

Provider Manual



Welcome

Welcome to AmeriHealth Caritas VIP Care Plus, a member of the AmeriHealth Caritas Family of Companies – a mission-driven managed care organization that has served its members for over thirty (30) years. The AmeriHealth Caritas VIP Care Plus product is available to qualified residents of Michigan in Region Macomb and Wayne who are enrolled in Medicare and Medicaid.

This *Provider Manual* was created to assist you and your office staff with providing services to our members, your patients. As a provider, you may use this *Provider Manual* as a reference pertaining to the provision of medical services for members of AmeriHealth Caritas VIP Care Plus.

This *Provider Manual* may be changed or updated periodically. Revisions will be posted on our website www.amerihealthcaritasvipcareplus.com. AmeriHealth Caritas VIP Care Plus will provide thirty (30) days' notice of the updates and providers are responsible for checking regularly for updates.

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

Thank you for your participation in the AmeriHealth Caritas VIP Care Plus provider network. We look forward to working with you!

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

TABLE OF CONTENTS

I.	Who We Are.....	8
	About Our Programs	8
	Program Eligibility.....	8
	Plan Overview.....	8
	Member Enrollment	8
	Michigan Medicare/Medicaid Assistance Program (MMAP) and Michigan ENROLLS	9
	Primary Care Selection & Assignment.....	9
	Member ID Card	9
	Member Identification and Eligibility Verification.....	10
	Member Rights and Responsibilities.....	10
	Member Rights.....	10
	Member Responsibilities.....	12
	Plan Privacy and Security Procedures.....	13
II.	Provider and Network Information.....	14
	Becoming a Plan Provider.....	14
	Provider Credentialing and Re-credentialing	14
	Credentialing/Re-Credentialing Criteria and Standards	15
	Initial Site Visit Review	16
	Site Visits Resulting from Receipt of a Complaint	16
	Member Dissatisfaction Regarding Office Environment	16
	Communication of Results	17
	Follow-Up Procedure for Initial Deficiencies	17
	Follow-Up Procedure for Secondary Deficiencies	17
	Re-Credentialing	17
	Facility Credentialing Criteria.....	18
	Practitioner Credentialing Rights	18
	Standards for Participation	19
	Access to Care.....	19
	Missed Appointment Tracking.....	20
	After-Hours Accessibility.....	21
	Monitoring Appointment Access and After-Hours Access	21
	Panel Capacity/Not Accepting New Patients and Notification.....	21
	Practitioner & Provider Responsibilities	22
	Responsibilities of All Providers.....	22
	Primary Care Provider (PCP) Responsibilities.....	23
	AmeriHealth Caritas VIP Care Plus Specialist Responsibilities	24
	Provider Directory Responsibilities	25
	Compliance Responsibilities	25
	The Americans with Disabilities Act and the Rehabilitation Act.....	25
	Health Insurance Portability and Accountability Act (HIPAA).....	25

Fraud, Waste and Abuse (FWA)	26
Fraud	26
Waste.....	26
Abuse	26
False Claims Act	26
Reporting and Preventing FWA	27
Reporting Abuse, Neglect and Exploitation	28
Advance Directives	28
Provider Marketing Activities and Compliance	29
Provider Affiliation Information	30
Provider Support and Training	30
Provider Network Management	30
New Provider Orientation	30
Ongoing Training and Education	31
Model of Care Training.....	31
Annual Fraud Waste and Abuse Training	32
Provider Specific On-Going Training	32
Plan-to-Provider Communications	32
Provider Complaint System.....	32
Provider Contract Terminations	32
Provider Initiated.....	33
AmeriHealth Caritas VIP Care Plus Initiated “For Cause”	33
AmeriHealth Caritas VIP Care Plus Initiated “Without Cause”	33
Mutual Terminations	34
Continuity of Care	34
Prohibition on Payments to Excluded/Sanctioned Persons	34
III. Provision of Services.....	36
Medicare and Medicaid Program Summary of Covered Services	36
Medicare/Medicaid Program Physical Health Services.....	36
Medicare/Medicaid Program Behavioral Health Services.....	40
Health Management Program.....	41
Maternal Infant Health Program.....	41
Medicare/Medicaid Program Non-Covered Services	41
Private Pay for Non-Covered Services	42
Emergency Services	42
Out-of-Network Use of Non-Emergency Services.....	42
IV. Model of Care and Integrated Care Management	43
Integrated Care Team Overview	43
Integrated Care Team Components	43
Model of Care	43
Integrated Care Team	44
PCP/Medical Home.....	44
Chronic Care Improvement Programs	44
Clinical Practice Guidelines	44
Care Management Team	44
Seamless Transition.....	45
Self- Determination	45

AmeriHealth Caritas VIP Care Plus Staff	45
PCP	45
Hospital	45
Care Coordination with the PCP	45
Care Coordination with Other Providers	46
Integrating Behavioral and Physical Health Care	46
Treatment Plans	46
Model of Care Evaluation	47
Data Sources	47
Methods of Communicating Updates and Outcome	47
V. Utilization Management	48
Referrals	48
Prior Authorization	48
Services Requiring Prior Authorization	49
Behavioral Health Services must be authorized through the PIHP access center	50
Services that Do Not Require Prior Authorization	51
Providers requiring an expedited decision should make this known at the time of request	51
Services that Require Notification	51
Organization Determinations	51
Standard Process	52
Expedited Process	52
Medical Necessity Standards	53
Notice of Adverse Determination	55
Peer to Peer Review	55
Reconsideration	55
Post-Service Reviews	56
Transmission of Transition of Care Records	56
VI. Grievances, Appeals and Fair Hearings	58
Standard and Expedited Grievances (Complaints)	58
Quality of Care Grievances	58
Filing a Grievance	58
Interpreter services, if needed, will be made available free of charge to the member.	59
Appeals	59
Standard Appeal Process	59
Expedited Appeal Process	60
Steps Following AmeriHealth Caritas VIP Care Plus Appeal Decisions	60
Filing an Appeal	61
AmeriHealth Caritas VIP Care Plus Attn: Appeals Department	61
PO Box 80109	61
London, KY 40742- 0109	61
Interpreter services are free of charge to the member.	61
Provider Administrative or Medical Review	61
Peer-to-Peer	61
Appeal for a Request for Payment of Denied Claims	62
VII. Quality Assurance and Performance Improvement Program	63
Quality Management Activities	63
Quality Assessment Performance Improvement Committee	64

Practitioner Involvement	65
QAPI Activities	65
Quality Improvement Projects.....	65
Health Status – Prevalence Documentation and Baseline Assessment.....	66
Ensuring Appropriate Utilization of Resources.....	66
Chronic Care Improvement Programs	66
Measuring Member and Provider Satisfaction	66
Participant and Provider Dissatisfaction.....	66
Member Safety Programs	66
Preventive Health and Clinical Guidelines.....	66
Health Care Equity	66
Credentialing Program	67
Availability and Accessibility Audits.....	67
Medical Record Requirements	67
Medical Record Audits.....	68
Adverse Action Reporting	68
Reporting & Managing Unusual Occurrences.....	69
Critical Incidents, Sentinel Events and Never Events	69
Managing Unusual Occurrences.....	70
Reporting Provider Preventable Conditions	71
Potential Quality of Care Concerns	71
Formal Sanctioning Process	72
Notice of Hearing.....	72
Conduct of the Hearing and Notice	72
Practitioner/Provider’s Hearing Rights	73
Appeal of AmeriHealth Caritas VIP Care Plus Decision	73
Summary Actions Permitted	74
VIII. Cultural Competency Program and Disability Competency Requirements.....	75
Cultural Competency Introduction	75
Cultural and Linguistic Requirements	76
Disability Competency	77
IX. Claims Submission Protocols and Standards	79
Encounter Reporting	79
Completion of Encounter Data/Claim Submission.....	79
General Procedures for Claim Submission.....	80
Electronic Claims Submission (EDI)	81
SNIP Level 4	81
Paper Claim Mailing Instructions.....	82
AmeriHealth Caritas VIP Care Plus	82
Presence of Referring/ Ordering Physician NPI on Claims Submissions.....	82
Claim Filing Deadlines.....	83
Common Causes of Claim Processing Delays, Rejections or Denials	83
Prospective Claims Editing Policy	85
Claims Inquiry.....	85
Balance Billing Members	86
Claim Disputes	86
Refunds or Recoveries for Improper Payment or Overpayment of Claims	87

AmeriHealth Caritas VIP Care Plus	87
Program Integrity	88
Prospective (Pre-claimspayment).....	88
Retrospective (Post-claims payment)	88
Credit Balance Issues.....	89
Readmission Review Program	89
Third Party Liability/Subrogation	90
Additional Information for Electronic Billing.....	90
Invalid Electronic Claim Record Rejections/Denials	90
Monitoring Reports for Electronic Claims	90
Plan Specific Electronic Edit Requirements.....	91
Electronic Billing Exclusions.....	91
Common Rejections	91
Rejected Claims	92
Corrected or Replacement Claims.....	92
How to Submit Corrected or Replacement Claims.....	92
Electronic Billing Inquiries	93
Provider Preventable Conditions.....	94
Mandatory Reporting of Provider Preventable Conditions	94
For Professional Claims (CMS-1500).....	95
For Facility Claims (UB-04 or 837I).....	95
Inpatient Claims	95
Indicating Present on Admission (POA)	95

I. Who We Are

AmeriHealth Michigan, Inc. is a member of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas). AmeriHealth Caritas, through AmeriHealth Michigan, Inc., has partnered with the Centers for Medicare and Medicaid Services (CMS) and the State of Michigan to support the Michigan Department of Health and Human Services (MDHHS) MI Health Link to integrate Medicaid and Medicare services for dual-eligible Michigan residents residing in Macomb and Wayne County. AmeriHealth Michigan was selected by the Michigan Department of Health and Human Services as an Integrated Care Organizations (ICOs) in Macomb and Wayne Counties.

AmeriHealth Caritas is proud to partner with the CMS and MDHHS to offer this plan – AmeriHealth Caritas VIP Care Plus.

Through our partnership with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

About Our Programs

MI Health Link was created for dual eligible members to better coordinate the care and services they receive from the Medicare and Medicaid programs. The Medicare program is administered through CMS. Michigan's Medicaid program is administered through MDHHS. AmeriHealth Caritas VIP Care Plus will be providing all covered Medicare and Medicaid services for enrollees of the Integrated Care Initiative in Macomb and Wayne County of Michigan.

Program Eligibility

Members are eligible to enroll in AmeriHealth Caritas VIP Care Plus if they are:

- Age 21 and older at the time of enrollment; and
- Entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D, and receiving full Medicaid benefits. This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(b)(c) waiver.
- Reside in Macomb or Wayne County
- Are not otherwise excluded from participation.
- Enrollees of the MI Choice Waiver Program or the Program for All-Inclusive Care for the Elderly (PACE) may choose to participate in the Integrated Care Program but must disenroll from MI Choice or PACE in order to do so.

Plan Overview

AmeriHealth Caritas VIP Care Plus is contracted to provide Medicare Hospital (Part A), Medical (Part B) services and Prescription Drug Coverage (Part D) and Michigan Medicaid services.

Members must live in Macomb or Wayne County in the State of Michigan to join the Plan. Please refer to Section III of this *Provider Manual* for a full description of Plan benefits including supplemental benefits.

Member Enrollment

AmeriHealth Caritas VIP Care Plus accepts members with dual Medicare/Medicaid eligibility.

AmeriHealth Caritas VIP Care Plus will accept members who voluntarily enroll and members who are assigned by MDHHS, without restriction and in the order in which they enroll.

AmeriHealth Caritas VIP Care Plus will work with CMS and MDHHS to utilize state or AmeriHealth Caritas VIP Care Plus brokers as defined by CMS and MDHHS.

AmeriHealth Caritas VIP Care Plus does not discriminate on the basis of religion, political beliefs, gender, sexual orientation, marital status, race, color, age, national origin, health status, disability, pre-existing physical or mental condition, previous health care history, or need for health care services and will not use any policy or practice that has the effect of such discrimination.

AmeriHealth Caritas VIP Care Plus members may change plans or opt out of MI Health Link from month to month. Members may call 1-888 667-0318 to make these changes. AmeriHealth Caritas VIP Care Plus will work with the State enrollment broker as directed by the State.

Michigan Medicare/Medicaid Assistance Program (MMAP) and Michigan ENROLLS

Michigan Medicare/Medicaid Assistance Program (MMAP) will assist people in reviewing eligibility for and comparing the MI Health Link plans available to the enrollee. Michigan ENROLLS representatives will assist with completing and submitting MI Health Link enrollment materials, opting out, or switching plans. MMAP counselors will review all ICO plan options with individuals and provide unbiased information to the enrollee. Enrollees may be referred to MMAP Counselors from a variety of sources including AmeriHealth Caritas VIP Care Plus member services.

Primary Care Selection & Assignment

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

- Match of member’s language preference (if available).
- Existing provider relationships including Home and Community Based Services (HCBS) and Long Term Supports and Services (LTSS).
- Selection of a PCP closest to the member’s residence based on ZIP code.

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

- The member’s name and Member ID number;
- ☒ AmeriHealth Caritas VIP Care Plus name, mailing address and member services number.

Member ID Card

		<p>In case of an emergency, dial 911.</p> <p>Member Services: 1-888-667-0318 (TTY 711) Contact Member Services for Dental and Vision benefit assistance.</p> <p>24-Hour Nurse Advice Line: 1-855-843-1145</p> <p>Pharmacy Provider Services: 1-855-327-0510 (TTY 711)</p> <p>Pharmacy Member Services: 1-855-328-0011</p> <p>Website: www.amerihealthcaritasvipcareplus.com</p> <p>Behavioral Health Services: 1-313-833-2500 (TTY 1-800-630-1044)</p> <p>24-Hour Behavioral Health Crisis Line: 1-800-241-4949 (TTY 711)</p> <p style="text-align: right;">AmeriHealth Caritas VIP Care Plus P.O. Box 7074 London, KY, 40742-7074</p> <p>Send medical claims to:</p> <p>Claim inquiry: 1-888-667-0318 (TTY 711)</p>
<p>Member name: <Cardholder Name> Member ID: <Cardholder ID#> Beneficiary ID: <Medicaid ID#> PCP Name: <PCP Name> PCP Phone: <PCP Phone> MEMBER CANNOT BE CHARGED Copays: \$0 H0192 001</p>	 <p>RxBIN: 019587 RxPCN: 06500000 RxGRP: Care Plus MI</p>	

Member Identification and Eligibility Verification

AmeriHealth Caritas VIP Care Plus member eligibility varies. As a participating provider, you are responsible for verifying member eligibility with AmeriHealth Caritas VIP Care Plus before rendering services, except when a member presents for services with an emergency medical condition.

Eligibility may be checked by:

- Visiting the provider area of the AmeriHealth Caritas VIP Care Plus website www.amerihhealthcaritasvipcare.com, to access a free, web-based application for electronic transactions and information through a multi-payer portal.
- Calling Provider Services at 1-888-667-0318.
- Using AmeriHealth Caritas VIP Care Plus's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system -to-system verification, including point of service (POS) devices.
- Asking to see the member's AmeriHealth Caritas VIP Care Plus ID card. Members are instructed to keep the ID card with them at all times. The member's ID card includes:
 - The member's name, AmeriHealth Caritas VIP Care Plus ID number, and the Plan's name, address, and Member Services telephone number.

PLEASE NOTE: AmeriHealth Caritas VIP Care Plus ID cards are **not** returned to the Plan when a member becomes ineligible. Presentation of an AmeriHealth Caritas VIP Care Plus ID card is **not** proof that an individual is currently a member of AmeriHealth Caritas VIP Care Plus. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to the Fraud Waste and Abuse Hotline at 1-866 833-9718.

In order to help match members with health care that meets their needs in a cost-effective manner, AmeriHealth Caritas VIP Care Plus uses a health risk assessment (HRA) to identify members who are at risk for chronic conditions, identify Long Term Support Service (LTSS) and other health care needs. The HRA will be completed in the first fifteen (15) days of enrollment and will be administered in person or by telephone. A face-to-face comprehensive assessment will be performed on all members within forty-five (45) days of enrollment based upon the member's needs.

Our HRA identifies actual or potential barriers that may hinder the delivery of optimum health care. Each question in the HRA is designed to gather information in which a positive response will trigger program referrals or action to support a specific issue. The HRA offers opportunities to quickly identify and engage members who have chronic conditions, or who have special health-related needs.

Member Rights and Responsibilities

AmeriHealth Caritas VIP Care Plus informs its members of the following rights and responsibilities, but members also have the right to request and receive from their health care provider a complete copy of these Rights and Responsibilities. As an AmeriHealth Caritas VIP Care Plus provider, it is your responsibility to recognize the following member rights and responsibilities:

Member Rights

- To be treated with dignity and respect.
- To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting medical care.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To have their medical records remain private, according to HIPAA rules.
- To have access to services, both clinical and non-clinical, regardless of whether a member has limited English proficiency or reading skills, has a diverse cultural and ethnic background, or a physical or mental disability.
- To receive free translation services as needed, including help with sign language if hearing impaired.
- To participate in making decisions about their own medical care, including the right to refuse treatment. Refusal of treatment is not considered a reason to request disenrollment of the member from a physician's practice.
- To receive a full, clear and understandable explanation of treatment options and the risks of each option in order to make an informed decision, regardless of cost or benefit coverage.
- To inform contracted providers that he or she refuses treatment, and to expect to have such providers honor his or her decision if he or she chooses to accept the responsibility and the consequences of such a decision. In this event, members are encouraged (but not required) to:
 - Complete an advance directive, such as a living will and provide it to the contracted plan providers.
- Female members have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.
- To have access to medical records in accordance with applicable Federal and State of Michigan laws.
- To choose a PCP from AmeriHealth Caritas VIP Care Plus list of providers.
- To change a PCP and choose another one from AmeriHealth Caritas VIP Care Plus list of providers.
- To choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life-threatening medical condition and the specialist agrees to act as the PCP.
- To voice his or her complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the AmeriHealth Caritas VIP Care Plus Evidence of Coverage or other procedures adopted by AmeriHealth Caritas VIP Care Plus for such purposes.
- To be provided good quality care without unnecessary delay.
- To receive a copy of the *Member Handbook*.
- To continue in current treatment until a new treatment plan is in place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of incentive plans for AmeriHealth Caritas VIP Care Plus practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.
- To receive a copy of AmeriHealth Caritas VIP Care Plus prescription drug formulary.
- To receive a copy of AmeriHealth Caritas VIP Care Plus "Dispense as Written" policy for *prescription* drugs.
- To receive information about AmeriHealth Caritas VIP Care Plus, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To seek a second opinion from a participating or non-participating qualified health care professional at no cost to the member.
- To be able to continue to use an independent care provider that a member has previously utilized or select a new provider that meets the state qualifications.

- To be informed of any cost-sharing obligations upon becoming a Plan member and at least 30 days prior to any change.
- To be informed about how and where to access any benefits that are available under Michigan Medicaid program but are not covered by AmeriHealth Caritas VIP Care Plus.
- AmeriHealth Caritas VIP Care Plus members have the right to receive non-emergency transportation to get health care services 24 hours a day, 365 days a year.
- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).
- To request information on the structure of AmeriHealth Caritas VIP Care Plus.
- To be treated no differently by providers or by AmeriHealth Caritas VIP Care Plus for exercising the rights listed here.
- To call or write AmeriHealth Caritas VIP Care Plus any time with comments, questions, and observations regarding positive or constructive comments. Members may also make recommendations about the members' rights and responsibilities.
- To have control over his or her choice in identifying, accessing, and managing supports and services in accordance with his or her needs and personal preferences.
- To be an active participant in his or her own person-centered planning, a right under the Michigan Mental Health Code/Contract and Waiver Requirement.
- To use his or her authority to exercise decision making over some or all home and community-based supports and services. By doing so, the member also accepts the responsibility for taking a direct role in managing them including who and how services are required.
- To be informed of his or her right to use arrangements that support Self-Determination and document the decisions regarding these arrangements.
- To be provided assistance with navigating, connecting and accessing services that support Self-Determination.
- To change plans or opt out of MI Health Link.

Member Responsibilities

- To understand to the best of his/her ability how AmeriHealth Caritas VIP Care Plus is used to receive health care.
- To treat AmeriHealth Caritas VIP Care Plus employees, practitioners and providers with respect.
- To comply with the rules of the AmeriHealth Caritas VIP Care Plus.
- To choose a PCP as soon as possible.
- To understand health problems, participate in developing treatment goals and to follow the practitioner or provider's instructions for care after deciding what treatment is needed.
- To keep scheduled doctor appointments.
- To call to cancel doctor appointments at least 24 hours in advance if the appointment must be re-scheduled.
- To ask questions, discuss personal health issues and listen to what treatment is needed.
- To inform providers of medical problems or any other issue that may conflict with following the plan of care.
- To know the difference between a true emergency and a condition needing urgent/symptomatic care.
- To know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
- To receive services from the PCP unless referred elsewhere by the PCP or otherwise permitted by AmeriHealth Caritas VIP Care Plus or the State of Michigan.
- To help get medical records from past providers.

- To report to AmeriHealth Caritas VIP Care Plus any other health care coverage.
- To report to AmeriHealth Caritas VIP Care Plus if injured in an accident or at work.

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

Plan Privacy and Security Procedures

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

II. Provider and Network Information

This section provides information for maintaining network privileges and sets forth expectations and guidelines for Primary Care Providers (PCPs), Specialists and Facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers.

Becoming a Plan Provider

Health care providers are invited to participate in the AmeriHealth Caritas VIP Care Plus network based on their qualifications and an assessment and determination of the network's needs. Providers must be eligible to participate in Medicare and Michigan Department of Health and Human Services (MDHHS) Medicaid in order to be credentialed with AmeriHealth Caritas VIP Care Plus.

Provider Credentialing and Re-credentialing

AmeriHealth Caritas VIP Care Plus is responsible for credentialing and re-credentialing its network of providers. Hospital-based physicians are not required to be independently credentialed if those providers serve AmeriHealth Caritas VIP Care Plus members only through the hospital and those providers are credentialed by the hospitals.

AmeriHealth Caritas VIP Care Plus maintains criteria and processes to credential and re-credential the following practitioners:

- Medical Doctors (MDs)
- Doctors of Osteopathic Medicine (DOs)
- Doctors of Podiatric Medicine (DPMs)
- Doctors of Chiropractic Medicine (DCs)
- Certified Registered Nurse Practitioners (CRNPs)
- Certified Nurse Midwives (CNMs)
- Optometrists (ODs)
- Audiologists (Au Ds)
- Occupational Therapists (OTs)
- Physical Therapists (PTs)
- Speech and Language Therapists
- Dentists (DMDs)
- Oral Surgeons (DDS or DMDs)

AmeriHealth Caritas VIP Care Plus also maintains criteria and processes to credential and re-credential the following provider types:

- Hospitals – Acute Care and Acute Rehabilitation
- Ancillary Facilities
- Home Health Agencies/Home Health Hospice
- Skilled Nursing Facilities
- Skilled Nursing Facilities, Providing Sub-Acute Services
- Nursing Homes
- Free-Standing Surgical Centers
- Sleep Center/Sleep Lab - Freestanding
- Durable Medical Equipment (DME) Suppliers
- Clinical laboratories (a CMS-issued CLIA certificate (or waiver) or a hospital-based exemption from CLIA is required for laboratory providers)
- Free Standing Imaging Centers

- Providers of outpatient diabetes self-management training
- Providers of ESRD services
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Providers of Long-Term Support Services (home-delivered meals, home modification, etc.)

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

AmeriHealth Caritas VIP Care Plus credentialing/re-credentialing criteria and standards are consistent with the Centers for Medicare and Medicaid Services (CMS) and the State of Michigan's requirements and NCQA requirements. Practitioners and facility/organizational providers are re-credentialed every three years.

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

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

There is no charge to providers to submit applications and participate in CAQH. Providers may access the application forms via the AmeriHealth Caritas VIP Care Plus website at www.amerihealthcaritasvipcare.com and submit to AmeriHealth Caritas VIP Care Plus as follows:

- Submit application to participate with AmeriHealth Caritas VIP Care Plus via CAQH.
- Send CAQH ID number to AmeriHealth Caritas VIP Care Plus via email to the Credentialing department. Visit the provider area of our website at www.amerihealthcaritasvipcareplus.com for the most current contact information.
- Register for CAQH (if not already enrolled) via a link from www.amerihealthcaritasvipcareplus.com to the CAQH website.

Providers who are not affiliated with CAQH or who prefer a paper credentialing process may contact an AmeriHealth Caritas VIP Care Plus Provider Network Account Executive for assistance. Paper applications may be faxed to the Provider Services at 1 -(888)-656-2431.

Credentialing/Re-Credentialing Criteria and Standards

AmeriHealth Caritas VIP Care Plus applies credentialing and re-credentialing criteria for all professional providers that, at a minimum, meet all applicable Federal and State requirements.

To that end AmeriHealth Caritas VIP Care Plus criteria include:

1. Current unrestricted medical licensure;
2. No revocation or suspension of the provider's state license by the applicable State licensing board;
3. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106);
4. Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training;

5. Evidence of specialty board certification, if applicable;
6. Evidence of the provider's professional liability insurance coverage, and claims history;
7. Satisfactory review of any sanctions imposed on the provider by Medicare or Medicaid;
8. The provider's Medicare identification number, Medicaid ID number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form whenever applicable. Plan laboratory providers including all contracted laboratory-testing sites will provide Clinical Laboratory Improvements Amendments (CLIA) certification (or waiver).
9. The provider has not opted out of Medicare.
10. All providers must also be registered with Michigan's web-based Medicaid claims payment system, known as CHAMPS (Community Health Automated Medicaid Processing System).

In addition, AmeriHealth Caritas VIP Care Plus credentialing and re-credentialing processes include verification of the following additional requirements for physicians:

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

As part of the application process AmeriHealth Caritas VIP Care Plus will request information on provider sanctions prior to making a credentialing or re-credentialing decision. Information may be gathered from National Practitioner Data Bank (NPDB), the HHS Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Federation of Chiropractic Licensing Boards (CIN-BAD), System for Award Management (SAM) and Michigan State Medicaid Excluded Provider List.

Initial Site Visit Review

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

To address any areas of deficiency identified on the initial visit, AmeriHealth Caritas VIP Care Plus requires a corrective action plan be submitted to the Plan within one week of the visit. Re-survey of the site will occur within thirty (30) days to ensure standards have been met.

Practitioners not meeting the minimal performance standard threshold of 85% will be reviewed by the AmeriHealth Caritas VIP Care Plus Medical Director and Credentialing Committee for recommendation.

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

Site Visits Resulting from Receipt of a Complaint

Member Dissatisfaction Regarding Office Environment

1. The Provider Services department or the Credentialing department may identify the need for a site visit due to receipt of an issue with member dissatisfaction regarding the provider's office environment.

2. At the discretion of the Provider Network Account Executive, a site visit may occur to address the specific issue(s) raised by a member. Follow -up site visits are conducted, as necessary.
3. These focused site visits, where a full site visit evaluation is not performed, do not count toward the three-year site visit requirements.

Communication of Results

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

Follow-Up Procedure for Initial Deficiencies

1. The Provider Network Account Executive requests a corrective action plan from the office contact representative. The corrective action plan must be submitted to AmeriHealth Caritas VIP Care Plus within one (1) week of the visit.
2. Each follow-up contact and visit is documented in the provider's electronic file.
3. The Provider Network Account Executive schedules a re-evaluation visit with the provider office within thirty (30) days of the initial site visit to review the site and verify that the deficiencies were corrected.
4. The Provider Network Account Executive reviews the corrective action plan with the office contact representative.
5. The Provider Network Account Executive reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact representative.
 - If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office contact representative.
 - If the site does not meet and/or exceed the passing score the Provider Network Account Executive follows the procedures outlined below for follow -up for secondary deficiencies.

Follow-Up Procedure for Secondary Deficiencies

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

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

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

Re-Credentialing

AmeriHealth Caritas VIP Care Plus will re-credential network practitioners at least every three years. The following information is requested in order to complete the re-credentialing process:

- Application – Credentials Update Form or CAQH Universal Provider Data Source
- Practitioner CAQH Reference Number
- Credentialing Attestation and Release Form
- Office Hours / Service Addresses
- Supporting Documents – State Professional License, Federal DEA Registration, State-Controlled Substance Certificate, Malpractice Face Sheet and Clinical Laboratory Improvement Amendments (CLIA) Certificate (if applicable) for all contracted laboratory testing sites.

We also consider the following at re-credentialing:

Source/Measure	Measure Standards
Member complaints, grievances and appeals about provider.	Three or more quality of care and/or service complaints per year
Member Satisfaction Survey	Two standard deviations below the mean
Complaints received from Michigan Department of Health and Human Services Contract Manager	Unsatisfied corrective action plans
State of Michigan Secret Shopper Calls	
PEER Review	Unsatisfactory results as deemed by Plan Medical Director and/or other members of Quality Improvement leadership
Quality of Care Concern	
Quality Improvement Activity information, including, but not limited to; Quality Improvement study results- Clinical data (medical records) as available	
Access and Availability Studies Secret Shopper Calls	Composite score in the lowest 10 percent

As with initial credentialing, all applications and attestation/release forms must be signed and dated one hundred and twenty (120) days prior to the Credentialing Committee decision date. Additionally, all supporting documents must be current at the time of the decision date.

Facility Credentialing Criteria

AmeriHealth Caritas VIP Care Plus credentialing criteria for facilities include:

- An Unrestricted and Current License
- Evidence of Eligibility with State and Federal Regulatory Bodies – including Medicare and Medicaid
- Current Malpractice Face Sheet
- A Copy of Accreditation Certificate from a Recognized Accrediting Body
- A Quality Site Visit for Non-Accredited Facilities

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

Practitioner Credentialing Rights

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

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

Questions regarding the status of a credentialing application may be directed to the AmeriHealth Caritas VIP Care Plus Credentialing department by calling Provider Services at (888) 667-0318.

Standards for Participation

By agreeing to provide services to AmeriHealth Caritas VIP Care Plus members, providers must:

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

Access to Care

AmeriHealth Caritas VIP Care Plus providers must meet standard guidelines as outlined in this *Provider Manual* to help ensure that Plan members have timely access to care.

AmeriHealth Caritas VIP Care Plus endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services.

AmeriHealth Caritas VIP Care Plus establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are convenient to AmeriHealth Caritas VIP Care Plus members and that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to medical care services, medical

providers, behavioral health and LTSS providers.

AmeriHealth Caritas VIP Care Plus monitors the following access standards on an annual basis. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or Provider Services at (888) 667-0318.

Provider Type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Urgently needed services or emergency	Immediately - Twenty-four (24) hours per day, seven (7) days per week
	Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within seven (7) business days
	Routine and preventive care	Within 30 business days
	Medical Follow-Up to Inpatient Care	Within seven (7) calendar days of discharge
Behavioral Health Providers	Urgently needed services or emergency	Immediately - Twenty-four (24) hours per day, seven (7) days per week
	Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within seven (7) business days
	Routine and preventive care	Within 30 business days
High-Volume Specialists (Cardiologist, Oncologist, Ophthalmologists, Orthopedic Surgeons, General Surgeons, Gastroenterologists, Pulmonologists, Otolaryngologists and Specialists in Physical Medicine and Rehabilitation)	Routine	Thirty (30) calendar days

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for the missed appointment. The medical record should reflect any reasons for delays in providing medical care as a result of missed appointments and should also include any refusals by the member. Providers are encouraged to advise AmeriHealth Caritas VIP Care Plus Care Coordination team at 1-866-263- 9181 if outreach assistance is needed when a member does not keep an appointment and/or when a member cannot be reached during an outreach effort.

After-Hours Accessibility

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

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

Monitoring Appointment Access and After-Hours Access

AmeriHealth Caritas VIP Care Plus will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews;
- Monitoring administrative complaints and grievances; and,
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care.

Non-compliant providers will be subject to corrective action up to and including termination from the network, as follows:

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three (3) to six (6) months after the initial survey.

Panel Capacity/Not Accepting New Patients and Notification

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

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

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

AmeriHealth Caritas VIP Care Plus will provide each PCP a monthly member panel roster by paper or electronically via the online Provider Portal.

Practitioner & Provider Responsibilities

Responsibilities of All Providers

AmeriHealth Caritas VIP Care Plus is regulated by the Michigan Department of Health and Human Services (MDHHS) and Federal laws. Providers who participate in AmeriHealth Caritas VIP Care Plus have responsibilities, including but not limited to:

- Be compliant with all applicable Federal, State, and local laws and regulations.
- Treat AmeriHealth Caritas VIP Care Plus members in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., communications regarding management of infectious or reportable diseases, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in the State of Michigan.
- Provide information to AmeriHealth Caritas VIP Care Plus and/or the Michigan Department of Health and Human Services as required.
- Inform members about all treatment options, regardless of cost or whether such services are covered by the Plan or other State of Michigan programs.
- As appropriate, work cooperatively with specialists, consultative services, and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment, provide services, or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program (Medicaid), source of payment, marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's special needs.
- Ensure that provider information is updated with AmeriHealth Caritas VIP Care Plus within thirty days (30) of a change. This includes but is not limited to hours of operation, licensure, special populations served, and providers joining or leaving the practice.
- Abide by and cooperate with the policies, rules, procedures, programs, activities, and guidelines contained in your Provider Agreement (to which this *Provider Manual* and any revisions or updates are incorporated by reference).
- Comply fully with AmeriHealth Caritas VIP Care Plus's Quality Improvement, Utilization Management, Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by AmeriHealth Caritas VIP Care Plus, the State of Michigan and/or CMS.
- Promptly notify AmeriHealth Caritas VIP Care Plus of claims processing payment or encounter data reporting errors.
- Accept AmeriHealth Caritas VIP Care Plus payment or third-party resource as payment-in-full for covered services.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to AmeriHealth Caritas VIP Care Plus or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.

- Immediately notify AmeriHealth Caritas VIP Care Plus of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify AmeriHealth Caritas VIP Care Plus of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Verify member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization and provide referrals for applicable services.
- Maintain all medical and Medicare-related member records and communications for a period of ten (10) years according to legal, regulatory, and contractual rules of confidentiality and privacy.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform member(s) of the availability of AmeriHealth Caritas VIP Care Plus interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas VIP Care Plus of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the AmeriHealth Caritas VIP Care Plus Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by State of Michigan and Federal law.

Primary Care Provider (PCP) Responsibilities

A Primary Care Provider (PCP) serves as the member's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of AmeriHealth Caritas VIP Care Plus members. The following practitioner types may serve as Plan PCPs:

- Internist
- Family practitioner
- Pediatrician
- General practitioner
- Naturopathic physician
- Physician's assistant
- Certified Nurse Practitioner
- Advanced Practice Registered Nurse (APRN)

Additionally, clinics, Federally Qualified Health Centers and specialists besides those listed above who are willing to perform the duties of a PCP may also serve as PCPs.

A PCP is responsible to AmeriHealth Caritas VIP Care Plus and its members for diagnostic services, care planning and treatment plan development. The PCP is expected to work with AmeriHealth Caritas VIP Care Plus to monitor the planning and provision of treatment.

All new AmeriHealth Caritas VIP Care Plus members with a newly assigned PCP (one who has not previously cared for the member) must receive a comprehensive initial examination and a screening for behavioral health and substance abuse. Members must also be screened for additional long term

support services. The PCP must report the determination of support needs to the AmeriHealth Caritas VIP Care Plus Care Coordination team at 1-866-263-9181.

AmeriHealth Caritas VIP Care Plus PCPs are also expected to assist members with accessing substance abuse and behavioral health services, as needed. The AmeriHealth Caritas VIP Care Plus Care Coordination team is available to members and providers to support care coordination and access to services. Members and providers may request Care Management support by calling 1-866-263-9181.

In addition, the PCP is responsible for:

- Providing covered services to all AmeriHealth Caritas VIP Care Plus assigned members and complying with all requirements for referral management and prior authorization.
- Providing AmeriHealth Caritas VIP Care Plus assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services and other community-based agency services.
- Providing continuous access to PCP services and necessary referrals of urgent/symptomatic or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the medical care of a member with a participating specialist(s), and/or behavioral health provider;
- Early identification of all members with special health care needs, and notification to the AmeriHealth Caritas VIP Care Plus Care Management team regarding any such identification as soon as possible;
- Collaboration with AmeriHealth Caritas VIP Care Plus 's Integrated Care Management programs to facilitate member care;
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas VIP Care Plus 's Medical Record Documentation Requirements;
- Providing follow-up services for members who have been seen in the Emergency Department;
- Promptly and accurately reporting all member encounters to AmeriHealth Caritas VIP Care Plus;
- Releasing medical record information upon written consent or request of the member;
- Providing preventive healthcare to members according to established preventive health care guidelines; and
- Advising AmeriHealth Caritas VIP Care Plus Care Management team at 1-866-263-9181 if outreach assistance is needed when a member does not keep an appointment and/or when a member cannot be reached during an outreach effort.

AmeriHealth Caritas VIP Care Plus Specialist Responsibilities

An AmeriHealth Caritas VIP Care Plus specialist is responsible for:

- Providing specialty care as indicated by a referral;
- Verifying a member's eligibility and reviewing a referral prior to the provision of services.
- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner via the referral;
- Documenting all care rendered in a complete and accurate manner, including maintaining a current medical record for Plan members that meets AmeriHealth Caritas VIP Care Plus 's

Medical Record Documentation Requirements, as described in the “Quality Assurance and Performance Improvement Program” section of this *Provider Manual*; and

- Refraining from referring members to other specialists without the intervention of the member’s PCP.

Provider Directory Responsibilities

As a Medicare-Medicaid Plan, AmeriHealth Caritas VIP Care Plus is required to ensure the accuracy of the required provider directory data. In addition to basic demographic data, AmeriHealth Caritas VIP Care Plus, must collect the following information for the provider directory:

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

Providers who have not provided this information or if there have been any changes to the provider’s office, such as an address, phone number, or the termination of a provider, notification must be made to the plan by one of the following ways:

- Contacting the Provider Network Account Executive.
- Calling Provider Services at 1-888-667-0318.

Compliance Responsibilities

AmeriHealth Caritas VIP Care Plus providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities.

Although not an exhaustive list, the primary areas of compliance with policies and laws/regulations for Plan providers are:

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

The Americans with Disabilities Act and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 (“Rehab Act”) and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require AmeriHealth Caritas VIP Care Plus providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas VIP Care Plus expects its network providers to be familiar with the requirements of the Rehab Act and the ADA and to fully comply with the requirements of these statutes. All providers are required to provide AmeriHealth Caritas VIP Care Plus an attestation of accessibility for each of their physical locations.

Health Insurance Portability and Accountability Act (HIPAA)

AmeriHealth Caritas VIP Care Plus is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on

a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Fraud, Waste and Abuse (FWA)

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

Fraud

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

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

Waste

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

- Incorrect coding/billing practices
- Utilizing higher level of care or diagnostic services

Abuse

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

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

False Claims Act

The False Claims Act (FCA) is a federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. It prohibits knowingly presenting (or causing to be

presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a claim paid or approved. Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from \$5,000 to \$11,000 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies, as well as possible exclusion from federal health care programs.

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

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

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

Reporting and Preventing FWA

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

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

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

Below are examples of information that will assist AmeriHealth Caritas VIP Care Plus with an investigation:

- Contact information (i.e. name of individual making the allegation, address, telephone number)
- Name and identification number of the suspected individual
- Source of the complaint (including the type of item or service involved in the allegation)
- Approximate dollars involved (if known)
- Place of service
- Description of the alleged fraudulent or abuse activities
- Timeframe of the allegation(s)

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

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

Michigan Office of Inspector General at: call toll-free: 1-855-MI-FRAUD (1-855-643-7283).

Reporting Abuse, Neglect and Exploitation

All AmeriHealth Caritas VIP Care Plus providers are required to identify, prevent, and report abuse, neglect and exploitations of enrollees.

- **Abuse:** Harm or threatened harm to an adult's health or welfare caused by another person. Abuse may be physical, sexual, or emotional.
- **Neglect:** Harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation (self-neglect) or the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare.
- **Exploitation:** Misuse of an adult's funds, property, or personal dignity by another person.

As soon as a provider suspects that abuse is occurring, they are required to call the Michigan Department of Human Services Adult Protective Services. Michigan provides a statewide 24- Hour Hotline: **1-855-444-3911**. If you suspect abuse, neglect, or exploitation of a resident of a nursing home by another resident or by a nursing home employee, notify:

Bureau of Health Services Abuse Hotline: 1-800-882-6006

Michigan Protection and Advocacy Service, Inc.:
Developmental Disabilities: 1-800-288-5923 Mental
Illness: 1-800-288-5923

Attorney General 24-hour Health Care Fraud Hotline: 1-800-24-ABUSE / 1-800-242-2873

Providers are also required to alert the AmeriHealth Caritas VIP Care Plus Case Manager within 24 hours of making a report to Adult Protective Services.

Advance Directives

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

In addition, AmeriHealth Caritas VIP Care Plus providers should maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advance directives must be furnished by providers and/or organizations as required by

federal regulations:

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

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

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

Provider Marketing Activities and Compliance

CMS and the State of Michigan are concerned with provider marketing activities for the following reasons:

- Providers may not be fully aware of all AmeriHealth Caritas VIP Care Plus benefits.
- Providers may confuse the member if the provider is perceived as acting as an agent of the plan versus acting as the member's provider.
- Providers may face conflicting incentives when acting as a Plan representative.

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

As a contracted provider, you are permitted to share the following with AmeriHealth Caritas VIP Care Plus members and prospective members:

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

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

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

- Offer inducements to persuade members to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from AmeriHealth Caritas VIP Care Plus for member enrollment activities.
- Distribute materials/applications within an exam roomsetting.

Provider Affiliation Information

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

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

AmeriHealth Caritas VIP Care Plus Compliance department will secure CMS approval on any provider affiliation communication materials that describe AmeriHealth Caritas VIP Care Plus in any way, (e.g., benefits, formularies).

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

Provider Support and Training

Provider Network Management

AmeriHealth Caritas VIP Care Plus Provider Network Account Executives function as a provider relations team to advise and educate AmeriHealth Caritas VIP Care Plus providers. Provider Network Account Executives assist providers in adopting new business policies, processes and initiatives or adapting existing ones in order to facilitate compliance with AmeriHealth Caritas VIP Care Plus policies and procedures. From time to time, providers will be contacted by

AmeriHealth Caritas VIP Care Plus representatives to participate in meetings that address topics including, but not limited to:

- Contract terms
- Credentialing or re-credentialing site visits
- Health management programs
- Orientation, education and training
- Program updates and changes
- Provider complaints
- Provider responsibilities
- Quality enhancements
- Self-service tools

New Provider Orientation

Upon completion of the AmeriHealth Caritas VIP Care Plus contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all AmeriHealth Caritas VIP Care Plus providers to online resources, including AmeriHealth Caritas VIP Care Plus provider orientation and training information and

this *Provider Manual*. The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. Providers may request a hard copy of this *Provider Manual* by contacting Provider Services at 1-(888)-667-0318.

Ongoing Training and Education

AmeriHealth Caritas VIP Care Plus training and development are fundamental components of continuous quality and superior service. AmeriHealth Caritas VIP Care Plus offers on-going educational opportunities for providers and their staff. Provider training and educational programs are based on routine assessments of provider needs. AmeriHealth Caritas VIP Care Plus has a commitment to provide all appropriate training and education to help providers comply with AmeriHealth Caritas VIP Care Plus standards, and federal and state of Michigan regulations. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed training information is available in the Provider area of the AmeriHealth Caritas VIP Care Plus website at www.amerihealthcaritasvipcare.com. Plan providers also have access to Provider Services at 1- 888-667-0318 and their Account Executive for questions.

Ongoing training and education is conducted throughout the calendar year; or by an ad hoc request from the provider.

- Training is available to all providers, including PCPs and LTSS, and topics include, but are not limited to:
 - a. Overview of the AmeriHealth Caritas VIP Care Plus plan;
 - b. Provider Manual review and updates;
 - c. Eligibility Requirements;
 - d. Benefits;
 - e. Long-Term Services and Supports
 - f. Access and availability standards;
 - g. Model of Care and working with a Multidisciplinary Team;
 - h. Availability of educational products that will assist providers in educating AmeriHealth Caritas VIP Care Plus enrollees on preventive care, disease specific education, plan benefits, and self-directed care;
 - i. Policies and procedures on Advance Directives;
 - j. Fraud, waste, and abuse policies and procedures;
 - k. Continuous Quality Improvement program and plan;
 - l. Prior Authorization requirements;
 - m. Appeals and Grievance Process;
 - n. Improper Billing Guidance;
 - o. Disability and Cultural Competency (Americans with Disabilities Act)
 - p. Critical Incident

Model of Care Training

The Model of Care (MOC), described more fully in Section IV, is a high quality, patient-centric medical care delivery system for dual eligible Medicare-Medicaid members and is designed to maintain the member's health and encourage their involvement in their health care. This training can be accessed online via a training module. The MOC may be revised from time to time, based on performance improvement activities.

Annual Fraud Waste and Abuse Training

As required by CMS, AmeriHealth Caritas VIP Care Plus providers and their staff are required to complete CMS- approved fraud, waste, and abuse training on an annual basis. AmeriHealth Caritas VIP Care Plus will accept the training that providers complete to fulfill compliance requirements for traditional Medicare. If an AmeriHealth Caritas VIP Care Plus provider needs assistance in accessing this training, please call Provider Services or contact your Account Executive.

Provider Specific On-Going Training

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

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

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

Plan-to-Provider Communications

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

- Provider Manual
- Provider Newsletters
- Website updates and information
- Provider letters and announcements
- Surveys
- Faxes
- E-mails
- Miscellaneous other materials

Provider Complaint System

AmeriHealth Caritas VIP Care Plus providers may file an informal dispute about AmeriHealth Caritas VIP Care Plus policies, procedures, or other aspects of AmeriHealth Caritas VIP Care Plus administrative functions. AmeriHealth Caritas VIP Care Plus will thoroughly investigate each provider complaint. All pertinent facts will be investigated and considered.

Providers may call Provider Services at 1-888- 667-0318 to notify AmeriHealth Caritas VIP Care Plus of a complaint.

Provider Contract Terminations

AmeriHealth Caritas VIP Care Plus provider agreements include termination provisions. . Provider

terminations are categorized as follows:

- Provider Initiated
- Plan Initiated “ForCause”
- Plan Initiated “WithoutCause”
- Mutual

Aside from those requirements identified in the provider agreement, AmeriHealth Caritas VIP Care Plus will comply with the following guidelines.

Provider Initiated

- The provider must provide written notice to AmeriHealth Caritas VIP Care Plus if intending to terminate from the Plan network. Written notice must be provided at least ninety (90) days before the termination date if without cause and sixty (60) days before termination date with cause. Under either circumstance, written notice must be delivered in accordance with the method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
- If the provider is a PCP, AmeriHealth Caritas VIP Care Plus will send a written notification to the members who have chosen the provider as their PCP no less than fifteen (15) calendar days after receipt of the termination notice or at least thirty (30) days prior to the termination date, whichever is sooner.
- If an AmeriHealth Caritas VIP Care Plus member has special health care needs and his or her treating provider gives notice of termination to the Plan, AmeriHealth Caritas VIP Care Plus Member Services and/or Case Management staff will personally contact the member by telephone and in writing to provide assistance in securing a new provider.

AmeriHealth Caritas VIP Care Plus Initiated “For Cause”

AmeriHealth Caritas VIP Care Plus may initiate termination of a Provider Agreement if the provider breaches the AmeriHealth Caritas VIP Care Plus Network Provider Agreement. A “for cause” termination may also be implemented when there is an immediate need to terminate a provider’s contract. If terminating a Provider Agreement for cause, AmeriHealth Caritas VIP Care Plus will:

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

AmeriHealth Caritas VIP Care Plus Initiated “Without Cause”

AmeriHealth Caritas VIP Care Plus may terminate a Provider Agreement “without cause” for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, AmeriHealth Caritas VIP Care Plus will:

- Send applicable termination letters in accordance with the notification provisions of the Network Provider Agreement;
- Notify AmeriHealth Caritas VIP Care Plus Network provider and members in active care;
- Offer Coordination of Care to transition members to new providers.

Mutual Terminations

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

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas VIP Care Plus Network Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members and effectuate continuity of care. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas VIP Care Plus will notify all members in active care.

Continuity of Care

AmeriHealth Caritas VIP Care Plus members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or,
- Until the member changes to a new provider.

Note: None of the above may exceed six (6) months after the termination of the Provider Agreement.

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

For continued care, AmeriHealth Caritas VIP Care Plus and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*. The provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas VIP Care Plus for cause.

Prohibition on Payments to Excluded/Sanctioned Persons

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

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

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

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

III. Provision of Services

AmeriHealth Caritas VIP Care Plus offers an individual, integrated care and supports plan that combines a member's Medicare and Medicaid benefits into one plan for improved coordination of benefits.

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

For detailed information about Medicare basic benefits please refer to www.Medicare.gov. For detailed information about Medicaid basic benefits, please refer to the Michigan Medicaid State Plan, available online at www.michigan.gov/MDHHS.

Medicare and Medicaid Program Summary of Covered Services

Medicare/Medicaid Program Physical Health Services

The following physical health services represent AmeriHealth Caritas VIP Care Plus Medicare/Medicaid program's benefit package:

- Acute Care Services
- Anesthesia
- Certified nurse midwife services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray, and other imaging services
- Emergency services
- End stage renal disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Home health services
- Immunizations
- Inpatient and outpatient hospital services
- Medically necessary weight reduction services
- Occupational therapy
- Organ & bone marrow transplant services
- Pharmacy services
- Physical therapy
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists, dentists, etc.)
- Preventive care and screening

- Respiratory care
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Telemedicine
- Therapy evaluation
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Transplants and Immunosuppressive Drugs
- Treatment for sexually transmitted disease (STD)
- Vision services
- Wellness services

- Durable Medical Equipment, Supplies, Orthotics, and Prosthetics
 - Durable medical equipment (DME) and supplies
 - Prosthetics and orthotics

- Dental Services
 - Preventive Dental
 - Covered services: Oral Exams, Prophylaxis (Cleaning) and Dental X-Rays as defined in the Michigan Medicaid State Plan
 - Excluded services: Fluoride Treatment
 - Restorative Dental
 - Covered Services: Restorative Services, Prosthodontics, Oral, and Oral/Maxillofacial Surgery and other services as defined in the Michigan Medicaid State Plan
 - Excluded Services: Non-routine Services, Crowns and Endodontics

- Vision Services
 - Routine Eye Exams
 - Glasses/Contact Lenses
 - Low Vision Aids

- Transportation
 - Ambulance and other emergency medical transportation
 - Non-Emergency Medical Transportation

- Long Term Supports and Services
 - Nursing Facility Services
 - Intermittent or short-term restorative or rehabilitative services in a nursing facility
 - Medicaid covered nursing facility services (including hospital and therapeutic leave days)

- Home and Community Based Services
 - State Plan Personal Care Services
 - Adaptive/Enhanced Durable Medical Equipment and Supplies
 - Chore Services
 - Community Living Supports
 - Community Transition Services
 - Environmental Modifications
 - Fiscal Intermediary Services
 - Medication Reconciliation
 - Preventive Nursing Services
 - Personal Emergency Response System (PERS)
 - Training and Counseling

- Adult Day Program
- Assistive Technology/Vehicle Modifications
- Home Delivered Meals
- Non-Medical Transportation
- Private Duty Nursing
- Respite

Medicare/Medicaid Program Behavioral Health Services

Behavioral health services are authorized and reimbursed through the Pre-Paid Inpatient Health Plan (PIHP) access center in the county where the member resides. AmeriHealth Caritas VIP Care Plus has contracted with the Detroit Wayne Integrated Health Network and the Macomb Mental Health Authority to provide behavioral health services to the AmeriHealth Caritas VIP Care Plus member. The following behavioral health services are also included in the AmeriHealth Caritas VIP Care Plus Medicare/Medicaid program's benefit package:

- **Outpatient Visits (Medicaid and Medicare)** for enrollees with mild, moderate and severe behavioral health needs;
- **Other Medicaid Behavioral Health Services** (for enrollees with specialized needs related to the behavioral health and/or intellectual or developmental disability beyond covered acute care services)
 - Assertive Community Treatment
 - Assessments
 - Assistive Technology
 - Behavior Treatment Review
 - Clubhouse Psychosocial Rehabilitation Programs
 - Community Living Supports
 - Crisis Interventions
 - Crisis Observation Care
 - Crisis Residential Services
 - Enhanced Pharmacy
 - Environmental Modifications
 - Family Support and Training
 - Family Therapy
 - Fiscal Intermediary Services
 - Health Services
 - Home-based Services
 - Housing Assistance
 - Individual/Group Therapy
 - Inpatient Psychiatric Hospital Admissions
 - Intensive Crisis Stabilization Services
 - Medication Administration
 - Medication Review
 - Nursing Facility Mental Health Monitoring
 - Occupational Therapy
 - Outpatient Partial Hospitalization Services
 - Peer Delivered or Operated Support Services
 - Personal Care in Licensed Specialized Residential Setting
 - Physical Therapy
 - Prevention Direct Service Model

- Respite Care Services
- Skill-Building Assistance
- Speech, Hearing and Language
- Substance Abuse
- Support and Service Coordination
- Targeted Care Management
- Telemedicine
- Transportation
- Treatment Planning

Health Management Program

AmeriHealth Caritas VIP Care Plus cares about our members' health and wellness. To help our members stay healthy and improve their quality of life, AmeriHealth Caritas VIP Care Plus has special programs available for members to address heart disease, diabetes, and an asthma, and can provide information about health education and wellness services such as our smoking cessation program. We also offer a 24/7 nurse hotline, 1-855-843-1145 where members can get personalized help from a registered nurse.

Maternal Infant Health Program

Pregnant AmeriHealth Caritas VIP Care Plus members are eligible for services through the State of Michigan's Maternal Infant Health Program (MIHP). These are preventive health home visit services intended to supplement regular prenatal and infant care and help providers manage the member's health and well-being. MIHP services are billed directly to the State of Michigan Medicaid program. These services may extend 60 days after delivery.

It is the objective of MDHHS and AmeriHealth Caritas VIP Care Plus to enroll all pregnant women in an MIHP. For information on how to access MIHP services, providers should call AmeriHealth Caritas VIP Care Plus Provider Services at 1-888-667-0318. In addition:

- MIHP providers must be certified by the Michigan Department of Health and Human Services.
- MIHP services include psychosocial and nutritional assessment; professional services rendered by a multidisciplinary team that includes a social worker, nurse, and nutritionist; transportation; childbirth (including midwife and nurse practitioner services, if billed as an obstetrics benefit); parenting education; referral to community services; and coordination with medical care providers.
- Care Management staff will contact eligible pregnant members and direct them to appropriate MIHP providers for service.

Medicare/Medicaid Program Non-Covered Services

AmeriHealth Caritas VIP Care Plus will refer members to local resources for services that are not covered by AmeriHealth Caritas VIP Care Plus, as appropriate. Providers may contact the AmeriHealth Caritas VIP Care Plus Care Management team at 1-866-263-9181 for assistance with coordination of non-covered services.

Private Pay for Non-Covered Services

Providers are required to inform members about the costs associated with services that are not covered under the AmeriHealth Caritas VIP Care Plus plan, prior to rendering such services. Providers must submit a request for prior authorization for all non-covered services, including statutorily excluded services and receive an organizational determination prior to attempting to make private pay arrangements with the member. Should the member and provider agree, such services would be rendered under a private pay arrangement. The provider must obtain a signed document from the member to validate the private payment arrangement.

Emergency Services

AmeriHealth Caritas VIP Care Plus ensures the availability of emergency services and care 24 hours a day, seven days a week (24/7) for Plan members.

AmeriHealth Caritas VIP Care Plus is responsible for coverage and payment of emergency services and post-stabilization care services for AmeriHealth Caritas VIP Care Plus members regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas VIP Care Plus.

AmeriHealth Caritas VIP Care Plus coverage responsibility for post-stabilization care that has not been pre-approved ends when:

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

AmeriHealth Caritas VIP Care Plus will not deny payment for treatment obtained when a member had an emergency medical condition, or when the condition was in fact non-emergent in nature but appeared on presentation and/or during medical screening to be an emergency condition under the "prudent layperson" standard. AmeriHealth Caritas VIP Care Plus does not require prior authorization for emergency services provided by network or non-network providers when an AmeriHealth Caritas VIP Care Plus member seeks emergency care.

AmeriHealth Caritas VIP Care Plus will not refuse to cover emergency services for AmeriHealth Caritas VIP Care Plus members based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider, AmeriHealth Caritas VIP Care Plus, or applicable State of Michigan entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. Non-network providers of emergency care for AmeriHealth Caritas VIP Care Plus members will be reimbursed according to the requirements set forth by the MDHHS.

Out-of-Network Use of Non-Emergency Services

AmeriHealth Caritas VIP Care Plus will provide timely approval or denial of requests for authorization of out-of-network service(s) (medical, behavioral, pharmacy and LTSS) through written notification, which refers to and documents the determination. The provider will be liable for the cost of unauthorized use of covered services from non-participating providers, except when seeking care for an emergency medical condition.

IV. Model of Care and Integrated Care Management

The following information is in regard to AmeriHealth Caritas VIP Care Plus Integrated Care Team (ICT) and Model of Care, which includes Case & Disease Management and Care Coordination for physical, behavioral, pharmacy and LTSS health services provided to AmeriHealth Caritas VIP Care Plus members.

Integrated Care Team Overview

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

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

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

Integrated Care Team Components

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

- Model of Care
- Integrated Care Team
- PCP/Medical Home
- Specialists, Behavioral Health Providers, LTSS Providers
- Chronic Care Programs
- Clinical Practice Guidelines
- Care Management Team

Model of Care

AmeriHealth Caritas VIP Care Plus has created a Model of Care (MOC) that addresses the physical, behavioral health, and external needs of the dual eligible population in Michigan. The MOC takes into consideration medical conditions, challenges presented by the members' social conditions, limitations in activities of daily living, evidence-based practices, and the potential health status of the population eligible to enroll in the AmeriHealth Caritas VIP Care Plus plan. AmeriHealth Caritas VIP Care Plus will assist the Integrated Care Team in creating the best plan of care and quality management for each member.

Integrated Care Team

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

PCP/Medical Home

The PCP/Medical Home has an important role in the Integrated Care Team. Key responsibilities include assisting members in determining which services are necessary, connecting members to appropriate service, serving as a central communication point for the member's care, reviewing the plan of care sent by AmeriHealth Caritas VIP Care Plus and providing feedback to AmeriHealth Caritas VIP Care Plus. Updates are routinely made to the plan of care and come from multiple sources such as member or provider calls, updated health risk assessment (HRA), care transition (hospital, nursing home), claim history, pharmacy or utilization triggers and care episodes.

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

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

Chronic Care Improvement Programs

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

Clinical Practice Guidelines

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

Care Management Team

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

management and care coordination support.

Members and providers may request Care Management support by calling 1-866-263-9181.

Seamless Transition

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

Self- Determination

AmeriHealth Caritas VIP Care Plus is committed to ensuring each member has the opportunity to exercise choice and control in identifying, accessing, and managing supports and services in accordance with his or her needs and personal preferences. Members have the authority to exercise decision making over some or all home and community-based supports and services, including who provides services and how the services are delivered. Self-determination can promote independent living for members and can also improve quality of life.

AmeriHealth Caritas VIP Care Plus Staff

- Notify medical home/PCP of planned or unplanned transition for admission and at discharge
- Contact members to verify plans, establish point of contact
- Provide plan-of-care information to sending and receiving facility/provider, including changes at discharge.

PCP

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

Hospital

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

Care Coordination with the PCP

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

Care Coordination with Other Providers

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

Integrating Behavioral and Physical Health Care

Members with behavioral health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions.

AmeriHealth Caritas VIP Care Plus understands that coordination of care for these members is imperative.

Plan staff work with the appropriate primary care and behavioral health providers to develop an individual, integrated care and supports plan for members in need of physical and behavioral health care coordination. Care managers will also assure that communication between the two disciplines, providers, and organizations, occurs routinely for all members with physical and behavioral health issues. Care managers will also work to coordinate with alcohol and drug abuse providers and community resources, as appropriate. Care managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed assessed and updated.

Treatment Plans

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

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

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

Treatment plans for members with special health care needs are reviewed and updated every thirty (30) days for high-risk enrollees, ninety (90) days for moderate risk enrollees and every one hundred and twenty (120) days for low risk enrollees. The revised treatment plan is expected to be incorporated into the member's medical record following each update.

Model of Care Evaluation

Data Sources

- Claims (medical, behavioral health, pharmacy)
- Authorization data
- HEDIS reports
- Member surveys
 - Consumer Assessment of Health Care Providers and Systems (CAHPS)
 - Health Outcomes Survey (HOS)
- Practitioner and facility surveys
- Provider feedback
- Complaint and grievance analysis

Methods of Communicating Updates and Outcome

- The AmeriHealth Caritas VIP Care Plus website – Quality and Satisfaction Updates
- Member News Bulletin
- Provider News Bulletin
- Provider Workshops – presentations are interactive via the website, face-to-face workshop presentations, as well as provider site visits
- All communications are available in hard copy or via the AmeriHealth Caritas VIP Care Plus website at www.amerihealthcaritasvipcareplus.com.

Providers may also contact Provider Services at 1-888-667-0318 or your Account Executive for assistance with questions.

V. Utilization Management

The AmeriHealth Caritas VIP Care Plus Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization Management activities are designed to assist our providers with the organization and delivery of appropriate health care services to members within the structure of the member's benefit plan. AmeriHealth Caritas VIP Care Plus does not structure compensation to individuals or entities that conduct utilization management activities to provide incentives for the denial, limitation, or discontinuation of medically necessary services to any member.

Per the provider agreement with AmeriHealth Caritas VIP Care Plus, providers are required to comply with AmeriHealth Caritas VIP Care Plus's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service;
- Providing clinical information to support medical necessity and evidence-based practices when requested;
- Permitting access to the member's medical information;
- Involving the Plan's medical management nurse in discharge planning discussions and meetings; and/or,
- Providing a plan of treatment, progress notes and other clinical documentation to AmeriHealth Caritas VIP Care Plus medical management, the receiving facility and the member's PCP as applicable within twenty-four hours of discharge.

Referrals

Referrals from PCPs to participating specialists for office visits are not required under AmeriHealth Caritas VIP Care Plus. Referrals from participating providers are required for Opioid Treatment Programs, Private Duty Nursing and Outpatient Blood Services under the AmeriHealth Caritas VIP Care Plus plan (no official, plan-issued or electronic referral required).

Prior Authorization

Prior Authorization is required for services provided by non-participating physicians and providers, with the exception of emergency services. The AmeriHealth Caritas VIP Care Plus UM department hours of operation are 8 a.m. to 6:00 p.m. Eastern time, Monday through Friday.

The general UM department telephone number is 1 -866-263-9011. The general UM department fax number 1 -866-263-9036.

AmeriHealth Caritas VIP Care Plus encourages providers to request prior authorization for non-emergent and elective services within twenty-four (24) hours of the identification of the need for service. For services needing prior authorization as part of post-stabilization following emergency services, we encourage providers to seek authorization within twenty-four (24) hours. Providers may request prior authorization by:

- Calling the general UM number or calling Provider Services and selecting the option for prior authorization/case management.
- Faxing a request for prior authorization.
- Providing an electronic request through the provider portal – NaviNet.

Providers requiring an expedited decision should make this known at the time of request.

Providers will receive notification of the organizational determination within fourteen (14) calendar days for standard requests or seventy-two (72) hours for expedited requests. For Inpatient Concurrent Review providers will receive notification of the organizational determination within twenty-four (24) hours. The provider will be notified of the authorization or denial by fax. Providers may also receive notification verbally or electronically. Prior authorization is not a guarantee of payment. AmeriHealth Caritas VIP Care Plus reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided.

Services Requiring Prior Authorization

The following is a list of services requiring prior authorization review for medical necessity and place of service. This list may change periodically. The most up-to-date list of services requiring prior authorization will be maintained in the provider area of our website at www.amerihhealthcaritasvipcareplus.com.

- Elective/Non-Emergent Air Ambulance Transportation
- All Out-of-Network Services (except emergency services)
- Inpatient Services
 - All Inpatient Hospital Admissions (including medical, surgical and rehabilitation)
 - Obstetrical Admissions/Newborn Deliveries (exceeding 48 hours after vaginal delivery and 96 hours after caesarean section)
 - Inpatient Medical Detoxification
 - Elective Transfers (for inpatient and/or outpatient services between acute care facilities)
 - Medicaid-Sponsored Long-Term Care Stay (initial placement and every 365 days)
- Home-Based Services
 - Home Health Care
 - Private Duty Nursing and Extended Home Health Services (when covered)
 - Home Infusions and Injections provided in an outpatient setting, not required for outpatient hospital setting
 - Enteral Feedings (including related DME)
- Therapy and Related Services
 - Speech Therapy, Occupational Therapy, Physical Therapy, and Cardiac Rehabilitation
- Transplants (including transplant evaluations)
- All DME Rentals
- DME Purchases (for allowable charges \$500 and over, including prosthetics and orthotics)
- Hyperbaric Oxygen
- Implants (for allowable charges over \$500)
- Injectable Medications not listed on the Medicare and Medicaid Fee Schedule are not covered by AmeriHealth Caritas VIP Care Plus
- Medications: 17-P and all infusion/injectable medications listed on the Medicare Professional Fee Schedule
- Surgical Services that may be considered cosmetic, including:
 - Blepharoplasty
 - Mastectomy for Gynecomastia

- Mastopexy
- Maxillofacial
- Panniculectomy
- Penile Prosthesis
- Plastic Surgery/Cosmetic Dermatology
- Reduction Mammoplasty
- Septoplasty
- Cochlear Implantation
- Gastric Bypass/Vertical Band Gastroplasty
- Hysterectomy
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks
- Radiology Outpatient Services, including but not limited to:*
- CT Scan
- MRI
- MRA
- MRS
- PET scan
- SPECT scan
- Nuclear Cardiac Imaging
- Long Term Support Services
 - State Plan Personal Care Services
 - Adaptive/Enhanced Durable Medical Equipment and Supplies
 - Chore Services
 - Community Living Supports
 - Community Transition Services
 - Environmental Modifications
 - Fiscal Intermediary Services
 - Medication Reconciliation
 - Preventive Nursing Services
 - Personal Emergency Response System (PERS)
 - Training and Counseling
 - Adult Day Program
 - Assistive Technology/Vehicle Modifications
 - Environmental Modifications (in excess of those covered above)
 - Home Delivered Meals
 - Non-Medical Transportation
 - Private Duty Nursing
 - Respite
- All miscellaneous/unlisted or not otherwise specified codes
- All services that may be considered experimental and/or investigational

Behavioral Health Services must be authorized through the PIHP access center

**Emergency room, observation care and inpatient imaging procedures do not require prior authorization.*

***All requests for services are subject to Medicare and Michigan Department of Health and Human Services Medicaid coverage guidelines and limitations.*

Services that Do Not Require Prior Authorization

The following services do not require prior authorization from the Plan:

- Emergency Services.
- Women's Health Specialist Services (to provide women's routine and preventive health care services).
- Low-level plain films – i.e. x-rays, etc.
- EKGs.
- Post Stabilization Services (in-network and out-of-network).
- Imaging procedures related to emergency room services, observation care and inpatient care.
- Laboratory services.
- Ultrasounds.

AmeriHealth Caritas VIP Care Plus encourages providers to request Prior Authorization for non-emergent and elective services within twenty-four (24) hours of the identification of the need for service. For services needing prior authorization as part of post-stabilization following emergency services, we encourage providers to seek authorization within twenty-four (24) hours.

Providers may request Prior Authorization by:

- Calling Provider Services and selecting the option for Prior Authorization/Case Management.
- Faxing a request for Prior Authorization. You may also submit a prior authorization request via [NaviNet](#). Select the **Medical Authorizations** option, which is a robust, intuitive, and streamlined online authorizations workflow.

Providers requiring an expedited decision should make this known at the time of request.

Providers will receive notification of prior authorization within fourteen (14) calendar days for standard requests and seventy-two (72) hours for expedited requests. The provider will be notified of the authorization or denial by fax. Providers may also receive notification verbally or electronically.

Services that Require Notification

- All Admissions (elective admissions require preauthorization)

Organization Determinations

An organization determination is any determination (i.e. approval or denial) by AmeriHealth Caritas VIP Care Plus regarding the benefits a member is entitled to receive from AmeriHealth Caritas VIP Care Plus. Examples include:

- Payment for emergency services, post-stabilization care or urgently needed services;
- Payment for any other health service furnished by a non-contracted provider and the member believes;
 - The services are covered under Medicare or Medicaid; or,
 - If not covered under Medicare nor Medicaid, should have been furnished, arranged for or reimbursed by AmeriHealth Caritas VIP Care Plus

- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the member believes should be furnished, arranged for or reimbursed by AmeriHealth Caritas VIP Care Plus;
- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or
- Failure of AmeriHealth Caritas VIP Care Plus to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of the member.

The procedures for appealing an organization determination are described in the “Grievances, Appeals and Fair Hearings” section of this *Provider Manual*.

Standard Process

AmeriHealth Caritas VIP Care Plus must notify the member of its determination as expeditiously as the member’s health condition requires, or no later than fourteen (14) calendar days after AmeriHealth Caritas VIP Care Plus receives the request.

The timeframe may be extended up to fourteen (14) additional calendar days if:

- The provider or the member requests an extension; and,
- The Plan justifies the need for additional information and the extension is in the member’s best interest.

Expedited Process

The member’s physician may request an expedited determination, including authorizations, from AmeriHealth Caritas VIP Care Plus when the member or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the member’s life, health, or ability to regain maximum function.

If AmeriHealth Caritas VIP Care Plus decides to expedite the request, Plan staff will render a decision as expeditiously as the member’s health condition requires but no later than three (3) business days after receiving the request.

If AmeriHealth Caritas VIP Care Plus requires medical information to make the determination, AmeriHealth Caritas VIP Care Plus is required to request the information within twenty-four hours and to respond to the member within seventy-two (72) hours of receiving the request.

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

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

AmeriHealth Caritas VIP Care Plus will provide an expedited organization determination if the

member's physician indicates, either verbally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If AmeriHealth Caritas VIP Care Plus denies the request for an expedited determination, we will:

- Automatically transfer the request to the standard timeframe for determination within fourteen (14) calendar days of the original request;
- Provide the member and provider with prompt verbal notice of the denial, including the member's right to appeal;
- Deliver written notice to the member and provider, including:
 - o Explaining that the request will be addressed under the standard timeframe.
 - o Informing the member of his/her right to file an expedited grievance if he or she disagrees with the decision not to expedite the determination;
 - o Informing the member of his/her right to re-submit a request for an expedited determination.

Medical Necessity Standards

Medically Necessary Services as defined by CMS and MDHHS are services that are provided in a way that provides all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.

The need for the item or service must be clearly documented in the patient's medical record.

Medically necessary services or items are:

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

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

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

In addition to Medicare coverage guidelines, AmeriHealth Caritas VIP Care Plus uses the following criteria: as guidelines for determinations related to medical necessity:

InterQual®

- Adult ISD (Intensity of Service, Severity of Illness and Discharge Screens)
- Outpatient Therapy
- Home Care
- Imaging
- Procedures
- DME

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

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

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the AmeriHealth Caritas VIP Care Plus Medical Director or other designated practitioner under the clinical direction of the Medical Director. The AmeriHealth Caritas VIP Care Plus Medical Director is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The AmeriHealth Caritas VIP Care Plus Medical Director is a physician with a current license to practice medicine in Michigan.

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

Upon request by a member or practitioner/provider, the criteria used for medical necessity decision making in general, or for a particular decision, is provided in writing by the

AmeriHealth Caritas VIP Care Plus Medical Director or designee. AmeriHealth Caritas VIP Care Plus will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member.

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

Notice of Adverse Determination

If AmeriHealth Caritas VIP Care Plus decides to deny authorization for services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment, then it will give the member a written notice of its determination. AmeriHealth Caritas VIP Care Plus will provide notice via mail to the member. If the member has a representative, the representative will be given a copy of the notice.

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

- Informs the member of the right to file an expedited grievance if he or she disagrees with AmeriHealth Caritas VIP Care Plus' decision not to expedite a coverage determination;
- Informs the member of the right to resubmit a request for an expedited determination; and that if the member gets any physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically; and
- Provides instructions about the expedited grievance process and its time frames.

Peer to Peer Review

Providers may only request a peer-to-peer review during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the decision is rendered.

Reconsideration

Any party to an organization determination (including a reopened and revised determination), i.e., a member, a member's authorized representative or a non-contracted physician or provider to AmeriHealth Caritas VIP Care Plus may request that the determination be reconsidered. A member, a member's representative, or physician (regardless of whether the physician is affiliated with AmeriHealth Caritas VIP Care Plus) is the only parties who may request that AmeriHealth Caritas VIP Care Plus expedite reconsideration. AmeriHealth Caritas VIP Care Plus will accept a verbal reconsideration from a member or a member's representative.

Reconsiderations are performed in accordance with AmeriHealth Caritas VIP Care Plus policy.

If AmeriHealth Caritas VIP Care Plus affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it will prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. Specific information on filing a reconsideration can be found in Section VI of this *Provider Manual*.

Post-Service Reviews

In certain situations, AmeriHealth Caritas VIP Care Plus conducts post-service reviews for medical services or items which have already been rendered or received, but for which prior authorization was not obtained. Further, requests for a post-service review may be honored under certain circumstances.

Requests for post-service reviews may be made by members, individual practitioners, or facilities. A post-service review may be performed in the following circumstances:

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

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

Transmission of Transition of Care Records

As a state of Michigan MI Health Link Medicare-Medicaid plan (MMP), AmeriHealth Caritas VIP Care Plus is required to verify that hospitals are following MI Health Link requirements for the transmission of transition of care (TOC) records following an inpatient admission. The requirement is derived from the MMP contract among AmeriHealth Caritas VIP Care Plus, the Michigan Department of Health and

Human Services, and the Centers for Medicare and Medicaid Services. Specifically, the MMP contract requires MI Health Link plans to verify that inpatient treatment providers transmit TOC records for discharged members within 24 hours of discharge to the home, facility, primary care provider or other health care professional designated for the member's follow-up care. This requirement applies regardless of the age of the member.

In accordance with this obligation and to satisfy reporting requirements for the MI Health Link program, AmeriHealth Caritas VIP Care Plus is also asking inpatient treatment providers to provide us with copies of TOC records your facility prepared for our members. We are requesting the TOC record be submitted to AmeriHealth Caritas VIP Care Plus at the time of discharge during the discharge planning process, so we are able to assist in the TOC process.

Please submit copies of AmeriHealth Caritas VIP Care Plus member TOC records to our plan via the following methods **prior to or at the time of discharge**:

Secure Fax: 1-866-263-9164

Mail: AmeriHealth Caritas VIP Care Plus
Attn: Care Management
Suite 1300
4000 Town Center Southfield,
MI 48076

All participating providers are expected to comply with this request to allow the plan to access to medical records and any other patient care documentation relevant to services rendered to the member. Noncompliance will be referred to the plan Provider Network Management department.

If you have any questions, please contact the AmeriHealth Caritas VIP Care Plus Care Management department at 1-866-263-9181 or Provider Services at 1-888-667-0318

VI. Grievances, Appeals and Fair Hearings

Standard and Expedited Grievances (Complaints)

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

A grievance expresses dissatisfaction about matters related to the services offered by AmeriHealth Caritas VIP Care Plus. The member may file a grievance in writing or by phone. It may be filed by the provider (or another authorized representative) on behalf of the member with the member's written consent. A grievance may be filed about such things as the quality of the care the member receives from an AmeriHealth Caritas VIP Care Plus provider, rudeness from an AmeriHealth Caritas VIP Care Plus employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas VIP Care Plus or any service or item that did not meet accepted standards for health care during a course of treatment.

AmeriHealth Caritas VIP Care Plus will contact the member within five (5) business days of receiving the grievance to acknowledge receipt. AmeriHealth Caritas VIP Care Plus will send a resolution letter within thirty (30) calendar days of receiving the grievance.

Quality of Care Grievances

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

Filing a Grievance

To file a grievance, the member, the member's physician, or other representative, may call Member Services for AmeriHealth Caritas VIP Care Plus at 1-888- 667-0318. or write to:

AmeriHealth Caritas VIP Care Plus Attn: Grievances Department
Box 7140
London, KY 40742-7140

Note: Providers should forward any grievances they receive directly from the members to the plan using the contact information.

To file a quality of care grievance with the QIO, the member, the member's physician, or the member's representative may contact MPRO for an independent review through their website at

<http://www.mpro.org/> or at 1-800-365-5899.

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services toll free at for AmeriHealth Caritas VIP Care Plus at 1- (888)-667-0318.

Interpreter services, if needed, will be made available free of charge to the member.

Appeals

Following the receipt of a Notice of Action from AmeriHealth Caritas VIP Care Plus denying payment for a service, denying authorization of a service or discontinuing services the member is in the process of receiving, the member or the member's authorized representative (physician, family member or any other person who has received authorization) may file a request for an appeal. The request may be filed in writing or verbally by contacting MemberServices.

The member or the member's representative may file two types of appeals: a standard appeal or an expedited appeal. A standard appeal can consist of appealing an action that denies payment for a service, denies authorization of a service, or discontinues services a member may be in the process of receiving. An expedited appeal may be an appeal that as a result of the action by AmeriHealth Caritas VIP Care Plus, the member's health may be jeopardized if the standard appeal process is followed.

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

Standard Appeal Process

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

AmeriHealth Caritas VIP Care Plus must issue a resolution to a standard appeal request within thirty (30) calendar days from the date it received the request or as expeditiously as the member's health requires. A decision will be rendered within seven (7) calendar days for routine Medicare Part B drug appeals. This time frame may be extended up to fourteen (14) calendar days by AmeriHealth Caritas VIP Care Plus if AmeriHealth Caritas VIP Care Plus justifies a need for additional information and documents how the delay is in the interest of the member. However, the extended timeframe cannot delay the decision beyond thirty (30) calendar days of the request for appeal, without the informed consent of the member.

Expedited Appeal Process

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

AmeriHealth Caritas VIP Care Plus can also have an additional fourteen (14) days if AmeriHealth Caritas VIP Care Plus documents that additional information is needed, and the delay is in the member's best interest. If AmeriHealth Caritas VIP Care Plus needs more time, the member will be informed of the reason for the extension in writing.

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

Steps Following AmeriHealth Caritas VIP Care Plus Appeal Decisions

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

For appeals not resolved wholly in favor of the members, the written resolution letter will include:

Information on how to file an External Appeal, also called a Level 2 Appeal. This appeal is reviewed by an independent organization that is not connected to the plan. There are different independent organizations for Medicare and Michigan Medicaid:

- For a **Medicare** service, the case will be sent automatically to the Medicare Independent Review Entity (IRE) for an External Appeal. The IRE will give you an answer within 30 calendar days of when it gets your appeal.
- For a **Michigan Medicaid** service, there are two ways to make an External Appeal:
 1. Request a Michigan Medicaid Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) within **120**

- calendar days** after the mailing date of the notice of appeal decision and/or
2. External Review with the Department of Insurance and Financial Services (DIFS) within **127 calendar** days of the receipt of the notice of appeal decision.
- For a service that could be covered by **both Medicare and Michigan Medicaid**, the case will be automatically sent to the Medicare IRE for an External Appeal. You can also ask for a Michigan Medicaid Fair Hearing with MOAHR within **120 calendar days** after the mailing date of the notice of appeal decision and/or an External Review with DIFS within **127 calendar** days of the receipt of the notice of appeal decision.

Note: To ask for an External Review from DIFS, you must complete the Health Care Request for External Review form. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form.

Filing an Appeal

To file an internal appeal or for more information regarding the appeals process, you or the member may call Member Services at for AmeriHealth Caritas VIP Care Plus at 1-888- 667- 0318 or fax appeal information to 1-855-221-0046 or write to:

AmeriHealth Caritas VIP Care Plus Attn: Appeals Department
PO Box 80109
London, KY 40742- 0109

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

Interpreter services are free of charge to the member.

Provider Administrative or Medical Review

Peer-to-Peer

Providers may only request a peer-to-peer review during initial outreach by the Clinical Care Reviewer notifying the provider that the authorization request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer-to-peer must occur before the decision is rendered.

Note: The purpose of the appeals process is to address medical determinations regarding health care services. This process is not intended to address denied claims or other issues. For information on filing an informal provider complaint, please refer to the “Provider and Network Information” section of this *Provider Manual*. For information on disputing a claim, please refer to the “Claims Submission Protocols and Standards” section of this *Provider Manual*.

Appeal for a Request for Payment of Denied Claims

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

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Member Appeals telephone line at 1-888- 667-0318.

VII. Quality Assurance and Performance Improvement Program

AmeriHealth Caritas VIP Care Plus's Quality Assurance and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. The Plan's Board of Directors provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into AmeriHealth Caritas VIP Care Plus operations. Operational responsibility for the development, implementation, monitoring and evaluation of the QAPI program is delegated by the Board of Directors through the Plan President to the AmeriHealth Caritas VIP Care Plus Executive Director and Quality Assessment Performance Improvement Committee (QAPIC).

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

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing, and re-designing of services and programs to meet the health care needs of our diverse membership.

AmeriHealth Caritas VIP Care Plus develops goals and strategies considering applicable State of Michigan and Federal laws and regulations and other regulatory requirements, NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. AmeriHealth Caritas VIP Care Plus also uses performance measures such as HEDIS®, CAHPS®, consumer and provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

Quality Management Activities

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

- Every provider in the AmeriHealth Caritas VIP Care Plus provider network is required by contract to cooperate with and participate in AmeriHealth Caritas VIP Care Plus's quality management/quality assessment & performance improvement (QM/QAPI) program. We rely on your cooperation and participation to meet our own state and federal obligations as a Medicare-Medicaid ICO.
- AmeriHealth Caritas VIP Care Plus's access to the medical records maintained by our providers is a critical component of our data collection as we seek to ensure appropriate and continued access to care for our member population. AmeriHealth Caritas VIP Care Plus or its designee must receive medical records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program. AmeriHealth Caritas VIP Care Plus will reach out from time to time to request records for these purposes; it is essential that you provide requested records within the timeframes set forth in those notices.
- As our technological capabilities continue to advance, AmeriHealth Caritas VIP Care Plus will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including through the use of bi-directional automated data exchange with our providers. These exchange opportunities, as available, are intended to capture data related to gaps in care, and to identify social determinants of health that may also be targets for intervention. AmeriHealth Caritas VIP Care Plus will work with our providers to identify and implement the most appropriate format and cadence for data exchange.
- AmeriHealth Caritas VIP Care Plus clinical reviewers fully investigate potential quality of care (QOC) concerns, in accordance with AmeriHealth Caritas VIP Care Plus policy. Providers are expected to comply with QOC review processes, beginning with the timely submission of records in response to requests from AmeriHealth Caritas VIP Care Plus. Your support of and participation in this critical review process helps to ensure the provision of high-quality care and service to the AmeriHealth Caritas VIP Care Plus member population.

Quality Assessment Performance Improvement Committee

The QAPIC oversees AmeriHealth Caritas VIP Care Plus efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas VIP Care Plus members, and evaluate the effectiveness of the QAPI program. Additional committees and councils support the QAPI program and report into the QAPIC:

Member Advisory Council – Provides a forum for member participation and input to AmeriHealth Caritas VIP Care Plus programs and policies to promote collaboration, maintain a member focus and enhance the delivery of services to AmeriHealth Caritas VIP Care Plus communities.

Quality of Service Committee – Monitors performance and quality improvement activities related to AmeriHealth Caritas VIP Care Plus services; reviews, approves and monitors action plans created in response to identified variances.

Pharmacy and Therapeutics Committee – Monitors drug utilization patterns, formulary composition, pharmacy benefits management procedures and quality concerns.

Credentialing Committee – Reviews practitioner and provider applications, credentials, and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas VIP Care Plus Network.

Practitioner Involvement

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at 1-888 667-0318 or their Provider Network Account Executive.

QAPI Activities

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

- **Plan** – Establish objectives and processes necessary to meet performance or outcome goals.
- **Do** – Implement plan and processes; collect data for further analysis.
- **Check** – Evaluate and compare the results to the performance/outcome goal; identify differences between the actual/expected/target outcomes.
- **Act** – Develop and implement corrective action to address significant differences between the actual and planned results; conduct root cause analysis; as necessary, return to Plan step.

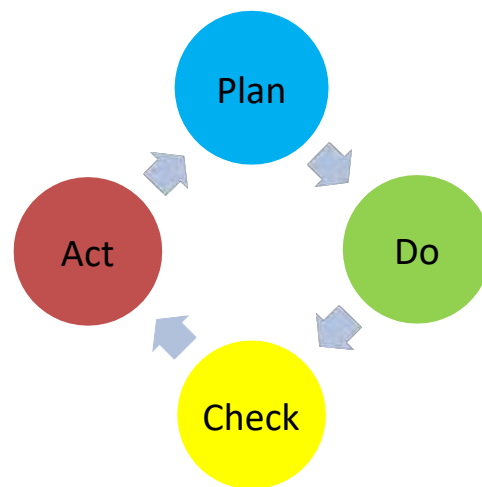


Figure 2: PDCA Quality Process

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

On-going QAPI activities include:

Quality Improvement Projects

AmeriHealth Caritas VIP Care Plus develops and implements Quality Improvement Projects (QIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

Health Status – Prevalence Documentation and Baseline Assessment

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

Ensuring Appropriate Utilization of Resources

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

Chronic Care Improvement Programs

AmeriHealth Caritas VIP Care Plus Chronic Care Improvement Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

Measuring Member and Provider Satisfaction

AmeriHealth Caritas VIP Care Plus uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. AmeriHealth Caritas VIP Care Plus also conducts provider satisfaction studies annually. Survey results, along with analysis and trends on dissatisfaction and member opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

Participant and Provider Dissatisfaction

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Member Safety Programs

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

Preventive Health and Clinical Guidelines

The QAPIC is responsible for approving all preventive health and clinical guidelines. Guidelines are developed using criteria established by nationally recognized professional organizations and with input from the AmeriHealth Caritas VIP Care Plus Provider Advisory Council. Guidelines are distributed via the Plan's website, with hard copies available upon request. Current guidelines include COPD, Diabetes, Heart Failure, Hypertension and Heart Failure.

Health Care Equity

Health care equity is assessed and promoted through a variety of activities that leverage resources across the organization. Activities are outlined below:

- Collect and analyze practitioner race/ethnicity and language data to determine if the

network is responsive to the needs of the membership.

- Develop a plan to address network race/ethnicity and language gaps.
- Support practitioners in providing appropriate language services.
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities.

Credentialing Program

AmeriHealth Caritas VIP Care Plus Quality Assessment and Performance Improvement Program (QAPI) provide oversight of the Credentialing program. The activities described below are additional functions of the Credentialing program. For more information on the credentialing and re-credentialing processes, please refer to the “Provider and Network Information” section of this *Provider Manual*.

Availability and Accessibility Audits

Compliance with AmeriHealth Caritas VIP Care Plus access and availability standards is monitored annually to ensure sufficient numbers of network providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Quality of Service Committee (QSC) evaluates the report annually. AmeriHealth Caritas VIP Care Plus also conducts an annual assessment of primary care providers’ compliance with appointment standards for routine, urgent/symptomatic and sick office visits. Results of the survey are reported to the QSC for review and recommendations.

Medical Record Requirements

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

Providers are required by contract to make medical records accessible to the State of Michigan Department of Community Health, the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), AmeriHealth Caritas VIP Care Plus and their respective designees.

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

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient’s name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations, and illnesses.
- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking, and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk

screening.

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

Providers must maintain medical records for a period not less than ten (10) years from the close of the participating provider agreement with the Plan and for a longer period if the records are under review or audit (until the audit or review is complete).

Medical Record Audits

AmeriHealth Caritas VIP Care Plus conducts medical record audits to assess the provision and documentation of high-quality primary care according to established standards. PCP sites with ten (10) or more linked members undergo a medical record review (MRR) annually. A PCP practice may include both an individual office and a large group facility site. Ad-hoc reviews of OB-GYN's and specialists may also be conducted, as needed, using the same process.

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

Adverse Action Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas VIP Care Plus sends information on reportable events, (as outlined in the NPDB Reporting Manual instructions) to the NPDB and to the Michigan State Board of Medical or Dental Examiners, as appropriate, in the state

where AmeriHealth Caritas VIP Care Plus is located.

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

Reporting & Managing Unusual Occurrences

Critical Incidents, Sentinel Events and Never Events

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

Important definitions include:

- **Critical Incident** – Retrospective identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function, to include:
 - Exploitation
 - Neglect
 - Verbal abuse
 - Physical abuse
 - Sexual abuse
 - Theft
 - Provider no shows, particularly when enrollee is bed bound all day or there is a critical need
 - Illegal activity in the home with potential to cause a serious or major negative event
 - Worker consuming drugs/alcohol on the job
 - Suspicious or Unexpected Death - Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect. These types of incidents must also be reported to MDHHS within two business days of the ICO receiving the notice.
 - Medication errors
 - Use of Restraints, seclusions, or restrictive interventions. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

Critical incidents differ from sentinel events only in terms of the timeframe in which they are identified.

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as “sentinel” because they signal the need for immediate investigation and response. Please note, the terms “sentinel event” and “medical error” as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above.

AmeriHealth Caritas VIP Care Plus goals are to:

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

Managing Unusual Occurrences

Providers are expected to report unusual occurrences, as described above and including near misses, to AmeriHealth Caritas VIP Care Plus in real time. AmeriHealth Caritas VIP Care Plus recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All unusual occurrences must be reported to the Plan within twenty-four (24) hours of occurrence. Reports may be made to the AmeriHealth Caritas VIP Care Plus Care Coordinator by calling 1-866-263-9181.

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

Once an AmeriHealth Caritas VIP Care Plus staff member identifies or is notified of an unusual occurrence, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The AmeriHealth Caritas VIP Care Plus Medical Director is notified of the event via an incident report, telephone, email, or personal visit as soon as reasonably possible after identification of the occurrence.
2. The AmeriHealth Caritas VIP Care Plus Medical Director will collaborate with the Medical Management, Quality and Compliance departments and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All unusual occurrences require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance. A multidisciplinary team led by the Medical Director will perform all root cause analysis.
5. As appropriate, issues are identified for correction and corrective action plans are developed to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, timelines and strategies for measuring the effectiveness of the actions.

6. Confirmed critical incidents and sentinel events will be reported to the Michigan Department of Health and Human Services (MDHHS) and the Plan's MDHHS Contract Administrator within twenty-four (24) hours of occurrence or as soon as a determination is made that the occurrence is a critical incident or sentinel event. Additionally, AmeriHealth Caritas VIP Care Plus will report all critical incidents and sentinel events, as well as actions taken, to the MDHHS and the Plan's MDHHS Contract Administrator on a quarterly basis.
7. As appropriate, other agencies will also be notified of confirmed critical incidents and sentinel events.
8. As appropriate, information from the investigation of unusual occurrences will be provided to the Credentialing Committee to support the re-credentialing process and to the QAPIC on a quarterly basis.

Reporting Provider Preventable Conditions

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

Potential Quality of Care Concerns

Potential quality of care concerns are investigated by AmeriHealth Caritas VIP Care Plus.

The Medical Director's outcome determination of the quality of care concern may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from AmeriHealth Caritas VIP Care Plus network.

If the concern is referred to the QAPIC, follow-up actions are conducted based on the QAPIC's recommendation(s), which may include sanctioning the practitioner/provider.

If the QAPIC investigation involves a reportable action, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and State regulatory agencies as required.

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

- Requiring the practitioner/provider to submit a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record audit.
- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by AmeriHealth Caritas VIP Care Plus to ensure that adverse events do not continue. This requirement will be documented in writing. A corrective action plan may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.
- Implementing formal sanctions, including termination from the AmeriHealth Caritas VIP Care Plus network if the offense is deemed an immediate threat to the well-being of AmeriHealth Caritas VIP Care Plus members. AmeriHealth Caritas VIP Care Plus

reserve the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

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

Formal Sanctioning Process

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

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

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

Notice of Hearing

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

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

Conduct of the Hearing and Notice

The hearing will be held before:

- A panel of individuals appointed by AmeriHealth Caritas VIP Care Plus (the Hearing Panel).

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

Practitioner/Provider's Hearing Rights

The practitioner/provider has the right to:

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

Appeal of AmeriHealth Caritas VIP Care Plus Decision

The practitioner/provider may request an appeal after the final decision of AmeriHealth Caritas VIP Care Plus.

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

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

Summary Actions Permitted

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

- Suspension or restriction of AmeriHealth Caritas VIP Care Plus participation status for up to fourteen (14) days, pending an investigation to determine the need for formal sanctioning process, or
- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within thirty (30) days of the summary action to review the basis for continuation or termination of this action.

VIII. Cultural Competency Program and Disability Competency Requirements

Cultural Competency Introduction

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

AmeriHealth Caritas VIP Care Plus routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas VIP Care Plus's population. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

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

- Each AmeriHealth Caritas VIP Care Plus member experiences culturally and linguistically competent care that considers the values, preferences and expressed needs of the member.
- AmeriHealth Caritas VIP Care Plus has built a staff that adequately mirrors the diversity of the membership.
- AmeriHealth Caritas VIP Care Plus provides on-going education and training in culturally and linguistically appropriate service delivery to staff at all levels and across all disciplines.
- AmeriHealth Caritas VIP Care Plus offers language assistance services, including bilingual staff and interpreter services, at no cost to the member with Limited English Proficiency (LEP).
- AmeriHealth Caritas VIP Care Plus assures the competency of language assistance services and discourages friends and family from providing interpretation services (except upon request by and with informed consent of the member).
- AmeriHealth Caritas VIP Care Plus informs the member, in a language they can understand, that they have the right to free language services and that these services are readily available.
- The AmeriHealth Caritas VIP Care Plus language assistance program ensures that written materials routinely provided in English to members, applicants, and the public are available in commonly encountered languages other than English.
- AmeriHealth Caritas VIP Care Plus has developed, implemented and promoted a written strategic action plan to ensure culturally and linguistically appropriate services.
- AmeriHealth Caritas VIP Care Plus assesses CLAS-related activities and incorporates mechanisms to measure the success of these activities into our internal audits, performance improvement programs, member satisfaction surveys and outcomes-based evaluations.
- AmeriHealth Caritas VIP Care Plus ensures that data on a member's race, ethnicity, and spoken and written language are collected in health records, integrated into our management information systems, and updated on a regular basis.

- AmeriHealth Caritas VIP Care Plus maintains a current demographic and cultural profile and needs assessment of our service area. This demographic and cultural profile is used in planning services that respond to the cultural and linguistic characteristics of our service area.
- AmeriHealth Caritas VIP Care Plus is committed to both community and member involvement in designing and implementing CLAS-related activities by our Community Advisory Committee.
- AmeriHealth Caritas VIP Care Plus grievance and appeals process is culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by members.
- AmeriHealth Caritas VIP Care Plus publicizes information regarding our progress and success in implementing CLAS standards and also provides public notice regarding the availability of this information.

Providers may request more information on the Cultural Competency Program by contacting Provider Services at 1-888 667-0318

Cultural and Linguistic Requirements

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

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

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

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

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

Providers should discourage members from using family or friends as verbal translators. Members should be advised that translation services from AmeriHealth Caritas VIP Care Plus are available.

Providers are required to:

- Provide written and verbal language assistance at no cost to plan members with limited English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Provide members verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient

information forms and treatment consent forms, must be made available in other languages and formats.

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

When a member uses AmeriHealth Caritas VIP Care Plus interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner.

AmeriHealth Caritas VIP Care Plus contracts with a competent telephonic interpreter service provider. If you need more information on using this telephonic interpreter service, please contact Provider Services at 1-888 667-0318.

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact AmeriHealth Caritas VIP Care Plus Member Services at 1-888 667-0318 (TDD/TTY: 1-(866)-428-7583), and a representative will help locate a professional interpreter to communicate in the member's primary language.

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

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

Disability Competency

Disability Competency is the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their disability knowledge, experience, and expertise.

AmeriHealth Caritas VIP Care Plus is committed to treating all members with respect and dignity. AmeriHealth Caritas VIP Care Plus informs members through the Member Handbook, the website www.amerihealthcaritasvipcareplus.com or by calling Member Services 1-888-667-0318 that they have the right to reasonable accommodations.

In all cases, AmeriHealth Caritas VIP Care Plus requires that all members are provided with reasonable accommodations in the following areas: communication with AmeriHealth Caritas VIP Care Plus, communication with the member's providers, and physical access to provider offices and equipment. AmeriHealth Caritas VIP Care Plus will inform members of providers who meet ADA compliance for communications and physical access in the online provider directory or by calling Member Services at 1-888-667-0318. Providers are required to attest and provide updates to AmeriHealth Caritas VIP Care Plus regarding ADA accessibility requirements within 30 days of contracting or changes to accessibility.

AmeriHealth Caritas VIP Care Plus members may submit a request for reasonable accommodation for either communication or physical access if the member believes that his/her needs are not being met. The member or member's representative may request that a reasonable accommodation be made by AmeriHealth Caritas VIP Care Plus or a provider by submitting a request orally or in writing to the member's Case Manager. AmeriHealth Caritas VIP Care Plus will use clinical information, state and federal laws or regulations as applicable to evaluate the need and reasonableness for the requested accommodation.

AmeriHealth Caritas VIP Care Plus will deliver a decision no later than thirty (30) days following the meeting or as expeditiously as the member's request requires.

IX. Claims Submission Protocols and Standards

Encounter Reporting

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

Completion of Encounter Data/Claim Submission

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

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

AmeriHealth Caritas VIP Care Plus accepts claim submissions via paper or electronically (EDI). In order to support timely statutory reporting requirements, we encourage all providers to submit claims within thirty (30) days of the visit. However, all claims must be submitted within three hundred and sixty-five (365) days from the date services were rendered or compensable items were provided.

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

- Member's (patient's) name.
- Member's AmeriHealth Caritas VIP Care Plus ID number.
- Member's date of birth and address.
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs).
- Information advising if member's condition is related to employment, auto accident or liability suit.
- Date(s) of service, admission, discharge.
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the highest level of specificity available.
- Authorization, as applicable.
- Name of referring physician, if appropriate.
- HCPCS procedures, services or supplies codes.
- CPT procedure codes with appropriate modifiers.
- CMS place of service code.
- Charges (per line and total).

- Days and units.
- Physician/supplier Federal Tax Identification Number (TIN) or Social Security Number.
- National Provider Identifier (NPI) and Taxonomy.
 - o AmeriHealth Caritas VIP Care Plus requires nontraditional providers who are not required to obtain an NPI use their Tax Identification Number or Social Security number when submitting claims for services rendered to members.
- Physician/supplier billing name, address, ZIP code, and telephone number.
- Name and address of the facility where services were rendered.
- NDCs required for physician-administered injectable drugs.
- Invoice date.
- Signature.

AmeriHealth Caritas VIP Care Plus monitors encounter data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Encounters may be rejected or denied for inaccurate, untimely, and incomplete information. Network providers will be notified of a rejection via a remittance advice and are expected to resubmit corrected information to AmeriHealth Caritas VIP Care Plus.

Network providers may also be subject to sanctioning by AmeriHealth Caritas VIP Care Plus for failure to submit accurate encounter data in a timely manner.

The Provider Services department at AmeriHealth Caritas VIP Care Plus is available at 1-888- 667-0318 to address questions concerning claims submission.

General Procedures for Claim Submission

AmeriHealth Caritas VIP Care Plus is required by the State of Michigan and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by providers in order to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be **rejected** by AmeriHealth Caritas VIP Care Plus for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas VIP Care Plus members must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas VIP Care Plus are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under AmeriHealth Caritas VIP Care Plus during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of- network provider received authorization to provide services to the eligible member.
- Verification that an authorization or referral exists for services that require prior authorization or referral per AmeriHealth Caritas VIP Care Plus policies as defined in this *Provider Manual*.
- Verification of whether there are any other third-party resources and, if so, verification that AmeriHealth Caritas VIP Care Plus is the “payer of last resort” on all claims submitted to AmeriHealth Caritas VIP Care Plus.

AmeriHealth Caritas VIP Care Plus accepts paper and electronic claims. Plan providers and practitioners are encouraged to submit claims electronically for faster turn-around.

Electronic Claims Submission (EDI)

AmeriHealth Caritas VIP Care Plus encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare's Provider Support at 1-866-506-2830 for more information.

There are many different products that may be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may contact the EDI Technical Support team at 1-888-667-0318 to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare at 1-866-506-2830 to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas VIP Care Plus.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

AmeriHealth Caritas VIP Care Plus EDI
Payer ID#: **77013**

Providers interested in using EFT should reach out to Change Healthcare at 1-866-506-2830 and for ERA at 1-877-363-3666. You may also locate the necessary enrollment forms under Resources > Enrollment Services > Medical/Hospital Enrollment at the following link:

<https://legacy.changehealthcare.com/>

Enrollment in EFT will require your AmeriHealth Caritas VIP Care Plus provider ID number (trading partner ID #). If you do not know your provider ID number you may contact Provider Services to obtain it.

SNIP Level 4

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

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

Submission of Electronic Documentation (275 Transactions)

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

The following 275 claims attachment report codes are available for use. When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04.

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

Paper Claim Mailing Instructions

Please submit paper claims to the appropriate address below:

AmeriHealth Caritas VIP Care Plus

Claims Processing Department
P.O. Box 7074
London, KY 40742-7074

Presence of Referring/ Ordering Physician NPI on Claims Submissions

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

Claim Filing Deadlines

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

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

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

Denied claims are registered in the claim processing system but do not meet requirements for payment under AmeriHealth Caritas VIP Care Plus guidelines. Claims originally denied may be re-submitted as a corrected claim within three hundred and sixty-five (365) calendar days from the date services were rendered (or the date of discharge for inpatient admissions) for any reason(s) other than timely filing.

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted within one hundred and eighty (180) days of the date on the primary insurer's EOB.

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

Common Causes of Claim Processing Delays, Rejections or Denials

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

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

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

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

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

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

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

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

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

Highlighted Claim Fields – (See “Illegible Claim Information”)

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

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

Member Name Missing – The name of the member must be present on the claim form and must match the information on file with AmeriHealth Caritas VIP Care Plus.

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

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

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

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

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

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

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

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

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

Tax Identification Number (TIN) Missing or Invalid - The Tax ID number or Social Security number must be present and must match the service provider name and payment entity (vendor) on file with AmeriHealth Caritas VIP Care Plus.

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

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

Taxonomy –The provider’s taxonomy number is required if needed by AmeriHealth Caritas VIP Care Plus to determine the provider’s plan ID when using NPI only is not effective.

Prospective Claims Editing Policy

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

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

Claims Inquiry

If a provider does not receive payment for a claim within forty-five (45) days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the Provider area of AmeriHealth Caritas VIP Care Plus website, www.amerhealthcaritasvipcareplus.com, to access a free, web-based solution for electronic transactions and information through a multi-payer portal called NaviNet.
- Calling Provider Services at 1-888-667-0318.

Balance Billing Members

Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing Qualified Medicare Beneficiaries (QMB) for Medicare cost-sharing.

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas VIP Care Plus to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balance-billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims inquiry processes to resolve any outstanding claims payment issues.

Claim Disputes

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

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

If you believe the payment amount you received for treating our member is less than the expected payment, you have the right to dispute that payment. Requests for a claims dispute may be submitted by calling Provider Services at 1-888-667-0318 or in writing within one hundred eighty (180) calendar days of the date of the initial remittance advice from AmeriHealth Caritas VIP Care Plus using the Provider Claims Dispute form which is available on our website. If the form is not used, you must include the following:

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

Mail your claims dispute to:

AmeriHealth Caritas VIP Care Plus Attn:
Claim Disputes
P.O. Box 7074
London, KY 40742-7074

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

Refunds or Recoveries for Improper Payment or Overpayment of Claims

If an AmeriHealth Caritas VIP Care Plus provider identifies improper payment or overpayment of claims from AmeriHealth Caritas VIP Care Plus, the improperly paid or overpaid funds must be returned to the Plan. Providers are required to return the identified funds to AmeriHealth Caritas VIP Care Plus which is carried out through an offset notification or by notifying AmeriHealth Caritas VIP Care Plus of the overpayment and submitting a refund check directly to the appropriate claims processing department:

AmeriHealth Caritas VIP Care Plus

Attn: Provider Refunds
P.O. Box 7074
London, KY 40742-7074

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

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

If you ...	Then...
Agree with the overpayment notice	<ul style="list-style-type: none"> The provider does not need to do anything. The claims will be reprocessed and all overpayments will be recovered from future payments
Have questions regarding the recovery or the calculation of the overpayment amount	<ul style="list-style-type: none"> Contact Provider Claim Services 1-888-667-0318 Refer to the Project Number from the letter when calling or sending an e-mail.
Do not agree with our findings and would like to dispute the overpayment notice	<p>The provider <u>must</u> notify us in writing. The letter should include the following:</p> <ul style="list-style-type: none"> A copy of the letter the provider received from us with the Project Number The reason for the dispute with our findings Supporting documentation for the dispute including claims information <p>Send correspondence to:</p> <p>AmeriHealth Caritas V IP Care Plus P.O. Box 7 07 4 London, KY 407 42-7074</p>
Would like to send a check for the recovery amount	<p>The provider submit a check</p> <p><u>AND</u></p> <p>a copy of the letter the provider received from us with the Project Number to the following address:</p> <p>AmeriHealth Caritas VIP Care Plus 200 Stevens Dr. Attn: CRRU CC286 Philadelphia, PA 1 9113</p>

Program Integrity

AmeriHealth Caritas VIP Care Plus is obligated to ensure the effective use and management of public resources in the delivery of services to its Members. AmeriHealth Caritas VIP Care Plus does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas VIP Care Plus, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

Prospective (Pre-claimspayment)

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

Retrospective (Post-claims payment)

- Third Party Liability (“TPL”)/Coordination of Benefits (“COB”)/Subrogation – As a Medicare-Medicaid plan, AmeriHealth Caritas VIP Care Plus is the payor of last resort. The effect of this rule is if AmeriHealth Caritas VIP Care Plus determines a member has other health insurance coverage, payments made by AmeriHealth Caritas VIP Care Plus may be recovered.
- Please also see Section IX for further description of TPL/COB/Subrogation.
- Data Mining – Using paid claims data, AmeriHealth Caritas VIP Care Plus identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
- Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis, or diagnosis-related group (“DRG”) billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
 - *Please note, if medical records are not received within the requested timeframe, AmeriHealth Caritas VIP Care Plus will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*

Credit Balance Issues

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

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

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas VIP Care Plus reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided.

Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

Readmission Review Program

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

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

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

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

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

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

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

Third Party Liability/Subrogation

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

Additional Information for Electronic Billing

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to AmeriHealth Caritas VIP Care Plus must first pass Change Healthcare HIPAA edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be re-submitted with all necessary and valid data elements within three hundred and sixty-five (365) calendar days from the date services were rendered (or the date of discharge for inpatient admissions). It is important that you review the Acceptance Report* or R059 Plan Claim Status Reports** received from Change Healthcare or your EDI software vendor in order to identify and re-submit these claims accurately.

Monitoring Reports for Electronic Claims

Change Healthcare will produce an Acceptance Report* and a R059 Plan Claim Status Report** for its

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

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

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

Plan Specific Electronic Edit Requirements

AmeriHealth Caritas VIP Care Plus currently has two specific edits for professional and institutional claims sent electronically.

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

Statement date must not be earlier than the date of service.
Plan-assigned individual practitioner ID number is strongly encouraged.

Electronic Billing Exclusions

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

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

(These exclusions apply to inpatient and outpatient claim types.)

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Change Healthcare
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10 or successor codes, etc.).

Claims without member ID numbers
Invalid Electronic Claim Records – <i>Common Rejections from AmeriHealth Caritas VIP Care Plus (EDI Edits within the Claim System)</i>
Claims received with invalid provider numbers (including NPI and Taxonomy, or Plan ID, as applicable).
Claims received with invalid member ID numbers
Claims received with invalid member date of birth.

Rejected Claims

Rejected claims are those returned to the provider without being processed or adjudicated, due to a billing issue.

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

Corrected or Replacement Claims

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

- In cases where resubmission serves to correct a claim that has already been denied/paid, the claim must be clearly identified as a corrected claim and resubmitted within 365 days from the date of service.
- If there is an identified overpayment beyond 365 days from date of service, please contact Provider Services to arrange repayment. You may either send a refund check with documentation directly to the AmeriHealth Caritas VIP Care Plus, P.O. Box 7074, London, KY 40742-7074, or arrange to have the repayment withheld from future payments.
- Corrected claims may be submitted electronically through Change HealthCare or NaviNet, or on paper submission to AmeriHealth Caritas VIP Care Plus, P.O. Box 7074, London, KY 40742-7074.
- Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original AmeriHealth Caritas VIP Care Plus claim number.
 - You can find the AmeriHealth Caritas VIP Care Plus claim number on the 835 ERA, the paper Remittance Advice, or from the claim status search in NaviNet.
 - If you do not have the AmeriHealth Caritas VIP Care Plus claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the AmeriHealth Caritas VIP Care Plus claim number.

How to Submit Corrected or Replacement Claims

- Corrected/replacement and voided claims may be sent electronically or on paper.
 - If sent electronically, the **claim frequency code** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain

the values '7' for the Replacement (correction) of a prior claim or '8' for the Void of a prior claim. The value '6' should no longer be used.

- In addition, you must also provide the original claim number in **Payer Claim Control Number** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated *HIPAA Version 5010 Implementation Guide*.
- If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
 - On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" and the Plan's original claim number must be in Field 22.
 - On an Institutional UB04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the Plan's original claim number must be in Form Locator 64A Document Control Number.

Reminders:

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

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact Change Healthcare: 1-877-363-3666
If you have general EDI questions ...	Contact EDI Technical Support: 1-877-363-3666
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports...	Contact y our EDI software vendor or call the Change Healthcare Provider Support Line: 1-800-845-6592
If you have questions about y our R059 – Plan Claim Status (receipt or completion dates)...	Contact Provider Claim Serv ices: 1-888-667-0318
If you have questions about claims that are reported on the remittance advice...	Contact Provider Claim Serv ices: 1-888-667-0318
If you need to know y our provider NPI number...	Contact Provider Services: 1-888-667-0318
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information OR For questions about changing or verifying provider information...	Please Contact Provider Services: 1 -888-667-0318
If you would like information on the 835 remittance advice...	Contact y our EDI vendor or call Change Healthcare: 1-877-363-3666
Check the status of y our claim...	Review the status of y our submitted claims on NaviNet at www. NaviNet.net .

Sign-up for the Provider Portal...	Go to www.NaviNet.net or contact One Health Port/NaviNet Customer Service: 1 -888-482-8057
Sign-up for Electronic Funds Transfer...	Contact Change Healthcare: 1-877-363-3666

Provider Preventable Conditions

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

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

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

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

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

Mandatory Reporting of Provider Preventable Conditions

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

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

- No payment reduction is imposed if the condition defined as a PPC for a particular member

existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a “Present on Admission” indicator.

- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; AmeriHealth Caritas VIP Care Plus will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the diagnosis codes, such as Y 65.51, Y66.52 or Y65.53 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

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

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52;
- Surgery on wrong site Y65.53
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

Inpatient Claims

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

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

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

Indicating Present on Admission (POA)

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

Valid POA Indicators Include:

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

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



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AmeriHealth Caritas VIP Care Plus is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.