HAMASPIK MEDICARE SELECT
(HMO-D-SNP)

and

HAMASPIK MEDICARE CHOICE
(MAP)

PARTICIPATING PROVIDER MANUAL

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Section One: Introduction

1.1.1 About the Manual

The Hamaspik Medicare Participating Provider Manual is a reference and source document for physicians and other providers who participate with Hamaspik's Medicare line of business. The manual clarifies and supplements various provisions of a provider's participation agreement. In the event of a conflict between the provisions of this manual and a specific provider's agreement with Hamaspik, the agreement controls.

The Hamaspik Medicare Participating Provider Manual contains relevant program policies and procedures with accompanying explanations.

Hamaspik Medicare encourages providers to give this document to staff who perform the administrative, billing, and quality assurance functions in their organizations. It is essential that they understand Hamaspik Medicare programs and the procedures Hamaspik has established for effective implementation and operations. Hamaspik updates this manual as needed.

Please note that this document may be amended as necessary to remain compliant with state and federal regulations, as well as changes in the plan's policies and procedures. An updated version of this Manual is available on the Hamaspik website, or will be sent upon request.

Representatives of the Provider Relations department are also available to provide information and clarifications, as necessary, including on-site visits when feasible. For information, call the Provider Relations Department.

1.1.2 About Hamaspik

In recent years, Hamaspik has broadened its range of offerings to include managed care plans, and the number of managed care plans operated by the plan is growing. This supports the State of New York's strategy of providing "care management for all," and the direction of providing the vast majority of Medicaid covered services through managed care. Each of the Hamaspik health plan options is developed to ensure access to care for a group of beneficiaries with complex health care needs, and each plan includes care management services to ensure that services are individualized to the member's needs, and carefully coordinated. The current and future plan offerings of the related Hamaspik companies are described below.

- Hamaspik Choice Managed Long-Term Care MLTC) provides a range of home and community based long term care services and supports, and other Medicaid benefits to enrollees residing in six counties in the Mid-Hudson Valley. All members must be nursing home eligible, based on an assessment conducted by a registered nurse. As with many MLTC plans, membership tends to be smaller than a more traditional health plan, focusing on the special needs of the population through intensive care management that helps ensure they can remain safe in their homes and communities.

- Hamaspik's Medicare Advantage plans

    - Hamaspik Medicare Select, is a special needs plan designed to serve individuals who are dual eligible (for Medicare and Medicaid). In this plan, commonly referred to as a "D-SNP," Hamaspik builds on the plan's expertise over the past years serving a complex, dual eligible population in a MLTC environment. This plan was also introduced in support of New York State's and CMS's direction to develop and nurture managed care models that can provide fully integrated services for dual eligibles.

    - Hamaspik Medicare Choice is a Medicaid Advantage Plus (MAP) plan that integrates the benefits of a Medicare plan with those of an MLTC plan. Members are dual eligibles who qualify for the plan based on an assessment conducted by a registered nurse and must be nursing home eligible.

- Hamaspik Inc. Medicaid Plan

  Hamaspik has submitted an application to the State of New York Department of Health to expand its certificate of authority to add an additional Medicaid product, and to expand its service area from its current six county service area to serve fourteen additional counties. This "mainstream" Medicaid plan would enroll any individual with Medicaid who chooses to enroll.

  The Medicaid plan will then become the springboard for the development of a Medicaid specialized health plan to enroll and provide services for intellectually and developmentally disabled individuals. Given Hamaspik's long history of providing a range of services to I/DD individuals, we are optimistic that we will become a designated plan for this population when the State of New York establishes Specialized I/DD Plans and selects the Plans that will be allowed to serve this population. The service area for the Hamaspik plan will be aligned with the Tri-County Care health home, in order to integrate the care management services with the health plan infrastructure. As with other Hamaspik plans, the focus on care management with help to drive successful clinical outcomes for this complex population.

1.1.3 Hamaspik Medicare Plan's Responsibilities

In working with participating providers, Hamaspik Medicare has responsibilities set forth in individual provider contracts.

Below are some of the Hamaspik Medicare 's responsibilities:

- Determining enrollment status and eligibility for covered services.
- Arranging for utilization management decision-making that:
  - Is based only on appropriateness of care and service
  - Does not specifically reward participating physicians, providers, or employees for issuing denials
  - Does not offer incentives to encourage inappropriate underutilization.
- Providing and administering grievance and appeal processes for members and

providers, and offering information on how to access the process.
- Promptly paying clean and uncontested claims for covered services to eligible members in accordance with the time frames required by law and provider agreements.
- Compensating participating physicians and other providers directly, consistent with the reimbursement methodologies described in provider agreements.
- Ensuring that all participating providers meet the credentialing requirements of the plan, and have not been excluded from participating in Medicare and Medicaid programs.
- Implementing policies and procedures to maintain quality functioning and improvement of Hamaspik Medicare processes.
- Contracting with primary care physicians and specialists for 24-hour telephone coverage to advise members of procedures for emergency and urgent health care services.
- Implementing policies and procedures designed to prevent and detect fraud, waste, and abuse.

1.1.4 Prohibition on Restricting Provider Discussion with Members

As mandated by New York State Public Health Law, Hamaspik Medicare will not by contract, written policy or written procedure prohibit or restrict any provider from:

- Disclosing to any member, enrollee, patient, designated representative or, where appropriate, prospective enrollee, any information that such practitioner/provider deems appropriate regarding a condition or a course of treatment with an enrollee including the availability of other therapies, consultations, or tests, or the provisions, terms, or requirements of Hamaspik Medicare products as they relate to the enrollee, where applicable.
- Filing a complaint or making a report or comment to an appropriate governmental body regarding Hamaspik Medicare policies or practices when the practitioner/provider believes that the policies or practices have a negative impact on the quality of, or access to, patient care.
- Advocating to Hamaspik Medicare on behalf of the enrollee for approval or coverage of a particular treatment or for the provision of health care services.

In addition, no contract or agreement between Hamaspik Medicare and a health care provider, or between the delivery system network and a health care provider, shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise, any liability relating to activities, actions, or omissions of Hamaspik Medicare as opposed to those of the health care provider.

1.1.5 Business Continuity

Hamaspik Medicare is responsible for creating and maintaining business continuity plans for all of its business units. In the event of a business interruption, we have plans designed to allow us to continue operations of critical business functions, such as claims processing, utilization management, and provider relations. We accomplish this in part by:

- Relocating impacted business units to designated recovery locations.

- Using redundant processing capacity at other locations.
- Designing our technology and systems to support the recovery process for critical business functions.
- Using business and technology teams that are responsible for activating and managing the recovery process.
- Adopting a communication plan to ensure that Hamaspik Medicare employees receive emergency notifications and instructions via a variety of sources, including in-building announcements, telephone contact, toll-free numbers, and websites.

Rehearsing our recovery procedures and testing those procedures on a regular basis. In the event of a business interruption impacting Hamaspik Medicare, its communities, and/or key stakeholders, all business units directly or indirectly involved in ensuring notification to providers will assess the impact, develop the message, obtain executive approval, and deploy the message to providers. Information may include any claims submission changes including the elimination of referrals and authorization requirements, if necessary, and anticipated changes to the payment cycle. Additionally, frequent updates will be available on the Hamaspik Medicare website, www.hamaspik.com.

1.1.6 Hamaspik Medicare Programs

Hamaspik Medicare offers two Medicare Advantage plans:

- Hamaspik Medicare Select, a Medicare Advantage D-SNP (Medicare coverage for beneficiaries who also have Medicaid)
- Hamaspik Medicare Choice, a Medicaid Advantage Plus (MAP plan); this combines the Medicare and Medicaid benefits.

1.1.7 How to Select or Change PCP

Members should select a PCP at the time of enrollment. The Hamaspik Medicare website includes a "Find a Doctor" option.

Members may change their PCPs by calling the member service numbers on their ID cards. If a Member needs assistance in locating a PCP in his/her area, the member service staff can provide help.

If a member changes his/her PCP, a new ID card will be issued and mailed to the member.

1.1.8 Hamaspik Medicare Service Area

Hamaspik Medicare Select covers the following counties in New York:

- The New York City metro area – Bronx, Kings, Nassau, New York (Manhattan), Queens, Richmond (Staten Island), and Westchester Counties
- The Hudson Valley area – Dutchess, Orange, Putnam, Rockland, Sullivan, and Ulster Counties
- The Capital area – Albany, Columbia, Greene, Montgomery, Rensselaer, Saratoga, Schenectady Counties.

Hamaspik Medicare Choice covers the following counties in New York:

- The New York City metro area - Bronx, Kings, Nassau, New York (Manhattan), Queens, Richmond (Staten Island), Westchester
- The Hudson Valley area – Dutchess, Orange Putnam, Rockland, Sullivan, Ulster

A member's eligibility for Hamaspik Medicare is always month-to-month, from the first of the month through the last day of the month.

1.1.9 Member Service

Providers may tell members who have any questions or concerns about their coverage to contact Member Service. (The telephone number for Member Service is listed on the member's ID card.) Providers may also contact Hamaspik Medicare with questions and concerns.

Hamaspik Medicare also encourages members of Hamaspik Medicare to contact Member Service if they are dissatisfied with any aspect of their care or coverage. If a complaint cannot be resolved immediately on the telephone, a Member Service representative will assist the member, his/her designee, or his/her provider in initiating an appeal or grievance.

1.1.10 Privacy and Confidentiality

Hamaspik Medicare has established procedures for compliance with all federal and state statutes, regulations and accreditation standards governing the use, protection and dissemination of medical records and protected health information, including medical records, claims, benefits, surveys, and administrative data. Both organizations utilize protected health information and data to assist in the delivery of health care, to compensate providers, and to measure and improve care.

Hamaspik Medicare recognizes that an individual who submits or authorizes his or her health care provider to submit, medical and dental claims information for processing and payment has an expectation that such information, to the extent it identifies the individual, will not be disclosed in any manner that violates federal or state law or regulation.

Hamaspik Medicare affords members the opportunity to authorize or deny the release of identifiable protected health information, in certain circumstances. When an individual enrolls in the Plan, we are authorized to share information for purposes of treatment, payment, or operations. However, by law, a member must provide a special authorization for Hamaspik Medicare to release protected health information, including mental health, alcohol and substance abuse, abortion, sexually transmitted diseases, genetic testing, and HIV/AIDS-related information. Members may authorize the release of some or all of their protected health information by completing an authorization form.

For those members who lack the ability to give authorization, Hamaspik Medicare will obtain authorization from a legally designated, qualified person, such as the member's legal guardian or person with the member's power of attorney.

A copy of Hamaspik Medicare Health Plan's Privacy Notice is posted on the Hamaspik Medicare website (www.hamaspik.com) and is available upon request from the Provider Relations Department, as is Hamaspik Medicare Health Plan's overall privacy policy.

1.1.11 Member Rights and Responsibilities

Members of Hamaspik Medicare have certain rights and responsibilities, as outlined below. Our plan must honor your rights as a member of the plan.

Member Rights:

- We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- We must give you information about the plan, its network of providers, and your covered services.
- We must support your right to make decisions about your care.
- You have the right to make complaints and to ask us to reconsider decisions we have made.
  If you believe you are being treated unfairly or your rights are not being respected, or for more information about your rights you may review the Evidence of Coverage.

Member Responsibilities:

- Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- Be considerate - we expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Tell us if you move.
- Call Member Services for help if you have questions or concerns.

1.1.12 Member Surveys

Hamaspik Medicare conducts member satisfaction surveys at least annually. The surveys assess member satisfaction with the care and services members receive. The surveys are used to identify opportunities for improvement. They may also be used to measure the success of any actions that are taken to improve the care and services members receive.

1.1.13 Speaking with Members

Hamaspik Medicare expects participating providers to maintain certain standards when speaking with members. Participating Hamaspik Medicare providers must:

- Provide complete and current information concerning diagnosis, treatment, and prognosis - in terms a member can understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.
- Prior to initiating a service, inform a member if the service is not covered and specify the cost of the service. Providers must notify the member in writing prior to providing a service that is not covered, informing the member that he/she will be liable for payment.
- Prior to initiating a procedure or treatment, provide the information a member needs to give informed consent.
- Tell the member to contact Member Services for information about accessing services not covered by the Hamaspik Medicare Health Plan.
- Disclosure of Hamaspik Medicare affiliations to patients. If a patient asks for assistance in selecting a Medicare Advantage plan, participating providers must advise patients of their affiliation with all Managed Care plans. Participating providers may display Hamaspik Medicare marketing materials, provided that appropriate notice is clearly posted for all health plans with which they have a contract.

Section Two: Administrative Information

2.1.1 Contacting Hamaspik Health Plans

Quick Reference Guide	
Member Services Department	Call 888-HAMASPIK; 888-426-2774 or 833-426-2774 TTY users should call 711 October 1 thru March 31: 8:00 am to 8:00 pm - 7 days per week April 1 thru September 30: 8:00 am to 8:00 pm – Monday thru Friday
Plan Enrollment Information	Call 888-HAMASPIK or 888-426-2774 TTY users should call 711
Website	www.hamaspik.com
Behavioral Health Services	Beacon Health Options Call 866-201-1401
Pharmacy Services	MagellanRx Call 800-424-4437
Dental Services	DentaQuest Call: 844 265 7592
Provider Relations Department	Call 833-426-2774 Email address: providerrelations@hamaspikchoice.org
Care Management	Call: 833-426-2774 Fax Number: 845-503-1911
Referrals/Authorizations	Call: 833-426-2774 Fax Numbers: 845-503-1911
Claims EDI Help Desk	Change Healthcare Clearinghouse Call (855) 886-3963 Hamaspik's Payer ID is 47738
Member Eligibility Info	833-426-2774
Provider Participation	
New Applicants	Email: providerrelations@hamaspikchoice.org
Credentialing	
Provider File Maintenance	
Hamaspik Medicare Claim Submissions	
Medical Claims *Same claims address for Medicare Select and Medicare Choice	Attn: Claims Department Hamaspik Medicare 58 Route 59, Suite 1 Monsey, NY 10952
Behavioral Health Claims	Beacon Health Options Attn: Claims Department 200 State Street Boston, MA 02109 Beacon Health's Payer ID is 43324

2.1.2 Obtaining Member Information from Hamaspik Medicare

The privacy rights of members are very important to Hamaspik Medicare, as is its relationship with participating physicians and other health care providers. Hamaspik Medicare has procedures in place to ensure that only properly authorized parties have appropriate access to members' protected information. In addition, Hamaspik Medicare has implemented a process that places extra emphasis on protecting confidential patient information.

Note: For more information about Hamaspik Medicare policies regarding privacy and confidentiality, see the Introduction section of this manual.

When a physician or other health care provider calls Hamaspik Medicare requesting information about a member, the provider will be required to answer a few questions before Hamaspik Medicare will release the information.

- First, the participating provider must confirm his/her identity by supplying a provider identification number.
- Next, the provider must confirm his/her relationship with the member by supplying the member's full name and ID number. If the provider is unable to provide the member ID number, the provider must supply at least one of the following, **in addition to the member's name:**
  - Patient birth date
  - A claim number or authorization number
  - Patient address
  - Name of primary physician (when applicable)

If neither the provider's identity nor the provider/patient relationship can be confirmed, Hamaspik Medicare will not release the information.

2.1.3 Contacting Hamaspik Medicare Health Plan

The Hamaspik Medicare website, www.hamaspik.com, carries up-to-date information for members and providers. It includes:

- Detailed information about Hamaspik Medicare
- Evidence of Coverage
- Formulary – coverage and prior authorization requirements can be found here
- Prescription Drug Exception/Authorization form
- A directory of providers who participate in Hamaspik Medicare
- Online eligibility, referral and claims status system
- Provider forms and news about Hamaspik Medicare, including the most recent Hamaspik Medicare member and provider newsletters

The material presented on the Hamaspik Medicare website is also available by calling the Provider Relations Department.

Note: In case of a discrepancy between any materials presented on the Hamaspik Medicare website and the up-to-date version of that material on file at Hamaspik Medicare, the latter

version controls.

2.1.4 Electronic Billing

Hamaspik Medicare is compliant with guidelines from the Centers for Medicare & Medicaid Services (CMS) regarding the HIPAA EDI Transaction and Code Set regulation and is prepared to receive HIPAA-compliant transactions.

2.1.5 Determining Member Eligibility for Benefits

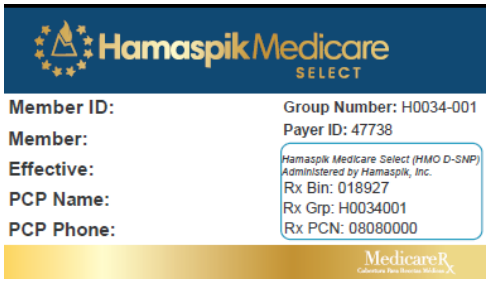
Because eligibility for government programs requires periodic recertification, it is important to verify that the patient has coverage before providing services. Participating providers may check member eligibility by calling Hamaspik Medicare. Providers must be registered in order to have access through Hamaspik Medicare.

Member ID cards also contain valuable information, but it is still important to verify benefits before providing services.

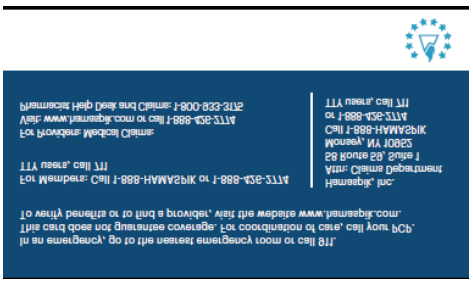
Member ID Cards
Each member is assigned an individual member identification (ID) number and sent an ID card.

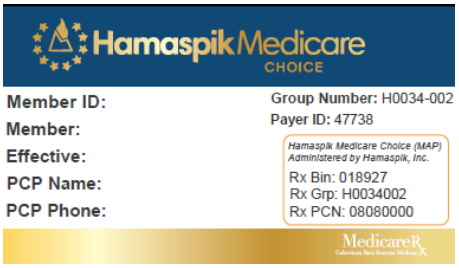
A sample ID card is displayed below:

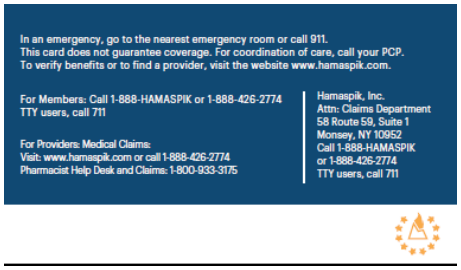
Front of Card



Back of Card







2.1.6 What to Look for on the ID Card Check the wording in first bullet

Identification cards carry vital information to assist providers in doing business with Hamaspik Medicare. Provider offices should copy the front and back of ID cards, as both sides contain important information. While our ID cards differ from product to product, there are some standard elements:

- Logo – The Hamaspik logo is on all member identification cards.
- Member's name.
- Member Identification Number –All members have a member ID assigned by Hamaspik.
- Group Number
- Payer ID
- Effective Date
- PCP Name
- PCP Phone
- Pharmacy Benefits – Hamaspik Medicare cards include pharmacy benefits information, for members to use when obtaining prescription medicines.
- Instructions for emergency care.
- Member Service and other helpful telephone numbers.

2.1.7 Member Eligibility Internet Inquiry: Hamaspik Medicare

An online provider portal is in development. Providers may call our Member Services Department to verify eligibility. See key contact numbers for the telephone number.

2.1.8 PCP Change

If the member's PCP is not listed correctly on the member's ID card, the member may make a change by calling the Member Service number on the ID card at the time of the appointment.

2.1.9 Participating Provider Manual

The Hamaspik Medicare Participating Provider Manual is intended as a reference and source document for physicians and other providers who participate in Hamaspik Medicare. The manual is intended to clarify various provisions of a provider's Hamaspik Medicare Participation Agreement.

2.1.10 Ad Hoc Communications

As needed, Hamaspik Medicare sends written notifications to participating providers regarding new and revised policies and procedures and other information of value. Hamaspik Medicare issues bulletins, letters, and other notices in instances when notification is required outside the normal newsletter schedule, or when the information affects only a small, specific audience of providers.

2.1.11 Office Site Review

Hamaspik Medicare may conduct site reviews of the office locations of physicians and other health care providers at initial credentialing and when a provider opens a new location. An office site review includes assessments of patient safety and privacy, office operations and confidentiality, appointment and accessibility, security of pharmaceuticals and prescription pads, and office record maintenance.

Hamaspik Medicare will conduct a site visit upon receiving two formal or informal complaints within 12 months. A complaint may, but not always, pertain to physical appearance, access for people with disabilities, waiting room or exam room space. The areas to be reviewed include but are not limited to the following requirements on the checklist:

- Facility and Environment,
- Office Operations, and
- Pharmaceuticals and Office Record Maintenance.

All applicable standards must be met.

Wheelchair Accessibility

As part of the Office Site Review, Hamaspik Medicare reviewers gather information to better serve members with disabilities. This information does not affect a provider's credentialing status. Accessibility information is included in provider directories.

2.1.12 HIPAA Compliance

Note: *This section gives a general overview of HIPAA requirements. For information about Hamaspik Medicare compliance with HIPAA standards on privacy and confidentiality, see the Introduction section of this manual. For information regarding HIPAA-compliant availability of eligibility, claims, and referral information, see paragraphs about Member Eligibility Remote Access Inquiry, Online Inquiry Systems, as well as referral and prior authorization information in the Benefits Management section of this manual. For information about Hamaspik Medicare compliance with HIPAA standards on electronic submission of claims, see the Billing and Remittance section of this manual.*

HIPAA, the Health Insurance Portability and Accountability Act of 1996, as amended, was designed to improve the efficiency and effectiveness of the health care system. It includes administration simplification provisions that required the U.S. Department of Health and Human Services to adopt national standards for electronic health care transactions. Recognizing that advances in electronic technology could erode the privacy of health information, Congress incorporated into HIPAA provisions that mandate the adoption of federal privacy protections for individually identifiable health information. This information is referred to as Protected Health Information or PHI.

The HIPAA Privacy Rule provides standards for the protection of PHI in today's world where information is broadly held and transmitted electronically. HIPAA's privacy rule requires that health care providers and other specified entities ("covered entities") take certain actions to maintain confidentiality. Some of these actions are:

- Notifying patients about their privacy rights and how their PHI can be used.
- Adopting and implementing privacy procedures.
- Training employees to understand privacy procedures.
- Designating a Privacy Officer responsible for seeing that privacy procedures are adopted and followed.
- Securing patient records containing PHI so they are accessible only to specified individuals.

Who Must Comply?

The following individuals and organizations must comply with HIPAA transaction standards. They are referred to as "covered entities."

- Health care providers who electronically conduct the financial and administrative transactions listed under Applicable Transactions, below.
- Health plans such as Hamaspik Medicare, employer health plans under the Employee Retirement Income Security Act (ERISA), Indian Health plans, and self-administered plans (except those with fewer than 50 participants).
- Health care clearinghouses.
- Business associates of any of the covered entities, even if a third party, that conduct the specified transactions on their behalf.

Applicable Transactions

All covered entities that conduct any of the following standard transactions are required to use HIPAA-compliant electronic language and codes:

- Health care claims or equivalent encounter information.
- Health care payment and remittance advice.
- Coordination of benefits.
- Health care claim status.
- Enrollment and disenrollment in a health plan.
- Eligibility for a health plan.
- Premium payments.
- Referral certification and authorization.

2.1.13 Updating Practice Information

Hamaspik Medicare requires that providers **submit updated information whenever there are any changes to a provider or his/her practice.** This is necessary to keep directory and claims systems information current. This includes changes in:

- Provider Name
- Provider Tax ID
- Provider NPI
- Provider Taxonomy Code
- Payment Address
- Directory Listing which includes the provider address, phone number, fax number and, for primary care providers who participate in managed care products, languages spoken and whether the practice is accepting new patients (open or closed)

- Service Address(es)
- Renewal or change in malpractice insurance
- Change in coverage arrangements
- When one or more practitioners join the group practice
- When one or more practitioners leave the group practice

To notify Hamaspik Medicare of such changes, complete a Provider Demographic Change form, indicating what information has changed. The form is available on the Hamaspik Medicare website or from the Provider Relations Department. Address and fax number are included on the form.

Note: *Providers also may notify Hamaspik Medicare of changes in practice information by emailing: providerrelations@hamaspikchoice.org or by submitting a letter on office letterhead specifying what the changes are. Letters can be faxed or mailed to Provider File Maintenance.* If a practitioner who is not already participating joins a currently participating group practice, the practice should contact the Provider Relations Department for application information.

2.1.14 Closing/Opening a Practice

In signing a participation agreement with Hamaspik Medicare, a participating physician agrees to accept as patients those members who elect to receive care from the physician, or those whom Hamaspik Medicare assigns to the physician. Physicians are responsible for assessing practice capacity. If the physician's practice is at capacity, the physician may close his/her practice to new managed care patients.

However, a participating physician shall not close or reopen his/her practice to new patients without giving Hamaspik Medicare 90-day prior written notice. For purposes of continuity of care, a participating physician shall continue to permit a current patient to designate the physician as his/her PCP when the patient chooses to enroll as a member of Hamaspik Medicare.

2.1.15 Access to Care

Hamaspik Medicare has established appointment availability standards to provide reasonable patient access to care. In addition, physicians are required to advise Hamaspik Medicare in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other. Physicians should also communicate coverage arrangements to their patients.
Hamaspik Medicare access to care standards are:

- Emergency coverage, 24 hours a day, seven days a week
- Urgent medical care available within 24 hours
- Adult base-line medical exam available within 12 weeks
- Routine health maintenance care within four weeks
- Non-urgent sick visits within 48 to 72 hours
- Routine behavioral health care within 10 business days
- Urgent behavioral health care within 48 hours

2.1.16 Medical Records

Hamaspik Medicare requires that participating provider medical records be kept in a manner that is current, detailed, organized, that complies with all state and federal laws and regulations, and that is accessible by the treating provider, member, or member representative, and Hamaspik Medicare to support this requirement, Hamaspik Medicare has established Medical Record Documentation Standards.

Information regarding these standards is included in the Quality Improvement section of this manual. (See Section 8.2.)

Hamaspik Medicare retains enrollees' medical records for at least 10 years after the date of service rendered or the medical record request, cessation of Hamaspik Medicare operations, or for a minor, 10 years after majority.

2.1.17 Access to Medical Records

Hamaspik Medicare Health Plan

A participating physician or other provider must maintain medical records and provide such medical, financial and administrative information to Hamaspik Medicare as it may reasonably require to ensure compliance with applicable laws, rules, and regulations; and for program management purposes. Upon request, medical records must also be provided to representatives from the New York State Department of Health or the Centers for Medicare and Medicaid Services (CMS). Participating physician offices must:

- Maintain medical records in a manner that is individualized, current, organized, detailed, legible and confidential.
- Make records available to Hamaspik Medicare staff for review when requested.
- Provide copies of patient charts to Hamaspik Medicare without cost, per the individual Participating Provider Agreement.

Note: *Medical record documentation auditing and reporting are part of "health care operations" as defined by HIPAA and thus do not require patient authorization for release of protected health information. For information about HIPAA, see the paragraph* headed HIPAA Compliance that appears earlier in this section of the manual.

Member Access to Their Medical Records

Members have the right to see their medical records. Hamaspik Medicare member handbooks state that any requests for medical records should be directed, in writing, to a member's physician. Each member age 18 or over, or an emancipated minor, must sign his or her own written request.

2.1.18 Charges for Photocopying Medical Records

Subject to the terms of a provider's participation agreement, a participating provider may not charge Hamaspik Medicare or the Department of Health for photocopying a patient's medical

record. New York State Public Health Law Article 1, Title 2, Section 18 (2.e) states that providers may impose reasonable charges when a patient (subject) requests copies of his/her medical records, not to exceed 25 cents per page. However, members may not be denied access to their records due to inability to pay.

2.1.19 Advance Care Directives

Hamaspik Medicare encourages providers to discuss with members end-of-life care and the appointment of an agent to assume the responsibility of making health care decisions when the member is unable to do so.

Information for members about advance care planning is available on Hamaspik Medicare's website.

Hamaspik Medicare Medical Records Documentation Standards state that medical charts must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children have been given information regarding advance directives. See the Quality Improvement section of this manual for additional information about this requirement and about advance care directives.

Note: *Treatment decisions may not be conditional on the execution of advance directives.*

2.1.20 Credentialing Site Visit Checklist

Hamaspik Medicare may perform an office site review as part of the provider credentialing / recredentialing process for PCPs, OB/GYNs and behavioral health providers or as a result of a complaint.

During the site survey, the surveyor will use an established site survey form to evaluate the provider's office on the following:

Facility and Environment
- Clean, private restroom for patients
- Waiting and treatment rooms clean, sanitary and of adequate size
- Patient care areas ensure privacy
- Handicap accessible

Office Operations
- Confidentiality policy for staff
- Process to identify and contact patients who miss appointments

Pharmaceuticals
- Medications and supplies stored in secure location

Office Record Maintenance
- System in place to ensure a neat and legible record for each patient
- Patient name, ID number on each page, all entries dated, sequential and signed or initialed by author (if paper records are used)
- Problem list included

- Office records stored securely to maintain confidentiality and privacy
- Records kept for individual patients
- Records maintained for period required by law
- System in place to ensure that provider reviews all clinical information
- Allergies displayed prominently
- System to capture biographic and personal data and appropriate medical history

Section Three: General Provider Information

3.1.1 Provider Support

Hamaspik Medicare has staff dedicated to assisting providers in doing business with Hamaspik Medicare.

3.1.2 Provider Service

Providers may call the Provider Relations Department whenever they have questions. (Representatives are available Monday through Friday, 9:00 a.m. to 5:00 p.m. Please see Section 2 for the Provider Relations Department telephone number.

Provider Relations representatives can answer most questions a provider might ask and, in situations where they cannot provide an answer, they will direct a provider to the appropriate department for questions about:

- Member eligibility and benefits
- Copayment and coinsurance information
- Referral and preauthorization status
- Claim status
- Medical Policies
- Fee schedules
- Request for claims adjustment
- Request for appeal
- Coordination of Benefits (COB)
- Hamaspik Medicare printed materials such as provider bulletins, provider newsletter or provider manual
- Any other provider-related issue

3.1.3 Provider Relations

Provider Relations Representatives are liaisons between provider offices and Hamaspik Medicare:

- Facilitate establishing contracts with individual providers
- Hold orientation sessions for participating providers and staff
- Educate providers about Hamaspik Medicare policies and protocol
- Answer provider inquiries regarding provider participation agreement reimbursements.
- Assist providers with other complex problems or concerns
- Train office staff on use of available electronic tools
- Visit provider sites

Contact Provider Relations at providerrelations@hamaspikchoice.org or by phone at 855-552-4642.

3.1.4 Provider Satisfaction Surveys

Hamaspik Medicare conducts provider satisfaction surveys at least annually. The surveys assess provider satisfaction with Hamaspik Medicare and are used to identify opportunities to improve Hamaspik Medicare services to the provider community and to members. Hamaspik Medicare develops action plans based on survey results and assesses these plans to determine effectiveness.

3.1.5 National Provider Identifier Required on All Standard Transactions

In order to be paid, each provider must include their NPI on all electronic or paper claims. ONLY NPIs are accepted on standard transactions (837, 835, 270/271, 276/277, 278), including both electronic and paper claims. Any transaction submitted without the NPI will be returned.

3.1.6 Taxonomy Codes

Taxonomy codes, also known as specialty codes, identify a provider's specialty category. A practitioner may have one National Provider Identifier (NPI) with multiple taxonomy codes, depending on the specialties in which he or she practices. A practitioner should select the simplest, most generic taxonomy code to describe his or her specialty.

To view a list of taxonomy codes, please visit the Washington Publishing Company website at: http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/.

Please note that all claims must be submitted with taxonomy codes. Failure to include taxonomy codes on claims may result in incorrect payments and rejections.

3.1.7 Credentialing and Recruiting

This section of the manual summarizes Hamaspik Medicare's credentialing and recredentialing policies. Copies of the complete policies are available upon request from the Provider Relations Department.

3.1.8 Overview

Providers who participate in Hamaspik Medicare programs must meet Hamaspik Medicare's credentialing requirements. Hamaspik Medicare credentials primary care physicians, most specialty physicians, certain allied health professionals and specific types of facilities.

Hamaspik Medicare does not currently credential the following physician specialties. (see the separate paragraphs on registering non-credentialed providers).

- Anesthesiologists who provide only basic anesthesia services. (Anesthesiologists who provide pain management services must be credentialed.)
- Emergency Room (ER) physicians
- Hospitalists
- Pathologists
- Radiologists
- Observation Unit Physicians
- Locum Tenens

***Note**: Federal and state regulatory agencies regularly notify Hamaspik Medicare of any providers who have been sanctioned, and Hamaspik Medicare does not credential providers who are prohibited from serving Medicaid recipients or receiving Medical Assistance payments.*

Hamaspik Medicare is responsible for assuring the provision of accessible, cost-efficient, quality care to its members. To that end, Hamaspik Medicare's Credentialing Committee reviews the credentials of all providers who apply for participation. The Credentialing Committee is composed of Hamaspik Medicare's corporate members. This peer group is responsible for the review of all practitioner credentials and the review of all credentialing and recredentialing policies.

***Note**: Hamaspik Medicare does not credential trainees who do not maintain practices separate from their training practices; nor does Hamaspik Medicare credential providers practicing on a limited permit. Hamaspik Medicare may not accept for credentialing a provider who practices exclusively within an inpatient setting or freestanding facility, and who supplies health care services to a Hamaspik Medicare member only as a result of the member being admitted to the facility.*

Hamaspik Medicare makes **credentialing decisions without regard to the applicant's race, ethnic/national identity, gender**, **age, sexual orientation, or the types of procedures or patients** in which the provider specializes. Hamaspik Medicare does not discriminate against providers who serve high-risk populations or who specialize in treating costly conditions.

***Note**: Hamaspik Medicare reserves the right to disapprove credentials in accordance with federal and state law and regulation. Once a provider receives credentials approval by the Credentialing Committee, Hamaspik Medicare may, but is not required to, offer to the provider a network participating provider contract. A contract signed by both the provider and Hamaspik Medicare is the only acceptable evidence of a current participating provider contact.*

The applicant has the burden of providing complete information sufficiently detailed for the Credentialing Committee to act. An applicant has the right upon request to be informed of the status of his/her application. The method of communication used by the applicant will determine the method of response. (For example, a phone inquiry will receive a phone response, a written inquiry will receive a written response).

A provider will not receive payment from Hamaspik Medicare for serving Hamaspik Medicare programs, until the provider is notified of Hamaspik Medicare's credentialing approval and both the provider and Hamaspik Medicare have executed a participating provider agreement.

Until these conditions are satisfied, a provider is not a member of the network. Providers are recredentialed at least every three years.

3.1.9 Provider's Right to Review Credentialing Information

A provider has the right to review certain information that Hamaspik Medicare uses when credentialing the provider. The information available for review is that obtained from primary source organizations such as the National Practitioner Data Bank, state licensing boards, medical professional liability insurance carriers, and hospitals. Any provider wishing to review his/her personal information obtained from these primary sources must submit a signed (original signature of requestor), written request to the Credentialing Department.
The provider has the right to correct erroneous information submitted by another party. The provider must notify Credentialing Staff in writing within 30 days of discovering the erroneous information. Hamaspik Medicare will include the provider's explanation and/or correction as part of the provider's application when it is presented to the Credentialing Committee for review and recommendation.

3.1.10 Web-based System for Submitting Credentialing Information Overview

For practitioners, Hamaspik Medicare utilizes the Council for Affordable Quality Healthcare (CAQH) ProView web-based system for providers to submit credentialing and recredentialing information. The system incorporates a nationwide universal credentialing application. This policy applies to physicians and to all non- physician health care providers for whom Hamaspik Medicare has credentialing responsibilities, including:

- Audiologists
- Certified Diabetic Educators
- Chiropractors
- Dentists
- Enterostomal Therapy Practitioners
- Language Therapists
- Nurse Midwives
- Occupational Therapists
- Optometrists
- Oral Maxillofacial Surgeons
- Physical Therapists
- Podiatrists
- Psychologists
- Registered Dieticians
- Social Workers

***Note**: For more information about the CAQH system, contact CAQH, Credentialing or Provider Relations departments. (For CAQH and Hamaspik Medicare contact information, see the Contact List in this manual.)*

Among the requirements of the credentialing process, physicians and non-physicians must:

- Maintain a practice within Hamaspik Medicare's service area
- Provide copies of all applicable certificates regarding training, licensure, specialty certification and medical professional liability

- Possess and maintain at all times medical professional liability insurance in amounts specified by Hamaspik Medicare. The provider must have a certificate of medical professional liability insurance that names the provider, documents the limits of liability and specifies the effective date and the expiration date
- Possess and maintain at all times a valid state license and current registration. Hamaspik Medicare will act when it learns of a lapsed or expired registration
- Possess and maintain at all times a valid Drug Enforcement Agency (DEA) Certificate if applicable to the provider's specialty
- Maintain admitting privileges with a plan-affiliated Article 28 or Article 40 facility. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify Hamaspik Medicare of any changes in their privilege status
- Authorize release of information
- Provide: historical information regarding physical or mental capacity impairments; criminal charges or convictions; loss, limitation or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; or medical professional liability claims, among other information. Physicians also must update this information on an ongoing basis
- Permit a site review of his/her office, if requested. See the paragraph headed Office Site Review in this manual
- Provide 24-hour coverage. In a managed care plan or a plan with managed care features, primary care physicians and specialists must provide continuous care of their patients through on-call coverage arrangements with other participating credentialed providers of the same or similar specialties. See the paragraph regarding Access to Care in the Administrative Information section of this manual.

Practitioner Credentialing

- When a physician or other health care practitioner is a first-time applicant for participation with Hamaspik Medicare, Hamaspik Medicare will send the practitioner a form that the practitioner must complete and return. The form includes a place for the practitioner to enter his/her CAQH ID, if already registered in that database.
- If a practitioner is not yet registered with CAQH, the practitioner should contact CAQH directly at https://proview.caqh.org/ or by telephone: (888) 599-1771.

Practitioners must list Hamaspik as an authorized plan in order for Hamaspik to be able to access their credentialing file.

Note: *Practitioners must promptly notify Hamaspik Medicare directly in writing of changes to information, such as remit address, tax ID, office locations, and contact information, to keep claims processing systems accurate and to ensure that the Provider Directory contains accurate information. Changes can be emailed to providerrelations@hamaspikchoice.org, or by calling Provider Relations at 855-552-4642.*

Provisional Credentialing

Practitioners must submit a completed application in its entirety, for review. As required by Chapter 551 amendments to Public Health Law 4406-d (1) and Insurance Law 4803(a), Hamaspik Medicare will respond to a complete application within 90 days. The notification will inform the provider as to whether they are credentialed, whether additional time is needed, or if Hamaspik Medicare's network is not in need of additional providers. Hamaspik Medicare will follow all applicable Managed Care legislation for any provider's credentialing application that is pending for more than 90 days. Credentialing staff cannot process an incomplete application, therefore, if any information is missing, the provider will be notified as soon as possible by telephone or in writing to request the missing information.

Hamaspik Medicare may offer provisional credentialing to physicians or other health care practitioners who join a group practice that already participates with Hamaspik Medicare. If the provider's complete credentialing application is not approved or declined within 90 days of receipt of a complete application by Hamaspik Medicare, the provider may request to be provisionally credentialed. The provider may contact Hamaspik Medicare 60 days after submission of the credentialing application to determine the status of the application and/or request provisional credentialing. Provisional credentialing will require the verification of the provider's license and sanction status.

If the request is granted, the provider will be provisionally credentialed and paid as an in-network provider from the 91st day of receipt of the application until the application is approved or declined. If the provider's application is declined, any amount paid by Hamaspik Medicare in excess of any out-of- network benefits payable under the member's coverage must be refunded to Hamaspik Medicare and neither the provider nor the group practice may pursue reimbursement from the member, other than applicable in- network cost-sharing amounts.

Practitioner Recredentialing

Hamaspik Medicare may recredential practitioners at any time, but in no circumstances less frequently than every three years. When a practitioner is due for recredentialing, Hamaspik Medicare uses the CAQH ProView application, which requires practitioners to re-attest every 90 days. If the on-line application has not been re-attested recently, Hamaspik Medicare will contact the practitioner to request that the practitioner review, update and re-attest to his or her CAQH application data.

3.1.11 Credentialing and Recredentialing Organizational Providers (including Facilities)

This section of the manual provides a brief overview of Hamaspik Medicare's organizational provider credentialing process. For more information, call the Credentialing Department. Hamaspik Medicare is committed to providing quality care and services to its members. To help support this goal, Hamaspik Medicare credentials and recredentials health delivery organizations with which it contracts. Health delivery organizations (as listed below) requesting participation in Hamaspik Medicare's provider network must be required to meet established credentialing criteria based on service type. Hamaspik Medicare will not contract with health delivery organizations that do not meet the criteria for that provider type. Hamaspik Medicare staff will review health delivery organizations at least every three years. Hamaspik Medicare will credential only licensed, regulated

facilities.

Each health delivery organization must meet the criteria listed below. In situations where an organization does not meet the criteria, Hamaspik Medicare may reconsider the organization for participation following an on-site review.

Acute General Hospitals

At a minimum, hospitals must provide inpatient, outpatient and emergency services and must have:

- Operating License and Certificate;
- Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (formerly called JCAHO and now known as the "Joint Commission") or Centers for Medicaid and Medicare Services (CMS);
- Medicare Certification as issued by the Centers for Medicare and Medicaid Services (CMS);
- Medicaid participation granted by the New York State Department of Health;
- Certification from the Office of Mental Health for Acute Care General Hospitals with Mental Health Services;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik or evidence of self-insurance.

Home Health Care Agencies:
Certified Home Health Agencies (CHHA) and Licensed Home Care Services Agencies (LHCSA)

At a minimum, a CHHA must make available the services of registered and licensed practical nurses, certified home health aides and occupational, physical and speech therapists. The agency also must have:

- Operating License and Certificate;
- Medicare Certification (applicable to CHHAs);
- Medicaid participation granted by the New York State Department of Health;
- Accreditation by the Joint Commission or the Accreditation Commission for Healthcare (ACHC) or other accrediting body. Organizations not accredited are must submit their most recent Department of Health Survey results acceptance letter;
- Certificate of Insurance: General and medical professional liability insurance in amounts specified by Hamaspik

Skilled Nursing Facilities/ Rehabilitation Facilities

At a minimum, facilities must provide discharge planning services; nursing supervision and services by registered or licensed practical nurses, nurse's aides and occupational, physical and speech therapists; routine medical supplies; and semi-private room and board. At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification;
- Accreditation by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Continuing Care Accreditation Commission (CCAC). Organizations that are not accredited must submit their most recent Department of Health Survey including the approval letter for any Plan of Correction (POC), if required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Freestanding Surgical Centers/Ambulatory Surgery Centers

At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification;
- Accreditation from a recognized accrediting body (e.g., Joint Commission or the Accreditation Association for Ambulatory Health Care [AAAHC]); Organizations not accredited are requested to submit their most recent Department of Health Survey including the approval letter for any Plan of Correction (POC) required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Freestanding Dialysis Center

At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification;
- Accreditation from a recognized accrediting body [e.g., Joint Commission or the Accreditation Association for Ambulatory Health Care (AAAHC)]; Organizations not accredited are requested to submit their most recent Department of Health Survey, including the approval letter for any Plan of Correction (POC) required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Chemical Dependency Treatment Centers

Hamaspik has executed an agreement with Beacon Health Options to administer and manage this benefit. This includes, but is not limited to, delegation of credentialing and recredentialing of providers. Physicians interested in participating in the Hamaspik provider network will be directed to Beacon.

Note: As required by the NY State Managed Care Contract, Section 21.4(a)(ii), for OMH-licensed, OMH-operated and OASAS-certified providers, Hamaspik and its vendor shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, the credentialing process for individual employees, subcontractors, or agents of such providers.

Community Mental Health Centers
Hamaspik has executed an agreement with Beacon Health Options to administer and manage this benefit. This includes but is not limited to delegation of credentialing and recredentialing of providers. Physicians interested in participating in the Hamaspik provider network will be directed to Beacon.

Inpatient Substance Abuse Facilities
Hamaspik has executed an agreement with Beacon Health Options to administer and manage this benefit. This includes but is not limited to delegation of credentialing and recredentialing of providers. Physicians interested in participating in the Hamaspik provider network will be directed to Beacon.

Inpatient Mental Health Facilities
Hamaspik has executed an agreement with Beacon Health Option to administer and manage this benefit. This includes but is not limited to delegation of credentialing and recredentialing of providers. Physicians interested in participating in the Hamaspik provider network will be directed to Beacon.

Freestanding Sleep Study Centers
At a minimum, the facility must have:
- Operating License and Certificate;
- Medicare and Medicaid Certification;
- Accreditation from American Academy of Sleep Medicine (AASM);
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Freestanding Urgent Care Centers
At a minimum, the facility must have:
- Attestation concerning minimum credentialing requirements specifying unrestricted licensure of all Practitioners working at the site
- CLIA certificate or waiver
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik
- For Article 28 Diagnostic and Treatment Centers (D&TC)
    - Operating certificate
    - Accreditation by a recognized accrediting body (i.e.) Urgent Care Center Accreditation (UCCA), American Academy of Urgent Care Medicine (AAUCM), or other accreditation body; Organizations not accredited are requested to submit their most recent Department of Health Survey including the approval letter for any Plan of Correction (POC) required

Clinical Laboratories
At a minimum, the facility must have:
- Operating License

- CLIA Certificate of hospital-based waiver;
- Medicare and Medicaid Certification, as applicable;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik
- Accreditation by Joint Commission or other laboratory accreditation organization

Residential Treatment Centers

At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification, as applicable;
- Joint Commission Accreditation, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation for children and family services (COA)-Organizations not accredited are requested to submit their most recent Department of Health Survey; including the approval letter for any Plan of Correction (POC) required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Comprehensive Outpatient Rehabilitation Facilities (CORF)

At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification, as applicable;
- Joint Commission Accreditation, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation for children and family services (COA)-Organizations not accredited are requested to submit their most recent Department of Health Survey; including the approval letter for any Plan of Correction (POC) required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Federally Qualified Health Centers or Rural Health Centers

At a minimum, the facility must have:

- Operating License and Certificate;
- CLIA certificate or waiver
- Medicare and Medicaid Certification, as applicable;
- Joint Commission or other accreditation. Organizations not accredited are requested to submit their most recent Department of Health Survey; including the approval letter for any Plan of Correction (POC) required;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Freestanding Radiology Centers or Portable X-ray Suppliers

At a minimum, the facility must have:

- Operating License and Certificate;

- Medicare and Medicaid Certification, as applicable;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Hospices

At a minimum, the facility must have:

- Operating License and Certificate;
- Medicare and Medicaid Certification, as applicable;
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Hamaspik

Hamaspik Medicare may conduct an on-site review if the above criteria are not met and report findings to the Credentialing Committee for consideration.

3.1.12 Registering Non-Credentialed Providers

Certain practitioners who participate in the Hamaspik Medicare network are not subject to credentialing but must, instead, be registered with Hamaspik Medicare. Currently, this includes:

- Anesthesiologists (if they practice as pain management specialists, they must be credentialed)
- Pathologists
- Radiologists
- Emergency Medicine physicians
- Intensivists
- Hospitalists
- Nurse Practitioners solely practicing in a hospital setting
- Observation Unit Physicians
- Locum Tenens (physician covering on a temporary basis)
- Physician Assistants

Procedures

1. Practitioners in the specialties that are not individually credentialed may participate with Hamaspik Medicare through a contracted entity, e.g., a hospital system or medical group.
2. Contracted entities must have internal credentialing procedures in place to ensure that the practitioner is qualified to practice in the specialty submitted to Hamaspik Medicare. . The contracted entity must submit the practitioner's credentials to the Provider Relations Department, including New York State license or registration number, copy of the practitioner's medical professional liability insurance policy, and demographic information. The Provider Relations Department can provide a template for submission of required information.

3.1.13 Provider Termination and Suspension

Hamaspik Medicare has established a policy that describes the procedures associated with termination and suspension of providers. The policy is designed to supply providers with all notice and hearing rights afforded by the New York State Public Health Law, the New York State Insurance Law, and the federal Health Care Quality Improvement Act. In cases where a provider has a participation agreement with Hamaspik Medicare, to the extent that the agreement contains any additional rights with respect to terminations or suspensions not set forth in the policy, such additional rights shall apply to the extent they are not contrary to applicable law.

3.1.14 Cases Involving Imminent Harm to Members

When the Hamaspik Medicare Medical Director or his/her designee determines, at his or her sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to members, Hamaspik Medicare shall:

- Immediately suspend the provider's right to provide patient care services to members, and subsequently afford the provider the hearing procedures described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. A provider's status as participating shall remain suspended until the conclusion of the hearing procedure and the provider is either reinstated, reinstated with conditions or terminated.
  OR
- Immediately terminate the provider's participation agreement or revoke the provider's credentials, as applicable, without affording the provider the hearing procedures described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual.

3.1.15 Cases Involving Fraud (as defined by the state in which the provider is licensed

In cases involving fraud, where the Hamaspik Medicare Medical Director or his/her designee determines, at his or her sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to members, Hamaspik Medicare shall proceed as described in the preceding paragraph.

When a criminal conviction has occurred, Hamaspik Medicare will terminate the provider's participation agreement or revoke provider's credentials, as applicable. Hamaspik Medicare shall NOT afford the provider the hearing procedures set forth in "Notice and Hearing Procedures" unless the state suspends or revokes licensure. In that case, Hamaspik Medicare immediately will terminate the provider's participation agreement and/or will revoke the provider's credentials without affording the provider the hearing procedures.

3.1.16 Cases Involving Final Disciplinary Action by State Licensing Boards or Other Governmental Agencies

Where a final disciplinary action has been rendered by any state licensing board or other governmental agency that impairs the provider's ability to practice, Hamaspik Medicare shall proceed in accordance with one of the following, as applicable:

Where Hamaspik Medicare determines, at its sole discretion, that the conduct of the provider that

resulted in the applicable disciplinary action poses a risk of imminent harm to members, Hamaspik Medicare shall proceed in accordance with the procedure described under "Cases Involving Imminent Harm to Members".

OR

Where Hamaspik Medicare determines, at its sole discretion, that the conduct that resulted in the applicable disciplinary action does not pose a risk of imminent harm to members, and the conduct did not result in a determination of fraud, Hamaspik Medicare may terminate the provider's agreement and/or revoke the provider's credentials, as applicable. In such cases, Hamaspik Medicare shall afford provider the hearing procedures described under "Notice and Hearing Procedures".

If the State Department of Health excludes or terminates a provider from its Medicaid program, Hamaspik Medicare will, upon learning of such exclusion or termination, immediately terminate the provider agreement with the provider with respect to Hamaspik's members.

3.1.17 Termination of Exclusion from Participation in Medicaid

If the New York State Office of the Medicaid Inspector General (OMIG) or U.S. Department of Human & Health Services Office of Inspector General (OIG) excludes or terminates a provider from participation in the Medicaid program, Hamaspik Medicare shall, upon learning of such exclusion or termination, immediately terminate the provider's agreement with respect to Hamaspik Medicare , and Hamaspik Medicare will no longer pay claims for the provider for services rendered to member with that coverage. The excluded provider will not be afforded a hearing as described in the paragraph entitled "Notice and Hearing Procedures" later in the section of the manual.

3.1.18 Termination for Other Reason

Where Hamaspik Medicare proposes to terminate a provider's participation agreement or revoke a provider's credentials, as applicable, for any reason other than those described in the previous sections (e.g., failure to comply with Hamaspik Medicare's utilization management or quality management policies and procedures, failure to satisfy Hamaspik Medicare's credentialing/peer review/quality review standards), Hamaspik Medicare shall afford the provider the hearing procedures described in the following paragraphs.

Before any such termination or suspension may occur, Hamaspik Medicare may implement an action or range of actions, including, but not limited to: corrective action plans with monitoring as recommended by Quality Management; conditional, time-limited credentialing as approved by the Credentialing Committee; required continuing medical education; or mentoring by an appropriate peer.

3.1.16 Notice and Hearing Procedures

Any hearing afforded a provider shall be conducted in accordance with Hamaspik Medicare's Provider Termination Policy as follows:

Notices

Hamaspik Medicare will send a provider a written notice of any proposed termination. The written notice of proposed termination shall be personally delivered or mailed by U.S. mail with return receipt requested to the provider. The notice shall explain:

- The proposed action.
- The reasons for the proposed termination
- A statement that the provider has the right to request a hearing or review, at the professional's discretion, before a panel appointed by Hamaspik Medicare
- The time limit, not less than thirty (30) calendar days, requesting a hearing
- A statement that the hearing will be held within thirty (30) calendar days after the date the hearing request is received
- A summary of the hearing rights

Hearing Requests

1. Any request for a hearing must be in writing, and be personally delivered or mailed by U.S. mail with return receipt requested, to the Medical Director
2. The provider is entitled to only one hearing
3. If the provider does not request a hearing in compliance with these rules, a proposed termination will be final and the provider will have waived any right to a hearing or review under any applicable law

Notice of Hearing

1. If the provider submits a written request for a hearing in compliance with these rules, Hamaspik Medicare shall give the provider a "Notice of Hearing." The Notice shall be in writing and shall state the place, time and date of the hearing, which date shall be within 30 days after the date of receipt of the hearing request. The Notice of Hearing shall be personally delivered or mailed by U.S. mail with return receipt requested to the provider.
2. The Notice of Hearing shall also state a list of the witnesses, if any, expected to testify against the provider and explain that the right to a hearing will be forfeited if the provider fails to appear at the hearing without good cause. The provider shall also provide a list of witnesses and representatives to Hamaspik Medicare no less than five (5) business days prior to the scheduled hearing.

Providers Evidence at the Hearing

1. The provider has the right to present witnesses at the hearing. A list on any such witnesses shall be provided to the Plan at least five (5) business days prior to the hearing.
2. Any materials the Practitioner intends to use as evidence during the hearing (e.g. relevant medical records, articles from peer-reviewed literature, statements of support from other physicians or providers), must be provided to the Plan at least five (5) business days prior to the hearing.
3. Practitioner's failure to provide the list of proposed witnesses and/or evidence to be presented at the Hearing may result in exclusion of the witnesses and/or evidence from the Hearing. In the alternative and in its sole discretion, the Plan may delay the Hearing by a reasonable time if the

witness list and/or evidence is not received within the time frame required; such delay will be communicated to the Practitioner in writing.

Conduct of Hearing

If the practitioner submits a written request for a hearing in compliance with these rules, the Credentialing Committee chair will appoint a hearing panel composed of three persons as follows: majority (2) who are clinical peers in the same discipline and in the same or similar specialty as the practitioner under review and one other person appointed by Hamaspik. Hamaspik may opt to engage a hearing panel of more than three persons provided that the number of clinical peers on the panel shall constitute the majority of the total membership of the panel.

In its sole discretion, Hamaspik may appoint a Hearing Officer to facilitate the Hearing. The Hearing Officer will be a Hamaspik employee and is not a voting member of the panel. The Hearing Officer ensures the Hearing is conducted with due process, objectivity, impartiality, effectiveness and consistency.

The proponent, Hamaspik leads with a discussion of the timeline of actions, notices and responses; the action(s) taken; and citations regarding policies, law, precedent and other rules that justify the action. The respondent practitioner then follows with his/her rebuttal to being informed in a timely manner of the adverse action, and/or rebuttal with documents or witnesses to the facts that are the basis of the adverse action. The provider may also propose alternate penalties or conditions.

The committee shall make decisions based on the evidence proposed for admission, decline testimonials and character witnesses, and permit both sides to present a case. The committee shall keep a record of the hearing, which includes the recording, transcript or summary; all admitted exhibits; committee decisions; committee notices; and orders. The practitioner may submit a written statement to the hearing panel at the conclusion of the hearing, to be maintained in the record.

Effective Date of Termination

1. If the provider does not request a hearing, the contract termination will become effective 60 days from the date the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination).
2. If the provider requests a hearing, the contract termination will become effective 30 days after the date the provider receives written notice of the hearing panel's decision, or 60 days after the date when the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination), whichever is later.

Reporting the Results of the Hearing

The decision of the hearing panel shall be reported to the Credentialing Committee. The minutes of the Credentialing Committee shall be reported to the QIC (Quality Improvement Committee). The hearing panel will render its decision in writing to the practitioner, and the panel's written decision shall communicate either reinstatement by Hamaspik Medicare, provisional reinstatement subject to conditions set by Hamaspik Medicare or termination.

3.1.20 Summary Suspensions to Conduct Investigations

The Hamaspik Medicare Medical Director, upon receiving information that a provider has engaged in activities related to professional competence or professional conduct that may adversely affect the health or welfare of a member, may summarily suspend the appointment of the provider for a period not longer than 14 days, during which an investigation will be conducted to determine the need for further action. The summary suspension shall be effective immediately upon notice to the provider. If the Medical Director determines, based upon the investigation, that termination is warranted, Hamaspik Medicare shall proceed in accordance with the applicable procedures described in the preceding paragraphs.

3.1.21 Non-Renewal

Upon 60 days' notice to the provider, or as otherwise set forth in a Hamaspik Medicare provider participation agreement, Hamaspik Medicare may exercise a right of non-renewal at the expiration set forth in the participation agreement or at the expiration of the credentialing period, whichever is applicable.

3.1.22 No Retaliatory Terminations/Non-Renewals

Hamaspik Medicare will not terminate or refuse to renew a participating agreement solely because the provider has:

a. advocated on behalf of an enrollee
b. filed a complaint against Hamaspik Medicare
c. appealed a decision of Hamaspik Medicare
d. provided information or filed a report to an appropriate governmental body regarding the policies or practices of Hamaspik Medicare that the provider believes may negatively impact upon the quality of, or access to, patient care
e. requested a hearing or review.

3.1.23 Reporting to Regulatory Agencies

To the extent required by all applicable state and federal laws and regulations, Hamaspik Medicare shall report terminations or suspensions for cause of greater than 30 days to the appropriate regulatory agency or agencies, including without limitation, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the New York State Department of Health's Office of Professional Medical Conduct, and the New York State Department of Education's Office of Professional Discipline.

The report must include the name, address, profession, and license number of the person being reported. The report shall also include a description of the action taken by Hamaspik Medicare and the specific reason for and date of the action. A Hamaspik Medicare Medical Director must sign the report.

Causes for termination/revocation or suspension of greater than 30 days include but are not limited to:

- Termination of a provider for mental or physical impairment, misconduct, or impairment of patient safety
- Voluntary or involuntary termination to avoid imposition of disciplinary action
- Termination for a determination of fraud or imminent harm to patient care
- Information that reasonably appears to show that a professional is guilty of misconduct
- Failure to provide services consistent with the terms of the provider contract, including but not limited to meeting Hamaspik access and availability standards

3.1.24 Transitional Care

Except for situations in which Hamaspik Medicare terminates the provider's participation in the network, and the reason for the termination does not permit the provider the right to request a hearing (i.e. cases of imminent harm to members, fraud, revocation or suspension of license to practice medicine, etc.), Hamaspik Medicare shall permit members to continue an ongoing course of treatment with practitioner during a transitional period of (i) up to ninety (90) days from the date of notice to the member of practitioner's disaffiliation or (ii) if the member has entered the second trimester of pregnancy at the time of practitioner's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery.

Hamaspik Medicare will authorize the transitional care described above only if practitioner agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of Hamaspik Medicare's policies and procedures, including without limitation, quality management and utilization management programs.

3.1.25 Provider-Initiated Departure from Hamaspik Medicare

The term of a provider's participation with Hamaspik Medicare is specified in the participation agreement. In a standard participation agreement, the agreement is designed to remain in effect until either Hamaspik Medicare or the provider terminates the agreement under the provisions outlined in the agreement. (Written notice is required.)

- Providers who elect to not renew their participation with Hamaspik Medicare at the renewal date must give Hamaspik Medicare at least 60 days' notice per the participation agreement. Other terminations require 90 days advance notice.
- Providers who plan to retire must notify Hamaspik Medicare within 60 days of the date they plan to stop seeing patients
- Upon the death of a provider, the provider's representative should notify Hamaspik Medicare as soon as possible
- Send the notification to Hamaspik Medicare.

3.1.26 Re-entry into the Hamaspik Medicare Provider Network after Resignation

Providers who wish to be considered for re-entry to the panel of providers permitted to treat Hamaspik members must contact the Provider Relations Department in writing to make that request. Hamaspik will consider readmittance based on Hamaspik policy. Depending on the length of time since the provider was most recently credentialed, or the length of time since he/she was a

participating provider, the provider may need to complete the credentialing process at time he/she re-enters the provider network.

3.1.27 Notifying Members following Provider Departure

Hamaspik Medicare Responsibilities

Within 15 days after receiving notification that a provider acting as a primary care physician will be disaffiliated with Hamaspik Medicare, or at least 30 days prior to the termination date, Hamaspik Medicare will send a letter to managed care members under that provider's care. The letter will inform the member of the date on which the provider's contract was terminated and encourage the member to select a new provider.

Specialist Responsibilities

When an individual specialist physician or a specialty group terminates participation in Hamaspik Medicare, the specialist or specialty group must notify affected members of the termination prior to the effective date of the termination. In the event an individual specialist is terminated from a specialty group, the group must notify affected members prior to the effective date of the termination. Hamaspik Medicare will also notify members with recent claims from the provider that he/she has terminated participation in the network.

"Termination" shall include termination of the contract between Hamaspik Medicare and the physician or group for any reason, or any other situation in which the physician or group is no longer available to see an affected member. "Affected members" refers to members enrolled in Hamaspik Medicare who are receiving ongoing treatment from the specialist physician or specialty group.

3.1.28 Change of Ownership of the Provider

If there is a change in ownership of the Provider, the Provider shall provide Hamaspik with complete ownership, control and relationship information, within 35 days of the change. Provider must provide the following, in writing:

(a) the name and address of each person (individual or corporation) with an ownership or control interest in Provider or in any subcontractor in which Provider has direct or indirect ownership;

(b) the date of birth and Social Security number for any individual with an ownership or control interest;

(c) whether any of the persons named, in compliance with this Section, is related to another as spouse, parent, child, or sibling;

(d) a tax identification number (in the case of a corporation) with an ownership or control interest in Provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which Provider has five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling;

(e) the name of any other Participating Providers in which a person with an ownership or control interest in Provider also has an ownership or control interest; and

(f) the name, address, date of birth and social security number of any managing employee of Provider.

3.1.29 Provider Reimbursement

Reimbursement is based on arrangements that Hamaspik Medicare has made with an individual provider or group. Specific reimbursement is determined from the member's benefit package, the product lines in which the provider participates, and the terms of the provider's participating provider agreement. Inquiries regarding the reimbursement terms of a provider's participation agreement should be directed to the Provider Relations Department.

3.1.30 Payment in Full and Hold Harmless

When Hamaspik pays a participating provider directly for covered services, the provider must accept the payment as payment-in-full and must agree not to collect from or bill the member. Payment does not include any copayments for which the member is responsible. If a member is dually eligible, he/she would have a 20% copayment if they lose their Medicaid coverage.

3.1.31 Fee Schedule

Hamaspik Medicare pays its participating provider on the basis of a fee schedule for covered services provided to Hamaspik Medicare members pursuant to the terms and conditions of the provider's specific participation agreement. These amounts are determined from the member's benefit package, the product lines in which the provider participates, and the terms established in the provider's participation agreement with Hamaspik Medicare.

3.1.32 Reimbursement of Mid-level Practitioners (NPs and PAs)

Hamaspik Medicare will reimburse nurse practitioners (NPs) and physician assistants (PAs) at 85% percent of the physician fee schedule for all services. Hamaspik Medicare reimburses claims submitted by an NP/PA as part of the remittance paid to the associated collaborating/supervising physician.

3.1.33 Hamaspik Medicare's Model of Care

Hamaspik Medicare Select (D-SNP) and Hamaspik Medicare Choice (MAP), like all Medicare Special Needs Plans, are obligated to conduct training for network providers on our model of care (MOC). Hamaspik's Provider Relations Department's primary responsibilities are to partner, educate, support, and maintain relationships between Hamaspik and its network of providers. Each new provider will be oriented to the health plan and its policies and procedures using a multi-faceted approach. The multi-pronged approach is inclusive of provider orientation conducted upon initial completion of the credentialing and contracting process.

The activities that will be used in orienting providers will include:

- A welcome mailing, including a quick reference card, Model of Care, reference to the online Provider Manual, and additional written materials about the plan.
- Information about the Hamaspik website, provider portal, and on-line population health management module
- An introduction to the assigned Provider Network Specialist, who will become the point person for the provider when he/she has questions or issues that require resolution.
- Field staff including the assigned Provider Network Specialist will assist with face-to-face Model of Care Training as needed and conduct follow up visits with providers (in-network and out-of-network) who provide care to members, in order to ensure MOC training is disseminated to all providers
- For some providers, an on-site visit will be conducted to provide an orientation to the plan. For large physician practices or institutions, this may include in- service educational programs for providers, conducted at the provider's location
- Field staff will provide updated MOC and training materials to provider offices when visiting
- The MOC training module printable copy and simplified key facts sheet will be available through the website and provider portal.
- An initial webinar video training on the Model of Care will be offered during Provider Relations' orientation with providers, and then annually thereafter.
- Video webinar trainings will be hosted by the Chief Medical Officer and management departments.
- Model of Care Training video webinars will be held annually for all providers both in and out of network.
- Attendees will be tracked through the website portal login
- The Information Technology department will track MOC training attendee participation and produce a webinar attendance report shared with Provider Relations alongside the management team at Quality Improvement Committee meetings.
- Provider Relations will compile a list of providers who service our membership who have not completed the MOC training.
- Provider Relations and Provider Network Specialists will reach out to these providers telephonically, via email, or setup face to face visits to prompt the completion of the MOC training and obtain attestations.
- Updates to the Model of Care will also be communicated to the provider network via email alerts, provider newsletter, and the provider portal/website.

The Chief Medical Officer, Provider Relations, and Operations departments are responsible for providing the Model of Care training(s). Any in-person training will be conducted by Provider Relations or Provider Network Specialists, in the context of a site visit. In addition, Provider Relations staff will be responsible for monitoring on-line training attendance and ensuring that documentation of provider attendance is added to the providers credentialing record. Semi-annual tracking reports will be developed and used to identify providers who need reminders.
All stakeholders in the ICT who interact with Hamaspik Select members receive consistent messages and can provide consistent information when caring for the enrolled members.

Section Four: Benefits Management

4.1.1 Utilization Review

Providers who agree to participate with Hamaspik Medicare have also agreed to cooperate in and comply with the standards and requirements of Hamaspik Medicare's utilization management (and other) initiatives.

Hamaspik Medicare conducts utilization review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a member are medically necessary. Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Hamaspik Medicare considers none of the following to be included in the utilization review process for medical necessity:

- A denial based on failure to obtain health care services from a designated or approved health care provider as required under a member's agreement
- A determination rendered pursuant to the dispute resolution provision of Public Health Law section 2807(c)(3-a)
- The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedures
- Any issues related to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination
- A determination of any coverage issues other than whether health care services are or were medically necessary or experimental/investigational
- A denial due to contractual exclusions
- A denial for failure to obtain preauthorization where required
- No financial incentives shall be given or received in the course of utilization review decisions.

Hamaspik Medicare has a process for reviewing health care services to ensure that they are evidence based, medically necessary, and being performed at the right level of care by qualified professionals. This utilization management (UM) process is conducted by licensed health care professionals and practitioners.

UM decision-making is based solely upon the application of nationally recognized clinical criteria, transparent corporate medical policies, and the existence of coverage. Hamaspik Medicare does not, in any way, encourage decisions that result in underutilization or reward UM decision-makers for denials of coverage or limits on access to care.

4.1.2 Utilization Review Criteria

Medical Necessity Determinations

Hamaspik Medicare conducts pre-service, concurrent and post-service reviews to determine whether the services requested are appropriate for the diagnosis and treatment of members' conditions.

Medical necessity criteria are selected and/or developed and approved by the Hamaspik Medicare QIC (Quality Improvement Committee) with input from participating physicians.

***Note**: The fact that a provider has furnished, prescribed, ordered, recommended, or approved a service does not make it medically necessary; nor does it indicate that the service is covered.*

Clinical Information/Case Documentation

In an effort to make an informed clinical decision, Medical Services staff may request copies of selected portions of a member's medical record from all sources involved in the member's care (e.g., the member's primary care physician, a physician specialist or an institutional or ancillary provider). If the documentation supplied is insufficient or requires clarification, the Medical Services reviewer, Medical Director or designee may make a request for additional information, either orally or in writing to the requesting provider. If Hamaspik Medicare does not receive the requested additional information, the Hamaspik Medicare Medical Director will make a medical necessity determination based on the information available within the applicable time frame.

Hamaspik Medicare will review the clinical information supplied against established clinical review criteria, standards, guidelines, policies, and state and federal law and regulations.

Criteria Selection and Application

In performing utilization review, Hamaspik Medicare utilizes nationally recognized criteria, such as InterQual®, medical coverage guidelines, as well as corporate medical policies and community-based criteria.

Criteria are reviewed with participating providers. Community-based criteria are developed using regional providers, who apply both regional standards of practice and nationally accepted standards. Medical Services reviewers use these standards to evaluate the medical necessity, level of care, and proposed alternative care settings for inpatient and outpatient services. Staff members apply Hamaspik Medicare medical policies associated with the requested service.

Hamaspik Medicare's utilization management criteria are available to participating providers, members, and prospective members upon request from Provider Relations Department and/or Member Service.

Review of New Technology and Local Capacity

Hamaspik Medicare's mission includes making affordable medical care available as widely as possible throughout the community. Overuse of services and the use of unproven technologies affect

both cost and quality. Therefore, Hamaspik Medicare has established a process to review and manage both technology and capacity.

Capacity includes incremental increases in capital equipment (for example MRI scanners), programs (for example, birthing centers), approved technology that is new to the local area (for example, PET scans) and changes in the distribution of services within the service area.

Hamaspik Medicare will cover new technologies, services, and capacity only as approved and reviewed by corporate committees. Hamaspik will cover anything that would be covered as a Part A or Part B service in fee-for-service Medicaid. New or incremental technology, programs or services that have not been reviewed through this process will not be eligible for coverage.

Participating providers who are planning to invest in new technologies, services, and/or added capacity should first verify that coverage will be available under the Hamaspik Medicare health benefit programs and that the new technologies, services, and/or added capacity are consistent with Hamaspik Medicare's views for additional capacity.

4.1.3 Types of Utilization Review

All utilization review processes follow the timelines shown in the chart below. This information can also be found on the plan's website, www.hamaspik.com. (See the paragraphs entitled Utilization Review Decision and Notification Time Frames in section 4.1.3 of the manual.) Hamaspik Medicare Health Plan's Medical Services staff conducts utilization review to:

- Determine the medical necessity of the services utilizing clinical criteria
- Determine appropriateness of the level of service and provider of service; and
- Identify and refer potential quality of care issues to the Quality Management Department

Pre-Service Review

Hamaspik Medicare's Medical Services staff conducts pre-service reviews on all member services that, according to the individual member's contract, require such determinations before services are rendered.

A participating provider or a member may initiate a pre-service determination request by telephone, fax, web or written request, as directed by the terms of the specific benefit plan and the member contract. The staff will assess services in keeping with established preauthorization processes, the member's contract and/or approved medical criteria. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/investigational.

A Hamaspik Medicare reviewer or designee will contact the member and the requesting provider by telephone to notify them of the determination. Hamaspik Medicare will follow this oral notification with a letter to the member and requesting provider.

Concurrent Review

Hamaspik Medicare's Medical Services staff conducts concurrent review for select services to monitor the medical necessity of an episode of care during the course of treatment. Hamaspik Medicare usually conducts concurrent reviews through telephonic care coordination. Concurrent review is performed for select inpatient and outpatient care. Cases not meeting criteria or requiring further evaluation are referred to a Medical Director or other clinical peer reviewer for determination.

Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/ investigational.

A Hamaspik Medicare reviewer or designee will contact the member and the requesting provider by telephone to notify them of the determination. Hamaspik Medicare will follow this oral notification with a letter to the member and requesting provider.

Urgent Requests

Providers requesting urgent review of a case must document the specific reason for the request (e.g., application of the standard time frames would seriously jeopardize the life of the patient) so Hamaspik Medicare can determine whether the request clearly meets the regulatory requirements for an urgent review.

Reconsiderations

Providers may call Hamaspik Medicare to request a reconsideration of an adverse determination, when the provider recommended a service, but Hamaspik Medicare made no attempt to discuss the matter with the provider prior to making its decision. Reconsideration for pre-service or concurrent reviews will take place within one business day of the request. Reconsideration decisions will be made by the same clinical peer reviewer who made the original determination, if he/she is available.

Reconsideration does not affect the right to appeal. (For example, an appeal may be initiated whether or not there has been a reconsideration or after a reconsideration has occurred.) Reconsideration is a telephonic process, initiated through Member Service.

4.1.4 Utilization Review Decision and Notifications Time Frames

Hamaspik Medicare has established time frames for utilization review that meet state and federal regulations and accreditation standards. These time frames are outlined below and posted in the Member Handbook and on the Hamaspik Medicare website: www.hamaspik.com. Notification to the member and the provider(s) is made in writing and by telephone, except that telephonic (oral) notice is not given in a post-service determination.

***Note**: Once Hamaspik Medicare has all the information necessary to make a determination, Hamaspik Medicare's failure to make a utilization review determination within the applicable time frame shall be deemed an adverse determination subject to appeal.*

Timeframes for Utilization Review Determinations	
Type of Decision	***Request for Service and Process Timeframes***
Pre-Service Pre-Authorization	For prior service authorization requests, the plan makes a determination as fast as the member's condition requires, within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt of the Service Authorization request. Standard-Decision, verbal and written notification to the member and provider must be completed within 3 days of receipt of the necessary information and no later than 14 calendar days after receipt of original request, plus (14 days totaling 28 days) if an extension. Expedited-Decision, verbal and written notification to the member and provider must be completed within 3 business days from the receipt of the request, plus 14 days (totaling 17 days) if an extension is used. If an expedited review is requested and denied, Hamaspik Medicare must send a notice stating that it has denied the expedited request and will review the case within standard timeframes.
Concurrent	Standard (Non-Inpatient) - Decision, verbal and written notification to the member and provider must be completed within 1 business day of the receipt of all necessary information but never more than 14 calendar days from the date of the request. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Expedited (Inpatient) - Decision, verbal and written notification to the member and provider must be completed within 1 business day of the receipt of all necessary information but never more than 3 business days from the date of the request. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.
Post-Service	Decision and written notification to the provider, and in some cases the member, and must be completed within 30 calendar days of receipt of necessary information. No verbal notification is required on post-service decisions.

Standard	*Request for Service and Process Timeframes*
Extended Decision Timeframe	If additional information is needed to render a decision, Hamaspik Medicare will send a written request to the member/provider for the specific information needed. If Hamaspik Medicare does not receive the information in time to make a decision within 14 calendar days of the original request, and it is in the member's best interest to have an extension, Hamaspik Medicare will send a notice extension. The member, the member's designated representative or the provider may also request an extension. Upon receipt of the information, the decision, verbal and written notification must be made within 3 business days of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made no later than the date the extension expires using whatever information has already been received. The notice of extension must specify the reason for the extension, an explanation of how the delay is in the best interest of the member, the additional information Hamaspik Medicare needs to make the determination, the right of the member to file a complaint regarding the extension, the process and timeframes for filing a complaint, the right of the member to designate a representative to file a complaint, and the right of the enrollee to contact CMS regarding their complaint. Notice of a decision in the extension period must be made verbally and in writing as fast as the member's condition requires and within 3 business days after receipt of necessary information, but no later than the date the extension requires.
Notice of Adverse Action	Notification of any decision to deny or authorize a service in an amount, duration, or scope that is less than requested will be provided in writing to the member/guardian, the member's case manager, and applicable providers within timeframes specified above and within at least 10 days before the date of action. The member or designated representative have the right to file an appeal if not in agreement with the Notice of Action. The appeal process and timeframes are provided in the "Grievance and Appeals" policy and in the Evidence of Coverage.

4.1.5 Who is Notified of Utilization Review Decisions?

If a request for a pre-service or concurrent referral or preauthorization is approved, Hamaspik Medicare will provide telephonic notice to the requesting provider and member, and send written confirmation of the approval to the member, to the requesting provider, and to the providing specialist (or facility). If a pre-service or concurrent authorization is denied, Hamaspik Medicare will provide telephonic notice and send written notification of the denial to the member and the requesting provider. The notification will explain the reason for the denial – including the specific utilization review criteria or benefit provisions used in making the determination – and information about the grievance or appeal process. For pre-service denial cases, notice is not given to the proposed specialist or facility (due to HIPAA privacy regulations). For post-service cases, the same written notifications are sent to the same parties as listed above, but no telephonic notification is required.

4.1.6 Written Notice of Initial Adverse Determination

An initial adverse determination is a determination made by Hamaspik Medicare or its utilization review agent that, based on the information provided, the admission, extension of stay, level of care, or other health care service is not medically necessary or is experimental/investigational and, thus, not covered.

All notices of adverse determination must include:

- The clinical rationale for the denial, including a reference to the criteria on which the denial was based
- A description of the actions to be taken (e.g., that Hamaspik Medicare will not provide coverage for the service at issue)
- Instructions for appealing the determination, including information describing the expedited and external appeal processes
- An explanation of the right to external appeal if the Level 1 Appeal is denied. In this situation, Hamaspik will automatically forward the determination to the Medicare Independent Review Agent (IRE) for review.
- Instructions for obtaining a copy of the clinical criteria used in making the determination
- A statement regarding the availability of the reviewer to discuss the denial
- A statement that the member's provider has the right to speak with a Medical Director if he/she has questions regarding the decision
- A statement that Hamaspik Medicare will not retaliate or take discriminatory action if an appeal is filed. Instructions on how the member can obtain information about the diagnosis or treatment code related to the case
- A statement that the notice is available in other languages and format for special needs and information on how to access these formats, and

- Any additional information required by Hamaspik Medicare to render a decision on appeal if a member disagrees with a utilization review decision, or if Hamaspik Medicare does not make the decision within the specified time frame, the member may request an internal appeal. Hamaspik Medicare has standard procedures for responding to requests for appeals of adverse determinations made by a member, the member's authorized designee or a provider. See the paragraphs under Member Grievance and UR Appeals Policy and Procedure later in this section of the manual.

4.1.7 Medical Policies

Hamaspik Medicare establishes and uses medical policies and clinical practice guidelines when determining medical necessity. Medical policies are either based on scientific evidence related to medical technology, or are intended to clarify coverage of services based on interpretation of member contracts.

Copies of the overview and of specific policies may also be obtained, upon request, from Provider Relations Department.

4.1.8 Primary Care Providers and Specialists

Hamaspik Medicare requires each member who is covered by Hamaspik Medicare to select a primary care physician (PCP) as a condition of his/her membership.

The member's PCP is responsible for monitoring and coordinating the member's health care. This may occur either by direct provision of primary care services or through appropriate referrals or pre-authorizations that allow the member to receive health care services from other physician specialists and providers when medically necessary. (Referrals and pre-authorizations are described later in this section of the manual.)

4.1.9 PCP Responsibilities

Primary care providers include physicians and nurse practitioners as defined below.

Physicians (MD/DO) practicing in one of the following specialties:

- Internal Medicine
- Family Medicine/Family Practice
- General Practice
- Geriatrics
- Pediatrics
- Gynecologists may also serve as PCPs for female members.

Nurse Practitioners licensed in one of the following:

- Adult Health
- Family Health
- Gerontology
- Women's Health

In certain situations, a member may select a specialty physician as a PCP.

Primary Care Providers:

- Provide all routine and preventive care
- Supervise and coordinate medically necessary health care for the enrollee
  - Work with specialty physicians and other providers for continuity and coordination of care
  - Work with Hamaspik Medicare care managers, as appropriate
- Provide and ensure availability to the enrollee, 24 hours daily/7 days per week
- Refer or request preauthorization for members to obtain:
  - Care from participating physicians (specialists and other health professionals
  - Laboratory tests, x-rays, and diagnostic tests
  - Inpatient care and treatment
  - Outpatient care and treatment
  - Prescription drug (Part D) exceptions and prior authorizations

All PCPs are expected to provide and arrange for care that is consistent with current professional and generally accepted standards of medical practice. In addition, PCPs are expected to support Hamaspik Medicare's quality initiatives, which may focus on improvements in delivery of health care services. Hamaspik Medicare has adopted a comprehensive outline of the plans' standards of care which are reflective of professional and generally accepted standards of medical practice.

PCPs are responsible for obtaining all consultation reports, lab tests and test results, and for reviewing and noting the results in the medical record, and for documenting the treatment plan.

4.1.10 Specialist Responsibilities

A specialist provides services to a Hamaspik Medicare member for a particular illness or injury, usually upon referral from the member's PCP. A participating specialist is responsible for rendering services to the member as ordered by the PCP and/or reported on a referral form.

Participating specialists must adhere to Hamaspik Medicare policies and procedures regarding preauthorization requirements for hospital admissions, home health care, durable medical equipment, and other specified medical care and procedures.

Use of a Specialist as PCP

A member with a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized medical care may receive a referral to a specialist who will be responsible for

and capable of providing and coordinating the member's primary and specialty care. This type of referral must be made pursuant to a treatment plan approved by Hamaspik Medicare, in consultation with the primary care physician, the specialist, and the member. In no event will Hamaspik Medicare be required to permit a member to elect to have a non-participating specialist as a PCP, unless there is no specialist in the network. In addition, female members may elect to have an OB/GYN serve as their PCP.

4.1.11 Out-of-Network

If Hamaspik Medicare's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. Hamaspik Medicare may grant a referral, pursuant to a treatment plan approved by Hamaspik Medicare's medical staff in consultation with the primary care physician, the non-participating provider and the member.

In such event, Hamaspik Medicare will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within the Hamaspik Medicare provider network. In no event shall Hamaspik Medicare be required to permit a member to receive services from a non-participating specialist except as approved above.

In no event will Hamaspik Medicare be required to permit a member to receive services from a non-participating specialty care center, unless Hamaspik Medicare does not have within the network an appropriate specialty care center to treat the member's disease or condition. Services must be provided pursuant to an approved treatment plan and at no additional cost to the member beyond what the member would otherwise pay for services received within the Hamaspik Medicare network.

4.1.12 Referrals to Specialty-Care Centers

A member with a life-threatening or a degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time may receive a referral to an accredited or designated specialty-care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. This type of referral must be made pursuant to a treatment plan approved by Hamaspik Medicare, in consultation with the primary care physician, the specialist, and the member.

In no event will Hamaspik Medicare be required to permit a member to receive services from a non-participating specialty care center, unless Hamaspik Medicare does not have within the network an appropriate specialty care center to treat.

4.1.13 Transitional Care When a Provider Leaves the Network

Hamaspik Medicare will permit a member to continue an ongoing course of treatment with a provider during a transitional period: (i) of 90 days from the last day of the provider's contractual obligation, or (ii) if the member has entered the second trimester of pregnancy at the time of the provider's disaffiliation, that includes the provision of postpartum care directly related to the delivery.

Hamaspik Medicare will authorize the transitional care described above only if the provider agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of Hamaspik Medicare's policies and procedures including, without limitation, quality management and utilization management programs.

Note: *The transitional care rights described in this section do not apply to patients of a provider who leaves the Hamaspik Medicare network without a right to a hearing under the provisions of the New York State Managed Care Law.4.4.8 Transitional Care for New Members*

In the following circumstances, Hamaspik, Inc. will permit a new member to continue seeing his/her previous health care practitioner for a limited time, even if that practitioner is not participating in Hamaspik, Inc.:

- If, on the effective date of enrollment, the member has a life-threatening or a degenerative and disabling disease or condition for which he/she is in an ongoing course of treatment, he/she may continue to see a non-participating practitioner who is caring for him/her, for up to 60 days.

4.1.14 Preauthorization

Hamaspik Medicare requires that it review certain services in advance to determine if the services are medically necessary, appropriate for the specific member, and experimental and/or investigational. Before providing these services, a provider must request authorization from Hamaspik Medicare, which initiates the review.

If a request for preauthorization is approved, Hamaspik Medicare will send written confirmation of the preauthorization request to the requesting physician, the providing specialist (or facility) and to the member. If the authorization is denied, for concurrent and post-service cases, Hamaspik Medicare will send written notification of the denial to the member and the ordering physician. The notification will explain the reason for the denial – including the specific utilization review criteria or benefit provisions used in making the determination – and information about the appeal process. For pre-service cases, notice is not given to the referred to specialist or facility (due to HIPAA privacy regulations).

Hamaspik Medicare may deny claims for services that require preauthorization but were not preauthorized.

Hamaspik Medicare makes coverage decisions based upon the presence of an authorization, the terms of a member's contract, and medical necessity. The presence of an authorization does not guarantee payment. Payment is based on the member's contractual benefit in effect at the time of service.

4.1.15 How to Request a Preauthorization

It is important to have all patient identification and clinical information readily available before beginning.

Information Needed to Request Preauthorization

- Patient's name
- Patient's birth date (for accurate identification)
- Member ID number
- Requesting physician
- Servicing provider
- Diagnosis, including the ICD-9 code (if available)
- CPT/HCPCS
- Time period
- Number of visits/quantity requested

Requesting Preauthorization by Telephone

- Call the number listed under Preauthorization on the Contact List in this manual
- Inform the representative that you are requesting preauthorization
- Provide all information requested
- The representative will enter the preauthorization request and, if required, forward it to a nurse in Hamaspik Medicare's Medical Services Department for review
- If you can provide all necessary clinical information over the telephone, you may choose to have your call forwarded to the Medical Services review nurse for clinical review. You also have the option of faxing requested clinical documentation to the Medical Services Department for review. The representative will provide the appropriate fax number at the time of your call.

Once the Medical Services utilization review nurse or designee has all the necessary clinical information, a decision will be made within the time frames listed on the chart Utilization Review Time Frames, available from the Provider page of Hamaspik Medicare Health Plan's website, or from the Provider Relations Department.

Special Methods of Requesting Preauthorization for Selected Services

Please note that there are special methods to request preauthorization for Imaging Studies, Physical Therapy, and Occupational Therapy. See the separate paragraphs below that are devoted to these services.

4.1.16 Hamaspik Medicare Covered Services

Abdominal aortic aneurysm screening	Medicare Part B prescription drugs
Ambulance services*	Obesity screening and therapy to promote sustained weight loss
Acupuncture	Opioid Treatment Program Services
Annual wellness visit	Outpatient diagnostic tests and therapeutic services and supplies*
Bone mass measurement	Outpatient Hospital Observation*
Breast cancer screenings (mammograms)	Outpatient hospital services
Cardiac rehabilitation services*	Outpatient mental health

Cardiovascular disease risk reduction visit (therapy for vascular disease	Outpatient rehabilitation services*
Cardiovascular disease testing	Outpatient substance services
Cervical and vaginal cancer screening	Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*
Chiropractic services*	Over-Counter Health Items
Colorectal cancer screening	Partial hospitalization services*
Dental Services*	Physician/Practitioner services, including doctor's office visits
Depression screening	Podiatry Services
Diabetes screening	Prostate cancer screening exams
Diabetes self-management training, diabetic services and supplies	Prosthetic devices and related supplies*
Durable medical equipment and related supplies*	Pulmonary rehabilitation services*
Emergency care	Screening and counseling to reduce alcohol misuse
Health and wellness education program*	Screening for lung cancer with low dose computed tomography (LDCT)
Hearing services*	Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
HIV screening	Services to treat kidney disease
Home Health agency care*	Skilled nursing facility care*
Hospice	Smoking and tobacco use cessation
Immunization	Supervised Exercise Therapy*
Inpatient hospital care*	Urgently needed services
Inpatient mental health*	Vision Care
Medical nutrition therapy	Welcome to Medicare Preventive Visit
Medicare Diabetes Prevention Program (MDPP)	Worldwide Emergency/Urgent Care

***The above covered services listed with an asterisk (*) require preauthorization.**

Hamaspik Medicare may deny claims for services that require preauthorization but that were not preauthorized, for failing to successfully complete a review for medical necessity, or timely filing based on the terms of the provider agreement. To determine the benefit requirements for a specific member, inquire through one of Hamaspik Medicare's member eligibility inquiry systems explained in the Administrative Information section of this manual. The provider can call our utilization review team at 1(888)426-2774.

Hamaspik Medicare Choice Covered Services

Hamaspik Medicare Choice includes all the covered services listed for Hamaspik Medicare Select PLUS the following additional services:

- Adult Day Health Care
- Consumer Directed Personal Assistance Services (CDPAS)
- Dental Care
- Home Delivered Meals and/or meals in a group setting such as a day care
- Home Health Care Services Not Covered by Medicare
- Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit
- Medical and Surgical Supplies, Parenteral Formula, Enteral Formula, Nutritional Supplements and Hearing Aid Batteries
- Nursing Home Care not covered by Medicare
- Nutrition
- Non-Emergency Transportation
- Outpatient Rehabilitation
- Personal Care Services
- Personal Emergency Response System (PERS)
- Private Duty Nursing
- Social Day Care
- Social/Environmental Supports

Telehealth

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member.

Telehealth services are covered for primary care provider and physician specialist services. Telehealth services allow members to access health care services remotely while their provider manages their care. The following services may be offered through Telehealth services:

- Primary Care Provider Services
- Physician Specialist Services
- Individual and Group Sessions for Mental Health Specialty Services
- Individual and Group Sessions for Psychiatric Services
- Individual and Group Sessions for Outpatient Substance Abuse

4.1.17 Reversal of Preauthorization Approval

Under New York state law, a managed care organization (MCO) (Hamaspik Medicare) may reverse approval of a preauthorized treatment, service or procedure when:

- The relevant medical information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The relevant medical information presented to the MCO or utilization review agent upon retrospective review existed at the time of the preauthorization, but was withheld from or not

made available to the managed care organization or utilization review agent; and
- The MCO or utilization review agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had the MCO or utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

This determination is to be made using the same standards, criteria and/or procedures used during the preauthorization review.

Hamaspik Medicare may also reverse or revoke preauthorization when it has been determined that:
- The relevant medial information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review, and
- The relevant medical information presented to the MCO or utilization review agent upon retrospective review existed at the time of the preauthorization, but was withheld from or not made available to the MCO or utilization review agent, and
- The MCO or utilization review agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had the MCO or utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same standards, criteria and/or procedures used during the preauthorization review

Hamaspik Medicare may also reverse or revoke preauthorization when it has been determined that:

- There is evidence of a fraudulent request
- There is a change in the status of the provider from participating to non-participating (subject to the state laws governing continuity of care)
- There is a change in the member's benefit plan between the approval date and date of service
- There is evidence that the information submitted was erroneous or incomplete
- There is evidence of a material change in the member's health condition between the date the approval was provided and the date of treatment that makes the proposed treatment inappropriate for the member
- The member was not a covered person at the time the health care service was rendered (Exceptions may apply if the member is retroactively disenrolled more than 120 days after the date of service.)
- The member exhausted the benefit after the authorization was issued and before the service was rendered
- The preauthorized service was related to a pre-existing condition that was excluded from coverage
- The claim was not timely under the terms of the applicable provider or member contract

4.1.18 Preauthorization for Imaging Studies

Elective outpatient imaging studies require prior authorization, following the process outlined above. Ordering physicians must request preauthorization for selected imaging studies for those members who require, it **before** sending the member for the study.

Providers may request preauthorization by fax or by telephone.

Ordering physicians should make certain that all clinical information is available, including:

- Patient's name, date of birth and member ID number
- Ordering provider's name, Provider ID number, fax number and telephone numbers
- Rendering provider's information, including facility name, fax number and telephone numbers
- The CPT code and/or description of the test requiring authorization
- Patient data relevant to the request, such as: signs and symptoms, test results, medications, related therapies, dates of prior imaging studies, etc.

All requests will be reviewed within the appropriate time frame. If a request is approved, the requesting physician will be notified by phone and in writing, and an authorization number will be provided. The physician should contact the member with the approval and testing schedule. Hamaspik Medicare also will notify the member by letter.

Pre-authorizations for imaging studies are valid for 45 days from the date of approval.
If a request is not approved, then the member and the ordering provider are notified by phone and in writing. The letter will include the rationale for the decision, as well as information regarding the appeals process.

Claims for imaging services will process according to the member's health benefit program that is effective on the date of service. Failure to obtain preauthorization will likely result in payments being denied, and the member will be held harmless.

4.1.19 Preauthorization for Physical Therapy and/or Occupational Therapy

Providers requesting preauthorization for physical and/or occupational therapy follow the same process as for most other services requiring preauthorization except in the following circumstances:

- The request is for additional visits.
- The request is for a different diagnosis or to see a different practitioner.
- The request is for direct access (without being referred by a physician).

Additional Visits

If the physical or occupational therapist feels that more visits are warranted, he or she should request them prior to the last authorized visit, using the Physical Therapy Authorization form from the Provider Relations Department. The Physical Therapy authorization form may be completed by the physical or occupational therapist and faxed to the fax number on the form.

If Hamaspik Medicare determines that the request for additional visits does not meet Hamaspik Medicare's criteria, Hamaspik Medicare will ask the physical therapist or occupational therapist to send all case note documentation, including objective, measurable data and an updated physician order. Hamaspik Medicare will review patient progress over the previous two- week interval. The case will be presented to a Hamaspik Medicare Medical Director for review. The Medical Director may authorize additional visits or deny coverage for further services.

If treatment is denied, the member or his/her representative may initiate an appeal of this decision.

Different Diagnosis or Different Practitioner

If a physical therapist or occupational therapist requests another authorization while an earlier authorization is still active (due to a different diagnosis or a different practitioner), Hamaspik Medicare requires completion of a Physical Therapy Authorization Form. When the provider calls for the authorization, if the representative finds an authorization still open, he/she will request that the provider complete a Physical Therapy Authorization Form. This form is available on the Hamaspik Medicare website, or from the Provider Relations Department.

4.1.20 Medical Drug Preauthorization

Hamaspik Medicare has contracted with Magellan to provide prescription drug coverage for its members. The prescription drug formulary, including information about utilization review requirements, is available on the Hamaspik Medicare website at www.hamapsikchoice.org. All drugs that have requirements for prior authorization or step therapy are managed by Magellan.

4.1.21 Emergency Care Services (In-Area and Out-of-Area)

A referral or authorization is not required for treatment of an emergency medical condition in an emergency room. An emergency medical condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Emergency medical service is defined as a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

4.1.22 Inpatient Admissions

Participating facilities must notify Hamaspik Medicare when a member of Hamaspik Medicare is admitted. Authorization is required for admissions, excluding emergency services. Preauthorization is required for elective inpatient procedures and transfers from observation to inpatient admission. A physician certification of inpatient services of hospitals other than inpatient psychiatric facilities is required as a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act. Therefore, Hamaspik requires receipt of a physician certification of the medical necessity that such services be provided on an inpatient basis. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B and 42 CFR 412.3.

As of January 1, 2021, Hamaspik Medicare cannot deny a hospital claim for administrative reasons. If the provider supplies the information required to make a Utilization Management decision, Hamaspik Medicare may still deny a claim, but not solely for missing the pre-authorization requirement.

No authorization is required before emergency services rendered by a hospital, but hospitals must notify Hamaspik Medicare of admissions within the following time frames (except exempt units):

- During normal business hours, within 24 hours of rendering services
- Over a weekend, within 48 hours of rendering services
- Over a holiday, within 72 hours of rendering services

4.1.23 Notifying Hamaspik Medicare of an Admission

To notify Hamaspik Medicare of an inpatient admission, facilities may use any of the methods described in the Administrative Information section of this manual. Providers should have the following information readily available:

- Member name and date of birth
- Member ID number
- Name of attending physician
- Name of hospital or facility
- Date of admission
- Diagnosis and pertinent medical information
- Physician Certification

4.1.24 Physician Referral During Inpatient Stay

In most instances, Hamaspik Medicare does not require physicians to obtain a separate referral for managed care members for inpatient medical care, inpatient consultations, inpatient psychiatric care, or nursing home visits during an approved admission. These services are normally considered part of the Hamaspik Medicare authorization for the admission. However, the attending physician should obtain preauthorization for surgery or other care not defined above.

After Discharge

In addition, depending on the health benefit program, physicians and/or other service providers may need a referral from the member's PCP for continuing care following discharge.

4.1.25 Site of Service: Inpatient versus Outpatient

Several national standards indicate that many surgical procedures are most appropriately rendered in an outpatient setting, such as the outpatient department of a hospital, a freestanding ambulatory surgery center, or a physician's office. Hamaspik Select has established a list of these procedures.

Except in special circumstances, these procedures will be covered only when performed in an outpatient setting. **Any facility or individual provider who feels that the patient has a special medical condition or complication that requires an inpatient stay for a listed procedure should**

contact Hamaspik Medicare for authorization prior to scheduling the procedure.

If a required authorization is not obtained in advance, Hamaspik Medicare may deny payment for the services.

If the patient is already hospitalized and requires a surgical procedure that is on the Outpatient Procedure List, the procedure is covered as part of the inpatient stay if it is deemed medically necessary that the patient remain hospitalized.

4.1.26 Care Coordination

One aspect of Hamaspik Medicare's care management and utilization management functions are to coordinate the care of select hospitalized members who are enrolled in specific health benefit programs. The goal is to not only ensure that the member receives the appropriate level of care while in the hospital and experiences a smooth transition to appropriate post-discharge services (e.g., home care and case and disease management programs.

While hospital medical staff remains responsible for all medical care and treatment decisions, Hamaspik Medicare staff is available to make timely referral into services and programs that could benefit the patient after discharge, or while still hospitalized.

4.1.27 Care Management Programs

Hamaspik Medicare maintains disease and care management programs and services that span the continuum of care from early-stage conditions through acute events, severe chronic disease, and death with dignity.

Disease Management

The disease management program offers a community-based program utilizing internal and community resources. The program provides education and resources to those members who are identified as having a chronic condition such as asthma, diabetes, and heart disease. The program spans from early-stage conditions through acute events and severe chronic disease to enhance members' understanding of their condition and encourage positive lifestyle changes to better manage their disease and make informed decisions on their treatment options. The program provides a three-part strategy:

- First identify individuals with a chronic condition,
- Second, provide targeted information and interventions based on the severity of the illness and
- Third, work with health care providers to improve chronic conditions.

The program includes assistance with medical supplies and community resources to better control the member's condition and avoid complications. A 24-hour a day nursing line is available seven days per week to assist members in managing their chronic condition.

Care Management

Care management goes beyond traditional "case" management and provides a holistic approach in identifying psychosocial and medical issues that may impact the members and their enrolled family. The program manages members with non-complex and complex case management needs. Hamaspik assesses all enrollees to determine their level of stratification for Care Management, develop their as well as to identify and establish specially tailored services for the most vulnerable beneficiaries. Assessment of this population and interventions by an interdisciplinary care team are vital to identifying the health risk factors of these members while providing important information about a member's physical and mental well-being.

For members enrolling in the MAP plan, an assessment is conducted by a registered nurse in the member's home, using the Uniform Assessment System (UAS) tool as prescribed by NYS DOH (UAS-NY) will be completed prior to enrollment and every six months thereafter, or more frequently if there is a reported significant change in the member's status. UAS Data will be closely reviewed to identify Hamaspik MAP members specific actual and potential health care concerns. UAS data will be utilized to develop the ICP inclusive of self-management and other goals, opportunities, interventions, specially tailored care management, and appropriate services.

For all individuals enrolled in the Hamaspik Medicare Advantage Dual Eligible SNP and MAP plans, Care Managers complete a Health Risk Assessment Tool (HRAT) within 90 days of enrollment, annually, and when there is a change is a member's condition, such as a change in the member's health status or if the member experiences a transition in their care, or a change from living in their home to a hospital stay or nursing home stay. The Care Manager (CM) coordinates and collaborates with internal care management programs, providers, and community resources to ensure family needs are met, and that they have the ability to overcome barriers to receiving health care services. In addition, all members are provided a 24-hour seven-day per week nursing line to review medical issues and preference sensitive condition support.

Emergency Management

The safety net population has several risk factors that limit the ability to access health care services. In addition, many members lack a physician or transportation forcing them to seek treatment in an emergency room. Hamaspik Medicare collaborates with a Regional Health Information Organization (RHIO) to promote early identification of members seeking ER services. The RHIO system alerts Hamaspik Medicare through daily admission reports. This allows the CM to make contact with the member, educate and coordinate discharge orders, and assist the member in overcoming barriers that may affect their ability to seek follow-up care.

Outreach

The Outreach Program (OP) provides a holistic care-coordinated approach by enhancing the engagement rate of those members who are difficult to locate by telephone and are listed as high-risk. The OP team collaborates with members' IDT, including their providers and community resources, to thereby ensure that members are placed in the most appropriate program(s) to meet their needs. They serve as representatives for our care management programs to facilitate the patient-provider relationship and support the medical home. They assist practitioners through member and

family education on plan services and benefits, as well as in member compliance with healthcare appointments and regimen.

Policies

- Members who may benefit from case management are identified by the member's primary care physician or through risk assessment or another internal mechanism
- The Plan of Care is developed in collaboration with the member, the member's physician, a registered nurse care manager, a medical social worker, and specialty care physicians, as appropriate
- Members meet defined discharge criteria before case closure is considered

Procedures

1. Hamaspik Medicare's Care Management Department has established criteria for identifying individuals who may appropriately be considered for case management services. These criteria are available upon request from the Provider Relations Department. Physicians also may refer a member to the Care Management Program by calling Case Management and providing the following information:

    - Member's name and ID number
    - Referring physician's name and Provider ID number
    - Primary diagnosis
    - Facility (if any) where patient is located
    - Anticipated case management needs
    - Anticipated services required

2. Once the member is identified, a care manager contacts the member to discuss the proposed case management services and ensures the member's willingness to participate. Using standard telephone assessment tools, the care manager assesses the member's needs and determines the acuity and intensity of case management services required.

3. With the member and physician's participation, the care manager develops an individual Plan of Care that supports the physician's treatment plan. The Plan of Care specifies goals to be met, planned interventions, frequency of follow-up care and discharge criteria.

4. The Plan of Care is implemented and regularly evaluated for effectiveness towards goal attainment.

5. The care manager follows Hamaspik Medicare policy to determine when a member is appropriate for discharge from case management. Discharge criteria are explained to the member during case closure, and the physician is notified.

6. Hamaspik Medicare conducts quality reviews of cases to ascertain, among other criteria, the appropriateness and effective ness of services provided the timeliness of follow-up, and staff compliance with case management standards.

4.1.28 Health Promotion

Hamaspik Medicare encourages members to adopt healthy life habits with reminders in our member newsletters about the importance of preventive care services, getting and staying in shape, and suggestions for safe and inexpensive ways to do so. In addition, there are reminders about screening tests for a range of preventive services, including screenings for breast cancer, Chlamydia, colorectal cancer, etc., as well as important information about dental care and summaries of our preventive health guidelines.

4.1.29 Hamaspik Medicare Grievance Procedures

Hamaspik Medicare encourages members to voice both positive and negative comments regarding care and services they have received. A member or their representative has the right to file a grievance (or complaint) when concerned with any aspect of services rendered by Hamaspik Medicare that does not relate to a medical necessity or experimental or investigational determination. Examples of such complaints include, (but are not limited to) quality of care issues, access to care issues, or dissatisfaction with a provider or Hamaspik Medicare. Grievance procedures may also be used to resolve a dispute in which Hamaspik Medicare decided that the member did not meet requirements for coverage of a particular service, or that an out-of-network authorization was not unnecessary.

Concerns are documented at the request of the member or their representative, and when appropriate, their provider, and Hamaspik Medicare responds in a timely manner. If the concern cannot be resolved immediately on the telephone, Hamaspik Medicare informs of the right to file a formal grievance. Hamaspik Medicare describes these rights in the member handbook.

In no event will Hamaspik Medicare retaliate or take any discriminatory action because a grievance has been filed. Hamaspik Medicare endeavors to make grievance procedures accessible to non-English speaking, visually impaired, and hearing-impaired individuals and provides reasonable assistance in completing forms and other steps for filing a grievance. Upon request, Hamaspik Medicare will provide a written copy of the grievance procedure and the review criteria upon which our decisions were based upon. Members or their representative, have the right, both before and during the grievance process, to examine the case file, including medical records and any other documents and records considered during the grievance process. Members or their representative are provided with a reasonable opportunity to present evidence regarding the grievance, in person as well as in writing.

Filing a Grievance

A member or their representative may contact Hamaspik Medicare by calling Member Services at 1-833-426-2774, or may come in person to register a grievance. Alternatively, a member or their representative may submit a grievance in writing to:

Hamaspik Medicare
Member Services
58 Route 59, Suite 1
Monsey, NY 10952

Hamaspik Medicare members have **60 days** to file a grievance from the date of an incident that caused them to experience dissatisfaction with their services.

If the grievance was filed orally, a staff member at Hamaspik Medicare will document a summary of the grievance, and investigation of the grievance will be conducted.

Member Service representatives are available to document the member's grievance during regular business hours. After regular business hours and on weekends, the member may leave a message for Member Service on the voice mail system by calling the after-hours number listed under Member Grievances on the Contact List in this manual. If a member or their representative, and when appropriate, their provider, leaves a message or submits a grievance in writing, a Member Service representative will call to verify receipt of the appeal the next business day. The grievance is recorded and a thorough file review is initiated.

Grievance Review & Documentation Process

All grievances are investigated thoroughly. The research/investigation phase includes, but is not limited to the following interventions:

- Contact with appropriate providers and/or Hamaspik Medicare personnel.
- Contact with designated Hamaspik Medicare personnel for all concerns regarding quality of care and treatment issues
- Review of written records & information gathering from internal and external sources with appropriate releases. Additional required information may include, but is not limited to such items as medical records, a chronology of events, or legal documents related to the grievance. In cases where additional information is deemed necessary, the following guidelines will apply:

  - **Standard Grievances**: Hamaspik Medicare will identify and request information in writing from the member or their representative, and when appropriate, their provider, within the applicable case time period but no later than **15 calendar days** of receipt of the grievance. If, subsequently, only partial information is received, the member or their representative, and when appropriate, their provider will be contacted in telephone and in writing requesting and identifying the additional information needed within **5 business days** of receipt of the partial information.
  - **Expedited Grievances**: Hamaspik Medicare will expeditiously identify and request information via phone or fax to the member or their representative, and when applicable, their provider, followed by written notification.
  - **All Grievances:** If Hamaspik Medicare was unable to make a determination because insufficient information as presented or available, Hamaspik Medicare will send a written statement that the determination could not be made to the member or their representative, and when applicable, their provider, on the date the allowable time to resolve the grievance has expired.

Grievances related clinical matters are decided by personnel qualified to review the grievance, including licensed, certified or registered health care professionals not involved in any previous determinations regarding the grievance, and at least one of whom must be a clinical peer reviewer.

Hamaspik Medicare provides reasonable access to its clinical peer reviewers within 1 business day of receiving notice of taking an expedited grievance. A clinical peer reviewer is defined as:

- a physician who possesses a current and valid non-restricted license to practice medicine;
- a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration, or where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession.

Grievances related to non-clinical matters shall be reviewed by personnel qualified to review the grievance, who were not involved in any previous determinations regarding the grievance, and when applicable, who are of a higher level than the personnel involved in any previous determinations regarding the grievance.

Hamaspik Medicare maintains a file on all grievances that includes the following:

- Date the grievance was received.
- Names of the individuals contacted for intervention or for informational purposes regarding the grievance.
- Documentation compiled related to the grievance.
- Date the Acknowledgment Letter was sent and to whom, as well as a copy of the Acknowledgement Letter.
- A copy of the responses received on the grievance.
- The final resolution, the date in which it was made, and the name and title and/or credentials who reviewed the grievance.
- Date that the verbal and written notice of the grievance decision was given and to whom, and documentation of the verbal and written notice.

Time Frames for Response

Within 15 calendar days of receipt of the grievance, a representative of Hamaspik Medicare shall send the member or their representative a written acknowledgment, including the name, address and telephone number of the individual or department handling the grievance. This acknowledgment shall inform the member of the status of the grievance and advise whether any additional information is required for Hamaspik Medicare to process the grievance. If a grievance determination is reached before the written acknowledgement is sent, Hamaspik Medicare may include the written acknowledgement with the grievance determination. Once all necessary information has been received, Hamaspik Medicare will resolve the grievance on the following schedule:

- **Standard Grievances:** We will decide the grievance as fast as the member's condition requires, but no more than **30 calendar days** from the date we receive the grievance. Written notice of the decision will be issued to the member or their representative, and when appropriate, their provider, within **2 business days** of our decision. This time frame may be extended for up to **14 calendar days** if the member or designee requests an extension, or if we need additional information to review the grievance. Written notice to the member or their representative, and when appropriate, their provider, will be issued when an extension is taken. For members with other contracts, we will decide the grievance as fast as the member's condition requires, but no

more than **30 calendar days** from the date we receive the grievance. Written notice of the decision will be issued to the member or their representative, and where appropriate, their provider, within **2 business days** of our decision, but no later than **30 calendar days** from the date we receive the grievance.

- **Expedited Grievances:** If the grievance relates to a situation in which a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function or any other urgent matter, Hamaspik Medicare handles the grievance on an expedited basis.

  A request that does not meet the criteria for an expedited grievance will automatically default to a standard grievance. The member or their representative, and when appropriate, their provider, will be notified in writing within two (2) business days that the expedited grievance request has been declined, and that the grievance will be reviewed within standard time frames. We will make reasonable effort to provide verbal notice as prompt as possible.

  We will decide an expedited grievance and provide verbal notice of the decision as fast as the member's condition requires, but no later than **3 business days** from the date we receive the grievance, or **2 business days** after receiving all necessary information to decide the grievance. Written notice of the decision will be issued to the member or their representative, and when appropriate, their provider, within **2 business days** of our decision. This time frame may be extended for up to **14 calendar days** if the member or their representative requests an extension, or if we need additional information to decide the grievance. Written notice to the member or their representative, and when appropriate, their provider, will be issued when an extension is taken. For members with other contracts, we will decide the grievance and provide verbal and written notice of the decision to the member or their representative, and when appropriate, their provider, as fast as the member's condition requires, but no later than **72 hours** from the date we receive the grievance, or **48 hours** after receiving the information necessary to decide the grievance.

Notice of Decision

Grievance determination notices to the member or their representative, and when applicable, their provider, includes detailed reasons for the determination, the clinical rationale for the determination in cases where the determination has a clinical basis, information (with toll free numbers) on how to contact the New York State Departments of Health and the member's local department of Social Services to file a complaint, and instructions for any further appeal or grievances processes for the member.

4.1.30 Hamaspik Medicare DSNP and MAP Appeal Procedures

A member or their representative, and, in connection with retrospective determinations, a member's health care provider, may appeal an adverse determination related to medical necessity and experimental or investigational denial rendered by Hamaspik Medicare through the internal appeal process described below. In no event will Hamaspik Medicare retaliate or take any discriminatory action because an appeal has been filed.

Hamaspik Medicare makes appeal procedures accessible to non-English speaking, visually impaired,

and hearing-impaired individuals and provides reasonable assistance in completing forms and other steps for filing an appeal. Upon request, Hamaspik Medicare will provide a written copy of the appeal procedure and the review criteria upon which our decisions were based upon. Members or their representative, have the right, both before and during the appeal process, to examine the case file, including medical records and any other documents and records considered during the appeal process. Members or their representative are provided with a reasonable opportunity to present evidence regarding the appeal, in person as well as in writing.

Filing an Appeal

A member or their representative may contact Hamaspik Medicare by calling Member Services at 1-833-426-2774, or may come in person to file an appeal. Alternatively, a member or their representative may file an appeal in writing to:

Hamaspik Medicare
Member Services Department
58 Route 59, Suite 1
Monsey, NY 10952

Medicaid Managed Care and CHP members have 60 business days to file an appeal from the date of an action notice issued by Hamaspik Medicare Health Plan. All appeals will be acknowledged by Hamaspik Medicare in writing, within 15 days from the date or receipt.

Member Service representatives are available to document the member's appeal during regular business hours. After regular business hours and on weekends, the member may leave a message for Member Service on the voice mail system by calling the after-hours number listed under Member Appeal on the Contact List in this manual. If a member or their representative, and when appropriate, their provider, leaves a message or submits an appeal in writing, a Member Service representative will telephone to verify receipt of the appeal the next business day. The appeal is recorded and a thorough file review is initiated.

***Note**: If the member and Hamaspik Medicare jointly agree to waive the internal appeal process Hamaspik Medicare must provide a written letter agreeing to the waiver within 24 hours of the agreement to waive the Hamaspik Medicare internal appeal process. The written letter will contain information regarding filing an external appeal.*

Appeal Review & Documentation Process

All appeals are investigated thoroughly. The research/investigation phase includes, but is not limited to the following interventions:

- Contact with appropriate providers and/or Hamaspik Medicare personnel.
- Contact with designated Hamaspik Medicare personnel for all concerns regarding quality of care and treatment issues
- Review of written records & information gathering from internal and external sources with appropriate releases. Additional required information may include, but is not limited to such items as medical records, a chronology of events, or legal documents related to the grievance. In cases

where additional information is deemed necessary, the following guidelines will apply:

- **Standard Pre-Service & Post-Service Appeals:** Hamaspik Medicare will identify and request information in writing from the member or their representative, and when appropriate, their provider, within the applicable case time period but no later than 15 calendar days of receipt of the appeal. If, subsequently, only partial information is received, the member or their representative, and when appropriate, their provider will be contacted in telephone and in writing requesting and identifying the additional information needed within 5 business days of receipt of the partial information.
- **Expedited Pre-Service & Post-Service Appeals**: Hamaspik Medicare will expeditiously identify and request information via phone or fax to the member or their representative, and when applicable, their provider, followed by written notification.

Appeals are decided by clinical peer reviewers qualified to review the appeal and not involved in any previous determinations regarding the appeal. Hamaspik Medicare provides reasonable access to its clinical peer reviewers within 1 business day of receiving notice of taking an expedited appeal. A clinical reviewer is defined as:

- A physician who possesses a current and valid non-restricted license to practice medicine;
- A health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration, or where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession.

Hamaspik Medicare maintains a file on all appeals that includes the following:

- Date the appeal was received.
- Names of the individuals contacted for intervention or for informational purposes regarding the appeal.
- Documentation compiled related to the appeal.
- Date the Acknowledgment Letter was sent and to whom, as well as a copy of the Acknowledgement Letter.
- A copy of the responses received on the appeal.
- The final resolution, the date in which it was made, and the name and title and/or credentials who reviewed the appeal
- Date that the verbal and written notice of the appeal decision was given and to whom, and documentation of the verbal and written notice.

Time Frames for Appeals

Within **15 calendar days** of receipt of the appeal, a representative of Hamaspik Medicare shall send the member or their representative a written acknowledgment, including the name, address and telephone number of the individual or department handling the appeal. This acknowledgment shall inform the member of the status of the appeal and advise whether any additional information is required for Hamaspik Medicare to process the appeal. If an appeal determination is reached before the written acknowledgement is sent, Hamaspik Medicare may include the written acknowledgement with the appeal determination. Once all necessary information has been received, Hamaspik Medicare will resolve the appeal on the following schedule:

- **Standard Pre-Service & Post-Service Appeals:** We will decide the appeal as fast as the member's condition requires, but no more than **30 calendar days** from the date we receive the appeal. Written notice of the decision will be issued to the member or their representative, and when appropriate, their provider, within **2 business days** of our decision. This time frame may be extended for up to **14 calendar days** if the member or designee requests an extension, or if we need additional information to review the appeal. Written notice to the member or their representative, and when appropriate, their provider, will be issued when an extension is taken. For members with other contracts, we will decide the appeal as fast as the member's condition requires, but no more than **30 calendar days** from the date we receive the appeal. Written notice of the decision will be issued to the member or their representative, and where appropriate, their provider, within **2 business days** of our decision, but no later than **30 calendar days** from the date we receive the appeal.

- **Expedited Appeals:** If the appeal relates to a review of continued or extended health care services, additional services rendered in the course of treatment, services in which a provider requests an immediate review, or a situation in which a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function or any other urgent matter, Hamaspik Medicare handles the appeal on an expedited basis.

  A request that does not meet the criteria for an expedited appeal will automatically default to a standard appeal. The member or their representative, and when appropriate, their provider, will be notified in writing within two (2) business days that the expedited appeal request has been declined, and that the appeal will be reviewed within standard time frames. We will make reasonable effort to provide verbal notice as prompt as possible

  We will decide an expedited appeal and provide verbal notice of the decision as fast as the member's condition requires, but no later than **3 business days** from the date we receive the grievance, or **2 business days** after receiving all necessary information to decide the grievance. Written notice of the decision will be issued to the member or their representative, and when appropriate, their provider, within **2 business days** of our decision. This time frame may be extended for up to **14 calendar days** if the member or their representative requests an extension, or if we need additional information to decide the appeal. In this case, the Hamaspik Medicare staff will notify the enrollee and his/her provider by telephone to request the necessary information. Written notice to the member or their representative, and when appropriate, their provider, will also be issued when an extension is taken. For members with other contracts, we will decide the appeal and provide verbal and written notice of the decision to the member or their

representative, and when appropriate, their provider, as fast as the member's condition requires, but no later than **72 hours** from the date we receive the appeal, or **48 hours** after receiving the information necessary to decide the appeal.

Note: *Failure by Hamaspik Medicare to make a determination within the applicable time frames in the section shall be deemed to be a reversal of the adverse determination.*

Notice of Decision

Appeal determination notices to the member or their representative, and when applicable, their provider, and will be sent within 2 business days of rendering the decision, but no later than the deadline for completing the appeal review. Notices will include the following:

- A clear statement describing the basis and clinical rationale for the denial.
- A clear statement that the notice constitutes a final adverse determination and specifically uses the terms "medical necessity" or "experimental/investigational."
- A summary of the appeal, and the date the appeal was filed.
- The date the appeal process was completed.
- Hamaspik Medicare's contact person and his or her telephone number.
- The member's coverage type.
- The name and full address of Hamaspik Medicare's utilization review agent.
- The utilization review agent's contact person and his or her telephone number.
- A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service.
- A description of further "Level 2" appeal rights
- Statement that the notice is available in other languages and formats, and how to access these
- formats.

A. Hamaspik Medicare Select DSNP

The Provider has the right to appeal our decision.

- For Medicare Advantage DSNP appeals, an appeal must be filed within 60 days of the date of the denial notice.

There are 2 kinds of appeals with Hamaspik Medicare Select DSNP.

- Standard Appeal – We will give the provider a written decision on a standard appeal within 30 days after we get the appeal request. Our decision might take longer if you ask for an extension, or if we need more information about the case. We will tell you if we are taking extra time and will explain why more time is needed. If the appeal is for payment of a medical service/item or Part B drug you have already received, we will give you a written decision within 60 days.

- Fast Appeal – We will give you a decision on a fast appeal within 72 hours after we get the appeal request. You can ask for a fast appeal if you believe the member's health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you

are asking us to pay you back for a {medical service/item or Part B drug} that the member has already received.

How to ask for an appeal with Hamaspik Inc.

Step 1: The provider must ask us for an appeal. The request must include:

- The Member's name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the medical service/item or Part B drug or Medicaid drug.
- If you are asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

Step 2: Mail, fax, or deliver your appeal. You can also call us, but you will need to submit any applicable records to us by mail or fax. If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

What happens next?

- If you ask for an appeal and we continue to deny the request for payment of a medical service/item or Part B drug or Medicaid drug, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

- For additional detailed information on Hamaspik Inc Medicare Advantage DSNP appeal process please refer to the Hamaspik Evidence of Coverage.

B. Hamaspik Medicare Choice MAP

- If you are appealing a decision for a member who is enrolled in the Hamaspik Inc. Medicaid Advantage Plus (MAP) plan and has been denied coverage for a health service or item before they received the service or item, you can appeal on the member's behalf to ask your plan to reconsider its decision.
- Because the member has MAP coverage, an integrated process will be utilized and the member will receive Medicare and Medicaid coverage determinations through the same appeal. To file a MAP appeal for a denial, follow the steps below.

- Note: Providers will use a different appeal process if the service being denied is for inpatient hospital care, skilled nursing facility (SNF) care, home health services, or Comprehensive Outpatient Rehabilitation Facility (CORF) services. A different process will also be used if the denial is for coverage of a Part D-covered prescription drug.

- How to ask for an appeal with Hamaspik Inc.

  1. **Read the plan's coverage decision**. Once the member/provider receives an official written decision from the plan, the provider can file an appeal on the member's behalf by following the instructions in the formal denial notice.

  2. **Request a Level 1 appeal.** Follow the appeal instructions on the formal denial notice received from your plan. File the appeal within 60 days of the date on the notice. If the member/provider plans to request aid continuing, the appeal must be filed within 10 days of the postmark date on the formal denial letter or by the intended effective date of the denial, whichever is later (see #3).

    - Send the appeal to the address on the notice. As part of the appeal, you will need to include a letter explaining why the service or item that has been denied is needed. Members must complete an Appointment of Representative form which allows the provider to file an appeal on their behalf.

    - You can request a fast (expedited) appeal for coverage of a service or item the member has not yet received if the provider feels that your health would be seriously harmed by waiting the standard timeline. The plan will also process appeals more quickly if the member has been denied coverage for a Part B-covered drug.

  3. Request aid continuing. if the member needs it. Aid continuing allows a member to continue receiving coverage for the service or item that is being denied while the appeal is pending. To automatically receive aid continuing, providers must file the appeal within 10 days of the postmark date on the formal denial letter or by the intended effective date of the denial, whichever is later.

  4. Wait for the plan's decision.

    - The plan should make a decision on the appeal within 30 days of receiving it. If an expedited appeal was filed, the plan will typically make a decision within 72 hours. In some cases, the plan can extend its decision deadline up to 14 days. You will be notified if this happens.

    - If the appeal is successful, the service or item will be covered. If the appeal is denied, you have the right to continue appealing.

  5. Get an independent review. If the appeal is denied, you can appeal to the Integrated Administrative Hearing Office (IAHO). The plan will automatically forward the appeal to this second level. IAHO will make a decision within 30 days of the date on the plan's denial notice. If you filed an expedited appeal, you will receive a decision within 72 hours of when IAHO receives the appeal. In some cases, IAHO can extend its decision deadline up to 14 days. You will be notified if this happens.

- You can call IAHO to check on your appeal, or to provide additional information to support your appeal. Their contact information will be included on your plan level denial notice. You also have the right to ask your plan for a free copy of the member's case file

6. Continue to additional levels of appeal. If the appeal is denied at the IAHO level, you have the right to continue appealing to the Council and then to Federal Court. At each of these levels, there are separate requirements for when you must file the appeal.

- Note: members can receive aid continuing through the Council level of appeal.
- Appealing when a member is being discharged
- If the member is enrolled in a MAP plan, receiving inpatient care from a hospital, SNF, home health agency, or CORF, and are told that your plan will no longer pay for the member's care (meaning that the member will be discharged), you have the right to a fast (expedited) appeal if you do not believe the member's care should end. There are separate processes for hospital and non-hospital appeals.
- In either case, the member will receive a notice explaining their rights. If you choose to appeal on behalf of the member, follow the notice's instructions on appealing to the Quality Improvement Organization (QIO) within the given timeframe.
- In some circumstances, members may be eligible for Medicaid coverage of the same services, even though the Medicare portion of their plan is denying coverage. Contact the MAP plan care manager when receiving a denial of coverage to determine the best path forward.
- For more information about the inpatient care appeal processes:
- https://www.medicarerights.org/fliers/Rights-and-Appeals/MA-Ending-Care-Appeals-Packet.pdf
- Part D appeals
- If a member has been denied coverage for a prescription drug, you can choose to file a Part D appeal on their behalf. The Part D appeal process is exactly the same for MAP plan members, individuals enrolled in stand-alone Part D plans, and individuals receiving coverage through Medicare Advantage Plans with Part D coverage.
- For more information about the Part D appeal process:
- https://www.medicarerights.org/fliers/Rights-and-Appeals/Part-D-Appeals-Packet.pdf

4.1.31 External Appeal Procedure

Most managed care enrollees have the right to request an independent agency to review their case if a managed care plan denies coverage of a health care service because it has determined that the service is not medically necessary or is experimental or investigational.

You must first appeal the denial with your plan, or you and your plan must agree to waive the internal appeal process. Applications for an external appeal must be filed within 45 days of the plan's final adverse determination from the first level of appeal or from receipt of the plan's letter waiving the internal appeal process. Providers may also request an external appeal to obtain payment from a plan when there has been a retrospective adverse determination.

There are 2 steps in the external review process:

1. **You file an external review:** You must file a written request for an external review within four months (120 days) after the date you receive a notice or final determination from insurer that claim has been denied.
2. **External reviewer issues a final decision:** An external review either upholds insurer's decision or decides in member/provider favor. The insurer is required by law to accept the external reviewer's decision.

Types of denials that can go to external review

- Any denial that involves medical judgment where the member or the provider may disagree with the health insurance plan
- Any denial that involves a determination that a treatment is experimental or investigational

Cancellation of coverage based on insurer's claim that gave false or incomplete information when member applied for coverage

Section Five: Pharmacy Management

5.1.1 Prescription Drugs

Hamaspik Medicare is committed to effectively providing members with access to prescription drugs and managing prescription drug benefit costs. We have contracted with Magellan Health Services to manage this benefit. Physicians should direct pharmacy benefits, authorizations, or inquiries to Magellan: 800-933-3175.

Covered Drugs: The Formulary is a list of covered drugs which represents the prescription therapies believed to be a necessary part of a quality treatment program. Hamaspik will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and other plan rules are followed.

Some covered drugs may have additional requirements or limits on coverage. The formulary and any changes must be submitted to and approved by CMS.

These requirements and limits may include:

Prior Authorizations: Hamaspik Medicare requires members or their physician to get prior authorization for certain drugs. This means that members will need to get approval from Hamaspik Medicare before the prescription is filled. If approval is not obtained, the drug may not be covered.

Quantity Limits: For certain drugs, Hamaspik Medicare limits the amount of the drug that the plan will cover. For example, Hamaspik Medicare provides a maximum of 60 capsules every 30 days for Lyrica (300 MG). This may be provided in a standard one-month or three-month supply.

Step Therapy Criteria: In some cases, Hamaspik Medicare will require members to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the member's medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, we will then cover Drug B.

Visit www.hamaspik.com to find out which drugs require Prior Authorizations, have quantity limits, or are subject to Step Therapy. This information can be found on the Formulary under '*Find a Covered Drug.* Providers may be asked to submit supporting documentation for any drug with utilization management requirements.

Pharmacy Network

The list of network pharmacies is available on www.Hamaspik.com, under the '*Find a Pharmacy*' Option.

Exception Requests

Providers may submit a Coverage Determination Request for a drug that is not included in the Formulary, or to cover a drug without restrictions. This is considered an Exception Request. Exception Requests may be submitted to Magellan. The Exception Request Form is available for

download on www.hamaspik.com.

Hamaspik will process exception requests made by an Enrollee, his/her authorized representative, prescribing physician, or another prescriber consistent with CMS requirements outlined in "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" (Released February 2019) sections 40.5.2 Formulary Exceptions l and 40.5.3 Supporting Statements for Exception Requests for medical review of Non-Formulary Drug requests and to determine whether to approve or deny the request, if appropriate, based on the exception criteria established for the Non-Formulary Drugs.

Should Hamaspik deny an exception request, the Enrollee and his/her prescriber will be sent a Notice of Denial of Medicare Prescription Drug Coverage that includes the information regarding appeal rights and description about appropriate formulary alternatives that must be satisfied for approval. Enrollee may switch to these therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

5.1.2 Transition Policy

To promote continuity of care and avoid interruptions in drug therapy for newly enrolled members and when formulary changes impact an existing member, Hamaspik has implemented a transition policy that allows the member to obtain coverage of an existing drug for a period of time. During the first 90 days of membership, a member can generally obtain a 30-day supply of their medication, even if it is not on the Hamaspik formulary. During this time, the member is encouraged to work with his/her provider to switch to a therapeutically equivalent drug, or complete an exception request. Members will receive a notice when their drug was filled under the provisions of the Transition Policy.

Members who are eligible for a Transition Fill include:

1. New members enrolled into a Hamaspik Medicare plan following the annual coordinated election period;
2. Newly eligible Medicare beneficiaries enrolled into a Hamaspik Medicare plan;
3. Members who switch from one plan to another after the beginning of the contract year;
4. Members with an effective enrollment date of either November 1 or December 1 are provided a 90- day transition period extending across the following contract year;
5. Current members affected by Negative Formulary Changes across contract years; and 6. Members residing in long-term care (LTC) facilities.

For more information on the Transition Policy, please refer to the plan's policy which is available on our website www.hamaspik.com.

The transition policy was submitted to and approved by CMS.

5.1.3 Opioid management

Hamaspik Medicare has a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug

Management Program (DMP). Through this program, we identify members who use opioid medications for an extended period of time, or from multiple doctors or pharmacies.

We may talk to the providers to make sure the use of opioid medications is appropriate and medically necessary. Through this program, which is implemented based on CMS requirements, the following limits have been established:

- Members whose opioid daily drug dose exceeds established limits may be required to obtain authorization before the drug can be dispensed.
- Members who are prescribed opioid medication from 2 or more providers will be required to obtain authorization before the drug can be dispensed.
- Members who are opioid "naïve" (defined as not having an opioid prescription during the previous 108 days) will be limited to a 7-day supply at the time of the first fill of their prescription.

In addition, working with the member's providers, if the plan determines that the use of prescription opioid or benzodiazepine medications is not safe, we may limit how a member can get those medications. The limitations may include:

- Requiring the member to get all prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring the member to get all prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for the member

Hamaspik Medicare will send a letter to notify members in advance, if any of these limitations apply. Members will have an opportunity to tell us which doctors or pharmacies they prefer to use, and about any other information they think is important for us to know. After a member has had the opportunity to respond, if we decide to limit the coverage for these medications, we will send another letter confirming the limitation. If a member thinks we made a mistake or disagrees with our determination that they are at-risk for prescription drug misuse or with the limitation, the member or their prescriber have the right to ask us for an appeal.

The DMP may not apply to members who have certain medical conditions, such as cancer, are receiving hospice, palliative, or end-of-life care, or members who live in a long-term care facility.

Pharmacies may reach out to prescribers at the point of sale concerning prescriptions for opioid or benzodiazepine medications.

5.1.4 Medication Therapy Management Program

Hamaspik Medicare has a program that can help our members with complex health needs. This

program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program.

MTM Eligibility Criteria

Members who have 5 or more prescriptions, plus at least 3 of the following Chronic Diseases, are eligible for this program:

- Alzheimer's disease
- Diabetes
- Dyslipidemia
- Hypertension
- Respiratory Disease - COPD

Description of MTM Program

Magellan Rx Management (MRx), on behalf of Hamaspik Medicare, provides a full service MTM Program. The members who are eligible are automatically enrolled unless they opt out.

5.1.5 Annual Comprehensive Medication Review

All eligible beneficiaries, regardless of setting (long term care and non-long-term care) and/or cognitive impairment, who are identified quarterly based on prescription claims, will receive, at least annually, an offer for an annual comprehensive medication review (CMR). The CMR is an interactive, person to person consultation that is performed by telephone with a Magellan clinician.

The CMR is patient centered and includes the review of prescriptions, over the counter medications, herbal therapies, and dietary supplements. This review may result in the identification of drug therapy problems that are preventing the member from achieving the desired goals of therapy. In addition, the CMR also includes an understanding of the beneficiary's reported medication experience, a medication history, a current medication profile, a review of allergies and adverse drug reactions. Working with the member, the review includes the development of a prioritized list of medication related problems, and creating a plan to resolve them.

This CMR assessment will result in an individualized, written summary that is prepared and provided to the beneficiary (or authorized individual) and is sent within 14 days of the CMR assessment. In the event the beneficiary is cognitively impaired and cannot make decisions regarding his/her medical needs, the Magellan personnel will reach out to the beneficiary's prescriber, caregiver, or other authorized individual, such as the beneficiary's health care proxy or legal guardian, to take part in the CMR.

A beneficiary who receives a CMR may also receive a follow up evaluation by the MTMP clinician as dictated by beneficiary need.

Quarterly Targeted Medication Reviews

On a quarterly basis, targeted medication reviews (TMRs) are performed under the MTMP for all eligible beneficiaries. TMRs are also performed on beneficiaries who choose to opt out of individual

MTM services, such as the annual CMR, beneficiaries with cognitive impairment, and in any setting of care.

TMRs identify medication related problems for specific interventions using pharmacy claims data. Beneficiary's prescribers are sent intervention letters that identify specific or potential medication related problems or other opportunities to optimize medication use. The prescriber is asked to use the information to assess the potential risk, opioid and contact the beneficiary or pharmacy if change in therapy is deemed appropriate. If the specific issue warrants additional outreach, follow up calls may be necessary to the beneficiaries and/or prescribers to ensure optimal therapy is achieved. The MTMP clinician will provide follow up interventions with beneficiaries and/or prescribers if necessary.

Section Six: Behavioral Health Services

Hamaspik Medicare has contracted with Beacon Health Options to administer and manage this benefit. Physicians should direct all claims, authorization, inquiries, or benefit questions directly to Beacon.

Through its agreement, Beacon provides the following services on behalf of the plan:

- Fully credentialed provider network
- Utilization management for delegated behavioral health services (including inpatient, outpatient, and home/community-based services)
- Claims payment for delegated behavioral health services
- Assessments for home and community-based services
- Grievances and appeals

We have reviewed Beacon's policies for the delivery of services to Medicaid beneficiaries and have authorized them to follow their policies, as reviewed and approved by the State. Please refer to the Beacon Provider Manual for detailed information. In addition, please note that the following State policies have been incorporated into the Hamaspik and Beacon policies for behavioral health and substance abuse services:

- OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)
- OASAS Clinical Guidance: (https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm)

For behavioral health emergencies, please see Section 2 for the phone number to be connected with a trained mental health professional. Services are available 24 hours per day, 7 days per week. You can also call 911.

Hamaspik Medicare offers additional telehealth services for Part B services:

- Primary Care Physician Services;
- Physician Specialist Services;
- Individual Sessions for Mental Health Specialty Services;
- Group Sessions for Mental Health Specialty Services;
- Individual Sessions for Psychiatric Services;
- Group Sessions for Psychiatric Services;
- Individual Sessions for Outpatient Substance Abuse;
- Group Sessions for Outpatient Substance Abuse;

No referrals nor authorizations are required for additional telehealth services.

Medicare also covers the following Services:

- Ambulance Services
- Emergency Department Services

- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Home Health Services
- Hospice
- Inpatient care in a hospital
- Many preventive services (such as screenings, shots or vaccines, and yearly “Wellness” visits)
- Medicare Part B prescription drugs
- Outpatient care
- Physical Therapy
- Preventive Services
- Services from doctors and other health care providers
- Skilled nursing facility care
- Speech-language pathology services
- Welcome to Medicare Preventive visit
- Yearly wellness visits

Section Seven: Billing and Remittance

This section describes billing and reimbursement policies and procedures that apply to benefit packages offered by Hamaspik Medicare Health Plan. It includes instructions for submitting claims to Hamaspik Medicare. either electronically or on paper.

7.1.1 Electronic Submission of Claims Required

In 1994, New York State enacted Public Health Law Section 2807-e (4) requiring hospitals, outpatient clinics, and physicians to submit health care claims to third-party payors electronically, using electronic formats designated by the New York State Department of Health. These formats have since been replaced by federally required formats (see below). However, the requirement to submit electronically still exists. Physicians who annually submit fewer than 1,200 claims to third party payors for direct payment were exempted from this requirement, but only by obtaining a waiver from the Department of Health.

The federal Health Insurance Portability and Accountability Act (HIPAA) also includes provisions affecting claims submission. While HIPAA does not require providers to submit claims electronically, it requires all providers who submit claims electronically to do so using national HIPAA claims formats and standards.

All hospitals, outpatient clinics, and physicians in New York who have not obtained a waiver from the Department of Health must submit claims to payors electronically using HIPAA claims formats and standards. In addition, any other provider who submits claims electronically must do so using HIPAA-compliant electronic formats. See paragraphs under heading "How to Submit Electronic Claims" for more information about submitting claims electronically.

7.1.2 General Requirements for Claims Submissions

- Claims must be completed accurately and in full, in accordance with the instructions presented in this manual. (See subsequent paragraphs). Hamaspik Medicare cannot pay claims that are inaccurate or incomplete.
- Procedures must be identified by Current Procedural Terminology (CPT-4)[1] or HCPCS codes. Diagnoses must be identified by ICD-9-CM[2]/ICD-10-CM diagnosis codes.

***Note**: CPT, ICD-9, ICD-10 and HCPCS codes are revised at various times of the year by the organizations responsible for them, the Centers for Medicare & Medicaid Services (CMS) and/or the American Medical Association (AMA). Hamaspik Medicare's manager accepts these codes as implementation dates are designated by these organizations.*

- Place of service (POS) must be identified using the codes established by CMS. These codes apply

[1] The AMA is the owner of all copyright, trademark and other rights to CPT and its updates. AMA reserves all rights.
[2] ICD-9/10-CM refers to the clinical modification (CM) of the most recent revision (9) of the International Classification of Diseases, a book that lists diagnosis codes according to a system assigned by the World Health Organization of the United Nations. The ICD is distributed by the U.S. Printing Office in Washington, DC, and by commercial publishers.

to paper submittals of professional claims. Valid place of service codes for electronic submittals are included in providers' implementation guides for HIPAA-compliant electronic transactions.

- Procedures and diagnoses should be coded to the highest degree of specificity. For example, include 4th and 5th digits on ICD-9-CM, or 7th digit on ICD-10-CM codes when applicable.
- Claims with referral or prior authorization requirements must include the authorization number.
- Facility billers must include a revenue code to identify services rendered.
- All required supporting material must be made available to Hamaspik Medicare upon request.
- **Claims submitted to all payors, must include an NPI to identify each provider for which data is reported on the claim.** Hamaspik Medicare cannot accept any claims that do not include an NPI.
- Taxonomy codes are required on all claim submissions. Claims submitted without taxonomy will be returned. Providers may have multiple taxonomy codes and should only include the taxonomy code that applies to the services performed and reported on the claim submission.

7.1.3 Timely and Accurate Filing

Hamaspik Medicare requires that participating providers submit claims in a timely manner.

- Participating providers should submit all claims as soon as possible after rendering service (or after the processed date of a primary payor's explanation of benefits, or EOB). Most participating provider agreements contain a time limit within which claims will be accepted. Claims submitted after that time limit may be denied for late filing. Providers should review their participating provider agreements for these time limits. In the event of a declared pandemic, Hamaspik Medicare may extend the time limit to one year from date of service.
- Hamaspik Medicare will reject claims with incorrect or incomplete entries in required fields outlined in later paragraphs regarding submittal of electronic claims and paper claims. For example, Hamaspik Medicare will reject all claims submitted without member ID numbers.

7.1.4 Accurate and Complete ICD-10-CM Diagnosis Coding

In order for claims to process appropriately, it is important that submitters enter accurate and complete ICD-10-CM diagnosis codes on all claims. Hamaspik Medicare encourages participating providers to follow the Tips for Accurate and Complete ICD-10-CM Diagnosis Coding included at the end of this section of the manual when coding any claim.

7.1.5 Using Modifiers

Hamaspik Medicare requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the right modifier may affect how the claim is paid.

Complete information about CPT codes and their modifiers is found in the most current issue of the American Medical Association (AMA) manual on current procedural terminology (CPT). Complete information about HCPCS (Health Care Procedure Coding System) codes and their modifiers is available through the Hamaspik Medicare website, www.hamaspik.com, or from various publications about the codes.

7.1.6 Additional References to Support Accurate Claims Submission

In addition to this manual, providers should refer to the following materials for information regarding claims submission.

- **Participating Provider Agreement**. The Participating Provider Agreement describes the provider's rights and obligations with respect to claims submission to Hamaspik Medicare. This manual is intended to clarify provisions of the Agreement. In the event of a conflict between the provisions of this manual and a Participating Provider Agreement, the Agreement supersedes this manual.
- **Current Procedural Terminology (CPT).** CPT code books list descriptive terms and identifying CPT codes for reporting medical services and procedures performed by providers. Hamaspik Medicare requires the use of these codes on claims. CPT codes and all CPT materials are under copyright by the American Medical Association.
- **International Classification of Diseases, Clinical Modifications (current version**). ICD- CM is a classification system that arranges diseases and injuries into groups according to established criteria. ICD-CM codes are required for reporting diagnoses and diseases to all CMS programs. Hamaspik Medicare also requires the use of these codes.
- **HCPCS Level II National Codes.** HCPCS is the acronym for the HCFA (CMS) Common Procedure Coding System. This system is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. Hamaspik Medicare requires use of HCPCS codes and associated modifiers for certain kinds of claims.
- **InterQualCriteria®.** InterQual Criteria are guidelines for screening the appropriateness of medical interventions. The criteria are the property of McKesson Health Solutions LLC. McKesson owns the copyright. Hamaspik Medicare uses InterQual guidelines in evaluating inpatient appropriateness of care.
- **CMS Website.** The CMS website is an extensive resource for forms, information and training materials associated with claims submission. The Web address is https://www.cms.gov**.**

7.1.7. Claims for Sterilization or Hysterectomy

Sterilization procedures, whether incidental to maternity or not, require completion of a patient consent form in accordance with Medicaid guidelines covering informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR, Part 441, sub-part (F), and 18 NYCRR Section 505.13 and 18 NYCRR, Part 508.

Patients must be at least 21 years of age at the time of informed consent and mentally competent, and they must complete and sign DSS-3134, Sterilization Consent Form, at least 30 days but not more than 180 days prior to a bilateral tubal ligation or vasectomy procedure or any other medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of having a child.

"Informed consent" means that the patient gave consent voluntarily after the provider planning to perform the procedure:

- Offered to answer any questions,
- Told the patient that he or she is free to withhold or withdraw consent to the procedure at any

time before the sterilization without affecting his or her right to future care or treatment and without loss or withdrawal of any of his or her federally funded benefits,
- Told the patient that there are alternative methods of family planning and birth control,
- Told the patient that the sterilization procedure is irreversible,
- Explained the exact procedure to be performed on the patient,
- Described the risks and discomforts the patient may experience including effects of any anesthesia,
- Described the benefits and advantages of sterilization, and
- Advised the patient that the sterilization will not be performed for at least 30 days following the informed consent.
- In addition, the provider planning to perform the procedure:
- Has made arrangements so that the above information was effectively communicated to a blind, deaf or otherwise disabled person;
- Provided an interpreter if the patient did not understand the language on the consent form or the person who obtained informed consent; and
- Permitted the patient to have a witness present when consent was given.

Hysterectomy

Hysterectomy is covered only in cases of medical necessity and not solely for the purpose of sterilization. Patients must be informed that the procedure will render them permanently incapable of reproducing. A patient must complete DSS-3113, Acknowledgment of Receipt of Hysterectomy Information, at least 30 days prior to the procedure. Prior acknowledgment may be waived when a woman is sterile prior to the hysterectomy or in life-threatening emergencies where prior consent is impossible.

Where to Get Forms

Providers must request blank forms, Sterilization Consent Form or Acknowledgment of Receipt of Hysterectomy Information, from the NYS Department of Health by completing a Request for Forms or Publications form and faxing or mailing it to the DOH.

7.1.8 How to Submit Electronic Claims

Hamaspik Medicare accepts electronic claims through a clearinghouse. This clearinghouse, Change Healthcare (formerly known as Emdeon), accepts claims directly, and also has the ability to accept and route electronic claims directly to SDS. For more information, contact Change Healthcare at: 855-886-3963. Our payor ID# is 47738.

7.1.9 Filing Tips

- To support accurate and prompt claims processing, providers must use the correct Payor Identification Number (Payor ID) when submitting claims electronically.
- All required fields must be populated. If any required field has no entry, the clearinghouse will reject the claim.
- Use valid codes in fields such as those defining relationship, sex, and place of service. If the code

entered does not match the type of service being billed, the claim may pend and require manual intervention to be processed.

- **Claims submitted must include an NPI to identify each provider for which data is reported on the claim.**

7.1.10 Response Reports

Following submission of electronic claims, the provider will receive three reports:

- **Clearinghouse Acknowledgment Report**. This report indicates whether the transmission was successful.
- **Clearinghouse Response Report**. This report validates claims and lists both accepted and rejected claims.
- **Payor Response Reports**. Each type of claim—indemnity, managed care, etc.—will have its own Payor Response Report. These reports will be available within 24 to 48 hours after submission and will list both accepted and rejected claims.

Providers must review these reports, identify those claims that were rejected and correct the errors and resubmit the claims.

A provider should not consider that the clearinghouse has accepted an electronic claim until he/she has received all three reports, and the Payor Response Report shows that the claim was not rejected. Providers are encouraged to keep copies of these reports to help verify claims submission.

7.1.11 Secondary Claims

Hamaspik Medicare cannot accept secondary claims electronically. If Hamaspik Medicare is not the primary payor, the claims must be submitted on paper with primary payor documentation attached.

7.1.12 Use Correct Payor ID Number

To support accurate and prompt claims processing, providers must use the correct Payor Identification Number (Payor ID) when submitting claims electronically. The Payor ID# for medical claims is # 47738 (clearinghouse = Change Healthcare). For Behavioral Health claims (Beacon) ID# 43324. For Dental (DentaQuest) ID# CX014.

7.1.13 How to Submit Paper Claims

There are two types of paper claim formats:

- CMS-1500 for most professional services
- UB-04 (CMS-1450) for hospital and other facility services

As stated earlier, all hospitals, outpatient clinics and physicians in New York who have not obtained a waiver must submit claims to payors electronically, using HIPAA claims formats and standards. See preceding information about electronic claims submission. In addition, the requirements related to the national provider identifier (NPI) apply to paper claims as well.

Providers that submit on paper must do so according to the general requirements listed below under the heading General Paper Claim Requirements.

As stated in those requirements, claims submitted to all payors, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.

7.1.14 Paper Claim Requirements

Hamaspik Medicare's uses Optical Character Recognition (OCR) technology to read most paper claims. The following are important points to observe so that a paper claim can be processed using OCR rather than manually. Following these guidelines, helps ensure timely processing.

- Use original forms that are printed in red. Do not use photocopies.
- Do not use red ink to fill in data field or attachment information. OCR equipment does not recognize red ink.
- Entries should be typed and dark enough to be legible. Change the toner cartridge in your printer regularly.
- So that information prints in the appropriate field, forms should be properly aligned prior to printing.
- When submitting multi-page claims, submitters must ensure that the Tax ID, NPI, Patient ID and patient account number are reproduced and consistent on all pages.
- Use these guidelines when including attachments, such as medical records or primary payor information.

For more information about accurate submission of paper claims, contact the Provider Relations Department.

7.1.15 Professional Services

The CMS-1500 form, entitled the Health Insurance Claim Form, was designed for use by non-institutional providers and suppliers.

Hamaspik Medicare follows New York State Insurance Department claim submission guidelines in determining what constitutes a complete, or "clean," claim, unless stated otherwise in a provider's participating provider agreement. See Clean Claim Guidelines below.

7.1.16 New York State Clean Claim Submission Guidelines for CMS-1500

In addition to the NPI requirements, the New York State Insurance Department has issued claim submission guidelines (Regulation No. 178, 11 NYCRR 230.1) to interpret the prompt pay law. The guidelines specify that:

- A health insurer cannot reject a claim submitted on a CMS-1500 claim form as incomplete if the claim contains accurate responses in specified fields, unless otherwise specified.
- In situations where one or more of the required fields is not appropriate to a specific claim, the submitter may leave the field blank.

Additionally, the guidelines state that health plans may request additional information other than that on the claim form if the health plan needs this information to determine liability or make payment. In other words, depending on the service being billed**, there may be other fields that Hamaspik Medicare requires for processing**. Further, Hamaspik Medicare is not prohibited from determining that a claim is not payable for other reasons.

See the chart, CMS-1500 Field Descriptions, at the end of this section of the manual, for a description of all fields on the CMS-1500.

7.1.17 Hospital and Other Facility Services

CMS-1450, the UB-04 uniform billing form, is most commonly used by hospitals, skilled nursing facilities, home health agencies and other selected providers to submit health care claims on paper.

Providers that submit on paper using the UB-04 must do so according to the general requirements listed above under the heading Paper Claim Requirements.

Hamaspik Medicare's requirements for the completion and submission of the UB-04 claim form are, for the most part, consistent with Medicare, Medicaid, and other major payors.

To support accurate completion of UB-04 forms, providers should refer to the following:

- The contractual arrangements between Hamaspik Medicare and the provider as described in the participating provider agreement.
- CMS requirements as specified in the instructions for form CMS 1450 can be found on the CMS website, at: http://mynmhc.org/uploads/files/Health%20Care%20Professionals/Clean%20Claim%20UB%202-7-14.pdf.
- The chart, UB-04 Field Descriptions, at the end of this section of the manual.

7.1.18 Submitting Claims for Mid-Level Practitioners

When submitting claims to Hamaspik Medicare, mid-level practitioners i.e., Nurse Practitioners (NPs), Physician Assistants (PAs) Certified Registered Nurse Anesthetists (CRNAs) should follow the billing guidelines below:

- **Billing as "Rendering Provider"** (not incident to): When billing mid-level practitioner services as a rendering provider, the rendering provider information should be indicated in field 24 on the CMS Form 1500 paper claim. The supervising (or billing) provider's NPI should be indicated in field 33a on the CMS Form 1500 paper claim.
- **For the ANSI 837 electronic claim**, supervising provider information should be indicated in loop 2310D and the supervising provider's NPI would be indicated in loop 2310D, segment NM1.09. The billing provider information should be the same as the supervising provider/group information.
- **Billing "Incident" to**: Hamaspik Medicare follows Medicare guidelines for billing mid-level practitioner services performed incident to physician services. In such cases, the mid-level practitioner's incident to services are to be billed using only the collaborating/supervising

physician's provider ID number indicated in field 24J on the CMS Form 1500 paper claim.

- A mid-level practitioner should not submit another claim for him/herself.
- **Taxonomy Code:** When billing for services rendered, mid-level practitioners must include the taxonomy code used to register their NPI number through the CMS website. Omitting this information will lead to claims processing and payment delays.
- **Billing Modifiers:** Hamaspik Medicare requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the correct modifier may affect how a claim is reimbursed.

7.1.19 Prompt Payment Law

***Note**: Agreements with specific groups may include more rigorous prompt pay requirements. In the absence of such an agreement, NYS law governs prompt pay requirements.*

- Under New York State prompt payment law, applicable to claims received on or after January 22, 1998, Hamaspik Medicare is required to decide, within 30 calendar days after receipt of a claim, whether to pay, deny, or require additional information.
- Hamaspik Medicare requires providers to submit a "clean" claim (see above).
- Effective with claims received on or after January 1, 2010, if adjudication leads to the decision to pay the claim, Hamaspik Medicare will pay an electronically submitted claim within 30 calendar days after receipt, and will pay a paper claim submission within 45 calendar days. Providers should not resubmit before the applicable time period is up, unless the claim has been denied or returned unprocessed due to being incomplete.
- If Hamaspik Medicare pays a claim more than 30 calendar days (electronic submission) or more than 45 calendar days (paper submission) after receiving it, Hamaspik Medicare in most cases will apply interest at the annual rate set by the Commissioner of Taxation or 12 percent, whichever is greater. Hamaspik Medicare will make adjustments and/or pay interest when a claim was incorrectly paid due to Hamaspik Medicare in error, but only if the original claim was "clean."
- If adjudication leads to the decision to deny the claim, Hamaspik Medicare will notify the claimant within 30 calendar days of receipt of the claim and include an explanation of why the claim was denied.
- If adjudication requires more information regarding the claim, Hamaspik Medicare will submit to the claimant a detailed request for such information within 30 calendar days following receipt of the claim.
- Hamaspik Medicare periodically performs prompt pay audits, and as a result of those audits, a reconciliation of prompt pay interest paid to you may be required. If necessary, Hamaspik Medicare will contact you regarding these audits.

7.1.20 Fee Schedule

Hamaspik Medicare pays a participating provider for covered services provided to members on the basis of a fee schedule pursuant to the terms and conditions of the provider's participation agreement.

7.1.21 Clinical Editing

As part of the claims adjudication process, the Hamaspik Medicare will review the claim to determine that it fulfills Hamaspik Medicare medical policies, referral requirements, preauthorization requirements (including those for medical necessity) and other benefit management specifications.

Hamaspik Medicare uses clinical editing criteria based on code edits recommended by multiple sources for the purpose of coding accuracy. The two principal sources are the American Medical Association's Current Procedural Terminology (CPT) publications and the Centers for Medicare & Medicaid Services national Correct Coding Initiative (CCI).

Hamaspik Medicare has incorporated clinical editing software into its claims system. This software is used to determine the accuracy of procedural and diagnostic coding. The systems detect irregularities such as:

- **Unbundled procedures.** Providers should not bill using several procedure codes when there is a single inclusive procedure code that describes the same services.
- **Incidental procedures.** Providers should not bill separately certain procedures that are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
- **Mutually exclusive procedures.** Providers should not bill a combination of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or accomplish the same result are considered mutually exclusive. Generally, an open procedure and a closed procedure performed in the same anatomic site are not both recommended for reimbursement. Mutually exclusive edits are developed between procedures based on, but not limited to, the following CPT descriptions: limited/complete, partial/total, single/multiple, unilateral/bilateral, initial/subsequent, simple/complex, superficial/deep, with/without.
- **Procedures inappropriate for gender, age, etc.**
  For information to help avoid these errors, refer to the chart Accurate and Complete ICD-9/10 Coding at the end of this section of the manual.

  Certain clinical edits will cause the system to generate a letter requesting additional information. Other clinical edits may result in a denial, which will appear on the provider's remittance advice. Providers can also initiate a provider inquiry related to the edit determination by completing the Clinical Editing Review Request Form.

7.1.22 Clinical Editing Reviews

Providers who disagree with a clinical editing determination for a procedure code combination may request a clinical editing review. The Clinical Editing Review Request Form is available on the Hamaspik Medicare website or from the Provider Relations Department. Submit the form to the address listed on the form.

It is important to include any clinical documentation that will support the request. Hamaspik Medicare will make a determination on the review and notify the provider in writing within 45 days of receipt of all necessary information.

7.1.23 Submission of Medical Records

Hamaspik Medicare may request submission of relevant medical records to facilitate reviews for:

- Services or procedures requiring preauthorization.
- Services or procedures where a Hamaspik Medicare Medical Policy indicates criteria for medical appropriateness or for services considered cosmetic, experimental, or investigational.
- Quality of care and quality improvement.
- Medical necessity.
- Pre-existing conditions.
- Determination of appropriate level of care.
- Case management or care coordination.

In addition, medical records may be needed for processing claims with:

- Modifier 22 (unusual procedural services) appended
- Modifier 52 (reduced services) appended
- Modifier 53 (discontinued procedure) appended
- Modifier 62 (co-surgeon) appended

For services billed with unlisted, not otherwise specified, miscellaneous or unclassified codes, a description of service is required. Additional records may be requested for these services, depending on the description provided.

In addition to the above, Hamaspik Medicare may request medical records relevant to:

- Credentialing and Coordination of Benefits.
- Claims subject to retrospective audit.
- Investigation of fraud and abuse or potential inappropriate billing practices in circumstances where there is a reasonable belief that such a need exists.
- Quality initiatives

There may be additional individual circumstances when Hamaspik Medicare needs to request medical records to support claim processing and other initiatives.

Such documentation may be provided by:

- Granting Hamaspik access to the provider's electronic medical records/health records system
- Providing notes and reports in electronic format, e.g. a data extract from the provider's system
- Providing notes and reports in printed format

You may be required to include medical records with your initial claim submission if the service requires review to determine medical necessity, including possible experimental/investigative services, under one of Hamaspik Medicare Medical Policies.

A listing of the codes that require up-front submission of records and the clinical information needed to perform the review is located on our website. If you do not submit the records as required, claims may be denied, and you may be required to resubmit a new claim with the necessary information.

Guidelines for up-front submission of medical records, including details on specific procedure codes and the records required for review, are on the website.

7.1.24 Retrospective Medical Claim Review

The purpose of medical claim review is to analyze whether a claim reflects services rendered, and to verify that the services rendered are appropriate to the clinical variables of each case, based on the standards of medical care, subscriber contract benefits and terms of participating provider agreements. This review includes:

- Reviewing supporting documentation to determine medical necessity post-service.
- Reviewing coding/pricing as appropriate.
- Adhering to quality-of-care standards of care.
- Assisting with special studies such as the Healthcare Effectiveness Data and Information Set (HEDIS®), as designed or recommended by the Quality Management department; and
- Referring cases to Quality Management as needed.

7.1.25 Coordination of Benefits - Hamaspik Medicare as Secondary Payor

***Note**: On occasion, there may be a brief overlap in coverage between Hamaspik Medicare and a commercial health insurance carrier. Or there may be times when a Medicare member has other health insurance that is billed as the primary payer. In that situation, Hamaspik Medicare will follow the processes described in this section.*

Hamaspik Medicare follows COB rules set forth by the New York State Insurance Department's regulations, as well as COB guidelines established by CMS and the National Association of Health Insurance Commissioners (NAIC). Medicare secondary payor rules take precedence. Letter about secondary insurance?

Participating providers agree to accept Hamaspik Medicare's secondary payment for covered services and not balance-bill the member/subscriber in excess of deductibles, copays and/or coinsurance.

***Note**: If a member has benefit coverage under two (or more) insurance plans that both require referrals, the member must have obtained a valid referral and/or authorization from each plan to which a claim will be submitted.*

Hamaspik Medicare will follow the procedures below in order to prevent duplication of payment, prevent overpayment for services provided when a member has health benefits coverage under more than one plan, and clarify the order of primacy for Other Party Liability (OPL), Worker's Compensation and No-Fault claims.

General Adjudication Policies

Brief summaries of special, statutory-based claims adjudication policies are provided below. They are furnished only to provide information to providers in the context of this manual, and are not to be relied upon as definitive legal statements of the coverage requirements relating to these programs.

- **Benefits will be coordinated as follows when members are covered under Hamaspik Medicare**

  - When Hamaspik Medicare is primary, Hamaspik Medicare will reimburse the full extent of covered services, which is the provider's billed charge or the fee schedule maximum (less any applicable copayment, coinsurance or deductible), whichever is less.
  - When Hamaspik Medicare is secondary, Hamaspik Medicare will reimburse the provider for covered services in conjunction with the primary plan so that the two plans pay no more than 100 percent of charges or the Hamaspik Medicare fee schedule maximum, whichever is less.
  - If a member does not have a legal obligation to pay all or a portion of the provider's billed charges, then Hamaspik Medicare shall have no obligation to pay any portion of the provider's billed charges.
  - When Medicare is primary and the claim is for covered services, Hamaspik Medicare will process the claim as primary. All services provided will be subject to copayments, preauthorization, and all other Hamaspik Medicare policies regarding claims.

- **As a secondary payor, Hamaspik Medicare will never pay more than it would have if Hamaspik Medicare had been the primary plan.**

Workers' Compensation and Other Employer Liability Laws

Hamaspik Medicare excludes coverage for services obtained by a member as a result of injury or illness that occurs on the job. These expenses are covered under the state's Workers' Compensation Laws.

Hamaspik Medicare will closely review claims for such injuries or illnesses to determine if they are work-related. If necessary, Hamaspik Medicare will send the member a questionnaire. Hamaspik Medicare will deny any claim determined to be work-related, and will notify the provider that he/she must file the claim through the applicable Workers' Compensation carrier or through the member's employer.

If Hamaspik Medicare mistakenly pays a claim on a work-related injury or illness, and it is later discovered that the injury or illness was work-related, Hamaspik Medicare will take legally-permissible steps to obtain appropriate recoveries from all parties who received claim payments.

No-Fault Claims

Hamaspik Medicare health benefit programs exclude coverage for services obtained by a member as a result of injury related to an automobile accident for members who reside in a mandatory no- fault state. These expenses are covered under the member's mandatory no-fault benefits.

Hamaspik Medicare will closely review claims for injuries to determine if they are related to an automobile accident. If necessary, Hamaspik Medicare will send the member a questionnaire. Hamaspik Medicare will deny any claim determined to be related to the motor vehicle accident, and will notify the provider that he/she must file the claim through the no-fault insurance carrier.

If Hamaspik Medicare mistakenly pays a claim on a motor vehicle related injury, and later discovers that the injury was related to the motor vehicle accident, Hamaspik Medicare will take steps to obtain appropriate recoveries from all parties who have received claims payments.

Please note: Hamaspik Medicare will consider claims if the no-fault insurance carrier's rejection was based on the carrier's independent medical examination. However, Hamaspik Medicare will deny claims that were not submitted within the no-fault timely filing limit or if a required authorization was not obtained for services provided. Hamaspik Medicare will send a letter of inquiry to the member to determine the status of his/her injuries and follow up with the member.

Payment and Coordination of Benefits

Hamaspik Medicare reviews claims to determine the primary and/or secondary payor. Hamaspik Medicare may generate a COB questionnaire to help determine the coordination of benefits payment order.

Claims that are denied because the Explanation of Payment (or Explanation of Medicare Benefits) was not attached must be resubmitted with the Explanation of Payment attached.

If it is determined that Hamaspik Medicare is the primary carrier, Hamaspik Medicare will process the claim and make payment for the covered services provided in accordance with the fee schedule.

If Hamaspik Medicare is determined to be the secondary carrier, Hamaspik Medicare will deny the claim. Providers should resubmit these denied claims to the primary carrier. After the primary carrier has made payment, resubmit the claim to Hamaspik Medicare to be considered for payment of a portion of services.

7.1.26 Inquiring About the Status of a Claim

Providers may use one of the inquiry systems described in the Administrative Information section of this manual to inquire about the status of a Hamaspik Medicare claim. Providers may also fax or mail a completed Claims Status Request form (available on the Hamaspik Medicare website or from the Provider Relations Department), or they may call the Provider Relations Department.

Upon receipt of a Claim Status Request form, a Provider Relations Department representative will research the claim to determine if it has been, or shortly will be, processed. If the claim is still outstanding, the representative will complete the bottom section of the form and promptly return it to the submitter.

7.1.27 Remittance

Participating physicians who submit claims for Hamaspik Medicare, receive a remittance advice that summarizes all claims processed since the last payment was made to the submitter.

***Note**: Remittances may come in multiple envelopes. This occurs when a remittance exceeds the number of pages that Hamaspik Medicare's remittance processing system is able to mail in a single envelope.*

7.1.28 When Additional Information is Required

For some claims, Hamaspik Medicare may need additional information before it can make a determination to cover or deny the service. These claims will be so marked on the remittance with a message asking the submitter to provide additional information. A provider has 45 days from the date printed on the remittance to submit supporting documentation related to the service in question.

7.1.29 Requesting a Change in Claims Payment / Corrected Claims

There are a number of circumstances after a claim has been processed that may require Hamaspik Medicare to take another look. These include incorrect payments or denials, or services billed incorrectly or in error.

If a provider determines that they need to submit a "Corrected Claim" for a previously adjudicated claim, the provider has sixty (60) days from the date of the remittance notice to submit the corrected claim.

7.1.30 Adjustments

Hamaspik Medicare has a claims adjustment process that providers can initiate after the claim has been processed.

Please note that **claims returned to the submitter because they were inaccurate or incomplete have not been processed and consequently cannot be adjusted**. This includes electronically submitted claims that do not pass edits at the clearinghouse or payor system. In addition, Hamaspik Medicare cannot adjust a claim when the dollar amounts change due to the provider's corrections (such as adding a service line or a modifier). A corrected claim must be submitted. This form can be found on the Hamaspik Medicare website.

Policies

- Hamaspik Medicare will make adjustments when a claim is paid incorrectly due to Hamaspik Medicare error, but only if the original claim was "clean."
- If Hamaspik Medicare mistakenly underpays a provider for a claim, Hamaspik Medicare will make an adjustment on a subsequent remittance.
- Hamaspik Medicare calculates interest on adjustments in accordance with specifications of New York State prompt payment law.
- If Hamaspik Medicare mistakenly overpays a claim to a participating provider, Hamaspik Medicare will make an adjustment and deduct that amount from future payments.
- Review of a claim does not guarantee a change in payment disposition.

***Note**: Providers must return overpayments to Hamaspik Medicare. See the paragraph below headed Overpayments.*

Procedure

Adjustments may be requested via:

- Paper Request for Research/Claim Adjustment form. This form is available on the Hamaspik Medicare website or from the Provider Relations Department. Attach a copy of the remittance advice that included the claim, a copy of the original claim form, and other relevant supporting documentation.

  If a claim was denied for no authorization, but there **was** an authorization, the provider can use the Request for Research/Claim Adjustment form and attach a copy of the authorization.

  Inpatient claims denied for no preauthorization, medical necessity or combined admissions, or claims paid at a different DRG than billed cannot be corrected through claims adjustment. Instead, they must be processed through Inpatient Appeals.

- If a claim denied for timely filing, the provider should submit the Request for Timely Filing Review form with supporting documentation. A Timely Filing denial can be overturned if one of the situations listed on the Request for Timely Filing Review form applies, and the provider has sufficient supporting documentation for the situation. Please note: The Request for Research/Claim Adjustment form is not appropriate for questioning timely filing denials.

The Request for Research/Claim Adjustment form is also not appropriate for questioning edits made by our electronic claim review system. See paragraph below that addresses this issue.

- Provider Relations Department Representatives may be able to take information over the phone, in limited amounts, to initiate an adjustment. If documentation is required, provider may be advised to use the Request for Research/Claim Adjustment form.

7.1.31 Clinical Editing Review Requests

For certain claims, the claim systems may have determined that a procedure was mutually exclusive (or incidental) to a primary procedure. **The Request for Research/Claim Adjustment form is not appropriate for questioning the results of electronic claim review.** Instead, providers should use the Clinical Editing Review Request process described earlier in this section of the manual.

7.1.32 Overpayments

Hamaspik Medicare has a process for receiving returned overpayments in lieu of an adjustment on a subsequent claim. In order to credit the returned payment properly, Hamaspik Medicare requires the claim number, member or subscriber ID, and the date of service. Providers may supply this information separately or by including a copy of the applicable remittance.

Do not return overpayments for claims involving NYHCRA pools. Instead, notify Hamaspik Medicare in writing and include a copy of the remittance in question so that Hamaspik Medicare can initiate a retraction.

Overpayments must be mailed directly to the Credit and Collections Department.

As a reminder, if Hamaspik Medicare mistakenly overpays a claim to a participating provider, Hamaspik Medicare will make an adjustment and deduct that amount from future payments. If the provider disagrees with Hamaspik Medicare's decision regarding the adjustment, the provider should contact the Provider Relations Department.

7.1.33 Charts and Samples

The charts and samples listed below are presented on the following pages:

- Chart: Tips for Accurate and Complete ICD-9/10-CM Diagnosis Coding
- Chart: CMS-1500 Field Descriptions
- Chart: UB-04 Field Descriptions

Tips for Accurate and Complete ICD-9-CM Diagnosis Coding

- Review the Patient's Medical Record
- Maintain patient medical records in keeping with standards
- Identify the main reason for the patient's visit.
- Locate other conditions and confirmed diagnoses that are related to the reason for the visit.
- Create a clear relationship between or amongst diagnoses - causal relationships should be stated and not inferred (i.e., nephropathy due to diabetes mellitus).
- Do not include conditions that are described as "to rule out," "possible" or "suspected."
- Do not include diseases that are described as "to rule out," "possible" or "suspected."
- Code only those conditions that are supported by clinical medical record documentation.
- Use "history of" only when appropriate. For coding purposes, this terminology means the patient no longer has this condition rather than it existing as a chronic medical condition.
- Find the Condition in the ICD's Alphabetical Index
- The Index lists conditions in alphabetical order.
- Locate a term for each condition listed in the medical record.
- For each term located, examine sub-terms under the main condition term(s) to find the closest description of the condition. More than one term may be required to describe the condition fully.
- Find the appropriate diagnosis code(s) associated with all documented conditions.
- Look up the Diagnosis Code(s) from the Index on the ICD-9/10's Tabular List
- The Tabular List, which appears along the edges of each page, presents the diagnosis codes in alpha-numeric order.
- Find the main diagnosis code category for each documented condition.
- Read all Definitions and Notes Presented with Each Code Category
- Follow all cross-reference notes, inclusion notes and exclusion notes.
- Select Diagnosis Codes of the Highest Specificity Possible
- If the code falls in "not elsewhere classified" (NEC) or "not otherwise specified" (NOS) categories, refer to the medical record to see if other more specific codes in the code category may apply.

- Determine if Any of the Conditions May Be Combined
- Also determine if some conditions are actually symptoms of another condition and therefore are not to be coded.
- Record the Diagnosis Codes on the Claim Form
- First, list the diagnosis code chiefly responsible for the service(s) provided.
- Then list codes for all other conditions that are documented in the medical record for:
    - The date of service.
    - Report all secondary diagnoses that affect clinical evaluation, management or treatment.
    - Report all relevant V codes and E codes pertinent to the service(s) provided.

CMS-1500 Field Descriptions See key at the end of this chart.		
Field No.	**Name**	**Entry**
N/A	Blank open area between 1500 Health Insurance Claim Form and vertically printed CARRIER	Enter name and address of payor to whom claim is being sent.
1.	(Type of health insurance coverage)	Check the box OTHER for HMOs, commercial insurance, etc.
***1a.**	**Insured's ID Number**	**Enter the ID number (number assigned by HAMASPIK MEDICARE) of the subscriber (person who holds the policy).**
***2.**	**Patient's Name (Last, First, MI)**	**Enter name of person who received treatment or supplies, in order indicated on form.**
***3.**	**Patient's Birth Date/Sex**	**Enter patient's date of birth in order indicated on form MM/DD/YYYY - and check M or F** (to indicate male or female).
*4.	Insured's Name	Enter the name of the person holding the insurance coverage, in order indicated on form. This is the individual whose ID is entered in field 1a.
*5.	Patient's Address	Enter the patient's box number or street, city, state, zip code and telephone no. (if available).
6.	Patient Relationship to Insured	Mark the appropriate box.
7.	Insured's Address	Enter the insured's box number or street, city, state, zip code and telephone no. (if available).
8.	Patient Status	Check only one box per line to describe the patient's marital and employment or student status.
*9.	Other Insured's Name	If there is other insurance (Field 11d), enter the name (in order indicated) of the person who holds the other insurance.
*9a.	Other Insured's Policy or Group Number	If there is other insurance (Field 11d), enter the policy or group number of the other insurance.
*9b.	Other Insured's Date of Birth/Sex	If there is other insurance (Field 11d), enter the date of birth and sex of the person who holds the other insurance.
*9c.	Employer's Name or School Name	If there is other insurance (Field 11d), enter the name of the employer or school that offers the other insurance

CMS-1500 Field Descriptions See key at the end of this chart.		
Field No.	**Name**	**Entry**
*9d.	Insurance Plan Name or Program Name	If there is other insurance (Field 11d), enter the name of the other insurance or program.
*10a.	Is Patient's Condition Related to Employment?	Check YES or NO to indicate whether the patient's condition is related to employment.
*10b.	Is Patient's Condition Related to an Auto Accident?	Check YES or NO to indicate whether the condition is related to an auto accident. If Yes, enter two-letter postal code of state in which accident occurred.
*10c.	Is Patient's Condition Related to Another Accident?	Check YES or NO to indicate whether the condition is related to some other kind of accident.
10d.	Reserved for Local Use	Not used.
*11.	Insured's Policy Group or FECA Number	If known, indicate the policy, group or FECA (Federal Employees Compensation Act) number of the individual named in field 4.
11a.	Insured's Date of Birth/Sex	Enter the insured's date of birth and check M or F.
11b.	Employer Name or School Name	Enter the name of the employer or school through which the insured obtains his/her insurance.
11c.	Insurance Plan Name or Program Name	Enter the name of the insured's health insurance plan or program.
*11d.	Is there another Health Benefit Plan?	Check YES or NO to indicate whether the patient has other insurance. If Yes, complete info in boxes 9 a through d.
*12.	Patient's or Authorized Person's Signature	Enter the phrase SIGNATURE ON FILE, or include legal signature (and date) of patient or authorized person.
*13.	Insured's or Authorized Person's Signature	Enter the phrase SIGNATURE ON FILE, or include legal signature of insured or authorized person. If neither, may leave blank or state no signature on file.
14.	**Date of Current: Illness, Injury, Pregnancy (LMP)**	**For illness, enter the onset date (acute medical emergency only). For injuries, enter the date of the accident. For pregnancy, enter the date of the last menstrual period (LMP).**
15.	If Patient Has Had Same or Similar Illness, Give First Date	Enter the first date the patient had the same or similar illness. Do not include previous pregnancy.

CMS-1500 Field Descriptions See key at the end of this chart.		
Field No.	**Name**	**Entry**
16.	Dates Patient Unable to Work in Current Occupation	Enter the From/To dates that the patient was unable to work, in the order indicated on the form.
*17.	Name of Referring Provider or Other Source	When applicable, enter the name of the referring, ordering or supervising provider.
	Blank shaded areas for other ID number.	Blank shaded areas for qualifier and other ID numbers when applicable.
17b.	NPI	When applicable, enter the national provider identifier (NPI) number of the referring, ordering or supervising provider.
***18.**	**Hospitalization Dates Related to Current Services**	**This field is used for medical services furnished as a result of, or subsequent to, a related hospitalization. Enter the admission and discharge dates of hospitalization associated with the current services. If discharge has not yet occurred, leave the TO date blank.**
19.	Reserved for Local Use	Not used.
20.	Outside Lab? $ Charges	If applicable, check the appropriate box and enter the charges. If YES is checked, enter appropriate information in field 32 (service facility location information).
***21.**	**Diagnosis or Nature of Illness or Injury**	**Enter the appropriate diagnosis code(s). Always code to the highest level of specificity where appropriate.**
22.	Medicaid Resubmission Code/Original Ref. No.	Not used by Hamaspik Medicare.
23.	Prior Authorization Number	If applicable, enter the referral or prior authorization number assigned by Hamaspik Medicare.
24.	NOTE: Shaded lines in item 24 A-J are not service lines. They are for supplemental info (such as narrative description of an unspecified code) and to allow for submission of the non-NPI ID number (shaded area of 24J).	
***24A.**	**Dates of Service**	**Enter the date(s) of service applicable to each procedure, service or supplies.** If one date of service only, either leave TO blank or enter same date as FROM.

CMS-1500 Field Descriptions See key at the end of this chart.		
Field No.	**Name**	**Entry**
***24B.**	**Place of Service**	**Enter the appropriate CMS Place of Service (POS) code describing the place where the service was rendered. Place of service codes are available from CMS at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set**
24C.	EMG	Place a Y in this field for accidental injury or medical emergency services rendered in an office setting. Otherwise, leave blank.
***24D.**	**Procedures, Services or Supplies**	**Enter the appropriate CPT/HCPS code(s) and associated modifier(s) (if appropriate) specific to the procedure, service or supply item provided. If billing anesthesia, include start and stop times in the shaded area.**
*24E.	Diagnosis Pointer	Enter the diagnosis code reference number associated with each procedure, service, or supply item listed in field 21. This is the line number from field 21 that relates to the reason for the service.
***24F.**	**Charges**	**Enter the charge for each procedure, service, or supply item listed.**
*24G.	Days or Units	As applicable, enter the number of days or units (such as anesthesia) associated with each procedure, service, or supply item listed.
24H.	EPSDT Family Plan	This field is to show whether the service was provided under the federal Early & Periodic Screening, Diagnosis & Treatment benefit.
24I.	ID. QUAL.	In shaded area above where it says NPI, enter ZZ (indicates provider taxonomy).
*24J.	Rendering Provider ID	• Shaded area (top): Enter rendering provider taxonomy. • Non shaded area (bottom): Enter national provider identifier (NPI) number. If rendering provider is the same for all lines of the claim, it is acceptable to enter the NPI on the first claim line only and leave the others blank.
***25.**	**Federal Tax I.D. Number (SSN/EIN)**	**Enter the Federal Tax I.D. (employer identification number or social security number) of the group, PC or provider and check the appropriate box.**
26.	Patient's Account Number	Enter the provider's account number for the patient. If billing for early intervention services, enter "EIP" preceding account number.

CMS-1500 Field Descriptions See key at the end of this chart.		
Field No.	**Name**	**Entry**
27.	Accept Assignment?	Indicates whether provider agrees to accept assignment under the terms of the Medicare Program.
*28.	Total Charge	Enter the total of all charges listed on all lines in field 24F.
*29.	Amount Paid	When applicable, enter the amount paid by the patient or other payors.
*30.	Balance Due	When available, enter the balance due.
*31.	Signature of Physician or Supplier Including Degrees or Credentials	Enter the phrase SIGNATURE ON FILE, or include legal signature of practitioner or supplier (or representative), including title.
32.	Service Facility Location Information	If the services were provided at a location different from the address specified in field 33, enter the name and address of that location here.
32a.	NPI	If different from billing provider, enter the national provider identifier (NPI) number of service facility given in field 32.
32b.	Blank shaded area	If different from billing provider, enter ZZ (qualifier indicating that what follows is the taxonomy) followed immediately by the taxonomy of the service facility (no spaces between qualifier and code).
33.	Billing Provider Info & PH #	Enter the provider's or supplier's billing name, address (including zip code) and telephone number.
33a.	**NPI**	**Enter the national provider identifier (NPI) number of the billing provider in field 33.**
33b.	Blank shaded area	Enter ZZ (qualifier indicating that what follows is the taxonomy) followed immediately by the billing provider's taxonomy (no spaces between qualifier and code).

KEY

- Bolded and shaded fields indicate that the claim cannot be processed if information in these fields is missing, illegible or invalid. Claim will reject at front end.
- An (asterisk) indicates information listed in New York State Insurance Department (NYSID) claim submission guidelines. Hamaspik Medicare cannot reject as incomplete a claim submitted on a CMS-1500 claim form if the claim contains accurate responses in these fields, unless otherwise specified. Depending on the type of claim, the Hamaspik Medicare may not require all the information designated in the NYSID claim submission guidelines.

Note: *Hamaspik Medicare requires information in certain other fields before it can adjudicate the claim. These fields may vary with the type of service being billed. Completion of all fields does not guarantee payment.*

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
1	Unlabeled	4 lines for Provider Name, Address, Telephone, Fax, Country Code (only if address/phone outside the U.S.)
2	Unlabeled	4 lines for Pay-to Name, Address, etc.
3a	PAT CTL #	Patient Control Number assigned to patient by provider
3b	MED REC #	Medical record number assigned to patient's medical record by provider
4	**TYPE OF BILL**	**4-digit code that identifies type of facility, bill classification (variations for hospital, clinic, or special facilities), and frequency (indicates sequence of bill in particular episode of care).**
5	**FED. TAX NO.**	**Tax identification number (TIN) or employer identification number (EIN)**
6	**STATEMENT COVERS PERIOD (From/Through)**	**Enter beginning and ending dates of the period included on the claim**
7	Unlabeled (2 lines)	2 lines – not used
8a	PATIENT NAME - ID	Patient ID number (depending on primary, secondary, tertiary in field 60)
8b	**PATIENT NAME**	**Enter name of patient**
9	PATIENT ADDRESS	Lines a through e for street and number or box number, city, state, zip code and country code (if address outside the U.S.)
10	**BIRTHDATE**	**Enter patient's date of birth**
11	SEX	Enter F or M
12	**ADMISSION DATE**	**Date of admission or commencement of services**
13	ADMISSION HOUR	Time of day of admission or commencement of services
14	ADMISSION TYPE	Appropriate code for emergency, urgent, elective, newborn, etc.
15	ADMISSION SRC	Source of admission code

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
16	DHR	Discharge hour
17	STAT	Patient discharge status code
18-28	CONDITION CODES	Relate to type or lack of coverage
29	ACDT STATE	Accident state
30	Unlabeled (2 lines)	Not used – 2 lines
31-34	OCCURRENCE CODE and DATE	Enter applicable occurrence code(s) and associated date in lines a and b
35-36	OCCURRENCE CODE and SPAN (FROM/ THROUGH)	Enter applicable occurrence code(s) and associated date span in lines a and b
37	Unlabeled	Unused – lines a and b
38	Unlabeled	5 lines for responsible party/subscriber name and address
39-41	VALUE CODES and AMOUNTS (lines a through d)	Lines a through d. Value codes and amounts, including those for covered days (80), non-covered days (81), coinsurance days (82) or lifetime reserve days (83) should be placed here.
42	**REV CODE**	**Revenue code for each service billed – 22 lines**
43	DESCRIPTION	Revenue code description for each service billed – 22 lines
44	**HCPCS / RATE / HIPPS CODE**	**HCPCS or HIPPS code corresponding to each service billed – 22 lines**
45a	**SERV. DATE**	**Service date of each service billed – 22 lines**
45b	CREATION DATE	Date claim form is completed
46	SERV. UNITS	Service units corresponding to each service billed – 22 lines
47	**TOTAL CHARGES**	**Total charges for each service billed – 22 lines**
48	NON-COVERED CHARGES	Non-covered charges for each service billed – 22 lines
49	Unlabeled	22 lines – not used
47-48	TOTALS	Total amount of charges and total amount of non- covered charges
50	PAYER NAME	3 lines, one each for primary, secondary, and tertiary payers.
51	ID	This spot reserved for the national health plan identifier when one is established. 3 lines, one each for primary, secondary, and tertiary payers.

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
52	REL INFO	Release of information certification indicator (Y or I). 3 lines, one each for primary, secondary, and tertiary payers.
53	ASG BEN	Assignment of benefits certification indicator. 3 lines, one each for primary, secondary, and tertiary payers.
54	PRIOR PAYMENTS	Payments from other payers or patient. 3 lines, one each for primary, secondary, and tertiary payers.
55	EST. AMOUNT DUE	Estimated amount due from patient. 3 lines, one each for primary, secondary, and tertiary payers.
56	**NPI**	**NPI for billing provider.**
57	OTHER PRV ID	Other provider identifier.
58	INSURED'S NAME	Name of holder of the insurance contract. 3 lines, one each for primary, secondary, and tertiary payers.
59	P REL	Patient's relationship to insured. 3 lines, one each for primary, secondary, and tertiary payers.
60	**INSURED'S UNIQUE ID**	**Insured's insurance identification number. 3 lines, one each for primary, secondary, and tertiary payers.**
61	GROUP NAME	Insured's group name. 3 lines, one each for primary, secondary, and tertiary payers.
62	INSURANCE GROUP NO.	Insured's group number(s), if available. 3 lines, one each for primary, secondary, and tertiary payers.
63	TREATMENT AUTHORIZATION CODES	Hamaspik Medicare authorization number. 3 lines, one each for primary, secondary, and tertiary payers.
64	DOCUMENT CONTROL NUMBER	Area for Hamaspik Medicare to assign claim number
65	EMPLOYER NAME	Insured's employer name. 3 lines, one each for primary, secondary, and tertiary payers.
66	DX	Qualifier code reflecting ICD revision. Enter 9 for 9th Revision.
67	**Label is 67**	**Enter principal diagnosis code. Include all digits (4-5) where applicable**

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	**Name**	**Entry**
67	A through Q	Other diagnosis codes. Include all digits (4-5) where applicable.
68	Unlabeled	2 lines – not used
69	**ADMIT DX**	**Admitting diagnosis code (if inpatient claim)**
70	PATIENT REASON DX	Patient's reason for visit (diagnosis) code(s) (3 blocks)
71	PPS CODE	Prospective Payment System code
72	ECI	External cause of injury code(s) (3 blocks)
73	Unlabeled	Input DRG code here.
74	**PRINCIPAL PROCEDURE CODE and DATE**	**Enter principal procedure code and date of procedure**
74a-e	OTHER PROCEDURE CODE and DATE	As applicable, enter other procedure codes and dates
75	Unlabeled	4 lines - not used
76	ATTENDING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of attending provider and last and first names of attending provider
77	OPERATING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of operating provider and last and first names of operating provider
78	OTHER – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of other provider and last and first names of another provider
79	OTHER – NPI, QUAL, LAST, FIRST	Same as above
80	REMARKS	4 lines for notation that does not go elsewhere
81	CC	Code-Code (lines a through d, 3 boxes each)
81a	Taxonomy code qualifier and taxonomy code(s)	In first box, enter qualifier code B3 for field 56 billing provider taxonomy code. In second (and third, if applicable) boxes, enter taxonomy code(s) for the field 56 billing provider.
81b	Other code qualifier and other code	As needed
81c	Other code qualifier and other code	As needed
81d	Other code qualifier and other code	As needed

***Note**: Bolded and shaded fields indicate that claim cannot be processed if information in these fields is missing, illegible or invalid. Claim will reject at front end.*
***Note**: Hamaspik Medicare requires information in certain other fields before it can*

adjudicate the claim. These fields may vary with the type of service being billed. Completion of all fields does not guarantee payment.

Section Eight: Quality Improvement

8.1 Quality Improvement Program (QIP)

The Hamaspik Medicare QIP provides a programmatic framework to improve the health outcomes of its membership, especially, its most vulnerable population. This is accomplished by implementing evidenced based clinical guidelines and standards, ensuring access to needed benefits and services, collaborating with network providers, and accessing pertinent data.
This framework is based upon the philosophy of Continuous Quality Improvement (CQI), utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

Hamaspik Medicare utilizes multiple data sources to evaluate the health plan's performance including, but not limited to:

- Claims and encounter data,
- Critical events,
- Grievance and appeals data, and
- Member survey data including the Consumer Assessment of Healthcare Providers Systems (CAHPS) and Health Outcomes Survey (HOS).

The QIC (Quality Improvement Committee), comprised of executive leadership, has the responsibility to implement the QIP and ensure the health plan achieves performance targets. The QIC reports to the Board of Directors who have oversight of the QIC and all performance improvement initiatives.

Provider involvement in the various quality projects, programs and initiatives is essential for Hamaspik Medicare to achieve the performance goals and provide optimal care and services to its members. The following section describes the quality activities that will require the provider's involvement.

8.2 Healthcare Effectiveness Data Information (HEDIS) Measures

HEDIS is an audit tool developed by the National Committee for Quality Assurance (NCQA), that has the most widely used set of performance measures in the managed care industry. There are more than 90 performance metrics across six domains of care that utilize evidenced based clinical guidelines to determine standards of care. The results are validated by an auditor prior to being published on the www.medicare.gov website so Medicare beneficiaries can benchmark health plans against one another prior to selection. Some measures are highlighted as "Star" measures, providing quality incentive eligibility for health plans if certain percentile thresholds are achieved.

Educating providers about performance standards that are evidenced- based and holding providers accountable to these standards, is a critical component to achieving optimal performance as evidenced by HEDIS rates. A comprehensive manual describing HEDIS measures and specifications will be published on the Hamaspik Medicare website for providers to utilize as an educational resource. For Hamaspik Medicare, as dual eligible (Medicare and Medicaid) Special Needs Plans (SNP), CMS has identified additional performance measures to

address the specific needs of this population. The list below is a subset of HEDIS and SNP measures. Providers may reference the comprehensive manual describing HEDIS measures and CPT codes as a reference guide for HEDIS 2020 and 2021 measures:

- Breast Cancer Screening
- Colorectal Cancer Screening (SNP measure)
- Pharmacotherapy Management of COPD Exacerbation
- Controlling High Blood Pressure (SNP measure)
- Persistence of Beta-Blocker Treatment After a Heart Attack (SNP measure)
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post-Discharge (SNP measure)
- Potentially Harmful Drug-Disease Interactions in the Elderly (SNP measure)
- Statin Therapy for Patients with Cardiovascular Disease
- Comprehensive Diabetes Care
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Osteoporosis Management in Women who had a Fracture (SNP measure)
- Antidepressant Medication Management
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation (SNP measure)
- Us of High-Risk Medications in Older Adults/ Elderly (SNP measure)
- Care for Older Adults (SNP measure)
- Anti-depressant Medication Management (SNP measure)
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Flu Vaccinations (CAHPS survey measure)
- Pneumococcal Vaccination Status for Older Adults (CAHPS survey measure)

8.3 Consumer Assessment of Health Plan Providers and Systems and Health Outcome Surveys

CMS measures quality of services clinically, administratively, and through the use of patient experience of care surveys. In addition to reporting HEDIS measures, CMS requires health plans to participate in two surveys:

- Consumer Assessment of Health plan Providers and Systems (CAHPS), and
- Health Outcomes Survey (HOS).

CAHPS is a survey that is administered to a random sample of members annually. It focuses on how members experience, or perceive key aspects of their care, including communication with their doctors, understanding their medication instructions, and the coordination of their healthcare needs. The CAHPS surveys are an integral part of CMS' efforts to improve healthcare nationally and includes two HEDIS measures in its survey questionnaire, inquiring if the member received a flu vaccine and pneumococcal vaccine.

The HOS is the first patient-reported outcomes measure used to gather clinically meaningful health status data from Medicare beneficiaries. It is administered annually to a random sample, or new cohort of Medicare beneficiaries each year to obtain a baseline of their health outcomes status. Two years later, these same respondents are surveyed again (i.e., follow up measurement) to identify if their self -reported status has improved, declined, or unchanged.

The HOS is also used to collect three HEDIS® effectiveness of care measures e.g., Management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, and Fall Risk Management.

CMS publishes HEDIS rates, and results from both the CAHPS and the HOS on the medicare.gov website, allowing Medicare beneficiaries to compare health plans against one another. A "Star" rating of up to five stars is assigned to a health plan based on the results of various criteria including HEDIS, CAHPS, HOS and other administrative data. A health plan may be eligible for incentive bonus payment if it achieves a five -star rating. Consequently, a health plan risks its good standing should it receive a star rating less than three. Providers adhering to standards outlined in this provider manual is critical to achieving a five-star rating.

8.4 Quality Improvement Projects and Programs

In addition to reporting results from HEDIS, CAHPS and HOS, Hamaspik Medicare complies with Section 5 of the CMS Medicare Managed Care Manual. The following are additional quality projects and programs that have been implemented:

Quality Improvement Project (QIP)

- The QIP is an initiative that focuses on clinical or non- clinical areas with the goal of improving health outcomes. The quality topic to be addressed has been prescribed by CMS and expands over a three -year period with the goal of reducing 30-day all cause hospital readmission rates. "All cause readmissions" are defined as the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.

- The project design includes, but not limited to, multiple interventions including:

    - Transitional Care Management (TCM)- TCM refers to the continuous and coordinated transfer of patients from one care setting to another. It includes the logistical arrangements of patient care from the point of hospital admission through discharge to the home or another setting, communication and coordination among healthcare professionals involved in the member's care, education of the patient and family, and detailed assessments of the member's health status and preferences for healthcare. The care manager collaborates with facility staff and the PCP to ensure a safe discharge plan for the member to the least restrictive setting. The discharge plan includes identifying and addressing the member's health care needs, ensuring medication reconciliation occurs, follow up appointments with PCP are scheduled, appropriate follow up supportive care and services are ordered and provided in the home, or setting the member is being transferred. Medication reconciliation, a component of transitional care, involves comparing discharge medications with those in the home and ensuring the member understands the purpose, frequency, and importance of each medication.

    - Individual Care Plan (ICP) – All members who are receiving care management have an individualized care plan that identifies health related risks, including risk for an unplanned hospitalization and/or readmission. The ICP documents the interventions that mitigate those risks. The ICP also addresses clinical diagnoses that may be contributing factors to potentially avoidable hospitalizations.

Chronic Care Improvement Program (CCIP)

The CCIP is a clinically focused initiative designed to improve the health of a specific group of members with chronic conditions. CMS requires that health plans implement an initiative that reduces or prevents cardiovascular disease over a five-year period. Hamaspik Medicare will focus on reducing cardiovascular disease for members with Type 1 and Type 2 diabetes.

The CCIP is a comprehensive disease management program that is designed to manage a member with Type 1 or Type 2 diabetes from multiple approaches, adapting the approach based on the member's needs, his/her ability, and willingness to learn, support systems, or lack thereof, and clinical risks. Program components of the CCIP include:

- Effective self-management of diabetes to slow disease progression,
- Prevent complications, or mitigate long term complications of diabetes,
- Prevent development of cardiovascular complications and other associated comorbidities,
- Reduce/avoid preventable emergency room (ER) encounters and inpatient stays,
- Improve quality of life,
- Reduce cost of unnecessary treatments and inappropriate utilization of services

Care managers are integral to the CCIP and will collaborate with providers and other health care personnel to successfully implement the CCIP.

Quality of Care Concerns and Issues

All clinical grievances or critical events involving a provider and reported to Hamaspik Medicare will be investigated. Requests for medical records and/ or interviews with providers, will be conducted to determine if the event, or grievance is substantiated. Providers are required to fully cooperate and collaborate with Hamaspik Medicare staff during the investigation and comply with any requests to develop and implement a corrective action plan as required. Failure to cooperate with investigation will be reported to credentialing committee to determine appropriate actions.

8.5 Privacy Statement

Health Care Quality Improvement activities are conducted in a manner that assures the privacy of the member regarding their protected health information (PHI) according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Hamaspik Medicare has corporate policies and procedures that comply with HIPAA privacy regulations.
- Hamaspik Medicare employees will also sign a Confidentiality Agreement, take an online training program, and also pass a test when they become contracted employees at Hamaspik Medicare.
- Each employee also completes a corporate Compliance Training module for Hamaspik Medicare and must pass a proficiency test
- Hamaspik Medicare requires participating providers to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HIPAA Privacy Rule (45 CFR Parts 160 and 164).

8.6 Medical Records

Hamaspik Medicare requires that participating provider medical records comply with all state and federal laws and regulatory requirements, be current, detailed, and organized, and be accessible to Hamaspik Medicare. Medical records must be retained by the treating provider for at least ten years after the date of treatment.

Information from medical records may be requested from providers related to quality initiatives, including measures as defined by the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid (CMS) reporting requirements. HEDIS and other quality initiatives may require a review of the medical record as a part of its data collection and reporting process. Hamaspik Medicare staff may request access to the medical records throughout the year to fulfill regulatory reporting requirements.

Note: *Medical record documentation auditing and reporting are part of "health care operations" as defined by HIPAA and thus do not require patient authorization for release of protected health information.*

8.7 Medical Record Documentation Standards

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. Hamaspik Medicare has established medical record documentation standards consistent with CMS and NCQA requirements. These standards optimize health care delivery by requiring accurate and thorough documentation that reduce redundancy, medical errors, and legal liability. These standards facilitate confidential coordination and continuity of care among health care providers.

Hamaspik Medicare monitors compliance with these standards by conducting periodic audits and review of the PCP's medical records. Hamaspik Medicare defines PCPs as internal medicine practitioners, family practitioners, Obstetricians/gynecologists (OB/GYN), geriatricians, and pediatricians. The reviews include activities related to HEDIS, credentialing/recredentialing, grievance and appeals investigations, and other quality improvement initiatives.

The medical record review may include at least twelve months of progress notes. The performance goal for meeting medical record documentation standards is 80 percent. This documentation standard is solely for quality purposes and in no way is intended to diminish the documentation responsibilities imposed by law and regulations.

The following requirements reflect a set of commonly accepted standards for medical record documentation:

1. Each page in the record contains the patient's name or ID number.

2. **Biographical/personal data**
   The medical record must include the following biographical/personal data:
   - All pages must contain patient identification:
   - Patient Name
   - Patient Date of Birth

- Patient Current address
- Patient / Designated Representative Primary Phone Number

3. All medical records must be signed. Signature can be in the form of the provider's initials. Signature may be written or electronic.

4. All entries are dated.

5. The record is legible to someone other than the writer. Illegible notes are an automatic failure under this standard.

6. Problem List
Significant illnesses and medical conditions are indicated on the problem list, which is up to date. The problem list must contain all significant illnesses and active medical conditions, as well as behavioral and psychological health. For patients without active problems, the list must indicate either "health maintenance" as the active issue or "no problems noted".

7. Medication allergies
Medication allergies and adverse reactions are prominently noted in the record. If there are no known history of adverse reactions this is appropriately noted in the record.

8. Medical History
Must include past medical history (for patients seen three or more times). Past medical history for all ages must include illnesses, surgeries/operations, and mental history. For children and adolescents (18 years and younger), past medical history must also include prenatal history.

9. Social habits
The medical record must include, for patients 11 years and older, documentation of screening and/or counseling for:
- Tobacco use
- Alcohol use
- Substance use
- HIV/STD risk

10. Presenting complaints
The medical record must contain pertinent subjective and objective information on presenting complaints. Office visit notes must contain appropriate subjective and objective information pertinent to the patient's presenting complaints.

11. Lab and other studies and treatment plan
The labs/other studies indicated in the medical record must be appropriate to the findings/diagnosis stated.

12. Diagnosis/impression
The medical record must reflect a diagnosis that is consistent with findings.

13. Treatment plans are consistent with diagnoses.

14. Progress notes, or encounter forms must have notation regarding follow-up care, calls or visits when indicated**.**

15. Organization
The medical record must be organized. There must be an individual chart for each member. The record must be in sequential order, e.g., date, category, type of service.

16. Medication list
There must be a current medication list in the medical record. The medication list can be either a separate form or an entry in the progress notes. The medication list must include all medications, both prescription and over-the-counter, that the patient is taking.

17. Family medical history
The medical record must include, at a minimum, pertinent medical history of parents and/or siblings.

18. Social living environment
The medical record must include pertinent information such as occupation, education, and living situation.

19. Documentation of Advance Directives discussion
The medical record must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children have been given information regarding Advance Directives (see Appendix 1 for sample Health Care Proxy form).

20. Plans / actions
The plans/actions identified in the medical record must be consistent with diagnosis, including:

- Time frame for return visit (PRN is acceptable)
- Appropriate use of referrals/consultants

21. Chronic medical conditions
Chronic medical conditions identified in the medical record must be monitored, as appropriate.

22. No-shows or missed appointments
No shows or missed appointments must be documented in the medical record, along with follow-up efforts to reschedule appointments.

23. Emergency room / inpatient follow-up
The medical record must contain consultant reports from specialty providers to whom the patient has been referred and ER reports and/or facility discharge summaries as applicable.

24. Consultant summaries with PCP review
Consultant summaries must be in the medical record, with evidence (initials or some other confirmation) that the PCP has reviewed, if applicable.

25. Medically appropriate care

The medical record must reflect medically appropriate care rendered to the patient. No inappropriate risk to the patient should be identified from the care provided.

26. Preventive services and screenings

The record must reflect those preventive services and screenings were offered in accordance with protocols, including:

- Diet/nutrition discussion and/or counseling.
- Patient safety – i.e., seat belts, helmet, car seats
- Age/gender appropriate preventive health services as per the Hamaspik Medicare Preventive Care Guidelines with dates and results of any labs/tests
- Complete and up-to-date immunization information

Representatives of Hamaspik Medicare may request medical records for review against the medical record documentation standards cited above. The review may be conducted onsite at the PCP office, or specific excerpts of the medical record may be requested. Results of the review will be shared with the provider. Providers who score less than the performance goal off 80 percent will be asked to submit a corrective action plan (CAP) within 30 days. Subsequently, Hamaspik Medicare will conduct another medical record review to reassess if the standards have been achieved.

8.8 Appointment Availability Standards

Hamaspik Medicare has established appointment availability standards to provide reasonable patient access to care. Hamaspik Medicare monitors the standards for providers in the network. Members must be able to access their PCP 24 hours a day 7 days a week. An answering machine does not suffice as access to the provider. The minimum appointment availability standards are as follows:

Appointment Type	**Standard Timeframe**
Wellness/Routine health maintenance care	Within 4 weeks
Routine behavioral health care	Within 10 business days
Emergency coverage	24 hours a day, seven days a week
Urgent medical care	Within 24 hours
Non-urgent sick visits	Within 48 to 72 hours
Urgent behavioral health care	Within 48 hours

1) Coverage Arrangements

Physicians who participate in the Hamaspik Medicare provider network are required to advise Hamaspik Medicare in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other.

2) Office Waiting Time - Within 30 Minutes

Office waiting time for appointments should not exceed 30 minutes from the scheduled appointment time.

3) Telephone Access Standards

PCPs and Participating Specialists are required to provide 24 hour a day, 7 days per week telephone coverage:

(a) Emergency conditions must receive immediate response.

(b) Urgent conditions must be responded to within 4 hours.

(c) Non-urgent calls are required to be responded to during the same day the call was received.

(d) Routine conditions should be responded to within 2 working days.

4) Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high- volume Participating Specialists will be included in an accessibility audit/review for all categories and appointment types. Member complaints may also trigger an ad hoc measurement of a Provider's accessibility. Data will be analyzed on a system wide and individual Provider level for the development of system wide and/or individual improvement activities.

8.9 After-Hours Care

PCPs, OB/Gyn, and Specialists

When acting as a member's primary care physician, obstetrician/gynecologist, or specialist physician, the physician must make all necessary arrangements with other network physicians to assure the availability of covered services to Hamaspik Medicare members 24 hours a day, 7 days a week, including periods after normal business hours, on weekends, or when the physician is otherwise unavailable.

Acceptable Methods of After-Hours Coverage

Hamaspik Medicare has determined what constitutes acceptable versus unacceptable methods of after-hours coverage.

Hamaspik Medicare members with medical problems must be able to:

- Reach the practitioner or a "live-voice" person with the ability to patch the call through to the practitioner (i.e., answering service), or
- Reach an answering machine with instructions that result in the ability to contact the practitioner or his/her backup (i.e., message with number for home, cell phone or beeper), or
- Leave a message that is automatically forwarded to the physician's beeper or cell phone. This option is compliant only if the recording explains to the patient how his/her message

will be handled. The message must direct the enrollee to a live voice.

8.10 After Hours/Urgent Care Centers

With after-hours or urgent care centers, patients who have minor injuries or illnesses can get the care they need and avoid time-consuming and expensive visits to the emergency room. These centers specialize in treating minor illnesses or injuries after primary care physician offices have closed for the day. Examples of minor injuries or illnesses include cuts, sprains, simple fractures, flu-like symptoms, earaches, fever, and minor burns. A member who thinks he/she may need urgent care should first call his/her primary care physician to be sure the after-hours or urgent-care centers are the right place to go for treatment of his/her condition.

8.11 Communicable Disease Reporting

The NYS and NYC Departments of Health require the reporting of all cases of communicable diseases. We will assist in this process by notifying PCPs when there has been a report of a potential communicable disease to us through our claim system. The diagnosis will be clarified, and for those members with a confirmed diagnosis of COVID, tuberculosis, sexually transmitted disease, hepatitis, or HIV, we will help the PCP with case management services if necessary. Refer to Appendix 2 for a listing of Communicable Diseases.

8.12 Provider reporting obligations

Documentation of reasonable efforts must be conducted to assure timely and accurate compliance with NYS and NYC public health reporting requirements in the following areas:

- Infants and toddlers suspected of having a developmental delay or disability
- Suspected instances of child abuse
- Immunization Registry and Blood Lead Registry
- Communicable disease and conditions mandated in the New York City Health Code, pursuant to 24 RCNY§ 11.03-11.07 and Article 21 of the NYS Public Health Law

Section Nine: Compliance Summary

INTRODUCTION

In accordance with 42 CFR 438.608, 42 CFR 455, 42 CFR 422.503, 42 CRF 423.504, Social Services Law §363-d and 18 NYCRR Part 521, Hamaspik Choice, Inc., and Hamaspik, Inc. (or "Hamaspik") has developed a Compliance Program that is designed to prevent fraud and abuse and ensure prompt organizational response to detect offenses and development of corrective action initiatives.

STATEMENT OF POLICY ON ETHICAL PRACTICES

Hamaspik has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. Hamaspik has developed Regulatory Compliance Policies and Procedures that articulate the plan's commitment to comply with all Federal and State laws and regulations, including but not limited to those that govern New York State Medicaid Managed Long Term Care plans and Medicare Advantage/Prescription Drug (MA-PD) plans, as well as State Labor Laws and the minimum wage law. Our compliance standards and policies apply equally to all employees and board members regardless of tenure or rank within the organization, as well as to all providers, first-tier, downstream, and related entities that are contracted to provide services for our members.

DESIGNATION OF A COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

Hamaspik has assigned responsibilities of oversight of the operation and implementation of this compliance program to the Vice President, Compliance and Regulatory Affairs, an employee who has been appointed to this position by the Executive Director. Reporting to the Vice President are staff who oversee the monitoring and auditing of operations of Hamaspik's health plans, its delegated vendors, and providers.

Hamaspik has also established a Compliance Committee, which is accountable to the Executive Director and makes regular reports to the Board of Directors. The Compliance Committee meets ten times each year. During its meetings, the Compliance Committee reviews the following:

1. Development of Compliance Risk Assessment and strategy for mitigating risks
2. Results of auditing and monitoring activities
3. Required regulatory reporting
4. Compliance issues that have been identified and investigated
5. Regulatory updates and review of new policies
6. Trainings on compliance risk areas

POLICIES AND PROCEDURES

Hamaspik has developed a comprehensive policy and procedure manual that governs the functions and activities of its health plan operations. In addition to standard operating policies and procedures, Hamaspik policies include a Code of Conduct and Employee Handbook that applies to all staff at all times.

Policies and procedures for providers are outlined in this Provider Manual, which is supplied to all providers at the time that a contract is executed, and updated as appropriate.

COMMUNICATION

Under the Codes of Conduct/Ethics, all employees are responsible for promptly raising concerns about any possible misconduct including suspected fraud and abuse, violation of Federal or State laws and regulations, and violation of any of Hamaspik's ethical and business standards.

Employees are advised to first discuss a concern with their immediate supervisor, who is often closest to the situation and best able to help. If an employee is uncomfortable discussing a concern with their immediate supervisor, the employee may report the concern to someone in an appropriate position such as Human Resources or the Compliance Officer. The Compliance Officer will review the matter to determine if there is a reason for concern.

Hamaspik's policy is to protect employees from retaliation and maintain confidentiality in respect to all concerns raised. Hamaspik's managers, supervisors and employees must not engage in retaliation, retribution or any form of harassment directed against an employee who has reported, is considering reporting or who has cooperated in an investigation of a compliance concern. Any manager, supervisor or employee who engaged in such retribution, retaliation or harassment is subject to discipline, up to and including termination of employment.

All employees are also encouraged to contact the Compliance Officer to ask questions or seek guidance regarding specific activities or policies and procedures. Hamaspik will treat calls about compliance concerns in a manner that is confidential, but also consistent with the need to investigate, cooperate with the government, and comply with legal obligations.

Suspicious activity can be reported anonymously by calling the Compliance Hotline at (845) 503-0592, by email to corporatecompliance@hamaspikchoice.org, or the suggestion box located in the office. This phone number and email are available to staff, contractors, providers and other first-tier, downstream, and related entities.

ENFORCEMENT

When a potential compliance issue is identified, investigations will be conducted promptly and consistently, and determinations will be based on the facts that are established through the investigation and evidence. Disciplinary action will be taken on a fair and equitable basis and will be applied in an appropriate and consistent manner. The Vice President of Compliance and Regulatory Affairs works collaboratively with the Director of Human Resources in all staff disciplinary actions, and with the Vice President, Provider Relations and Contracting for concerns about provide conduct.

Providers and other contracted entities who do not comply with Hamaspik Policies and standards or applicable regulations will be subject to investigation, disciplinary action up to termination of contract.

AUDITING AND MONITORING

Auditing and monitoring activities are conducted under the direction of the Compliance Officer. Areas of focus for audits and monitoring are determined by the Compliance Committee, based on a risk assessment. The risk assessment is conducted annually, and is updated, as necessary. In developing the risk assessment, the following sources are used:

- State and CMS contracts and applicable regulations

- Findings from internal and external audits and monitoring activities
- Observations from the staff about areas of risk and vulnerabilities
- Review of workplans and audit priorities of the NY State OMIG, Federal OIG, and other regulatory authorities

A system for routine internal and external monitoring and auditing will be established and implemented. The system will include procedures for auditing of compliance risks, prompt responses to compliance issues as they are raised, investigation of potential compliance problems identified, and correction of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

In addition, Hamaspik will implement a service verification process to evaluate the delivery of billed services to the enrolled Members. The verification process will be based on statistically valid samples, and may include confirmation of services with members, review of direct care worker documentation, electronic visit verification, and other methods as appropriate.

Hamaspik will not knowingly hire or execute a contract with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or excluded from participation in any Federal or State health care program. State and federal databases are checked for all new providers, and are monitored periodically to ensure that individuals/entity have not been excluded. The plan monitors databases maintained by OMIG, OIG, the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES). Based on this review, Hamaspik ensures that it will not:

- Pay claims for a provider who is excluded from participation in the Medicaid or Medicare program,
- Provide services based on medical orders or a prescription from a physician who has been excluded, or
- Allow services to be furnished by an individual/entity to whom the state has suspended payments due to an investigation of credible allegation of fraud.

In addition, Hamaspik conducts audits of its providers to ensure that the Plan maintains a Provider Network that is adequate and is in compliance with all federal and state regulations and Hamaspik's requirements. Provider's compliance is evaluated by audits of the following:

- Billing accuracy
- Quality of care
- Credentialing
- Fraud and abuse policies and procedures
- Compliance with regulations and State or CMS policy guidance
- Compliance with appointment availability and access standards

As part of the monitoring process, the Compliance Officer will utilize techniques such as on-site visits, review of financial records and medical record documentation, and trend analyses that seek to identify deviations in specific risk areas over a given period of time.

RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION INITIATIVES

Upon identification of suspicious fraudulent, abusive, or non-compliant activity, a thorough investigation will be conducted by the Compliance Officer. Investigations will be conducted promptly and consistently, and determinations will be based on the facts that are established through the investigation and evidence. Documentation of such investigation will include:

- Records of the alleged violation,
- Description of the investigative process,
- Results of the investigation, and
- Actions taken in response.

Plans of corrective action will be developed specific to each incident and implemented immediately, to reduce the potential for recurrence and ensure ongoing compliance with regulations and requirements. Any corrective action plan will be reviewed and approved by the Compliance Officer. Depending on the nature of the issue(s), provider or subcontractor agreements may be terminated. At an appropriate time, the Compliance Officer will conduct a follow-up audit, to ensure that the corrective action plan has been implemented and to ensure that it has been an effective remedy to the identified issue(s).

REGULATORY OVERSIGHT AND REPORTING

Nothing in this Compliance Plan shall be construed to limit the authority of State and Federal regulatory agencies and law enforcement agencies to investigate, audit, or otherwise obtain recoveries from Hamaspik Choice and its participating providers, other providers, subcontractors or other third parties.

When Medicare or Medicaid compliance issues are identified that point to noncompliance by Hamaspik with its DOH or CMS contracts and/or regulatory requirements, the plan will self-report such noncompliance to the appropriate regulatory agency at the State of federal level. All self-reported compliance issues will be coordinated by the Compliance Officer. The Executive Director, Compliance Committee and Board of Directors will be informed of any self-reported compliance failing, along with the consequences from the issue, and the corrective actions taken as a result.

Hamaspik shall report all cases of potential fraud, waste, and/or abuse to DOH and OMIG within five (5) days of identification. This shall include acts committed by, the Plan and its management or staff, Participating or Non-Participating Providers, subcontractors, vendors, enrolled members, rendering professionals, ordering, or referring professionals, or any third party. In cases of potential fraud, waste, or abuse, after reporting the case to OMIG, Hamaspik will investigate the issue(s), unless otherwise directed by OMIG. All reporting will be consistent with the requirements of Article VIII, Section F.3.(d) of the Hamaspik agreement with DOH.

Hamaspik will coordinate its audit activities with OMIG, when the audit could result in post-payment recovery or a referral to OMIG. Hamaspik will notify OMIG of its intention to initiate an audit of a Participating Provider or Non-Participating Provider, in a form and format developed by OMIG and/or DOH. Within ten (10) business days of the notice, OMIG will (a) acknowledge receipt of the notification; and (b) either inform Hamaspik that there is no conflict with OMIG activities or alert Hamaspik to stop the audit if a conflict exists. If there is no response from OMIG, Hamaspik will proceed with its audit. Similarly, OMIG will notify Hamaspik of its intention to initiate an audit of a

participating provider or non-participating provider. Within ten (10) business days of receipt of such a notice from OMIG, Hamaspik will acknowledge the notice and will inform OMIG if it has any audits in process for the provider. Once Hamaspik is notified of an OMIG audit, it will not undertake an audit of the same provider, independent of OMIG. In addition, Hamaspik will cooperate with the OMIG audit, including the provision of copies of any records that are requested.

If Hamaspik refers a potential care of fraud or abuse to OMIG, Hamaspik may be eligible to share in the recovery. The shared amount will be comprised of non-federal funds, and will be not less than 1% and not more than 10% of the total recovered amount. It will be based on the extent to which Hamaspik has contributed to the investigation, and the amount will be solely determined by OMIG.

OMIG or DOH shall have the right to request that Hamaspik recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest and collection fees, from a Participating Provider. In such cases, Hamaspik shall remit to DOH, all amounts collected from the Participating Provider, but may retain the collection fee (as set by DOH or OMIG) upon collection of the full amount owed to the Medicaid program. Consistent with Article VII, Section F.6. of the Agreement with DOH, OMIG will only request that the Contractor recover an overpayment, penalty, or other damage where there has been a final determination that these funds are owed to the State.

In addition, OMIG may enter into an agreement with Hamaspik to conduct a combined audit or investigation of a participating provider, non-participating provider, or other subcontractor. Such agreement will be executed prior to the commencement of the audit, and the sharing of any recovered (non-federal) funds will be outlined in the agreement.

In addition, if directed by OMIG, DOH, or other regulatory authority, Hamaspik will withhold payments to participating providers and other providers. Payments may be withheld in whole or in part, and will be based on the determination by OMIG, DOH, or other regulatory authority that the provider is the subject of a pending investigation of a credible allegation of fraud. Hamaspik will commence withholding of payments as soon as possible upon receipt of direction by OMIG, DOH, or other regulatory authority, and no more than five (5) business days from the receipt of notification.

Appendix 1: Health Care Proxy

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/ or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor

cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosingonepersontoavoidconflictorconfusionamongfamilymembersand/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non- health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/ or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally

separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; a guardian appointed by a court prior to the donor's death; or another person authorized to dispose of the body.

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments.

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments.

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Surgical procedures
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I,

_____

hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____

_____

(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature_____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues
☐ The following organs and/or tissues_____
_____

☐ Limitations

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1
Date _____

Name *(print)* _____

Signature_____

Address _____

Witness 2
Date_____

Name *(print)* _____

Signature _____

Address _____

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

Appendix 2: New York State Communicable Disease Reporting Requirements

NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given[1]
Anthrax[2]
Arboviral infection[3]
Babesiosis
Botulism[2]
Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Coronavirus (severe or novel)
2019 Novel Coronavirus (COVID-19)
Severe Acute Respiratory Syndrome (SARS)
Middle East Respiratory Syndrome (SARS)
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli O157:H7 infection[4]
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis[2]
Meningitis
Aseptic or viral
Haemophilus
Meningococcal
Other (specify type)
Meningococcemia
Monkeypox
Mumps
Pertussis
Plague[2]
Poliomyelitis
Psittacosis
Q Fever[2]
Rabies[1]
Rocky Mountain spotted fever
Rubella (including congenital rubella syndrome)
Salmonellosis
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia[2]
Typhoid
Vaccinia disease[9]
Vibriosis[6]
Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person_____

Name_____

Address_____

_____

Phone_____ Fax_____

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call:
  (212) 442-3388

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1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥ 1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439 or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOH1.
To obtain reporting forms (DOH-389), call (518) 474-0548.

PLEASE POST THIS CONSPICUOUSLY