SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTENSIVE, GREATER THAN 10 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99411</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99412</td>
<td>PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99460</td>
<td>INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99461</td>
<td>INITIAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT SEEN IN OTHER THAN HOSPITAL OR BIRTHING CENTER</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Method 1</td>
<td>Payment Method 2</td>
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<tr>
<td>99462</td>
<td>SUBSEQUENT HOSPITAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99463</td>
<td>INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT ADMITTED AND DISCHARGED ON THE SAME DATE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99464</td>
<td>ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN) AND INITIAL STABILIZATION OF NEWBORN</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99465</td>
<td>DELIVERY/BIRTHING ROOM RESUSCITATION, PROVISION OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSIONS IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99466</td>
<td>CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR YOUNGER; FIRST 30–74 MINUTES OF HANDS-ON CARE DURING TRANSPORT</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99467</td>
<td>CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR YOUNGER; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99468</td>
<td>INITIAL INPATIENT NEONATAL CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL NEONATE, 28 DAYS OF AGE OR YOUNGER</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99469</td>
<td>SUBSEQUENT INPATIENT NEONATAL CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL NEONATE, 28 DAYS OF AGE OR YOUNGER</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99470</td>
<td>INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99471</td>
<td>SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99472</td>
<td>INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99473</td>
<td>SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99474</td>
<td>INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE NEONATE, 28 DAYS OF AGE OR YOUNGER, WHO REQUIRES INTENSIVE OBSERVATION, FREQUENT INTERVENTIONS, AND OTHER INTENSIVE CARE SERVICES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Details</td>
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<tr>
<td>99478</td>
<td>SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING VERY LOW BIRTH WEIGHT INFANT (PRESENT BODY WEIGHT LESS THAN 1,500 GRAMS)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>99479</td>
<td>SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING LOW BIRTH WEIGHT INFANT (PRESENT BODY WEIGHT OF 1,500–2,500 GRAMS)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>99480</td>
<td>SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING INFANT (PRESENT BODY WEIGHT OF 2,501–5,000 GRAMS)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td><strong>0521F</strong></td>
<td>PLAN OF CARE TO ADDRESS PAIN DOCUMENTED (COA) (ONC)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1125F</strong></td>
<td>PAIN SEVERITY QUANTIFIED; PAIN PRESENT (COA) (ONC)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1126F</strong></td>
<td>PAIN SEVERITY QUANTIFIED; NO PAIN PRESENT (COA) (ONC)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1157F</strong></td>
<td>ADVANCE CARE PLAN OR SIMILAR LEGAL DOCUMENT PRESENT IN THE MEDICAL RECORD (COA)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1158F</strong></td>
<td>ADVANCE CARE PLANNING DISCUSSION DOCUMENTED IN THE MEDICAL RECORD (COA)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1159F</strong></td>
<td>MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1160F</strong></td>
<td>REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTITIONER OR CLINICAL PHARMACIST (SUCH AS PRESCRIPTIONS, OTCS, HERBAL THERAPIES, AND SUPPLEMENTS) DOCUMENTED IN THE MEDICAL RECORD (COA)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>1170F</strong></td>
<td>FUNCTIONAL STATUS ASSESSED (COA) (RA)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td><strong>S0257</strong></td>
<td>COUNSELING AND DISCUSSION REGARDING ADVANCE DIRECTIVES OR END OF LIFE CARE PLANNING AND DECISIONS, WITH PATIENT AND/OR SURROGATE (LIST SEPARATELY IN ADDITION TO CODE FOR APPROPRIATE EVALUATION AND MANAGEMENT SERVICE)</td>
<td>$10.00 Incentive $10.00 Incentive</td>
<td></td>
</tr>
<tr>
<td>83036#</td>
<td>HEMOGLOBIN; GLYCOSYLATED (A1C)</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>D1206</td>
<td>TOP FLUORIDE VARNISH; TX APPL MOD – HI CARIES RISK</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>G0008</td>
<td>ADMINISTRATION OF INFLUENZA VIRUS VACCINE</td>
<td>Included in Cap Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>G0009</td>
<td>ADMINISTRATION OF PNEUMOCOCCAL VACCINE</td>
<td>Included in Cap Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>G0010</td>
<td>ADMINISTRATION OF HEPATITIS B VACCINE</td>
<td>Included in Cap Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>G0179</td>
<td>PHYSICIAN RE-CERTIFICATION FOR Medicare-Covered Home Health Services Under a Home Health Plan of Care (Patient Not Present), Including Contacts with Home Health Agency and Review of Reports of Patient Status Required by Physicians to Affirm the Initial Implementation of the Plan of Care That Meets Patient’s Needs, Per Re-Certification Period</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>G0180</td>
<td>PHYSICIAN CERTIFICATION FOR Medicare-Covered Home Health Services Under a Home Health Plan of Care (Patient Not Present), Including Contacts with Home Health Agency and Review</td>
<td>Paid at FFS</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Paid at FFS</td>
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<tr>
<td>G0182</td>
<td>OF REPORTS OF PATIENT STATUS REQUIRED BY PHYSICIANS TO AFFIRM THE INITIAL IMPLEMENTATION OF THE PLAN OF CARE THAT MEETS PATIENT'S NEEDS, PER CERTIFICATION PERIOD</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>PHYSICIAN SUPERVISION OF A PATIENT UNDER A MEDICARE-APPROVED HOSPICE (PATIENT NOT PRESENT) REQUIRING COMPLEX AND MULTIDISCIPLINARY CARE MODALITIES INVOLVING REGULAR PHYSICIAN DEVELOPMENT AND/OR REVISION OF CARE PLANS, REVIEW OF SUBSEQUENT REPORTS OF PATIENT STATUS, REVIEW OF LABORATORY AND OTHER STUDIES, COMMUNICATION (INCLUDING TELEPHONE CALLS) WITH OTHER HEALTHCARE PROFESSIONALS INVOLVED IN THE PATIENT'S CARE, INTEGRATION OF NEW INFORMATION INTO THE MEDICAL TREATMENT PLAN, AND/OR ADJUSTMENT OF MEDICAL THERAPY, WITHIN A CALENDAR MONTH, 30 MINUTES OR MORE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0250</td>
<td>PHYSICIAN REVIEW, INTERPRETATION, AND PATIENT MANAGEMENT OF HOME INR TESTING FOR PATIENT WITH EITHER MECHANICAL HEART VALVE(S), CHRONIC ATRIAL FIBRILLATION, OR VENOUS THROMBOEMBOLISM WHO MEETS MEDICARE COVERAGE CRITERIA; TESTING NOT OCCURRING MORE FREQUENTLY THAN ONCE A WEEK; BILLING UNITS OF SERVICE INCLUDE 4 TESTS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0270</td>
<td>MEDICAL NUTRITION THERAPY; REASSESSMENT AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), INDIVIDUAL, FACE-TO-FACE WITH THE PATIENT, EACH 15 MINUTES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0271</td>
<td>MEDICAL NUTRITION THERAPY, REASSESSMENT, AND SUBSEQUENT INTERVENTION(S) FOLLOWING SECOND REFERRAL IN SAME YEAR FOR CHANGE IN DIAGNOSIS, MEDICAL CONDITION, OR TREATMENT REGIMEN (INCLUDING ADDITIONAL HOURS NEEDED FOR RENAL DISEASE), GROUP (2 OR MORE INDIVIDUALS), EACH 30 MINUTES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0396</td>
<td>ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST) AND BRIEF INTERVENTION 15 TO 30 MINUTES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0397</td>
<td>ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST) AND INTERVENTION, GREATER THAN 30 MINUTES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0442*</td>
<td>ANNUAL ALCOHOL MISUSE SCREENING, 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0443*</td>
<td>BRIEF, FACE-TO-FACE BEHAVIORAL COUNSELING FOR ALCOHOL MISUSE, 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0444*</td>
<td>ANNUAL DEPRESSION SCREENING, 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0445*</td>
<td>SEMIANNUAL HIGH-INTENSITY BEHAVIORAL COUNSELING TO PREVENT STIS, INDIVIDUAL, FACE-TO-FACE, INCLUDES EDUCATION SKILLS TRAINING &amp; GUIDANCE ON HOW TO CHANGE SEXUAL BEHAVIOR</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Inclusion</td>
<td>Payment Method</td>
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<tr>
<td>G0446*</td>
<td>INTENSIVE BEHAVIORAL THERAPY TO REDUCE CARDIOVASCULAR DISEASE RISK, INDIVIDUAL, FACE-TO-FACE, ANNUAL, 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G0447*</td>
<td>FACE-TO-FACE BEHAVIORAL COUNSELING FOR OBESITY, 15 MINUTES</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>G9141</td>
<td>INFLUENZA A (H1N1) IMMUNIZATION ADMINISTRATION (INCLUDES THE PHYSICIAN)</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>H0001</td>
<td>ALCOHOL AND/OR DRUG ASSESSMENT</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>H0005</td>
<td>ALCOHOL AND/OR DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>H0028</td>
<td>ALCOHOL AND/OR DRUG PREVENTION PROBLEM IDENTIFICATION AND REFERRAL SERVICE (E.G., STUDENT ASSISTANCE AND EMPLOYEE ASSISTANCE PROGRAMS), DOES NOT INCLUDE ASSESSMENT</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>H0047</td>
<td>ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES, NOT OTHERWISE SPECIFIED</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>H0049</td>
<td>ALCOHOL AND/OR OTHER DRUG TESTING: COLLECTION AND HANDLING ONLY, SPECIMENS OTHER THAN BLOOD</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>H0050</td>
<td>ALCOHOL AND/OR DRUG SERVICES, BRIEF INTERVENTION, PER 15 MINUTES</td>
<td>$10.00 Incentive</td>
<td>$10.00 Incentive</td>
</tr>
<tr>
<td>J0290</td>
<td>INJECTION, AMPCILLIN SODIUM, 500 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0295</td>
<td>INJECTION, AMPICILLIN SODIUM/SULBACTAM SODIUM, PER 1.5 GM</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0561</td>
<td>INJECTION, PENICILLIN G BENZATHINE, 100,000 UNITS</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0690</td>
<td>INJECTION, CEFAZOLIN SODIUM, 500 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0696</td>
<td>INJECTION, CEFTRIAXONE SODIUM, PER 250 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0697</td>
<td>INJECTION, STERILE CEFUROXIME SODIUM, PER 750 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J0702</td>
<td>INJECTION, BETAMETHASONE ACETATE 3MG AND BETAMETHASONE SODIUM PHOSPHATE 3MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J1030</td>
<td>INJECTION, METHYPREDNISOLONE ACETATE, 40 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J1040</td>
<td>INJECTION, METHYPREDNISOLONE ACETATE, 80 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J2001</td>
<td>INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J2920</td>
<td>INJECTION, METHYPREDNISOLONE SODIUM SUCCINATE, UP TO 40 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J2930</td>
<td>INJECTION, METHYPREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J3301</td>
<td>INJECT, TRIAMCINOLONE ACETONIDE, PER 10 MG</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>J7300</td>
<td>INTRAUTERINE COPPER CONTRACEPTIVE</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J7302</td>
<td>LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>J7306</td>
<td>LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES</td>
<td>Paid at FFS</td>
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<tr>
<td>J7307</td>
<td>ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>J7506</td>
<td>PREDNSONE, ORAL, PER 5MG</td>
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<tr>
<td>J7607</td>
<td>LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J7609</td>
<td>ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>J7610</td>
<td>ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Service Code</td>
<td>Description</td>
<td>FFS Provider Coverage</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>J7611</td>
<td>ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>J7612</td>
<td>LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED</td>
<td>Paid at FFS</td>
<td></td>
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<tr>
<td>J7613</td>
<td>ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG</td>
<td>Paid at FFS</td>
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</tr>
<tr>
<td>J7614</td>
<td>LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NONCOMPOUNDED</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>J7615</td>
<td>LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>J7620</td>
<td>ALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, FDA-APPROVED</td>
<td>Paid at FFS</td>
<td></td>
</tr>
<tr>
<td>J7644</td>
<td>IPRATROPIUM BROMIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT</td>
<td>Paid at FFS</td>
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<tr>
<td>Q2035</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS</td>
<td>Paid at FFS</td>
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<tr>
<td>Q2036</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS</td>
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<tr>
<td>Q2037</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS</td>
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<tr>
<td>Q2038</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS</td>
<td>Paid at FFS</td>
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<tr>
<td>Q2039</td>
<td>INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS</td>
<td>Paid at FFS</td>
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<tr>
<td>S0630</td>
<td>REMOVAL OF SUTURES; BY A PHYSICIAN OTHER THAN THE PHYSICIAN WHO ORIGINALLY</td>
<td>Paid at FFS</td>
<td></td>
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<tr>
<td>S9449</td>
<td>WEIGHT MANAGEMENT CLASSES, NONPHYSICIAN PROVIDER, PER SESSION</td>
<td>$10.00 Incentive</td>
<td></td>
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<tr>
<td>S9451</td>
<td>EXERCISE CLASSES, NONPHYSICIAN PROVIDER, PER SESSION</td>
<td>$10.00 Incentive</td>
<td></td>
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<tr>
<td>S9452</td>
<td>NUTRITION CLASSES, NONPHYSICIAN PROVIDER, PER SESSION</td>
<td>$10.00 Incentive</td>
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<tr>
<td>S9453</td>
<td>SMOKING CESSATION CLASSES, NONPHYSICIAN PROVIDER, PER SESSION</td>
<td>$10.00 Incentive</td>
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<tr>
<td>S9470</td>
<td>NUTRITIONAL COUNSELING, DIETITIAN VISIT</td>
<td>$10.00 Incentive</td>
<td></td>
</tr>
</tbody>
</table>

* Paid only for Medicare members.

** Paid only for Medicare and CompleteCare members.

# Valid Clinical Laboratory Improvement Amendments (CLIA) certificate required to render the Please bill with CLIA cert # on HCFA AND use modifier QW to illustrate the place of service is CLIA certified.

**In Scope – Effective 01/01/2013.**

The following table lists additional CPT-4 Codes and service descriptions that are reimbursable to Healthfirst Family Practice Providers and clarifies the reimbursement methodology for each CPT-4 code.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>FFS Provider Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11301</td>
<td>SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57420</td>
<td>COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Method</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>57421</td>
<td>COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT; WITH BIOPSY(S) OF VAGINA/CERVIX</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57452</td>
<td>COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA;</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57454</td>
<td>COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX AND ENDOCERVICAL CURETTAGE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57455</td>
<td>COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57456</td>
<td>COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH ENDOCERVICAL CURETTAGE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57500</td>
<td>BIOPSY OF CERVIX, SINGLE OR MULTIPLE, OR LOCAL EXCISION OF LESION, WITH OR WITHOUT FULGURATION (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57510</td>
<td>CAUTERY OF CERVIX; ELECTRO OR THERMAL</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>57511</td>
<td>CAUTERY OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT</td>
<td>Paid at FFS</td>
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<tr>
<td>58555</td>
<td>HYSTEROSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>58558</td>
<td>HYSTEROSCOPY, SURGICAL; WITH SAMPLING (BIOPSY) OF ENDOMETRIUM AND/OR POLYPECTOMY, WITH OR WITHOUT D &amp; C</td>
<td>Paid at FFS</td>
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<tr>
<td>59020</td>
<td>FETAL CONTRACTION STRESS TEST</td>
<td>Paid at FFS</td>
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<tr>
<td>59025</td>
<td>FETAL NONSTRESS TEST</td>
<td>Paid at FFS</td>
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<tr>
<td>59160</td>
<td>CURETTAGE, POSTPARTUM</td>
<td>Paid at FFS</td>
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<tr>
<td>59200</td>
<td>INSERTION OF CERVICAL DILATOR (E.G., LAMINARIA, PROSTAGLANDIN) (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
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<tr>
<td>59300</td>
<td>EPISIOTOMY OR VAGINAL REPAIR, BY OTHER THAN ATTENDING PHYSICIAN</td>
<td>Paid at FFS</td>
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<tr>
<td>59350</td>
<td>HYSTERORRHAPHY OF RUPTURED UTERUS</td>
<td>Paid at FFS</td>
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<tr>
<td>59400</td>
<td>ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS), AND POSTPARTUM CARE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59409</td>
<td>VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS)</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59410</td>
<td>VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS); INCLUDING POSTPARTUM CARE</td>
<td>Paid at FFS</td>
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<tr>
<td>59412</td>
<td>EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLYSIS</td>
<td>Paid at FFS</td>
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<tr>
<td>59414</td>
<td>DELIVERY OF PLACENTA (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
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<tr>
<td>59425</td>
<td>ANTEPARTUM CARE ONLY; 4–6 VISITS</td>
<td>Paid at FFS</td>
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<tr>
<td>59426</td>
<td>ANTEPARTUM CARE ONLY; 7 OR MORE VISITS</td>
<td>Paid at FFS</td>
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<tr>
<td>59430</td>
<td>POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)</td>
<td>Paid at FFS</td>
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<tr>
<td>59510</td>
<td>ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59514</td>
<td>CESAREAN DELIVERY ONLY</td>
<td>Paid at FFS</td>
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<tr>
<td>59515</td>
<td>CESAREAN DELIVERY ONLY; INCLUDING POSTPARTUM CARE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59610</td>
<td>ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS) AND POSTPARTUM CARE, AFTER PREVIOUS CESAREAN DELIVERY</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59612</td>
<td>VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS)</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59614</td>
<td>VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS); INCLUDING POSTPARTUM CARE</td>
<td>Paid at FFS</td>
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<tr>
<td>59618</td>
<td>ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE, FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY</td>
<td>Paid at FFS</td>
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<tr>
<td>59620</td>
<td>CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL</td>
<td>Paid at FFS</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Payment Method</td>
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<tr>
<td>59622</td>
<td>CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY; INCLUDING POSTPARTUM CARE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59812</td>
<td>TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59820</td>
<td>TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; FIRST TRIMESTER</td>
<td>Paid at FFS</td>
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<tr>
<td>59821</td>
<td>TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; SECOND TRIMESTER</td>
<td>Paid at FFS</td>
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<tr>
<td>59830</td>
<td>TREATMENT OF SEPTIC ABORTION, COMPLETED SURGICALLY</td>
<td>Paid at FFS</td>
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<tr>
<td>59840</td>
<td>INDUCED ABORTION, BY DILATION AND CURETTAGE</td>
<td>Paid at FFS</td>
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<tr>
<td>59841</td>
<td>INDUCED ABORTION, BY DILATION AND EVACUATION</td>
<td>Paid at FFS</td>
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<tr>
<td>59850</td>
<td>INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS</td>
<td>Paid at FFS</td>
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<tr>
<td>59851</td>
<td>INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES</td>
<td>Paid at FFS</td>
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<tr>
<td>59852</td>
<td>INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY</td>
<td>Paid at FFS</td>
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<tr>
<td>59855</td>
<td>INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (E.G., PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (E.G., LAMINARIA)</td>
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<tr>
<td>59856</td>
<td>INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (E.G., PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (E.G., LAMINARIA), DELIVERY OF FETUS AND SECUNDINES</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>59857</td>
<td>INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (E.G., PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (E.G., LAMINARIA), DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY</td>
<td>Paid at FFS</td>
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<tr>
<td>76801</td>
<td>ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (&lt; 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76802</td>
<td>ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (&lt; 14 WEEKS, 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
<td>Paid at FFS</td>
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<tr>
<td>76805</td>
<td>ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (&gt; OR = 14 WEEKS, 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76810</td>
<td>ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (&gt; OR = 14 WEEKS, 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN</td>
<td>Paid at FFS</td>
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### ADDITION TO CODE FOR PRIMARY PROCEDURE

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<th>Code</th>
<th>Description</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>76815</td>
<td>ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (E.G., FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), 1 OR MORE FETUSES</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76818</td>
<td>FETAL BIOPHYSICAL PROFILE; WITH NONSTRESS TESTING</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76819</td>
<td>FETAL BIOPHYSICAL PROFILE; WITHOUT NONSTRESS TESTING</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76830</td>
<td>ULTRASOUND, TRANSVAGINAL</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76856</td>
<td>ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>76857</td>
<td>ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; LIMITED OR FOLLOW-UP (E.G., FOR FOLLICLES)</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>99499</td>
<td>UNLISTED EVALUATION AND MANAGEMENT SERVICE</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>J2010</td>
<td>INJECTION, LINCOMYCIN HCL, UP TO 300 MG</td>
<td>Paid at FFS</td>
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<tr>
<td>J3250</td>
<td>INJECTION, TRIMETHOBENZAMIDE HCL, UP TO 200 MG</td>
<td>Paid at FFS</td>
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</table>

The following table shows the reimbursement detail for all vaccines that are covered by the VFC program or otherwise included in the Healthfirst Incentive Program.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>EOP Code SV for ages 0-18*</th>
<th>Capitated Provider Coverage</th>
<th>FFS Provider Coverage</th>
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<tbody>
<tr>
<td>90633</td>
<td>HEPATITIS A VACCINE PEDIATRIC 2 DOSE SCHEDULE IM</td>
<td>X</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
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<tr>
<td>90647</td>
<td>HEMOPHILUS INFLUENZA B VACCINE PRP-OMP 3 DOSE IM</td>
<td>X</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90648</td>
<td>HEMOPHILUS INFLUENZA B VACCINE PRP-T 4 DOSE IM</td>
<td>X</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90649</td>
<td>HUMAN PAPILLOMA VIRUS VACCINE QUADRIV 3 DOSE IM</td>
<td>X</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90650</td>
<td>HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 16, 18, BIVALENT, 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE</td>
<td>X</td>
<td>Paid at FFS</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90655</td>
<td>INFLUENZA VIRUS VACC SPLIT PRSRV FREE 6-35 MO IM</td>
<td>X</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90657</td>
<td>INFLUENZA VIRUS VACCINE SPLIT VIRUS 6-35 MO IM</td>
<td>X</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
</tr>
<tr>
<td>90662</td>
<td>INFLUENZA VIRUS VACCINE, DERIVED FROM CELL CULTURES, SUBUNIT, PRESERVATIVE AND ANTIBIOTIC FREE, FOR INTRAMUSCULAR USE</td>
<td>X</td>
<td>Included in Cap</td>
<td>Paid at FFS</td>
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<tr>
<td>90669</td>
<td>PNEUMOCOCCAL CONJ VACCINE 7 VALENT IM</td>
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<td>90707</td>
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<td>90714</td>
<td>TD TOXOIDS ADSORBED PRSRV FR 7 YR + IM</td>
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<td>90715</td>
<td>TDAP VACCINE 7 YR + IM</td>
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<td>90716</td>
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<td>90733</td>
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<tr>
<td>90734</td>
<td>MENINGOCOCCAL CONJ VACCINE TETRAVALENT IM</td>
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<td>90740</td>
<td>HEPATITIS B VACCINE DIALYSIS DOSAGE 3 DOSE IM</td>
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<td>90744</td>
<td>HEPATITIS B VACCINE PEDIATRIC3 DOSE IM</td>
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<td>90747</td>
<td>HEPATITIS B VACCINE DIALYSIS DOSAGE 4 DOSE IM</td>
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<td>HEPB-HIB VACCINE INTRAMUSCULAR</td>
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* SV EOP Code for members 0–18 years of age vaccine obtained thru VFC.

**Appendix XIV-C — Glossary of EOP Code Messages**

Use the following glossary as a guide to understanding the most common payment determination messages found in the EOP.

<table>
<thead>
<tr>
<th>EOP Message</th>
<th>Explanation of Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Required, not Found</td>
<td>Prior authorization for service was not obtained or referral form not submitted. This includes authorizations that do not match the services billed.</td>
</tr>
<tr>
<td>Require Medical Record</td>
<td>Healthfirst requires the complete medical record for claim review.</td>
</tr>
<tr>
<td>Service Included in Case Rate</td>
<td>Payment for this service is included in the reimbursement for another service.</td>
</tr>
<tr>
<td>Service Capitated to Hospital</td>
<td>Monthly payment was made to the hospital for this service.</td>
</tr>
<tr>
<td>Denied: Medical Chart not Received Within</td>
<td>Service denied: provider did not submit records within 45 days</td>
</tr>
<tr>
<td>45 Days</td>
<td>of date of request.</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Denied: Information (INF) not Received Within 60 Days of Request</td>
<td>Service denied: requested information (INF) was not received within 60 days of original request.</td>
</tr>
<tr>
<td>Denied-INF/Appeal not Received Within 60 Days</td>
<td>Service denied: request for appeal/review or submission of additional information was not received within 60 days of original EOP denial.</td>
</tr>
<tr>
<td>Failure to Comply with Healthfirst Notification Policy</td>
<td>Healthfirst requires notification of emergency room care within 48 hours and notification of inpatient admission by the next business day. Notification was not received.</td>
</tr>
<tr>
<td>Provider Not Eligible for Service</td>
<td>Service rendered is not covered under the provider’s contract/specialty. Usually applies when PCP performs nonprimary care service.</td>
</tr>
<tr>
<td>Exact Duplicate of Closed Claim</td>
<td>Healthfirst has already received and processed a claim for these services.</td>
</tr>
<tr>
<td>Denied: Failure to Preauthorize</td>
<td>Service denied: required authorization from Medical Management department was not obtained.</td>
</tr>
<tr>
<td>Emergency Room Record Required</td>
<td>Healthfirst requires submission of complete emergency room medical record to process claim.</td>
</tr>
<tr>
<td>Failure to Provide Clinical Information/Review</td>
<td>Medical Management department did not receive clinical information during inpatient stay.</td>
</tr>
<tr>
<td>Admission Not Medically Necessary</td>
<td>Services denied: based on information provided, Healthfirst determined that services were not medically necessary.</td>
</tr>
<tr>
<td>Member Not Enrolled on Date of Service</td>
<td>Service denied: patient not a Healthfirst member on the date service was provided.</td>
</tr>
<tr>
<td>Claim Exceeds Filing Date</td>
<td>Service denied: claim was not received within 180 days of date of service.</td>
</tr>
<tr>
<td>XN</td>
<td>Intranetwork provider – not member’s PCP</td>
</tr>
</tbody>
</table>
Appendix XV — New York State Communicable Disease Reporting Requirements

NEW YORK STATE DEPARTMENT OF HEALTH
Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10-21.14). The primary responsibility for reporting lies with the physician, licensed laboratory, local boards of health, state health officers (DOHMH 2.10), school nurses (DOHMH 2.23), any agency director of nursing home hospitals (DOHMH 405.50), and state institutions (DOHMH 2.11) or other locations providing health services (DOHMH 2.12). All are required to report the diseases listed below.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Description</th>
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<tbody>
<tr>
<td>Influenza</td>
<td>Laboratory-confirmed influenza, epidemic influenza, influenza (swine strain)</td>
</tr>
<tr>
<td>Legionnaires' Disease</td>
<td></td>
</tr>
<tr>
<td>Lyme Disease</td>
<td></td>
</tr>
<tr>
<td>Menigitis</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Norovirus</td>
<td></td>
</tr>
<tr>
<td>Parvo</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Rocky Mountain Spotted Fever</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
</tr>
<tr>
<td>Salmonella</td>
<td></td>
</tr>
<tr>
<td>Shigellosis</td>
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<tr>
<td>Staphylococcal Infections</td>
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</tr>
<tr>
<td>Strep Infections</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
</tr>
<tr>
<td>Viral Hemorrhagic Fever</td>
<td></td>
</tr>
</tbody>
</table>

WHO SHOULD REPORT?
Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools,

WHERE SHOULD REPORT BE MADE?
Report to local health department where patient resides.

Contact Person:
Name:
Address:
Phone:
Fax:

WHEN SHOULD REPORT BE MADE?
Within 24 hours of diagnosis:
- All diseases in bold type.
- All case report, DOHMH 3.85, for all other diseases.
- In New York City, report DOHMH 16.

SPECIAL NOTES
- Disease listed in bold type require prompt action and should be reported immediately to local health departments by phone followed by submission of the confidential case report form (DOHMH 3.85). In NYC, use case report form DOHMH 16.
- In addition to the diseases listed above, any unusual disease defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbe should be reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, whooping cough, streptococcal infections) are reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- Cases of HIV infection, HIV-related illnesses, and AIDS are reportable on form DOHMH 4.109 which may be obtained by contacting the Division of Epidemiology, Evaluation, and Research, P.O. Box 237, ESP Station, Albany, NY 12202-2073, (518) 474-6346. In NYC, New York City Department of Health and Mental Hygiene, 51 W. 44th St., (212) 474-3380.

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control, (518) 474-4736 or visit the DOHMH website. For NYC, call (212) 474-6346.

PLEASE POST THIS CONSPICUOUSLY.
Appendix XVI — HEDIS/QARR Quick Reference Guides (QRG)

Healthcare Effectiveness Data and Information Set (HEDIS) and Quality Assurance Reporting Requirements (QARR) are Federal and New York State tools used to measure the performance of health plans and practitioners on important aspects of care and service. Healthfirst has placed on our web-site HEDIS/QARR Quick Reference Guides (QRG) at www.healthfirst.org/HEDIS.

The All Measures Quick Reference Guide is a comprehensive list of measures. It contains measure descriptions and acronyms, criteria for denominator inclusion, and numerator adherence requirements. Each measure has a hyperlink that will take you directly to the code list.

The Prenatal/Postpartum Care and Frequency of Prenatal Care Quick Reference Guide includes a measure decision tree to assist with determining numerator adherence, as well as all numerator adherent codes.

Please go to www.healthfirst.org/HEDIS to learn more.

<table>
<thead>
<tr>
<th>Code</th>
<th>Measure Description</th>
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<tr>
<td>AAB</td>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
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<tr>
<td>AAP</td>
<td>Adults’ Access to Preventive Care</td>
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<tr>
<td>ABA</td>
<td>Adult BMI Assessment</td>
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<tr>
<td>ADD</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
</tr>
<tr>
<td>ADV</td>
<td>Annual Dental Visit</td>
</tr>
<tr>
<td>AMM</td>
<td>Antidepressant Medication</td>
</tr>
<tr>
<td>AMR</td>
<td>Asthma Medication Ratio</td>
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<tr>
<td>APC</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</td>
</tr>
<tr>
<td>APC</td>
<td>Adolescent Preventive Care</td>
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<tr>
<td>APM</td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
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<tr>
<td>APP</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</td>
</tr>
<tr>
<td>ART</td>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
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<tr>
<td>AWC</td>
<td>Adolescent Well Care</td>
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<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
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<tr>
<td>CAP</td>
<td>Children’s and Adolescents Access to Primary Care Practitioners</td>
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<tr>
<td>CBP</td>
<td>Controlling High Blood Pressure</td>
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<td>CCS</td>
<td>Cervical Cancer Screening</td>
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<td>CDC</td>
<td>Comprehensive Diabetes Care</td>
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<td>CHL</td>
<td>Chlamydia Screening in Women</td>
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<td>CIS</td>
<td>Childhood Immunizations Status</td>
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<td>COA</td>
<td>Care for Older Adults</td>
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<td>COL</td>
<td>Colorectal Cancer Screening</td>
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<tr>
<td>CWP</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
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<tr>
<td>FPC</td>
<td>Frequency of Visits</td>
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<td>FUH</td>
<td>Follow-Up After Hospitalization for Mental Illness</td>
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<td>HCC</td>
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<td>HPV</td>
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<td>IET</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<td>IMA</td>
<td>Immunizations for Adolescents LBP Use of Imaging Studies for Lower Back Pain</td>
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<td>Medication Reconciliation Post-Discharge</td>
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<td>NCS</td>
<td>Non-Recommended Cervical Cancer Screening in Adolescent Females</td>
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<td>OMW</td>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
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<td>PCE</td>
<td>Pharmacotherapy Management of COPD Exacerbation</td>
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<td>PPC</td>
<td>Postpartum Care, Prenatal Visits, Timeliness of First Visit</td>
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<td>PSA</td>
<td>Non-Recommended Prostate-Specific Antigen (PSA) Screening in Older Men</td>
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<td>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</td>
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<td>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</td>
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<td>Diabetes Monitoring for People With Diabetes and Schizophrenia</td>
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<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</td>
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<td>URI</td>
<td>Appropriate Testing for Children with Upper Respiratory Infection</td>
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<td>W15</td>
<td>Well-Child Visits – 0–15 Months</td>
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<td>W34</td>
<td>Well-Child Visits – 3–6</td>
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<tr>
<td>WCC</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
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## Appendix XVIII – Quality Rating Measures

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<th>QUALITY RATING MEASURES</th>
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<td>Childhood Immunizations – Combo 3</td>
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<td>Chlamydia Screening – (16–24 yrs.)</td>
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<td>Immunizations for Adolescents</td>
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<td>Postpartum Care</td>
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<td>Well-Child Visit – 3 to 6 yrs.</td>
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<td>Well-Child Visit: up to 15 months (5+ Visits)</td>
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<td>Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
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<td>Diabetes Care: Eye Exam</td>
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<td>HIV Comprehensive Care: Engaged in Care</td>
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<td>HIV Comprehensive Care: Syphilis Screening</td>
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<td>HIV Comprehensive Care: Viral Load Monitoring</td>
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<td>Medication Management for People with Asthma 75% (5-64 yrs.)</td>
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<td>Osteoporosis Management in Women Who Had Fracture</td>
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<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
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<td><strong>Avoiding Admissions and Readmissions</strong></td>
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<td>All-Cause Readmission</td>
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<td>Potentially Preventable Readmissions</td>
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<td>PQI: Adult Composite</td>
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<td>PQI: Pediatric Composite</td>
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<td><strong>Medication Adherence and Use Measures</strong></td>
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<td>Medication Adherence for Hypertension</td>
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<td>Medication Adherence for Oral Diabetes Medications</td>
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<tr>
<td>Use of High-Risk Medication</td>
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<tr>
<td><strong>Enrollee Satisfaction Measures</strong></td>
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<tr>
<td>Access to Care and Appointment Availability Audits</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>&lt;15 Minutes in Waiting Room – PCP or Specialist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Getting Care As Needed</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Helpfulness of Office Staff</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Overall Rating of Care Received from PCP</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PCP Discussed Prescription Drugs</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Timely Follow-Up on Test Results</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Enrollee Health Risk Assessment Measures</strong></td>
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<tr>
<td>Task</td>
<td>Status</td>
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<td></td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Monitoring Physical Activity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Reducing the Risk of Falling</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Timely Risk Assessment for SNP Members</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Appendix XVIII - Behavioral Health Addendum

I. Primary Care Physicians’ Responsibilities

All members enrolled in Healthfirst select a PCP at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to members, including primary and specialty care, hospital care, diagnostic testing, and therapeutic care. If the member is in treatment in a behavioral health clinic that also provides primary care services, the member may select the lead provider to be the PCP. Healthfirst defines the following clinical specialty areas and practitioners as primary care providers.

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Medicine – GYN</td>
<td>Adolescent Medicine</td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td>Adolescent Medicine – GYN</td>
</tr>
<tr>
<td>Family Practice – GYN</td>
<td>Adult Health</td>
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<tr>
<td>Family Practice – OB/GYN</td>
<td>College Health</td>
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<td>Family Practice – OB</td>
<td>Family Health</td>
</tr>
<tr>
<td>General Practice</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Geriatrics (Medicare and Commercial only)</td>
<td>Women’s Health</td>
</tr>
<tr>
<td>Infectious Disease (HIV Specialist PCP)</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
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</tr>
</tbody>
</table>

II. Appointment Availability Standards for Behavioral Health Services and HARP Members

Healthfirst will provide appointment and availability times for the following Behavioral Health services, including the newly carved-in services for Mainstream members ages 0–21 and HARP members age 21 and over (for additional information regarding appointment availability standards, please refer to Appendix I of this manual):

For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services will be provided immediately upon presentation at a service delivery site.

For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential settings and mental health or Substance Use Disorder outpatient clinics, and Opioid Treatment Programs will be provided within 24 (twenty-four) hours of request. Urgently needed ACT would be immediately referred to SPOA, with mention of the urgent need in order for them to evaluate promptly. PROS referrals would be made within 24 hours, and we would encourage PROS to provide prompt service.

For Behavioral Health specialist referrals which are not urgent:

CDT, IPRT, and Rehabilitation services for residential Substance Use Disorder treatment services will be provided within two (2) to four (4) weeks of request

PROS programs other than clinic services will be provided within two (2) weeks of request

Following an emergency, hospital discharge, or release from incarceration, if known, follow-up visits with a behavioral health participating provider (as included in the benefit package) will be scheduled to occur within five (5) days of request, or as clinically indicated.

Non-urgent mental health or Substance Use Disorder visits with a participating provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS program with clinical
treatment, will take place within one (1) week of request.

(This section is an addendum to Section 9.2 in the Provider Manual.)

III. Authorization, Continued Stay, and Discharge Criteria

Healthfirst clinicians will be utilizing the following criteria sets, all of which contain criteria for initial authorization, continued stay, and discharge:

For mental health inpatient, Partial Hospital, and Intensive Outpatient settings of care, Healthfirst will utilize McKesson InterQual criteria, 2015 version.

For all OASAS services for Substance Use Disorder settings of care, LOCADTR 3.0 will be utilized by providers to determine the most appropriate treatment setting for treatment of a member. All Healthfirst clinical staff have access to the HCS system and have been trained on the LOCADTR 3.0 tool in order to best understand the recommended level of care for the member.

NYS has issued specific criteria for PROS, ACT, and CDT services. These criteria have been adopted and will be utilized by Healthfirst Care Managers in reviewing and managing these services.

NYS has also issued review guidelines and criteria for all adult and child Home and Community Based Services (HCBS).

This process will be followed by Healthfirst Care Managers as members complete the assessment by the Health Home (HH) care manager and recommended services are requested by HCBS providers. The guidance from NYS includes admission, continuing stay, and discharge criteria for each HCBS service.

(This requirement relates to Section 9.4 in the Provider Manual and supplements what is already in that section.)

IV. Behavioral Health Utilization Management

Healthfirst is committed to delivering a full continuum of integrated, person-centered care and provides fluid clinical pathways where individuals may enter treatment at any level and be moved to more- or less-intensive settings or levels of care as their changing needs dictate.

BH utilization management is the vehicle through which Healthfirst ensures that our beneficiaries receive:

A comprehensive assessment

A person-centered, needs-based, goal-oriented plan of care that includes services best suited to support recovery needs and preferences

Timely access to services that will engage and support individuals and families throughout stages of recovery

Cost-effective services in the most appropriate setting

Services consistent with medical necessity criteria and evidence-based practices

Active treatment at every level of care that supports progression toward recovery goals and takes into consideration the individual’s readiness to change, readiness to participate in treatment, and family, cultural, and linguistic needs

Integrated, coordinated care that includes services for co-occurring physical, behavioral health, and social conditions

The primary focus of our UM Program is to facilitate access to appropriate, high-quality treatments and recovery-focused services and to support providers in delivering clinically necessary and effective care. UM activities are conducted in collaboration with providers and with a process improvement mindset enhancing access, retention, and the quality of behavioral health treatment to achieve health, wellness, recovery, and
community inclusion for our members and improved medical cost-management. Continuity and coordination of care are important elements of care and as such are monitored. Opportunities for improvement are selected across the delivery system, including settings, transitions in care, patient safety, and coordination between medical and behavioral health care. Where opportunities to improve quality of care and service delivery are identified, recommendations for providers to prospectively adjust practices and policies are made.

Behavioral health care management is integrated with our physical health care management program to improve coordination of care between physical and behavioral health providers. As such, BH utilization management functions are designed to help identify and close gaps in care through evidence-based approaches to care planning and service delivery.

With oversight and clinical guidance from the CMO, the Executive Medical Director of Behavioral Health and the HARP Medical Director support the development and implementation of the UM Program through annual review of policies, criteria, and behavioral health utilization. They, along with additional board-certified peer reviewers, serve as physician reviewers for medical necessity determinations and consultations for quality-of-care concerns. Peer reviewers making determinations for denials, grievances, and appeals are board-certified psychiatrists, licensed doctoral-level psychologists, and physicians certified in addiction medicine or addiction psychiatry, as well as child, adolescent, and geriatric specialties. A physician board certified in child psychiatry will review all inpatient denials for psychiatric treatment for children under the age of 18. A physician certified in addiction treatment must review any inpatient denials for Substance Use Disorder services. A physician will review any denials for services for medically fragile children, and such determinations will consider the needs of the family and/or caregiver.

A. Utilization Management Level of Care Guidelines

UM Level of Care Guidelines are provided to Behavioral Health Care Managers. These tools serve as guidelines for review of medical necessity and appropriateness of services implemented and approved. All medical necessity criteria and level of care guidelines will be used as clinical tools to support decisions to determine components of person-centered plans of care.

Behavioral Health UM criteria tools include:

- McKesson’s behavioral health criteria, InterQual™, which is embedded in the online medical management system. The McKesson behavioral health criteria are proprietary and can be made available upon request.

- OASAS LOCADTR 3.0 criteria for SUD treatments

- New York State OASAS Clinical Guidance
  (https://www.oasas.ny.gov/AdMed/recommend/reommendations.cfm)

- The NYS HCBS Provider Manual. This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals, and preferences, and also ensures member choice of service options and providers (latest version available at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/ )

- New York State OMH Clinic Standards of Care:
  (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)

- New York State OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013
  (https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)

- New York State OCFS Working Together: Health Services for Children/Youth in Foster Care Manual
  (http://ocfs.ny.gov/main/sppd/health_services/manual.asp)

- New York State Principles for Medically Fragile Children

Authorization for traditional in-network outpatient Behavioral Health services delivered by Healthfirst providers is not required. Traditional outpatient Behavioral Health services, as defined by Healthfirst for this purpose, include individual, group, and family therapy and medication management, provided alone or in any
combination, to treat a behavioral health condition in a manner consistent with established clinical guidelines and provided at a frequency not exceeding five (5) hours a week.

Authorization is required for admissions, Home and Community Based-Services (HCBS), all out-of-network care, and select outpatient services such as ECT, neuropsychological testing, and others. Members in need of care, or providers wishing to arrange these services for Healthfirst members, should call the Healthfirst Medical Management department at 1-888-394-4327 for assistance.

BH Care Managers use these tools to support clinical decision making and authorizations for admission, continued stay, step-down, and community-based service level of care decisions to ensure the right intensity of treatment at the least restrictive level to meet the member’s needs. The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care, while facilitating access to essential person-centered, integrated, health- and recovery-oriented services in the community.

In addition to authorization reviews, BH Care Managers coordinate discharge-planning activities, including review of the member’s clinical status, reassessment of need for care, services, and support; risk assessment; changes in condition or treatment that would require updates to the Individual Care Plan; and referral and authorization of any needed care, service, or community supports, including follow-up visits, health home services, medications, DME, medical supplies, or home care that the member needs for a successful and sustained transition back into the community or to a lower level of care.

BH Care Managers at Healthfirst are trained and encouraged to consistently provide active care management as they do utilization concurrent reviews; their focus is obtaining appropriate clinical information in order to update and enhance the treatment plan for the member, and they collaborate with the provider on building out a complete plan of care for the member that extends beyond the current episode of care.

V. Clinical Practice Guidelines for Behavioral Health

Clinical practice guidelines (found in Appendix A) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH, OHIP, and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst.

Healthfirst has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two (2) years unless otherwise specified. Healthfirst adopts guidelines upon the recommendation and approval of the Health Care Quality Council. They are communicated to providers—along with performance indicators chosen by the clinical members of the Council—through the Provider Manual, annual mailings, newsletters, and the Healthfirst website.

Please note: Healthfirst disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our members. These guidelines provide a tool for objective comparison of clinical practices among network providers and ensure appropriateness of care to our members. These guidelines are readily available by virtue of their already broad publication and distribution.

To obtain a copy of the list of guidelines required by the NYSDOH and the list of guidelines adopted by Healthfirst, visit www.healthfirst.org/providers.

For the management and treatment of BH conditions, Healthfirst utilizes CPGs developed and published by the following organizations:

   American Psychiatric Association
   American Academy of Child and Adolescent Psychiatry
   American Academy of Pediatrics – Attention Deficit Hyperactivity Disorder (ADHD)

Healthfirst also incorporates OMH, OASAS, OHIP, and OCFS clinical standards, as appropriate, to support
clinical decisions and care planning. These standards are found below:

- OHIP Standards for Children in Foster Care: [www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)
- OHIP Principles for Medically Fragile Children

Healthfirst also has experience with the following clinical practice guidelines:

- Tobacco Cessation
- Seeking Safety
- Motivational Enhancement Therapy
- Integrated Care and Management of Depression
- Integrated Care and Management of Anxiety Disorders

The aim of the Healthfirst Clinical Partnerships program is to leverage relationships with providers caring for all aspects of a member’s care experience—primary care, specialists, mental health and behavioralists, community-based organizations, and ancillary to achieve the triple aim. Technical assistance and capacity building is available through face-to-face meetings, webinars, conferences, town hall meetings, workshops, and symposia. Evidence-based medicine and best clinical practice is promulgated through bulletins, email blasts and advisory workgroups. Training is offered to clinicians and office staff on specific topics of interest and importance such as SBIRT, improving the patient experience, and smoking cessation.

### VI. Behavioral Health Care Management Automatic Call Distribution

During business hours, Healthfirst’s Member Service staff and other Healthfirst staff have been trained to utilize a Behavioral Health Care Management Automatic Call Distribution queue. If an emergency or crisis call presents, the Member Service agent will activate the queue which looks for the first available Healthfirst behavioral health licensed Care Manager (CM), keep the member on the phone until the Care Manager responds, and do a warm transfer of the member to the CM who will immediately handle the call. In the unlikely event that all CMs are on calls, a Supervisor or Manager who is also logged in and monitoring the queue will receive the call. Once the call is received and handled, the CM will work with the member to ensure appropriate actions are taken; e.g., 911 if needed, assistance getting to an Emergency Room, an immediate face-to-face assessment with a Behavioral Health Provider if the emergency does not present imminent risk, and ongoing follow-up as to the result of these action steps.

Vibrant is Healthfirst’s after-hours crisis manager. They use licensed, trained clinicians as their agents, who respond immediately to calls that are warm transferred from Concentrix, Healthfirst’s call center after-hours vendor. Concentrix agents are trained to warm transfer to Vibrant for any behavioral health issue, and they understand the importance of keeping the member on the phone and completing the warm transfer. Vibrant agents utilize the Healthfirst medical management online system to enter notes and actions taken. They also send (via a reminder queue) the case to the day team of clinicians at Healthfirst so follow up and further actions on the member’s behalf can be seamlessly taken.

### VII. Emergent Care

Healthfirst members are covered for inpatient and outpatient emergency care services within the Healthfirst geographic operating area and also when members are traveling in or visiting out-of-area locations. Emergency services are reimbursed when an emergency medical condition exists or when a Healthfirst provider instructs the member to seek emergency care either in- or out-of-network as is appropriate to the
member’s situation. Services must be provided by facilities or healthcare professionals qualified to render emergency medical care.

**Prior authorization from Healthfirst is never required for reimbursement of an emergent medical condition.**

**Definition of an Emergency Medical Condition**

As set forth in Section 4900(3) of the New York State Public Health Law, an “emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
- Serious impairment to such person’s bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

**Emergency Guidelines**

When a Healthfirst member presents in the emergency room or CPEP (Comprehensive Psychiatric Emergency Program) for care, the hospital is responsible for providing medically necessary and appropriate treatment. The hospital must contact the PCP as soon as possible to obtain clinical information that may be necessary to provide appropriate treatment. If a member presents in the emergency room with a non-emergent condition, the hospital should contact the PCP and document that contact. The hospital is then responsible for deciding and carrying out the necessary and appropriate course of action. Referral to the PCP for non-emergency treatment may be arranged.

If the PCP is referring the member for emergency care, the PCP should send the member to his or her assigned hospital whenever possible or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information. Members should be instructed to return to the PCP’s office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency care and the follow-up care cannot be safely postponed until the member returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

**Emergency Inpatient Admissions**

For emergency admissions, prior authorization is not required, but the treating facility or physician should contact Healthfirst within 48 hours of the admission or as soon as possible (to ensure proper post-stabilization care and discharge planning). Providers should contact Medical Management via the telephone and fax numbers listed in Section 1. In addition, hospitals are responsible for contacting the member’s PCP to advise of the proposed admission and to obtain any relevant information regarding the member’s condition, medical history, and other relevant information. Healthfirst PCPs who practice in private, community-based settings and do not have admitting privileges at Healthfirst hospitals (Level III providers) should contact their hospital liaison to arrange for admission to the appropriate participating hospital in emergency situations as well as in elective cases.

If a Healthfirst member is hospitalized for emergency care in a nonparticipating institution, Healthfirst will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely transported to a participating facility. Healthfirst’s Medical Management staff will work with staff at both hospitals to arrange the transfer when it is judged to be safe by the member’s attending provider.

**VIII. Behavioral Health Services**

Members may make unlimited self-referrals to a participating Behavioral Health Specialist for assessment or
treatment of a mental health or substance use disorder. Healthfirst members may obtain assistance regarding behavioral health services by contacting the Intake Unit at 1-888-394-4327.

Authorization for routine in-network outpatient behavioral health services and crisis intervention services is not required.

**IX. Behavioral Health Quality Improvement Utilization Management Committee (BH QI-UMC)**

The Behavioral Health Quality Improvement Utilization Management Committee (BH QI-UMC) is a multidisciplinary Committee that meets on a quarterly basis. The BH QI-UMC is responsible for carrying out the planned activities of the BH QM and UM programs and is accountable to and reports regularly to the governing board or its designee concerning BH QM activities. The BH QI-UMC reports to the Quality Improvement Committee (QIC) at least quarterly to review behavioral health quality, utilization, and operational metrics, and to promote behavioral health programs and initiatives. Attendees include Vice President & Executive Medical Director, Behavioral Health (chairperson); Medical Director, Behavioral Health – HARP; Medical Director, Physical Health – HARP; Assistant Vice President, Business Operations, Behavioral Health; Director, Behavioral Health Clinical Services – HARP; Director, Pharmacy; Director, Clinical Quality; Director, Clinical Informatics; Director of Children's Services; Director, Clinical Program Management, BH; Senior Manager of BH Quality Improvement; stakeholders (one member, one family member, one peer specialist); provider representative; and other Healthfirst clinical and nonclinical staff members.

A. Healthfirst has expanded its Behavioral Health Quality Improvement Utilization Management Committee to meet the quality requirements and standards for Children's Medicaid Redesign to address the populations, benefits, and services carved into plan. Accordingly, the Children’s Quality Improvement Utilization Management Committee has been established.

B. Children's Quality Improvement Utilization Management Committee (Children's QI-UMC)

The Children's QI-UMC is a multidisciplinary committee that will meet on a quarterly basis. It is responsible for carrying out the planned activities of the Children's QM and UM programs. The Children’s QI-UMC reports to the BH QI-UMC at least quarterly.

Attendees include:

- Vice President & Executive Medical Director, Behavioral Health (Chairperson)
- Medical Director, Physical Health, HARP
- Medical Director, Medical Management
- The Medical Director, Children’s BH/Physical Health
- Assistant Vice President, Appeals and Grievances (or designee)
- Director, Behavioral Health Services (or designee)
- Director, Children’s Services (or designee)
- Director of Clinical Operations, Children (or designee)
- Director, Clinical Quality (or designee)
- Director, Clinical Informatics (or designee)
- Senior Manager, BH Quality Improvement (or designee)
- Pharmacy Director (or designee)
- Manager, Network/Ancillary Operations (or designee)
Network provider

Stakeholders in an advisory capacity:
- Member representative
- Family member representative
- Peer Specialist
- Advocate
- Health Home representative
- Providers
- Subcontractors
- Regional Planning Consortium
- Member-serving agencies
- Other Clinical and nonclinical staff from Healthfirst

Responsibilities:
The Children's QI-UMC reviews behavioral health quality, utilization, and operational metrics and promotes children's health and BH programs and initiatives. This committee is responsible for carrying out the planned activities for children with BH conditions who access BH benefits and/or HCBS. The Children's QI-UMC reviews and analyzes child-specific data, interprets variances, reviews outcomes, and develops and approves interventions based on the QM Work Plan, including the following findings:

- Critical-incident reports and trends including abuse, neglect, and exploitation occurrences
- Complaint tracking and resolution for both members and providers
- Over- and underutilization of costs and services
- Readmission rates, trends, post-discharge follow-up and average length of stay (ALOS) for mental health inpatient, and residential substance use disorder inpatient stays and RTCs
- Inpatient civil commitments and outpatient civil commitments (AOT)
- Follow-up after discharge rates from mental health inpatient, substance use disorder (SUD) inpatient, and RTC
- Rates of SUD IET initiation and engagement
- Emergency department utilization and crisis service use
- Behavioral Health prior authorization/denial and notices of action
- Psychotropic medication utilization a well as separate analysis for children in foster care
- Addiction medication utilization
- Recovery outcomes (i.e., housing, homeless, criminal justice)
- Avoidable hospital admissions and readmission rates and the average LOS for all MH, SUD, residential levels of care, and medical inpatient facilities
- Use of crisis diversion services
- Pharmacy utilization, including psychotropic, addiction, and physical health medications
- All applicable physical health measures required by the MCO model contract
All applicable behavioral health measures determined by the State
Rates of initiation and engagement of individuals with FEP in services
Health Home utilization and quality measures
Discussion, tracking/trending, analysis, and follow-up related to PH services for medically fragile children with complex conditions
Prior authorization/denials and notices of action
Maintains records (documenting attendance, committee findings, recommendations, and actions)
Implements a process to collect, monitor, analyze, evaluate, and report utilization data consistent with all reporting requirements
Informs of child-specific training needs for providers and staff
For children eligible for HCBS, the Child QI-UMC will report, monitor, and recommend appropriate action on the following metrics:
  Use of crisis diversion and crisis intervention services
  Prior authorization/denial and notices of action
  HCBS utilization
  HCBS quality assurance measures as determined by the State

X. Behavioral Health Credentialing Criteria

Healthfirst credentialing criteria for OMH and OASAS behavioral health providers include the following:

  Healthfirst will accept OMH license, OASAS licenses, and other state designations of providers, in place of Healthfirst's credentialing process, for individual employees, subcontractors, or agents of such providers. Healthfirst will collect and accept program integrity-related information as part of the licensing and certification process.

  When contracting with NYS-designated providers, Healthfirst will not separately credential individual staff members in their capacity as employees of these programs.

  Healthfirst requires that OMH and OASAS providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.

XI. Confidentiality

Policies and procedures regarding confidentiality requirements for mental health and substance use information are covered in the main provider manual, Section 5.3.

XII. Provider Training

Providers are required to be trained on Healthfirst policies and procedures. These include all contracted providers. Such policies and procedures cover any additional policies or reference documents about the needs for special-needs members and how to assist in the access of covered services. Such policies will ensure that providers are fully cognizant and compliant with federal and State regulations and program standards. Healthfirst requires that providers meet the applicable State minimum training requirements, including minimum hours and topics of training.

Healthfirst Behavioral Health Network Representatives (BH Reps) are assigned to service providers based on the Network Management Organizational chart and region. Each BH Rep can service hospitals, ancillary providers, or community-based providers. As BH Reps they are fully available throughout the week for the following purposes: provider education, technical support, and other service issues that either the provider or
Healthfirst may identify to warrant discussion in the appropriate face-to-face meeting. Other avenues of education can be through phone, email, webinar, or other appropriate mode of communication that the provider and representatives find most convenient and effective.

Below are examples of items that are reviewed and re-reviewed according to the various needs and requirements of the provider or the plan:

- Demographic Confirmation
- Introduction to Healthfirst
- Documentation Requirements
- Cultural Competence in Practice
- Authorization Requests and UM Protocols
- HCBS Eligibility Criteria and Processes for Adults and Children
- Healthfirst Provider Portal and other Online Tools
- Claims Submission

In addition to training provided by BH Reps, BH clinical training will be made available to providers.

Healthfirst regularly monitors the adherence of Health Homes, PCPs, and BH providers to offered trainings.

**XIII. Quality Assurance**

Healthfirst tracks any deficiencies in performance and corrective action taken with OMH and OASAS licensed, certified, or designated providers. Upon discovery, any serious or significant health and safety concerns will be immediately reported to OMH and OASAS.

Healthfirst follows a protocol to ensure that clinical quality of care issues/sentinel events are addressed and investigated in a timely manner. When the review/investigation has been completed, the outcome/recommendation is communicated to relevant parties; provider-level outcome data is forwarded to the Credentialing Unit annually for inclusion in the provider’s file, as appropriate. A summary report of all clinical quality-of-care referrals, including classification, disposition, recommendations, and status, will be presented to the HCQC/QIC as a standing agenda item.

**XIV. First-Episode Psychosis**

OnTrack-NY is an evidence-based program to address the specific needs of those suffering a first-episode psychosis. As HF expands its behavioral health management programs, we look to initially have the OTNY program available for our members 18–30 who are experiencing their first episode of psychosis. We anticipate identifying the initial cohort of members through our care management/utilization management (UM) of inpatient admissions, provider referrals, and member/family referrals. Once identified, we will offer OTNY programs to these members as a potential transition service, as described below.

Members identified through the Healthfirst Care Management Program will be referred to an HF Behavioral Health Case Manager and evaluated to determine if they meet criteria for first-episode psychosis (FEP). The member and his/her care team (including providers and support persons) will be educated about OTNY, and members who are interested in the program will be assisted with making a referral to facilitate engagement in services. HF Case Managers will provide appropriate, alternative treatment referrals to all members who are not interested in participating in OTNY.

During the course of utilization review of higher levels of care, HF Care Managers will collaborate with providers to determine if individuals meet criteria for FEP. Once a member has been identified as an individual with a first-episode psychosis, the HF care management staff will inform and educate the referring entity (i.e., inpatient treatment team, outpatient provider, family, etc.) of the availability of OTNY as a transition plan for the member and will assist with the referral. The member and family will also be educated and informed of other in-network services available to them.
If the member prefers not to attend OTNY, the HF staff will work with the treatment team and member to design and institute an appropriate plan for services. However, if the member wishes to attend OTNY, the HF staff will work to effectuate a referral to the appropriate OTNY program.

XV. Emergency Pharmacy Protocols for Enrollees with Behavioral Health Conditions

Except where otherwise prohibited by law, Healthfirst will allow a pharmacy to dispense, without prior authorization, up to a 72 (seventy-two)-hour emergency supply of the prescribed drug or medication when an individual with a behavioral condition experiences an emergency condition, defined by New York State as:

A. Placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;
B. Serious impairment to such person’s bodily functions;
C. Serious dysfunction of any bodily organ or part of such person;
D. Serious disfigurement of such person; or
E. Severe discomfort – for enrollees with a behavioral condition, a determination of severe discomfort shall include a situation where the enrollee is:
   Experiencing substantial discomfort or the expectation that such discomfort will result without the medication;
   Stable on a medication that is prescribed by the enrollee’s current provider but is transferring to a new provider or to a new level of care;
   Stable on a medication and is changing healthcare plans; and/or
   Experiencing a return or worsening of behavioral health symptomatology as a result of the anticipation of cessation of the medication.

Healthfirst will also allow a pharmacy to dispense up to a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization (e.g., buprenorphine, buprenorphine/naloxone).

XVI. Healthfirst Care Manager Responsibilities

The Care Manager for UM will make authorizations for admission, continued stay, and step-down level of care decisions to ensure the right intensity of treatment at the least restrictive level to meet the member’s clinical needs. The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-centered, integrated, health and recovery-oriented services in the community. If a medical necessity denial for a level of care takes place because the treatment plan is felt not adequate or appropriate for the member, and Healthfirst cannot reach an agreement on length of stay or adequacy of the treatment plan, the clinician managing this member will work with the facility on next steps for continued care for the member which might be at a higher or lower intensity setting of care and will collaborate to ensure that the member is referred and connected to the services that will be most appropriate for his/her clinical and psychosocial needs. The clinical staff is committed to continuing to follow the member’s care so long as the clinical needs exist, and matching services and settings of care to those needs will be the priority.

XVII. Continuity of Care

A. Section 12.6 of this manual addresses the continuity of care transition period for when a new member is currently undergoing a course of treatment with a non-participating provider as well as when a member’s current provider terminates their agreement with Healthfirst. In all cases, continuation of care with a non-participating provider depends upon the provider’s acceptance of state-mandated reimbursement rates as payment in full. The provider must also agree to do the
following:

i. Adhere to Healthfirst’s quality assurance requirements;

ii. Abide by all Healthfirst policies and procedures;

iii. Provide Healthfirst with medical information related to the member’s care;

iv. Obtain prior authorization from Healthfirst Clinical teams for applicable services;

v. Agree not to “balance-bill” the member for services provided.

B. Healthfirst will execute Single Case Agreements (SCAs) with non-participating adult and child providers to meet clinical needs of members when in-network services are not available. Healthfirst will pay at least the FFS fee schedule for 24 months following any BH carve-in for all SCAs.

C. Healthfirst will pay at least the Medicaid FFS fee schedule for 24 months after the carve-in date, or as long as New York State mandates (whichever is longer) for the following children’s services/providers:

   i. New EPSDT SPA services, including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports

   ii. OASAS clinics (Article 32 certified programs)

   iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)

   iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

D. Providers who historically delivered children’s care management services under one of the 1915(c) waivers being eliminated, and who will provide care management services that are being transitioned to Health Home:

   i. May receive a transitional rate for no more than 24 months after the carve-in date

   ii. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home

E. Healthfirst will contract with OASAS residential programs and pay their allied clinical service providers on a single-case or contracted basis for members who are placed in an OASAS-certified residential program to ensure access to and continuity of care for patients placed outside of Healthfirst’s service area.

F. Adult and child HCBS providers will be paid according to the NYS fee schedule as long as Healthfirst is not at risk for the service costs

   i. At least two years after the carve-in date for adults and children, or until HCBS are included in the capitated rates

XVIII. Behavioral Health Care Management Program – Supplement to Provider Manual Section 13.1

Healthfirst uses data analytics, HRAs, and pharmacy management tools to identify members for care management who are at risk for poor health outcomes due to persisting or unstable mental health or substance use disorders, complex care needs, or social risk factors such as homelessness, poverty, or lack of adequate supports.

Members are also identified for BH care management and targeted outreach through the following sources:

A. Utilization data identifies:
i. Members with chronic conditions; physical health, mental illness and/or substance use disorders

ii. Members with frequent emergency department (ED) utilizations

iii. Members with frequent hospitalizations

iv. Members with high-risk comorbidities

v. Other high-risk groups such as members with first-episode psychosis, pregnant, I/DD or older adults with a BH condition, individuals with a SUD in need of medication-assisted treatment

B. Demographic, encounter, and other data identify high-risk populations such as homeless individuals, transition age youth, individuals with AOT orders.

C. Community referrals

D. Internal referrals (e.g., Member Services, network, UR, A/G)

E. External referrals (e.g., PCP, specialist, home care agency, hospital discharge planners)

F. Member /Family self-referrals

Members who may qualify for HARP are notified of their option to review this possibility with the state-identified HARP enrollment broker.

Healthfirst regularly screens members to determine their eligibility to participate in New York State’s Health Home program. Members meeting program criteria established by the state are assigned to a Health Home for outreach and engagement in health home care management.

**XIX. Peer Reviewers**

Peer reviewers making determinations for denials, grievances, and appeals are board-certified psychiatrists, licensed doctoral-level psychologists, and physicians board certified in addiction medicine or addiction psychiatry, as well as child, adolescent, and geriatric specialties. Denials for services for medically fragile children will be reviewed by a physician.

All inpatient level of care determinations for psychiatric treatments will be made by a board-certified physician in general psychiatry. Furthermore, all inpatient level of care determinations for substance use disorders will be made by a physician certified in addiction treatment.

**XX. Health Home Care Management**

The Healthfirst (HF) Health Home Program promotes access to primary, specialty, and behavioral health care, social services, and community supports for members who meet program eligibility criteria defined by the New York State Department of Health (NYSDOH).

Through collaboration between Healthfirst and contracted Health Homes, the HF Health Home Program provides member assignment, data to support engagement and enrollment, member assessment, care planning and performance monitoring, and care coordination support as indicated.

Healthfirst reviews key clinical indicators within our membership, and initiates the assignment of eligible members to the Health Home that best suits the needs of the member.

Healthfirst Physical Health and Behavioral Health Care Managers collaborate with Health Home Care Managers on complex member issues, providing condition management support, navigation assistance, health and benefit information, and referrals. The HF Care Managers act as liaisons to other network providers and facilitate bidirectional communication between members of the care team to ensure effective coordination and delivery of services.

Healthfirst monitors performance of the Health Home program and meets regularly with Health Home partners.
to review key processes and quality indicators driving the achievement of program objectives. Healthfirst tracks, monitors, and analyzes Health Home data for discussion during monthly meetings including, but not limited to:

- Volume and transition of enrollment statuses of high-risk members;
- Health Home Care Management Agency network participation and outstanding issues;
- Quality-of-care issues (e.g., coordination of care efforts, access to care, reduction of gaps in care, etc.);
- Plan of Care creation, review, submission, and monitoring processes;
- Claims submission and quality of documentation

These meetings are designed to enhance the working relationship between HF, health homes, and the providers serving our members. The meetings are led by the HF Health Home Program team with members of HF’s clinical team also attending. The designated Health Home Program team is available for Health Homes and network providers to facilitate referrals and service coordination.

XXI. Children’s Medicaid Redesign

Consistent with New York State’s vision to promote better access to integrated services for children and youth with complex needs, Healthfirst will promulgate evidence-based practice guidelines that emphasize early identification and intervention, health maintenance, person- and family-centered care, and effective care coordination activities. This encompasses an expanded array of benefits in addition to the inclusion of some populations and services previously carved out of Medicaid Managed Care for individuals under age 21. On or after October 1, 2019, children covered under the following waivers will be transitioned into Medicaid Managed Care:

- OMH Serious Emotional Disturbance (SED) 1915c waiver (NY.0296)
- Bridges to Health (B2H) SED 1915c waiver (NY.0469)
- Bridges to Health (B2H) Medically Fragile 1915c waiver (NY.0471)
- Bridges to Health (B2H) DD 1915c waiver (NY.0470)
- DOH Care at Home (CAH) I/II 1915c waiver (NY.4125)
- Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176

Additionally, children in Voluntary Foster Care Agencies (VFCA) will begin to be enrolled no earlier than October 1, 2019. Medicaid eligibility criteria will be expanded to children who meet at-risk Level of Need criteria and are determined to be Medicaid eligible through Family of One and receive HCBS no earlier than January 1, 2020.

A. Continuity of Care: Healthfirst enrollees transitioning from Medicaid FFS who were receiving medical, Behavioral Health, Health Home Care Management, and/or HCBS will be allowed to continue with their same providers for continuity-of-care purposes. This will continue for the first 24 months of the transition, and it applies to episodes of care that were ongoing during the transition period. A Single Case Agreement (SCA) will be completed for any provider working with a transitioning member that is not contracted with Healthfirst.

B. Utilization Management: Please see sections IV, V, VII, and VIII of the Behavioral Health Addendum (Addendum A) for further guidance. Please also note the following:

i. Healthfirst will not apply utilization review criteria for a period of 180 days from the implementation date of the transition for all children’s services newly carved into managed care. However, this prohibition will not apply to services already covered before the transition.

ii. For children transitioning from a 1915c waiver, Healthfirst will authorize all covered HCBS and LTSS in accordance with the most recent Plan of Care (POC) for at least 180 days
following the transition date of children’s specialty services. This means that service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged. Additionally, Healthfirst will authorize any children’s specialty services that are added to the POC under a person-centered planning process without conducting utilization review during the initial 180 days of the transition. After 180 days, a new Plan of Care is to be developed.

iii. For a period of 24 months from the date of transition of children’s specialty services, Medicaid Fee For Service children receiving HCBS upon enrollment into Healthfirst will be authorized for all services covered in the most recent POC for 180 days without utilization review.

C. Medically Fragile Children: Healthfirst will make every effort to contract with providers who have expertise in caring for Medically Fragile (MF) children, to ensure that MF children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers will refer to appropriate network community and facility providers to meet the needs of MF children. In the event that network providers are unable to make such referrals, they will seek authorization to refer to out-of-network providers.

i. Healthfirst will authorize services for MF children in accordance with established timeframes in the Medicaid Managed Care Model Contract; OHIP Principles for Medically Fragile Children (Attachment G); under EPSDT, HCBS, and CFerto rules; and with consideration for extended discharge planning.

D. Children in Foster Care: Healthfirst will endeavor to contract with providers servicing children in Foster Care, including but not limited to Voluntary Foster Care Agencies (VFCA), primary care and other healthcare providers, and Behavioral Health providers in its service area. Healthfirst will execute Single Case Agreements with any provider for a child placed outside its service area, in order to ensure there is no disruption of the care plan in place for that child. Healthfirst will permit the enrollee to access a new primary care provider and other healthcare providers, including those with expertise treating children involved in Foster Care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services. Healthfirst will ensure there is no disruption in the Plan of Care.

E. Transition Period (90 days before go-live):

i. Healthfirst will begin accepting Plans of Care (POCs) for children receiving HCBS during the transition period, beginning July 1, 2019 for already enrolled members; and for families who have completed the selection process, chosen Healthfirst as their plan, and have consented to share the POC with Healthfirst.

ii. Beginning August 1, 2019, Healthfirst will accept POCs for children in the care of a LDSS/licensed VFCA, where Healthfirst has been selected as the plan

iii. After the transition period ends, Healthfirst will continue to accept POCs for children receiving HCBS in advance of the effective date of enrollment when notified by another plan, a Health Home Care Manager, or the independent entity that there is consent to share the POC with Healthfirst and the family has demonstrated the plan selection process has been completed, or the child is in the care of a LDSS/licensed VCFA and it has been confirmed that Healthfirst has been selected as the plan.

F. Home and Community-Based Services (HCBS) for Children

HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable State guidance. For children who are deemed eligible, access to an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced benefit package of Home and Community-Based Services (HCBS) is designed to assist children/youth in their recovery and continued tenure in the community. In order to receive HCBS, members must receive an initial assessment, with follow-up assessments annually. The process for referral and HCBS eligibility assessment is described below:
i. For members enrolled in a Health Home, the Health Home Care Manager (HHCM) will use the State-designated CANS-NY tool to conduct an HCBS Eligibility Determination. If eligible for HCBS, the HHCM will assist the member and family in selecting relevant HCBS providers from Healthfirst’s network.

ii. For members who opt out of Health Home care management, a State-designated Independent Entity (IE) will conduct the HCBS Eligibility assessment.

iii. When a member is found eligible for HCBS, the HHCM or IE will develop a fully integrated person-centered Plan of Care (POC) in collaboration with the member, and in consultation with providers, family members, and legal guardians as necessary. This plan will be shared with Healthfirst as a request to access HCBS. Healthfirst Care Managers will review the POC and issue an initial “level of service determination.”

iv. When an initial POC is received, and on an ongoing basis, Healthfirst will review and make determinations regarding the appropriateness of the POC submitted by the HHCM or IE. Healthfirst Care Managers will review Plans of Care to assure that all federal and state HCBS regulations are addressed in the member’s care.

v. Ongoing determinations regarding the appropriateness and utilization of HCBS will be made utilizing the OMH-approved UM guidelines for HCBS, taking into account the member’s preferences and desired outcomes. Healthfirst CMs will review care plans, along with authorization and claims data, to ensure appropriate utilization of HCBS as delineated in the POC.
Appendix XIX — Health and Recovery Plan (HARP)

I. Recovery-Oriented Principles

Roles and responsibilities relating to recovery-oriented principles are covered in the main provider manual, Section 9.1.

II. Non-Urgent Care

Policies and procedures regarding unscheduled or non-urgent care are covered in the main provider manual, Section 3.4.

III. Behavioral Health Home and Community-Based Services (BH-HCBS)

Within the HARP, access to an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced benefit package of Home and Community-Based Services (HCBS) is designed to assist enrollees in their recovery and continued tenure in the community. In order to receive HCBS, members must receive an initial assessment, with follow-up assessments done annually. Individuals enrolled in HARP will receive an assessment for HCBS eligibility using a tool derived from the interRAI Community Mental Health assessment designed for New York. The HCBS eligibility assessment will be conducted to determine if HARP enrollees appear eligible for HCBS. Where such eligibility potential is determined, the full Community Mental Health assessment will be administered to assist in the development of a strengths-based, person-centered care plan.

Required Steps for HCBS Eligibility Assessment and Authorization

It is anticipated that all individuals enrolled in a HARP will receive Care Management from a Health Home or another State-designated organization that have been identified by the HARP to provide care management. Additionally, the entity providing the care management services will conduct the functional assessment to determine eligibility for HCBS and to assist in developing plans of care which will include recommended HCBS. Entities providing care management will use the Health Commerce System (HCS) to access the assessment tools.

Guidelines listed in the NYS HCBS Provider Manual (latest version available at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/) outline how HCBS care planning and utilization management activities shall emphasize attention to member strengths, goals, and preferences and ensure member choice of service options and providers.

Care Plan Requirements

Members in the HARP will have a needs-based, person-centered, integrated, recovery-oriented plan of care. The plan of care will be developed by the Health Home or other State-designated organizations that have been identified by the HARP to provide care management, informed by the member and their family, and in collaboration with the care team.

Based on a conflict-free independent assessment of functioning, the HCBS portion of the plan of care will meet the following requirements:

- The plan of care will include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, to engage in community life, to control personal resources, and to receive services within the community;
- Include the individual’s strengths and weaknesses;
- Be developed to include clinical and support needs that are indicated by the independent functional assessment;
Comprise goals and desired outcomes chosen by the individual;

Include Medicaid and non-Medicaid services and supports (natural supports and other community resources) that will enable the individual to meet the goals and outcomes identified in their service plan;

Identification of risk factors and barriers with strategies to overcome them;

Be reviewed and approved by member and their family/support persons, as appropriate;

Include the individual and the entity that is responsible for the implementation and oversight of the plan of care, review of progress, and need for modifications if desired outcomes are not being met or the individual’s needs change;

Include an informed consent of the individual in writing, along with signatures of all individuals responsible for the plan implementation;

Be sent to all the individuals and others involved in implementing and monitoring the plan of care; and

The plan should not include services that are duplicative, unnecessary or inappropriate.

IV. Appointment Availability Standards for BH-HCBS

Healthfirst will follow the required appointment and availability standards for access for the following HCBS:

For Short-Term and Intensive Crisis Respite services, access will be provided within 24 (twenty-four) hours of the request.

For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training services will be provided within two (2) weeks of request (unless appointment is response to an emergency or hospital discharge or release from incarceration, in which case the standard is five [5] days of the request).

Educational and Employment Support Services will be provided within two (2) weeks of the request.

Peer Support Services (PSS) will be provided within one (1) week of request (unless appointment is pursuant to an emergency of hospital discharge, in which case the standard is five [5] days, or if PSS are urgently needed for symptom management, in which case the standard for access is 24 [twenty-four] hours).

V. Credentialing Criteria for Designated BH-HCBS Providers

Healthfirst credentialing criteria for designated HCBS providers is as follows, and is subject to final HCBS credentialing issues:

Healthfirst will accept State-issued HCBS designation, in place of Healthfirst’s credentialing process, for HCBS providers and any individual employees, subcontractors, or agents.

Healthfirst will collect and accept program integrity–related information as part of the licensing and certification process.

Healthfirst requires that HCBS providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

VI. Description of Referral Process for HCBS

The Home and Community-Based Services (HCBS) are available to HARP eligible members who are enrolled in Healthfirst’s HARP plan and in a Health Home (HH).

The process is as follows:

The HH Care Manager will conduct the HCBS eligibility assessment with the member. If eligible, the HH Care Manager will conduct the full HCBS assessment, the NYS Community Mental Health Assessment
to help determine the full array of recommended HCBS

In collaboration with the member, and in consultation with providers as necessary, HH Care Manager develops a fully integrated Plan of Care (POC) that includes physical and behavioral health services and recommended HCBS, including the scope, duration, and frequency of HCBS, and selected in-network providers. Member must be given a choice of at least two HCBS providers from Healthfirst’s network, and there must be documentation in the POC that choice was given to the member.

HH Care Manager forwards the fully integrated POC to Healthfirst for review and approval. Healthfirst care managers will work collaboratively with the HH Care Manager and member to finalize an approved POC.

The HH Care Manager ensures the member is referred for the services listed in the POC.

After assessment by the HCBS providers, the service plan will be forwarded by the HCBS provider to Healthfirst for authorization.

The HH Care Manager monitors the POC; ensures that the member is getting HCBS reflected in the POC; and revises the POC when necessary, incorporating member input and choice. When the POC is revised, the Healthfirst care manager will review and communicate back to the HH Care Manager.

VII. HCBS Utilization Monitoring

Please reference the Provider Contract Exhibit 1.5 and the main Provider Manual Sections 3.2 and 3.7 for requirements for monitoring HCBS utilization for each enrollee.

VIII. Utilization Management

Healthfirst views utilization management as an opportunity to review cases and engage in collegial clinical discussions. In the review, HF care manager (CM) will focus on the assessment, diagnosis, and treatment plan. The plan is expected to delineate clear goals and state how the plan of care will lead to movement toward those goals.

In addition, the HF CM will review the assessments by HCBS providers and recommended plan to address deficits. The overall plan of care is initially approved in discussion between Health Home (HH) CM and the HF physical health (PH) and behavioral health (BH) CMs. Once the global plan of care is approved, specifics of the plan for PH, BH, and HCBS will be developed, reviewed, and approved.

As described elsewhere in the BH supplement, the care plan development is done with the full involvement of the member and, as appropriate, his/her support system. The plan should not only meet the needs based on strengths and deficits but should also be culturally sensitive. It is expected that the member has consented to the plan submitted for approval.

The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-centered, integrated, health and recovery-oriented services in the community.

BH and PH clinical staff collaborate with the member’s Health Home, as appropriate, to ensure an integrated and consistent approach for members with co-occurring physical and behavioral health conditions. The care manager ensures that all community supports, including appropriate housing, are considered and in place whenever possible, before discharge and that all relevant providers are aware of the goals and interventions described in the member’s care plan to the extent necessary to facilitate communication, interface, and collaboration among clinical providers and community care/services and support.

IX. Maintenance of Member Records

Healthfirst will monitor HCBS provider adherence to established practice guidelines. All providers rendering HCBS to our members are required to maintain a member health record in accordance with standards adopted by Healthfirst and in compliance with CMS and NCQA Guidelines for record review.

Healthfirst also strongly recommends that HCBS providers comply with professional standards and take steps...
to safeguard confidentiality when sharing medical-record information with other providers.

Healthfirst periodically requests medical records to conduct reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. All Healthfirst medical-record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Healthfirst requires contracted HCBS providers to make medical records available upon request by Healthfirst.

Medical records are reviewed as part of the following activities:

- Investigating clinical quality of care
- Monitoring utilization to identify underuse and overuse of services, timely receipt of preventive and medically necessary services, and to determine root causes for potential action
- Monitoring for accuracy and completeness of coding
- Validating claims
- Monitoring for compliance with approved Clinical Practice Guidelines and Standards of Care, reporting for Quality Improvement studies
- Monitoring of HCBS provider compliance with regulatory guidelines and reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

The guidelines and performance indicators chosen by the clinical members of the HARP QI committee are communicated to providers through the Provider Manual, annual mailings, newsletters, and the plan’s website. Performance against chosen indicators is measured annually. The Annual Evaluation also helps to drive the activities for the next year’s Quality Improvement Work Plan by determining which successful interventions and actions should be continued or expanded and which actions and activities did not result in noticeable improvement and should be modified or discontinued.

The Annual Evaluation is developed by all relevant parties and is presented to the Quality Improvement Committee (QIC) and the Quality Committee (QC) for review and approval.

**X. Provider Education and Training**

Healthfirst Network Management will provide initial and ongoing provider education to ensure that providers and their office staff are knowledgeable about Healthfirst policies and procedures, reference documents about the needs for special-needs members and how to assist in the access of covered services to ensure that providers are fully cognizant and compliant with federal and state regulations and program standards.

Healthfirst, along with other plans, is collaborating with Managed Care Technical Assistance Center (MCTAC) on a monthly basis to create a robust online training program for providers that meets all of the training requirements for HARP. A clinical training curriculum and plan for Healthfirst Home Health, Primary Care Physicians, and Behavioral Health Providers will be made available. Additional trainings will be provided by Healthfirst’s Clinical Partnership department to all Behavioral Health providers and Health Homes in collaboration with the RPC. Clinical training courses will be posted on the Provider Portal and will be available for providers at various times.

**XI. HCBS Plan of Care and Utilization Review Criteria**

Healthfirst Care Managers will work closely with Health Homes and providers to oversee the development and management of integrated care plans. The Health Home submits the written plan of care to Healthfirst for review no less than annually. Each plan of care will be reviewed in collaboration with the member and their care team to ensure a person-centered, integrated, and recovery-oriented plan of care; an appropriate match of need to service; progression toward goals within expected time frames; adjustments with change in physical, behavioral, or social status; and effective use (no duplication) and coordination of Medicaid and non-Medicaid resources. Targets that are not achieved will be evaluated for appropriateness of attainability
for each individual.

Where questions arise, HF Care Managers will partner with the care team to discuss treatment and service alternatives, acting as a resource to the team to facilitate the development of an individualized plan of care that optimally utilizes network and community resources, including HCBS.

HF will utilize the HCBS criteria developed by the plans in concert with OMH. The process of HCBS review has been described in L3 B.6

XII. Billing Compliance

Please reference the MMC/FHP Contract Section 16.15 (b).

XIII. Required Documentation for Reimbursement

Please reference the MMC/FHP Contract Section 16.15 (b).

XIV. This section intentionally left blank

XV. Appeals and Grievances

Healthfirst provides an opportunity for current/potential HARP members to appeal decisions that adversely affect Home and Community-Based Waiver Services (see operating policy AG MCD-003v28).

Individuals have the right to appeal when any of the following adverse determinations occur:

- HCBS are either denied, reduced, or changed
- Individuals are denied the provider of their choice

For HARP and HCBS eligibility determinations, while NYS has delegated the HCBS evaluation to the HARP, only the State can make the final determination regarding denial of HCBS enrollment.

Members who require assistance with the appeal process can call the dedicated HARP Member Services at 1-855-659-5971.
Appendix XX — Provisions from the 2007 Managed Care Reform Bill

Managed Care Reform Bill

This legislation was signed into law in August 2007 and imposes new requirements on healthcare payors and providers. Specifically, the bill includes the following provisions:

Claims Deadline for Public Programs (effective January 1, 2008) Requires out-of-network providers of services to Medicaid, FHPlus and CHPlus beneficiaries to submit claims to plans within 15 months from the date of service.

Cooling Off Period for Hospitals and HMOs in Contract Terminations Imposes a two-month “cooling off period” after the expiration of a contract between a hospital and a health plan.

During this period, the terms of the terminated contract remain in place. Health plan members are notified of the impending termination 15 days after the commencement of the cooling off period. For example, if the contract terminated on December 31, 2007, the end of the newly mandated cooling off period is February 28, 2008. The 45-day advance notice to enrolled members would have occurred on January 15, 2008.

The purpose of this provision is to avoid the use of termination notices to health plan members and DOH as a vehicle for leveraging concessions in contract negotiations. The cooling off period may be waived by DOH in the event of a termination for cause. It is not required in the context of mutual terminations that are recorded in writing.

Binding Pre-authorizations (effective January 1, 2008) Prohibits plans from denying claims for preauthorized services, except under certain circumstances.

The exceptions include: (1) The patient was not covered at the time the service was provided; (2) The claim was not timely; (3) The patient exceeded policy limits; (4) The preauthorization was based on materially inaccurate or incomplete information; (5) The claim is related to a pre-existing condition that is excluded from coverage; (6) Provider fraud or abuse; and (7) The health plan that pre-authorized the service is not the primary payor.

Of particular importance is the first exception that imposes limits on when health plans may retroactively terminate coverage and thus reverse a preauthorization previously issued by the health plan. The bill states that if a provider submits the claims for per-authorized care within 90 days of the date of service, the health plan’s termination may be retroactive more than 120 days. If the retroactive period is longer than 120 days, the plan has to pay claims for any pre-authorized care rendered more than 120 days before the retroactive termination date.

Out-of-Network Treatments (effective April 1, 2008) Expands the scope of the external review process to include denials of treatments not approved by a physician participating in the health plan’s network and are to be provided by an out-of-network physician.

The appeal process for such denials involves a two-step inquiry: (1) Is the requested treatment materially different from the treatment available in the network? (2) If so, would it be “more clinically beneficial” and not substantially more risky than the in-network treatment?

The appeals process then has two steps. A single external reviewer first determines whether the proposed out of network service is materially different. If so, a larger external review panel is convened to determine whether the alternative is likely to be “more clinically beneficial” and whether the adverse risk of the proposed service would likely not be substantially increased over the in-network service.