Medicare Advantage Special Needs Plan with Prescription Drug Coverage

Provider Manual
California

Effective June 2017

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Section 1: Introduction

Thank you for your participation in PHP (formerly known as Positive Healthcare Partners), a Medicare Advantage special needs health plan with prescription drug coverage for Medicare beneficiaries who are HIV-positive. As a Provider, you play a critical role in the delivery of healthcare services to our members.

This manual contains information to assist you and your staff to provide appropriate covered services to our members when they are needed. The manual outlines Provider requirements and describes what you can expect from PHP. PHP is regulated by the Centers for Medicare and Medicaid Services (CMS).

This manual is provided for the convenience of Provider's participating in PHP. Nothing in this manual shall guarantee coverage of any service, treatment, drugs or supplies, because coverage is governed exclusively by the member evidence of coverage document.

As a PHP participating Provider, you are required to comply with applicable Medicare policies, procedures, laws and regulations. The contents of this manual are supplemental to your Provider agreement and its addendums. Should the contents of this Provider manual conflict with your Provider agreement, the agreement shall supersede the manual.

We look forward to working with you and your staff to provide quality managed healthcare services to PHP members.

Section 2: How to Contact Us

Administrative Office:
PHP
1001 N. Martel
Los Angeles, Ca. 90046
Tel: (323) 436-5000
Fax: (323) 436-5033

After-Hours Nursing Advice Line:
Tel: (800) 797-1717

Case Management:
Tel: (800) 474-1434
Fax: (323) 436-5032

Claims Department:
Tel: (888) 662-0626
Fax: (323) 337-9146

Claim Submissions:
Attn: PHP-CA Claims
P.O. Box 7490
La Verne, CA 91750

Credentialing:
Tel: (323) 436-5019
Fax: (323) 337-9142

Eligibility:
Tel: (800) 263-0067
Fax: (323) 436-5034

Member Services:
Tel: (800) 263-0067
Fax: (323) 436-5034

Pharmacy Benefit Line:
Tel: (866) 763-9096
Fax: (877) 243-3536

Provider Relations & Contracting:
Tel: (888) 726-5411
Fax: (323) 436-5033

Quality Management:
Tel: (323) 337-9164
Fax: (888) 235-7425

Transportation Services:
Tel: (800) 263-0067

Utilization Management
(Prior Authorizations)
Tel: (800) 474-1434
Fax: (888) 272-7656

Language Line (interpretation)
Tel: (888) 263-0067

Section 3: Member Enrollment and Eligibility

Enrollment Periods

PHP determines enrollment effective dates based on election periods defined by the Centers for Medicare & Medicaid Services (CMS). The following periods apply for enrollment:

Annual Election Period (AEP)	Occurs October 15 to December 7 every year. The AEP is also referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage and Medicare prescription drug coverage" in Medicare beneficiary publications and other tools. During the AEP, Medicare Advantage eligible individuals may enroll in or dis-enroll from a Medicare Advantage plan.
Initial Election Period (IEP)	Begins three (3) months before an individual becomes entitled to both Medicare Parts A & B, and ends on the later of a) the last day of the month preceding entitlement to both Part A and Part B, or; b) the last day of the individual's Part B initial enrollment period. The initial enrollment period for Part B is the seven (7) month period that begins three (3) months before the month an individual meets the eligibility requirements for Part B, and ends three (3) months after the month of eligibility.
Medicare Advantage Dis-enrollment Period (MADP)	Medicare Advantage plan enrollees have an annual opportunity to prospectively dis-enroll from any Medicare Advantage plan and return to Original Medicare between January 1 and February 14 of every year.
Special Election Period (SEP)	The SEPs include various circumstances, such as (a) a permanent move into or out the service area, (b) the Medicare Advantage contract is terminated, (c) the member demonstrates that the Medicare Advantage organization violated the contract or misrepresented the Plan when marketing the Plan, or (d) the beneficiary meets other exceptional conditions that CMS may provide, such as eligibility for a special needs Plan.

Member Enrollment

Individuals interested in joining PHP must meet the following conditions:

- A documented HIV-positive diagnosis
- Medicare eligibility (both Parts A & B)
- Resident of the health plan's CA service areas: Los Angeles County.

PHP receives and processes applications according to CMS guidelines for timeliness and appropriate handling of information. The Plan will not deny or discourage enrollment on the basis of health status, except for End Stage Renal Disease (ESRD).

PHP accepts applications for enrollment through its sales agents' in-person meetings with Medicare beneficiaries as well as applications completed online and by telephone. The health plan must obtain verification of HIV-positive status for eligibility within 30 days of enrollment and obtains written consent from applicants granting the Plan permission to contact their physician for confirmation of HIV-positive status.

Upon enrollment, applicants are required to select a network primary care provider (PCP). The PCP is responsible for providing and coordinating all of the member's care. By enrolling in the Plan, the member agrees to obtain all covered benefits from his or her PCP and other Plan participating providers, except for emergency or out-of-area urgently needed services.

Medicare beneficiaries interested in joining PHP should contact the Plan's Member Services Department at (855) 318-4387. TTY users should call 711. Member Services is available 8:00 a.m. to 8:00 p.m., seven days a week. Member Services has interpreters available to assist non-English speaking callers.

New Member Notification

Upon confirmation of enrollment from CMS, PHP sends the enrollee a notice confirming new enrollment and a new member welcome packet comprised of the Plan's Evidence of Coverage, Provider and pharmacy directories, notice of privacy practices, member ID card, Advance Directive form, and other member education materials. The Plan mails the enrollment confirmation notice and new member welcome packet within ten (10) days of receipt of enrollment confirmation by CMS.

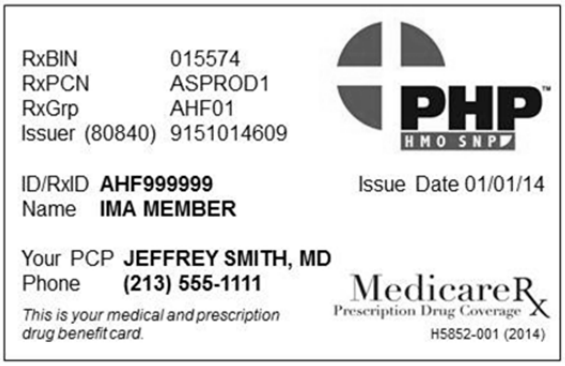
Member Identification Number

PHP has developed a unique identification (ID) number for all its members. The member ID number is a nine-character alphanumeric code, beginning with "AHF."

Provider-oriented materials, including eligibility reports and other health plan correspondence, include the member ID numbers for identification purposes. Providers should submit the member ID number on all claims or correspondence to PHP.

Member Identification Card

PHP members receive an ID card containing information that helps you process claims accurately. A sample card is shown below. Be sure to check each member's ID card at each visit. Providers should retain a copy of the member's ID card for reference.



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Eligibility Reports for Primary Care Providers

At the beginning of each month, PHP sends each PCP a member eligibility report, which is a computerized listing of Plan members known to be eligible for coverage and assigned to the PCP for the month of the report.

A member may not appear on the eligibility report for the following reasons:

- A member requests to transfer to a new PCP after the eligibility report is run and distributed for the month
- The Plan made a retroactive transfer to another PCP
- A newly enrolled member whose enrollment information has not yet been fully entered into the eligibility system.

Eligibility Verification

When a person seeks medical attention from a PCP—hospital or other Provider that Provider must attempt to determine eligibility with PHP before providing care.

The health plan verifies member eligibility at the time it issues an identification (ID) card; however, possession of the card does not guarantee eligibility. In cases where a member has lost an ID card or where eligibility may be in question, Providers may verify eligibility by referring to the current month's Member Eligibility Report (applies to PCPs only) or contacting Member Services at (855) 318-4387, option 2. Member Services is available 8:00 a.m. to 8:00 p.m., seven days a week.

Enrollment Effective Dates

Effective date of enrollment into all Medicare Advantage plans, including PHP, is the first day of the calendar month.

Primary Care Provider Changes

Members may contact Member Services at (855) 318-4387, 8:00 a.m. to 8:00 p.m., seven days a week, to change their PCP or to choose a PCP. TTY users should call 711.

Voluntary Dis-enrollment

Members requesting to dis-enroll from the Plan must contact Member Services to request a dis-enrollment form. Members must complete and sign the form and return it to Member Services to complete the dis-enrollment process. By dis-enrolling through PHP, members are leaving the Plan to go to Original Medicare (fee-for-service). Member Services can be reached at (855) 318-4387, 8:00 a.m. to 8:00 p.m., and seven days a week.

Members may also dis-enroll by calling 1-800-MEDICARE or by enrolling in another Medicare Advantage health plan or Medicare Advantage prescription drug (Part D) plan. If a member enrolls in another Medicare Advantage plan, the member is automatically dis-enrolled from PHP the day before membership in the new Plan becomes effective.

A member may only dis-enroll from PHP during one of the specified election periods, unless he or she is dually eligible (eligible for both Medicare and Medicaid).

The correct dis-enrollment date is determined by the election period as defined by CMS. PHP will send the dis-enrolling member a letter confirming the dis-enrollment or, if applicable, a notice of CMS rejection of dis-enrollment (due to the election period) within ten (10) days of receipt of the reply from CMS.

Dis-enrollment Effective Dates

Effective date of dis-enrollment from all Medicare Advantage plans, including PHP, is the last day of the calendar month.

Involuntary Dis-enrollment

PHP does not, verbally or in writing, or by any action or inaction, request or encourage a member to dis-enroll except for the following circumstances where it retains the right to pursue dis-enrollment:

- **Failure to pay monthly premiums**
  If a member pays a monthly premium, the Plan has the right to dis-enroll him or her for non-payment of premiums. Prior to dis-enrollment, the Plan must advise a member that failing to pay the premium subjects him or her to involuntary dis-enrollment.
- **Move outside of the geographic service area of the Plan**
  When the Plan confirms that a member has permanently moved outside the service area, it must dis-enroll him or her. When a member is temporarily outside of the Plan's service area for a period of six (6) months or longer, it is also required to dis-enroll him or her. PHP will attempt to contact the member or authorized representative to verify residency before initiating dis-enrollment.
- **Fraud or abuse of member benefits**
  If a member knowingly provides fraudulent information that materially affects the determination of an individual's eligibility to enroll in the Plan and/or intentionally permits others to use his or her enrollment card to obtain services or supplies from the Plan or any authorized Plan Provider, the Plan will dis-enroll the member.
- **Loss of Medicare Part A or Part B entitlement**
  If a member loses Medicare Part A and/or Part B entitlement, the Plan sends a notice to the member or authorized representative of impending dis-enrollment.
- **Disruptive, Abusive, Aggressive or Threatening Behavior**
  Should a PHP enrollee exhibit disruptive, abusive, aggressive or threatening behavior in your or your staff's presence, please advise the

Plan's Provider Relations Department without delay by calling (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. In addition, please carefully and thoroughly document the incident when our enrollee behaved in an inappropriate manner in the enrollee's medical record. Please also document the steps you or your staff took to address the enrollee, intervene and correct his or her behavior, which includes referring the enrollee to a behavioral health provider or back to the enrollee's primary care provider (PCP).

Providers may refuse to provide service to enrollees who repeatedly act in a disruptive, abusive, aggressive or threatening fashion only after consulting with Provider Relations so the Plan can assist you or your staff in working with the enrollee to remedy the cause of the inappropriate behavior or make alternative arrangements for the enrollee's care.

Upon notification by a Provider that an enrollee has acted in an inappropriate manner in your or your staff's presence, the Plan will issue a warning letter to the enrollee that advises him or her that continued inappropriate behavior will be grounds to pursue involuntary dis-enrollment subject to the approval of CMS. Any follow-up interactions and/or interventions with the enrollee related to his or her inappropriate behavior must be thoroughly documented in the enrollee's medical record. This information will be required by the Plan should it submit a request to CMS for an enrollee involuntary dis-enrollment for inappropriate behavior.

Dis-enrollment is effective the first day of the calendar month after the month in which notice is sent to the member of the intended action.

Retroactive Dis-enrollment

PHP may process retroactive dis-enrollments for the following reasons:

- Enrollment information was incomplete or inaccurate
- The individual did not meet eligibility requirements at the time of enrollment (i.e. negative HIV/AIDS diagnosis, eligibility for both Medicare parts A and/or B, etc.)
- Death of member
- Member did not intend to enroll
- Member's permanent move out of the Plan's service area

A written request for retroactive dis-enrollment must be submitted to Member Services by the member or authorized representative. Members requesting retroactive dis-enrollment should first call Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

Section 4: Covered Services

Covered Services, Limitations and Member Cost – Plan Year 2017

PHP's Plan benefit package and enrollee cost sharing is subject to change every year. To see the current Plan benefit package, please refer to Chapter 4 of the current year's Evidence of Coverage. Go to www.php-ca.org/for-providers/publications.

Optometric and Vision Services

PHP covers one routine eye exam every year and eyeglasses and/or contact lenses (up to $100 per year). PHP offers vision services through a contracted network whose Providers are listed in the PHP Provider Directory.

Transportation Services

PHP provides transportation to and from Provider offices for visits and other medical appointments if members need it up to 12 round-trips a year. Members should call (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week, to schedule a ride. TTY users should call 711. This service is not for emergencies.

Dental Services

PHP covers preventive services which include: oral exams; two cleanings, fluoride treatments and dental X-rays every year. In addition a yearly maximum dollar benefit is offered for additional dental services. The Plan offers dental services through its participating dental network. Members should consult the PHP Provider Directory to find participating dentists. Members may access services without a referral. Note that the dental benefit limit varies from Plan year to Plan year. To verify dental benefit limits for future years, please contact member Services at (800) 263-0067, Monday through Friday, 8:30 a.m. to 5:30 p.m. or visit http://positivehealthcare.net/california/php/for-providers/publications to download the most current Provider manual.

Section 5: Pharmacy

The management of outpatient prescription drugs is an integral part of the medical management program to improve the health and well-being of PHP members. Prescriber and member involvement is critical to the success of the pharmacy program. To help your patient get the most out of his or her pharmacy benefit, please be cognizant of the following guidelines when prescribing:

1. Follow national standards-of-care guidelines for treating conditions i.e., DHHS Guidelines for the Use of Antiretroviral Agents, NIH Asthma guideline
2. Prescribe drugs from the formulary
3. Prescribe generic drugs when therapeutic equivalent drugs are available
4. Evaluate medication profile for appropriateness and duplication of therapy

Generic drugs are equally effective and generally less costly than the brand medication. Generic drug use can contribute to cost-effective therapy and must be dispensed by the pharmacist when a therapeutically equivalent to a brand name drug is available.

Formulary Purpose

PHP pharmacy benefits cover medications that are listed in the PHP Formulary. The formulary is the foundation of the PHP pharmacy benefit. The formulary is a continually revised compilation of drugs, which reflects the current clinical judgment of the PHP Pharmacy and Therapeutics Committee. The goal of the formulary is to provide safe, efficacious and cost-effective drug therapy. PHP adheres to Medicare Part D regulations and requirements in the development, maintenance and oversight of its formulary. The PHP Formulary is available at: www.php-ca.org/for-providers/publications.

The PHP Pharmacy and Therapeutics Committee serves as the governing body for the formulary. The committee is comprised of medical personnel, including practicing physicians and pharmacists, whose primary purpose is to develop and monitor the formulary in accordance with Medicare Part D requirements and guidelines, and to establish programs and procedures promoting quality and cost-effective drug therapy.

Prescribing Policies

To maintain standardization throughout the program, Providers must follow the prescribing guidelines listed as follows:

1. Each prescription should be for one patient only, or if for more than one patient (e.g. family) each family member's name should be on the prescription.
2. The formulary should be used as a guide to selecting cost-effective medications for members. Prescriptions for non-formulary agents are subject to a prior authorization review process.
3. Patients being tested on a new drug or new drug regimen should be given only sufficient amounts to provide for the trial period.
4. Physicians should prescribe generic substitutions, unless certain patient criteria are met which would allow for coverage of the brand name or non-formulary drug.

Prescription Drug Prior Authorization

PHP has a "Prior Authorization and Exceptions" process in place to provide for coverage of non-formulary medications and for those medications listed in the formulary as requiring prior authorization (PA). The Pharmacy Services staff will adhere to PHP Pharmacy and Therapeutics Committee-approved criteria, National Pharmacy and Therapeutics (NPTC) practice guidelines and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines, and referring cases to clinical pharmacists or physicians in accordance with standing procedures. The current description of "Prior Authorization Requirements" with detailed criteria is available under Provider Materials on the PHP website at: http://positivehealthcare.net/california/php/for-providers/publications.

Non-Formulary and Non-Covered Medications

The exceptions process applies to all non-formulary medications. "Formulary" medications are covered as a pharmacy plan benefit. "Non-formulary" prescriptions are generally not provided as a Plan benefit. "Non-covered" medications are generally excluded from coverage. Examples of Medicare Part D non-covered medications include:

- Weight loss & weight gain drugs
- Agents for cosmetic purposes (i.e. treatment for wrinkles, hair growth)
- Over-the-counter (OTC) medications or agents
- Fertility Drugs
- Vitamins/Minerals (except for pregnancy use)

Covered Medications

All dosage forms and strengths of drugs listed on the formulary are eligible for coverage unless specified otherwise. The formulary applies only to medications obtained through outpatient community pharmacies and does not apply to drugs used in the hospital or while in a skilled nursing facility.

Prescriber Request for Non-Formulary Medications

The physician or a designated employee or individual making the request for a non-formulary drug must:

1. Be under the direction and control of the physician
2. Be located in the physician's office or other site where the member is receiving medical services
3. Not delegate the prior authorization function to a third party who is not located at the physician's office or other site where the member is receiving medical services
4. Include specific information related to the member's medical condition in the prior authorization request
5. Provide all of the information requested for the non-formulary drug before PHP approves the exception

PHP will communicate with the physician or a designated employee or other individual under the direction and control of the physician, regarding whether or not the non-formulary drug will be covered. The determination will be made within 48 hours of receipt of all of the necessary information requested.

If a member is stabilized on a non-formulary drug previously approved for coverage by the Plan, the physician can continue the therapy without further prior authorization if the drug is medically necessary. Non-formulary medications may be authorized when one of the following criteria is met:

- The requested non-formulary prescription has limited efficacy and relatively high incidence of side effects but indication for specific disease management meets criteria outlined in the National Pharmacy and Therapeutics Committee (NPTC) Guidelines
- Documented failure of a therapeutic trial of a formulary agent(s)
- The formulary alternative(s) is/are contraindicated for treatment
- The member is currently maintained and stabilized on a non-formulary medication previously approved by the Plan that is not excluded from coverage.

- The member experienced allergic reaction(s) to the formulary alternative(s) (e.g. rash, urticaria, drug fever, anaphylactic type, or established adverse effects as published in the package insert(s) of respective product(s) relating to the pharmacological properties of the medication(s), formulations or differences in absorption, distribution, or elimination of the medication(s)
- The prescriber provides compelling medical evidence supporting the use of the requested non-formulary medication over the formulary agent(s) where the requested therapeutic class is necessary for medical management

The following information is required to evaluate each case prior to issuance of an authorization:

1. Member Name
2. Member ID#
3. Member Birth date
4. Member Gender
5. Prescriber Name
6. Prescriber Specialty
7. Prescriber Address
8. Prescriber Phone/Fax Number
9. Name and dosage strength of the requested medication
10. Directions for use
11. Diagnosis
12. Date patient started on the non-formulary medication
13. Name of specific drugs tried and failed
14. Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice
15. Any other compelling medical information that would support the use of the non-formulary medication over a formulary alternative

A written communication of case resolution is faxed to the Provider for each case serviced. If prior authorization is approved, the medication will be covered. If prior authorization is denied the member is responsible for paying the cost of the prescription.

A copy of the PHP Authorization Request form is included in Section 36 (Forms) of this manual. Please make additional copies of the Authorization Request Form as needed for your use.

To request prior authorization for a non-formulary drug, please call the Pharmacy Services Department at (888) 436-5018, or fax the completed Authorization Request form to (888) 238-2244.

Section 6: Model of Care Program

To align with ongoing advancements in evidence-based healthcare delivery, PHP launched its Model of Care to address the special needs of people living with HIV/AIDS (PLWHA). The Centers for Medicare & Medicaid Services (CMS) require that health plans designated as Special Needs Plans provide an approved Model of Care to deliver coordinated care and case management for Plan enrollees.

Model of Care

Our Model of Care – Chronic Care Program (CCP) – is built on a Health Home philosophy that fosters relationships with members, Providers and the community. These relationships promote the engagement and integration in the processes of care. The Chronic Care Program serves to improve the administration, delivery and experience of care through these elements:

- Efficient utilization of resources
- Member education and self-management
- Effective management of services (e.g. inpatient, ambulatory, pharmacy and behavioral health)
- Promotion of patient-centered medical home with PCP
- Coordination and transition of care
- Multidisciplinary approach to comprehensive care
- Evidence-based practice
- Linkage with community resources
- Monitoring and improving quality of care

Care Management

Upon enrollment all Plan members are assigned to an RN Care Manager (RNCM) who assesses health status and psychosocial needs and assigns the severity level (SL). This assessment is provided by the RNCM in the member's home, care facility or Health Home primary care clinic. Follow-up occurs on a clearly defined schedule determined by member acuity. The RNCM and primary care provider create and implement the Individualized Care Plan (ICP) with the member and caregivers. Other members of the Interdisciplinary Care Team include the LVN Care Team Partner, Care Coordinator, Medical Social Worker and Pharmacist who also assist in the coordination of care and treatment planning. Increases in acuity result in increased intensity of care management under the direction of the RNCM.

Disease Management Background and Program Overview

In 1999, AHF implemented the nation's first and only HIV/AIDS Disease Management (DM) Program for the Florida Agency for Health Care Administration Medicaid. In 2005, AHF received the first HIV/AIDS Disease Management accreditation by the National Committee for Quality Assurance (NCQA). Today, the AHF DM Program is one of the only HIV accredited disease management programs in the nation.

AHF's DM Program is completing its 12th year in the implementation of best practice, evidence-based, disease management that improves enrollees' health, addresses co- morbidities, promotes member empowerment in taking an active role in their health care management, emphasizes adherence to the medical plan of care and medication regimens, and promotes disease management through motivational interviewing techniques, while consistently demonstrating cost savings and improved health outcomes and health resource utilization.

Health Risk Assessment

Acuity level is determined by the initial and annual health risk assessment (HRA). The assessment tool combines a traditional Health Risk Assessment (HRA) with additional information specific to needs of PLWHA. The RNCM conducts a comprehensive face-to-face or telephonic interview with the member within 90 days of enrollment, and annually thereafter. Targeted assessments are performed as needed. Members are assigned a stratified severity level (SL) of (1), (2), or (3) based on health status and risk. The SL determines intensity of care management, with higher acuity care follow-up assigned to RNCM (SL-3), LVN Care Partner (SL-2) or Care Coordinator (SL-1).

An important aspect of the HRA is a medication review for the Medication Therapy Monitoring Program (MTMP). Upon assessment the RNCM reviews all medications and OTC products with the member. The member's knowledge level about medications and medication taking behavior is assessed. The member receives a Medication List with information and Medication Action Plan that guide the member's treatment regimen.

Individualized Care Plan

The HRA informs the RNCM about the direction of the Individualized Care Plan (ICP). The RNCM develops the ICP in collaboration with the member using a problem/intervention framework. Follow-up on the care plan interventions occurs

at least quarterly and is determined by the SL stratification.

Interdisciplinary Care Team

PLWHA often have complex healthcare regimens, which benefit from a team-based approach to care management, coordination of care, and care transitions. Our Interdisciplinary Care Team (ICT) is comprised of the primary care provider, Health Home staff, RNCM, LVN/LPN Care Partner, Care Coordinator, Pharmacist, Utilization Management Nurse, Medical Social Worker and Authorization Coordinator. Every team meets at least monthly in the local Health Home where the member receives services.

Provider Expertise and Clinical Guidelines

Our Health Home primary care providers serve as gatekeepers for specialty referrals. Most are board-certified HIV disease specialists. PHP looks to all Providers to collaborate on the ICP with care managers and other members of the ICT and maintain member-specific documentation in the medical record. The ICT works together to ensure that Plan member information and resources are coordinated to manage HIV/AIDS and other concomitant chronic conditions (e.g., mental status changes, metabolic syndrome and co-morbidities). PHP offers CME Provider training about current clinical guidelines.

Medication Therapy Management Program

Medication adherence is essential for the management of HIV/AIDS and related co-morbid conditions. Members who demonstrate difficulty in adherence receive intensive interventions by professional nursing, pharmacist, and social services staff, in addition to their primary care providers. PHP uses the team approach in its MTMP program to reduce the risk of medication errors and reactions with this special needs population of people with HIV/AIDS and multiple chronic conditions and complex medication regimens. The 2017 CMS approved MTMP outcome measures include: Part D Reporting Requirements; Over/Underutilization; HIV Medication Adherence Measure (PDC). The Medication Therapy Management Program (MTMP) is a component of the PHP Model of Care. The MTMP offers the following services to all beneficiaries regardless of setting.

1. Comprehensive Medication Review (CMR)
2. Targeted Medication Reviews
3. Licensed Pharmacist consultation for all medical providers and clinical care management staff for consultation as needed.
4. The Plan RNCM communicates and documents interventions and/or

updates via the electronic care management system.

5. For beneficiaries in Long Term Care (LTC) settings, CMR will be offered at least annually.

In the event a member in any setting chooses to decline the CMR or cannot be reached, the Plan performs programmatic quarterly targeted medication reviews to evaluate the Plan member's medication use and offer any interventions to the prescribing Provider.

Outcomes Measurement

Success of the Chronic Care Program is determined by its impact on the individual. Outcomes evaluation utilizes quality assessment tools such as: Medicare Health Outcomes Survey (HOS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), and internal performance data. Performance is measured using multiple indicators in these core improvement areas:

- Satisfaction with access to health and social services
- Access to affordable care
- Coordination of care
- Assuring appropriate utilization of services
- Health outcomes
- Transition of Care

Special Needs Plans & Model of Care Provider Training

Special Needs Plans were created as part of the Medicare Modernization Act of 2003. A SNP is a Medicare Advantage plan approved to target a specific population based on its special needs. As of November 1, 2010, any Medicare beneficiary can qualify for enrollment in one of these SNP types:

- Severe or disabling chronic condition including HIV/AIDS (C-SNP);
- Dually eligible for Medicare and Medicaid benefits and services (D-SNP) ;
- Institutionalized or institutional equivalent residing in the community (I- SNP).

Chronic condition SNPs, (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs can focus on monitoring health status, managing chronic diseases, avoiding preventable hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. PHP is an approved Medicare C-SNP (Part C & D).

The SNP Model of Care is the architecture for our care management policy, procedures and operational systems. PHP is required to provide initial and annual Model of Care (MOC) training to all contracted medical providers. This training requirement is mandated by CMS and must be completed by December 31st of each year.

In accordance with this requirement, PHP offers the SNP Model of Care Annual Training for Provider s. This training can be provided on-site at your office by a PHP Provider Services Representative, through written training materials, which are available on our website: www.positivehealthcare.org or through PHP's Provider Relations Department. To schedule on-site training or to request copies of the written training materials, contact the Provider Relations Department at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Providers are required to sign an attestation form as evidence of receiving education and training on PHP's Model of Care.

IMPORTANT:

This is only an overview of PHPs Model of Care. More detailed information is available at http://positivehealthcare.net/california/php/for-providers/publications/ or by calling the Provider Relations Department at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. For the CMS overview of Special Needs Plans, go to www.cms.gov/SpecialNeedsPlans.

Section 7: Primary Care Provider Information

Responsibilities

Below is a summary of responsibilities specific to primary care providers (PCPs) who provide services to Plan members. Please refer to these responsibilities and the responsibilities outlined for all physicians:

- Accept and manage patients who have chosen that physician as their primary care provider
- Perform services normally in his or her scope of practice
- Utilize a standardized formal assessment instrument for HIV, during initial and subsequent patient assessments to:
  - Identify members who require behavioral health and substance abuse services
  - Determine the types of behavioral health and substance abuse services that should be furnished
- Accept Care Management responsibilities
- Coordinate/manage patient's care for specialty providers or other healthcare services
- Contact members to encourage them to obtain health assessment and preventative care
- Participate and abide by all decisions regarding member complaints, peer reviews, quality improvement, and utilization management programs
- Agree to provide or arrange coverage of services, consultation or approval for referrals 24 hours/day, seven (7) days /week by Medicare enrolled Providers, who will accept Medicare reimbursement. Coverage must be provided by a Medicare eligible PCP with demonstrated experience in the provision and management of medical and psychosocial health care for persons with HIV/AIDS.
- This coverage must consist of an answering service with call forwarding or Provider call arrangements. The 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be available using the medical office's daytime telephone number. The call must be returned by the PCP or covering medical professional within 30 minutes of the initial contact.
- In the event significant medical advice is given to a member by telephone, including medical advice provided by after-hours telephone information services or after-hours triage service providers, the Provider's medical

record will detail such advice and must be appropriately signed or initialed by the Provider.
- Provide direction and follow-up care for those members who have received emergency services.
- Accept and participate in peer review
- In the context of an emergency requiring hospitalization, the Provider will evaluate, stabilize, and facilitate transfer of the member to the appropriate care setting. The Provider shall ensure a detailed procedural Plan for handling medical emergencies.

Domestic Violence Screening

Primary care providers should screen members for signs of domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, dating abuse, and intimate partner violence (IPV), and offer referral services to applicable community agencies if needed. Community agencies for domestic violence referrals are located in Section 35 (Community Based Resources) of this manual. A short domestic violence screening tool is available at: www.orchd.com/violence/documents/HITS_eng.pdf.

Should a member need assistance accessing domestic violence resources, please direct him or her to contact PHP's Member Services at (855) 318-4387 for assistance. Member Services is available 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

Elderly and Disabled Abuse and Mistreatment

Primary care providers are to screen elderly and disabled members for signs of abuse and mistreatment and offer referral services to applicable community agencies, if needed. Elder and disabled abuse and mistreatment can occur in the member's home or in an institution. Forms of abuse and mistreatment include:

- Abandonment
- Emotional abuse
- Exploitation
- Neglect
- Physical abuse
- Sexual abuse

Should a member need assistance accessing elder and disabled abuse and mistreatment resources, please direct him or her to contact PHP's Member Services at (800) 263-0067 for assistance. Member Services is available 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

Alcohol and Substance Abuse Screening

Primary care providers should screen members for signs of alcohol and substance abuse and offer referral services to applicable community agencies if needed as part of preventative evaluation at the following times:

- Upon initial contact with member
- During routine physical examinations
- During initial prenatal contact
- When the member evidences serious over-utilization of medical, surgical, trauma or emergency services
- When documentation of emergency room visits suggests the need

Valid and reliable screening tools should be employed when screening for alcohol and substance abuse. The DAST-10 screen for drug abuse and AUDIT tool for alcohol abuse used in tandem can identify members for referral to treatment. These tools can be found at http://info.dhhs.state.nc.us/olm/forms/dss/dss-8218.pdf.

Should a member need assistance accessing alcohol and/or substance abuse resources, please direct the member to contact PHP's Member Services at (800) 263-0067 for assistance. Member Services is available 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

Tobacco Cessation

PHP offers a tobacco cessation program, *Quit for Life*, that will help members break both the physical and psychological addiction to cigarettes.

Primary care providers (PCPs) should screen and educate members regarding tobacco cessation by:

- Making members aware of and recognizing dangers of using tobacco products
- Teaching members how to anticipate and avoid temptation
- Provide basic information to the member about tobacco use and successful quitting
- Encourage the member to quit
- Encourage the patient to talk about the quitting process

PCPs should direct members who smoke or desire to quit using tobacco to contact the *Quit for Life* Program:

Call: 1-866-784-8454 (1-866-QUIT-4-LIFE)
Join online: www.quitnow.net/ahf

Instruct the member to tell the operator they are a PHP member. For more information, members can contact Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week TTY users should call 711.

Family Planning Services

Family planning services may be provided by any Florida Medicare provider. PHP members do not need an authorization for these services and they do not need to use a PHP provider.

These services include:

- Information and referral for learning and counseling
- Diagnostic procedures
- Contraceptive drugs and supplies
- Medically needed sterilization and follow-up care

Family planning services must also include HIV-primary and secondary prevention and risk reduction services that include the following:

- Education and counseling regarding reduction of perinatal transmission
- Harm reduction education and services
- Education for members regarding STDs
- Services available for STD treatment and prevention
- Education and counseling specific to HIV prevention and transmission
- Counseling and supportive services for partners/spouses

Advance Care Planning

A primary care practitioner/provider is required to educate each Plan member 18years or older about Advance Directives. This must be documented in the medical record. The Member does not need to sign any Advance Directive but must be informed and educated about what is an Advance Directive. Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care. Evidence of advanced care planning must include:

- The presence of an Advance Directive care in the medical record, ***or***
- Documentation of an advance care planning discussion with the Provider *and* the date when it was discussed ***or***

- Notation that the member previously executed an advance care directive/plan.

PHP also provides an ongoing class, Five Wishes, to all members about advance care planning. The Five Wishes Workshops provide our clients with a safe and informative small group setting to ensure that the documents are completed correctly and completely. Please contact the Member Services at (800) 263-0067, Monday through Friday, 8:30 a.m. to 5:30 p.m. for more information.

Section 8: Specialty Care Provider Information

Responsibilities

The following is a list of specialist responsibilities:

- Accept and manage patients who have been referred by the member's primary care provider (PCP)
- Communicate treatment plans to the member's PCP in a timely fashion
- Perform services normally in his or her scope of practice
- Participate and abide by all decisions regarding member complaints, peer reviews, quality improvement and utilization management programs
- Accept and participate in peer review
- Obtain prior authorizations as outlined by PHP Utilization Management Department. See Part 4 (Covered Services) for a list of services requiring prior authorization by either the PCP or by PHP.
- In the context of an emergency requiring hospitalization, the Provider will evaluate, stabilize, and facilitate transfer of the member to the appropriate care setting. The Provider shall ensure a detailed procedural plan for handling medical emergencies.
- In the event significant medical advice is given to a member by telephone, including medical advice provided by after-hours telephone information services or after-hours triage service providers, the Provider's medical record will detail such advice and must be appropriately signed or initialed by the Provider.
- Provider will clearly document in member's medical records any diagnostic or therapeutic intervention as part of clinical research from non-research related care.

Provider Advice to Members

PHP does not prohibit or restrict a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member. Providers are expected to:

- Share findings of medical health status with members
- Educate members on health needs and discuss potential treatment options, including any alternative treatments that may be self-administered
- Provide sufficient information to allow an opportunity for the member to decide among all relevant treatment options
- Discuss risks, benefits and consequences of treatment or non-treatment
- Allow the opportunity for the member to refuse treatment and to express preferences about future treatment decisions

Providers must provide information regarding treatment options in a culturally-competent manner including the option of no treatment. Providers must also ensure that members with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

Diagnosis and Treatment of Tuberculosis

Providers are required by law to report all tuberculosis suspects and/or cases within 72 hours of diagnosis to the health department in the county in which the patient lives or your office is located.

Emergency Care

If a member has an emergency medical condition, call 911 or advise him or her to go to the nearest hospital emergency room.

Members may access emergency care anytime. They may go to a hospital out of network for emergencies, if necessary.

An emergency is defined as a condition that the member believes will cause any of the following if he or she does not receive treatment at once:

- Serious harm to his or her health
- Serious injury to the body
- Serious damage of a body part
- Serious damage of an organ

Some examples of emergencies may include:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Shortness of breath
- Broken bones

For pregnant women, these medical problems may be considered emergencies*:*

- Serious harm to their health or the health of her unborn baby

- If the member thinks there is not enough time to go to her doctor's regular hospital
- If the member thinks that going to another hospital may cause harm to her and/or her baby

Out-of-Area Emergency Care

If the member becomes ill while traveling, he or she should seek care and then call PHP's Member Services Department at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

PHP will cover follow-up care to emergency treatment that is medically necessary. Prior authorization is not required to receive this care regardless of whether the member receives this care within or outside of the PHP Provider network.

Emergency Transportation

Members should call 911 if they need emergency transportation to a hospital.

Clinical Access Standards

PHP is committed to timely access to care for all members. Access standards are developed to ensure that all health care services are provided in a timely manner. These standards are based on community norms. PHP monitors Provider compliance to the standards. The access standards below must be observed by all network providers.

Type of Care	Description	Standard
Preventive Exams	Periodic Health Evaluations with no acute medical problem	Within 30 Calendar Days of
Initial Health Assessment	All Ages	Within 120 Calendar Days from enrollment
Primary Care – Routine	Symptomatic, not requiring immediate diagnosis and/or	Within 14 Calendar Days
Urgent Care	Non-life threatening conditions that may lead to harmful outcome if not treated in a timely	Within 24 hours
Specialty Care - Routine		Within 14 Calendar Days
Emergency	Services for potentially life threatening conditions requiring	Immediate, 24 hours a

	medical intervention.	days per week
Office Waiting Room Time	Waiting Room time for Members with scheduled appointments once checked in.	Within 30 minutes

After-Hours Care

Providers must be available 24 hours a day, seven days a week. PHP requires a practitioner or a registered nurse under his/her supervision to maintain a 24-hour phone service, seven days a week. This access may be through an answering service after office hours. The service should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Missed Appointments

Providers are responsible for the follow up of missed appointments. Providers must have a process in place to follow-up on missed appointments that includes written policy and procedure and documentation of all Provider efforts.

Non-Covered Services

PHP members may be billed for non-covered services, such as cosmetic procedures and items of convenience if the Provider informs the member that the service is not covered, the member agrees to pay for the service and the Provider documents the member's agreement to pay for such services.

Provider Incident Reporting Requirements

In the event of an adverse or untoward incident that occurs to a PHP member whether occurring in a facility of one of the Plan's Providers or arising from health care prior to admission to a facility, which may result in:

- The death of a member
- Fetal death
- Severe brain or spinal damage to a member
- A surgical procedure being performed on the wrong member/wrong site
- Surgical procedure to remove foreign objects remaining from a surgical procedure
- Surgical repair of injuries from a planned surgical procedure

The incident must be reported to the PHP Quality Improvement Department. Please fax incident report to (888) 235-7425 Attn: RN Risk Manager.

Reporting Unusual Incidents on Provider's Premises

Unusual incidents that occur on the property of the Provider must be reported to the designated risk manager at that location. The following are examples:

In the event of an incident/injury to a member or visitor at a Plan Provider:

- Report the occurrence to the Office Administrator or risk management contact person in the office immediately
- If injury has occurred, obtain immediate medical
- assistance for visitor by physician or offer ambulance to nearest contracted Emergency Room
- Medical record will be completed and documented in compliance with the Plan's medical record keeping as for other members

In the event, a patient or visitor becomes abusive (physically or verbally) at the Plan's participating provider premises:

- Report occurrence to the Office Administrator or risk management contact person in the office immediately. Attempt to calm patient or visitor. Do not argue or disagree with the abusive individual(s).
- Notify police if patient/visitor is physically threatening
- Remove other patients or visitors from the immediate area
- Do not attempt to restrain abusive individual unless another person is placed in danger. If restraint must be used, every effort must be made to keep the abusive person from physical harm (it is recommended that two individuals be present to assist with abusive individual).
- In the event the abusive individual is a member, the attending physician should also be notified immediately
- The Provider's office notifies the Plan's Member Service Department of the incident, if appropriate

Other incidences that are required to be communicated to the Plan include:

- A slip or fall by a patient or family member
- Medication error
- Reaction requiring treatment
- A theft or loss from provider's office
- Malfunction or damage of equipment during treatment
- Accusations of malpractice by a patient or family member
- Non-compliance with potential to be life threatening.

Further reporting to the Plan's insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan's risk manager. Providers are reminded that serious negative events or incidences that occur in a Provider's office or facility must be reported to PHP. Please fax incident report to (888) 235-7425 Attn: RN Risk Manager.

Other Provider Requirements

As of May 2007, each Provider is required to have a National Provider Identifier (NPI) in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

Additionally, NPI numbers can be obtained for your practice site location as well as for your billing entity. Many health plans now look for additional NPIs to ensure claims are matched accordingly for your services. This is not required but is something you can consider, if it applies to you and your practice.

Section 9: Clinical Practice Guidelines

These are evidence-based guidelines utilized by PHP to help practitioners and members make decisions about specific clinical situations. Nationally recognized guidelines and standards are utilized in the development of PHP Clinical Guidelines from major sources including:

- US Preventive Services Task Force
- US Department of Health & Human Services (DHHS) Health Resources and Services Administration HIV/AIDS Bureau(HRSA-HAB)
- Agency for Healthcare Research & Quality (AHRQ)
- American Geriatric Society
- American Diabetes Association
- American Cancer Society
- American Academy of Pediatrics

HIV/AIDS Specific Treatment Guidelines

The foundation and gold standard of the evidence-based medicine guidelines are from the U.S. Department of Health and Human Services (DHHS) expert panel for antiretroviral treatment, tuberculosis treatment, treatment and prevention of opportunistic infections. These specific HIV/AIDS treatment guidelines are updated according to convening the DHHS expert panels:

- Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, June 6, 2017 (aidsinfo.nih.gov)
- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection, April 27, 2017
- Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States, June 6, 2017
- Treatment of Tuberculosis, April 5, 2016 (cdc.gov)
- Treating Opportunistic Infections Among HIV-Infected Adults and Adolescents, July 8, 2013
- USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus, September 4, 2009

The nationally recognized evidence-based guidelines include HIV/AIDS in the aspect to primary care and specifically for women. The following guidelines for

HIV/AIDS primary care are utilized from the Department of Health and Human Services in the Health Resources and Services Administration (HRSA):

- A Guide to Primary Care for People with HIV/AIDS, 2006 Edition
- A Guide to the Clinical Care of Women with HIV/AIDS, September 2013

HIV/AIDS medicine changes rapidly mostly on a quarterly basis with four international meetings that provide additional clinical information during the interim of updates to the DHHS guidelines. International Scientific Meetings provide interim science about HIV/AIDS and are considered in developing Medical Policy as appropriate:

- Inter-science Conference on Antimicrobial Agents and Chemotherapy (ICAAC)
- Infectious Disease Society of America (IDSA)
- International AIDS Society (IAS)
- Conference on Retroviruses and Opportunistic Infections (CROI)

Guidelines are formally reviewed & approved for use by the Utilization Management Committee and/or Medical Policy and Procedure Committee.

In addition, PHP utilizes McKesson's InterQual Criteria in the issuance of authorizations for services requiring PHP express pre-service or concurrent service authorization.

PHP contracted Providers may obtain copies of these guidelines by calling Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. – 5:30 p.m. You may also find them on-line for your ease of access and use.

Section 10: Adult Health Screenings

Providers should perform an adult health screening to assess the health status of members age 21 or older unless otherwise indicated. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

Adult Preventive Health Exam

Elements of a preventive health exam include:

1. Risk Screening Guidelines
   Screening to identify high-risk individuals, assessing family medical and social history is required. Screening for the following risks are included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs and TB.
2. Interval History
   Interval histories are required with preventive health care. Changes in medical, emotional, and social status are documented.
3. Immunizations
   Immunizations are documented and current. If immunization status is not current, this is documented with a catch up plan. Immunizations are required as follows:
   - Influenza annually
   - Hepatitis B
   - Tdap booster every 10 years
   - Pneumococcal vaccine beginning at age 65. When an individual has received a Pneumococcal vaccination prior to the age of 65 years and five (5) years has passed since the vaccination, he or she should be revaccinated.
4. Height and Weight
   Documented height and weight is required for all preventive health care visits and at least every five (5) years, ages 21-40 years, and every two (2) years beginning at age 41 years.
5. Body Mass Index (BMI)
   Documented body mass index (BMI) and weight for patients 18-74 during an outpatient visit during the current calendar year or year prior.
6. Vital Signs
   Pulse and blood pressure are required for all preventive health care visits and at least every five (5) years, ages 21-40 years, and every two (2) years beginning at age 41 years.

7. Physical Exam
   Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are:
   - general appearance
   - skin
   - gums/dental/oral
   - eyes/ears/nose/throat
   - neck/thyroid
   - chest/lungs
   - cardiovascular
   - breasts
   - abdomen/GI
   - genital/urinary
   - musculoskeletal
   - neurological
   - lymphatic

If non-compliance or refusal is documented, the risk associated with the non-compliance must be documented as well.

8. Cholesterol Screening
   Screening required every five (5) years for men beginning age 35, and women beginning age 45, earlier if any risk factor for cardiovascular disease.
9. Visual Acuity Testing
   Visual acuity testing, at a minimum, documents the patient's ability to see at twenty feet. Referrals for testing must be documented.
10. Hearing Screening
    Test or inquire about hearing periodically/once a year.
11. Electrocardiogram
    Periodically after age 40-50, or as primary care deems medically appropriate.
12. Colorectal Cancer Screening
    Colorectal cancer screening must be documented. Screening should begin at age 50 years. Risk factors: first-degree relatives or personal history of colorectal cancer, Gardner's syndrome, hereditary non-polyposis colon cancer, and chronic inflammatory bowel disease.
13. Pap Smear
    Baseline pap smears annually for three consecutive years until three consecutive normal exams are obtained, then every two to three (2-3) years. May stop at age 65 if a patient has had regular, normal smears up to that age.

14. Mammography
    Required as appropriate for age: baseline between ages 35 and 40. Every one to two (1-2) years for women age 40 or older. Earlier and/or more frequent for women at high-risk.
15. Prostate exam/screening
    U.S. Preventive Services Task Force, July 2012
    Recommends against PSA-based screening for prostate cancer (grade D recommendation).This recommendation applies to men in the general U.S. population, regardless of age. This recommendation does not include the use of the PSA test for surveillance after diagnosis or treatment of prostate cancer; the use of the PSA test for this indication is outside the scope of the USPSTF.

    American Urological Association, May 2013
    - PSA screening in men under age 40 years is not recommended.
    - Routine screening in men between ages 40 to 54 years at average risk is not recommended.
    - For men ages 55 to 69 years, the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment. For this reason, shared decision-making is recommended for men age 55 to 69 years that are considering PSA screening, and proceeding based on patients' values and preferences.
    - To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening. As compared to annual screening, it is expected that screening intervals of two years preserve the majority of the benefits and reduce over diagnosis and false positives.
    - Routine PSA screening is not recommended in men over age 70 or any man with less than a 10-15 year life expectancy.
16. Education/anticipatory
    Health education and guidance must be documented in the medical record. Guidance: educational needs are based on risk factors identified through personal and family medical history, social and cultural history and current practices.
17. Osteoporosis
    Screening for women age 65 and older; begin at age 60 if at increased risk for osteoporotic fractures. Perform DEXA Scan for serial monitoring every

two (2) years; special conditions may need more frequent monitoring. All peril-menopausal women should have a DEXA Scan after a fracture if test has not been performed recently.

Persistent Medications

Annual monitoring for patients on persistent medications, (at least 180 days) for persons ages 18 and older.)

Medications Examined	Annual Monitoring
ACE inhibitors/ARBs Digoxin Diuretics	Serum potassium (K+), and either serum creatinine (SCr), or blood urea nitrogen (BUN)
Anticonvulsants: Carbamazepine Phenobarbital Phenytoin Valproic acid	Anticonvulsant drug serum concentration

Glaucoma Screening

Medicare members without a prior diagnosis of glaucoma or glaucoma suspect receive a glaucoma eye exam by an ophthalmologist or optometrist.

Care of Older Adults

For those ages 66 and older, complete the following:

- Advance care planning
- Medication review, at least one per year
- Functional status assessment (basic instrumental activities of daily living)
- Comprehensive pain screening, with each visit

Section 11: Chronic and Complex Conditions

Comprehensive Diabetes Care

Diabetic Retinal Examinations — PHP is committed to reducing the incidence of diabetes-induced blindness in its members. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the health plan's primary care providers (PCPs) will provide or manage services such that recipients with a history of diabetes will receive at least one fundascopic exam every 12 months.

Glycohemoglobin Levels — PHP acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycohemoglobin is one laboratory indicator of how well a person's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the health plan's PCPs will provide or manage services such that members with a history of diabetes will receive glycohemoglobin determinations at least twice a year.

Lipid Levels — PHP recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the health plan's PCPs will provide or manage services such that members with a history of diabetes will receive lipid and lipoprotein determination annually. If any anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

Nephropathy

Primary care provider (PCP) will screen for nephropathy so as to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. PCPs will manage members who have a positive test for protein in the urine (micro-albuminuria testing). Members are to be monitored for the disease, including end stage renal, chronic renal failure and renal insufficiency or acute renal failure and referred to a nephrologist as deemed medically appropriate.

Congestive Heart Failure

PHP is aware that today there is effective options for treating congestive heart failure (CHF) and its symptoms. It also recognizes that with early detection, symptoms can be reduced and many heart failure patients are able to resume normal active lives. To further these goals, the health plan's primary care providers (PCPs) will provide or manage care of the CHF member by prescribing and monitoring an ace inhibitor, angiotensin II receptor blockers (ARB), and diuretic, and reviewing the contraindications of those medications prescribed. An echocardiogram should be performed annually and member should be instructed on nutrition and education ongoing of his or her disease.

Asthma

PHP recognizes that asthma is a common chronic condition that affects children and adults. Primary care providers (PCPs) are expected to measure members' lung function, assess the severity of asthma, and monitor the course of therapy based on:

- Comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations
- Member education about the contributing environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations
- Education that fosters a partnership amongst the member, his or her family and clinicians

Hypertension

PHP recognizes that primary care providers (PCPs) can assist members by checking blood pressure at every opportunity and counseling them and their families about preventing hypertension. Members benefit from general advice on healthy lifestyle habits, in particular a healthy body weight, moderate consumption of alcohol and regular exercise. PCPs are expected to document the confirmation of hypertension and identify if the member is at risk for hypertension in the member's medical record.

Behavioral Health

PHP requires that primary care providers (PCPs) assist members in obtaining necessary care in coordination with health plan's staff. Providers must utilize a standardized formal assessment instrument for HIV members, during initial and subsequent patient assessments, to identify members who require behavioral

health and substance abuse services and determine the types of behavioral health and substance abuse services that should be furnished. Copies of appropriate guidelines can be accessed through: www.aids.gov and www.samhsa.gov/prevention.

Section 12: Prior Authorization and Referral Procedures

Utilization management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for PHP members.

UM staff performs assessments of referrals and authorization of services through evaluation and review of all pertinent clinical indications and medical records necessary to justify the medical necessity of the request. UM staff utilizes clinical guidelines of InterQual and state/Federal standards. UM decision making is based solely on appropriateness of care, service and existence of coverage. PHP does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. In addition, referrals or services that are beyond the UM staff scope of practice are forwarded to the health plan's Medical Director for review.

The UM/Care Management Department staff is responsible for identification of potential or actual quality-of-care issues, and cases of over or under-utilization of health care services for PHP members during all components of review and authorization.

PHP does not provide incentives to its staff for UM decision-making.

The comprehensive methods of review and authorization include the following processes:

Prior Authorization

Prior authorization is designed to promote the medical necessity of service, to prevent unanticipated denials of coverage and ensure that participating Providers are utilized and that all services are provided at the appropriate level of care for the member's needs.

The primary care provider (PCP) is always the initial source of care for members. A member may see the PCP without a referral and the PCP may perform essential services in the office environment. Prior authorization is required for necessary services ordered by the PCP, which cannot be performed in the office.

The following services typically require prior authorization:

- All inpatient care (acute, sub-acute and skilled nursing facility)
- Outpatient rehabilitation (including physical therapy, speech and occupational therapy)
- Outpatient surgeries (except for abortions and minor office procedures)
- Major diagnostic tests, e.g., MRI, CT scan, angiography
- Photo and radiation therapy
- Outpatient chemotherapy
- Orthotics and prosthetics
- Part B injectables administered in physician's office except for immunizations
- EMG, nerve conduction studies
- Cardiac testing (excluding EKG) and cardiac catheterization
- Dialysis in service area
- Endoscopies, colonoscopies
- Durable medical equipment
- New medical technology (considered investigational or experimental), including drugs, treatment, procedures, equipment, etc.
- Pharmacy drug formulary overrides and exceptions
- Home health care
- Non-participating practitioners/non-contracted facilities

PHP does not require referral or prior authorization for the following services:

- Emergency services
- Urgent care out of service area
- Dialysis out of service area
- Family planning services
- Treatment of sexually transmitted diseases
- Confidential HIV testing and counseling
- Obstetrical and gynecological care
- Therapeutic and elective pregnancy termination
- Dental and vision services
- Chiropractic services covered by Medicare

Providers should submit requests for prior authorization to PHP UM/Case Management Department by electronic medical records system if available. If not, complete an "Authorization Request" form and fax it to the number listed on the form. (It is also listed below.) The "Authorization Request" form can be found in Section 36 (Forms) of this publication.

A signed order or prescription will be required for all outpatient services, procedures and DME, excluding hospital observation visits. Failure to seek and obtain prior authorization for outpatient requests will result in a denial of services and procedures. Providers will not be entitled to compensation.

If an urgent referral is necessary, Provider s should always telephone the UM Department in addition to faxing the request. An urgent referral is one that requires action by the Plan within 24 hours of receipt during the Plan's regular business hours, Monday thru Friday, 8:00 a.m. to 6:00 p.m.

PHP issues prior authorizations on an "Authorization Letter."

UM/Care Management Department's contact information is:

Attn: UM/Care Management
PHP
1001 N Martel Ave
Los Angeles, CA 90046
Tel: (800) 474-1434
Fax: (888) 272-7656

Referrals

Referrals are made when medically necessary services are beyond the scope of the primary care provider's (PCP's) practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Upon initiation of the referral, the PCP is responsible for initiating the referral tracking system.

If the PCP determines that a specialist is necessary for consultation or care of the patient, the PCP must complete a Referral Form, see Section 36 (Forms), and obtain a prior authorization number for that referral, **unless the service does not require prior authorization as described in the previous section**. The PCP will specify the type of referral:

- Consultation for diagnostic purposes
- Consultation to recommend treatment plan
- Consultation and request to assume care

When the member is referred for "Consultation to Recommend Treatment Plan" the PCP will specify on the referral form if:

- The referral is for a consultation visit only, or

- The referral is for consultation plus two follow-up visits.

When a member is referred for consultation and subsequent care, the PCP will so specify. For diagnostic procedures and tests which are specifically related to the requested consultation, and which are not listed in the services/referral guidelines, prior authorization is required. This authorization is obtained by the PCP following PHP Prior Authorization policies and procedures. Such tests, procedures, and treatments must be performed in network facilities. This referral is valid for 90 days, unless otherwise specified on the Referral Form. If the specialist determines that a secondary specialist who is out of the PHP network is required, a medical review is required. PHP is financially responsible only for those services that are medically necessary and specified in the Referral Form by the PCP to the specialist (or referred specialist to secondary specialist), and have been prior authorized by PHP.

Only those diagnostic procedures, tests, and treatments specifically related to the consultation and not defined in the services/referral guidelines, may be performed by the specialist. This authorization is obtained directly by the specialist following PHP prior authorization policies and procedures. Tests, procedures, and treatments must be performed in network facilities. This type of referral is valid for a 90-day period. Procedures not related to the admitting diagnosis (or presenting symptom/diagnosis in the specialist's office) require prior authorization by PHP. The health plan retains the right to retrospectively review inpatient and specialist claims to identify inappropriate consultations and procedures. PHP also reserves the right to deny such consultations and procedures.

Referral appointments to specialists must be on the same day for emergency care, within three (3) days for urgent care and within 30 days for routine care. Verbal communication from the PCP should be provided on any urgent referrals. If there is any question regarding the scope of the referral, the PCP should be contacted for clarification.

Referrals are only made to specialists in the PHP provider network. Exceptions will be made only in rare circumstances and then only with the prior approval of the Medical Director.

Complete referrals are essential, stating exactly what is to be done and including any clinical information and previous diagnostic testing for the specialty provider/practitioner's review. A system within the PCP's practice should be developed to assure that written responses from specialty referrals are received

and incorporated into the member's medical record, e.g. a specialty referral log. A specialist may see a PHP member only upon an initial referral from the member's assigned PCP or as a secondary consultant from the primary referred specialist, except in a medical emergency.

A written response from the specialist should be provided to the PCP within three (3) weeks of care for inclusion in the member's medical record.

All in-patient services must have an approval number issued by PHP UM/Case Management Department. In-patient admission notification may be made by telephone at (800) 474-1434 or fax (888) 272-7656.

Prior authorization numbers must be clearly written on all bills submitted to PHP.

Referral Form

Primary care providers (PCPs) and referring specialists must complete the Referral Form in Section 36 (Forms) and obtain an authorization from PHP for all services described previously as requiring prior authorization before such services are provided, except in emergencies.

For a referral to be valid, the following conditions must be met:

1. The member must be currently enrolled in PHP
2. The member must be assigned to a PCP initiating the primary referral
3. The member must receive initial services within 90 days from the referral date

Providers are required to supply the following information, if applicable, for the requested service:

1. Demographic information (name, date of birth, etc.)
2. Provider demographic information, i.e., referring Provider and referred to Provider
3. Requested service/procedure, including specific CPT/HCPCS codes
4. Diagnosis, including ICD-10 code and description
5. Clinical indications necessitating service or referral
6. Pertinent medical history, treatment, and laboratory data
7. Location where service will be performed
8. Requested length of stay (for inpatient requests)

Pertinent data and information is required by the Utilization Management (UM) staff to enable a thorough assessment for medical necessity and assign

appropriate diagnosis and procedure codes to the authorization. A thoroughly completed Referral Form is essential to assure a prompt authorization.

To assure maximum benefit from a referral, the PCP must clearly state the purpose of the referral and desired services. Patient progress notes, labs, and imaging should be attached to the referral. A copy of pertinent clinical notes may be attached and substituted for the Clinical History segment of the Referral Form if the required information is present on those clinical notes.

Fax the completed Referral Form to the UM/Case Management Department for an assignment of an authorization number at (800) 474-1434.

Referral to Non-Participating Providers

Except in true emergencies, PHP provides coverage for only those services rendered by contracted Providers and facilities. The exceptions are:

- PHP is notified, approves, and authorizes the referral in advance. In these instances, the Utilization Management (UM)/Case Management Department will issue an authorization number for the services to be provided. The Provider recommending an out-of- Plan referral must obtain approval for those services before arrangements can be made for those services. To obtain an authorization number, contact the PHP UM/Care Management Department at (800) 474-1434 or fax (888) 272-7656.

- The patient's medical needs require specialized or unique service available only through a non-contracted Provider or facility. In this case, PHP will assist the referring Provider in identifying specialists or facilities with the needed capabilities. PHP must authorize any such referral.

Second Medical/Surgical Opinion

A member may request a second medical/surgical opinion at any time during the course of a particular treatment in the following manner:

- PHP members may request a second opinion through their primary care provider or PHP Utilization Management (UM)/Care Management Department. The UM/Care Management Department will assist the member in coordinating the second opinion request with the member's PCP and specialist.
- The Medical Director will review member's second opinion requests
- Second opinion requests will be reviewed and provided written approval

or denial within 48 hours of request receipt. In cases where the request identifies an urgent or emergent need, formal approval or denial will be provided within one (1) working day.

- If the request for second medical/surgical opinion is denied, both the member and Provider have the opportunity to appeal the decision through the appeals process
- If the requested specialty-care provider or service is not available within the PHP network, an approval to an out of network Provider will be facilitated by the UM/Care Management Department
- Only one request for a second medical/surgical opinion will be approved for the same episode of treatment. This applies to both the in-network and out-of-network requests for second medical/surgical opinion.

Under the authorization process used by the UM/Care Management Department, any medical or surgical procedure that does not meet medical policy criteria (refer to on-line InterQual criteria) is reviewed by the health plan's Medical Director. The Medical Director may request a second opinion at any time on any case deemed to require specialty practitioner advisor review. The UM review criteria may be obtained by request to the UM/Care Management Department.

Upon approval of the request for a second medical/surgical opinion, the PCP's office staff will assist the member in scheduling an appointment with the second opinion practitioner. The PCP or his staff will instruct the member to take a copy of the authorization form and pertinent medical records to the second opinion practitioner.

A list of resources used to make utilization and clinical decisions includes but is not limited to:

- InterQual
- Medicare Managed Care Manual
- Medicare National Coverage Determinations Manual
- Medicare Benefit Policy Manual
- Hayes Directory of New Medical Technology
- American Institute of Preventive Medicine Protocols
- American College of Obstetrics and Gynecology (ACOG) Guidelines for Perinatal Care
- American College of Radiology
- PHP Utilization Management Committee
- Department of Health and Human Services (DHHS), HRSA-HAB Guidelines for HIV/AIDS Primary Care

Providers who wish to discuss denial or modification of services may contact the health plan's Utilization Management Department at (800) 474-1434.

Prior Authorization Time Standards

Determinations regarding requests for elective services/procedures are made within 14 calendar days of request and receipt of medical record information required to evaluate medical necessity and appropriateness.

Determinations regarding urgent service/procedures (medically necessary within three [3] business days) are made within one (1) working day or 24 hours of receipt of medical record information required to evaluate medical necessity and appropriateness.

Providers will be notified of the decision within one (1) calendar day of the decision.

Direct Referral Process

Primary Care Physicians (PCPs) can directly refer their patients to in-network Providers for selected specialty care services without a Prior Authorization from the Plan.

- PCP's office will give a Direct Referral Authorization form to the member to a specific specialist.
- The member will be responsible to make an appointment and hand carry the form to the requested specialist or facility noted on the form.
- The Direct Referral Authorization form will be your authorization to provide the requested services.
- No authorization number will be required for reimbursement.

Key points regarding the Direct Referral Authorization form:

- Specialty consult services that do not require prior authorization are listed on the form.
- Procedures such as but not limited to, surgeries, colonoscopies, imaging guided procedures and device placements will require additional authorization.
- Services not listed on the form will require prior authorization.
- The member must be eligible at the time of service for payment. You must verify member eligibility and benefits prior to the date of service by calling the eligibility verification numbers provided at the bottom of the form.
- The Provider must be an in-network Provider and utilize only contracted facilities.
- The referral is valid for two (2) months from the date on the referral form.

- Follow up visits are valid for up to six (6) months after the initial evaluation without prior authorization.
- When submitting your claims attach the form to your payment request document.

Pharmacy Services

PHP requires pre-service reviews of a select group of injectable drugs that may be administered in a physician's office. These reviews are intended to ensure consistent adjudication of the patient's benefits as well as ensure that utilization of injectable medication is consistent with the Pharmacy and Therapeutics Committee's evidence-based criteria for coverage.

The review process gives the clinician a single point of contact for pre-authorization requests for listed drugs. The Pharmacy Services department will coordinate with PHPs Authorization Department to ensure decisions are rendered within the expected timeframe based on routine or expedited requests.

Which drugs require pre-service authorization?
The current list of "Injectable Drugs Requiring Pre-Service Approval" with detailed criteria is on the Plan's website at http://positivehealthcare.net/florida/php/for-providers/publications.

Financial liability
If you administer one of the listed injectable drugs without receiving authorization, and it does not meet criteria for approval, PHP may not reimburse you for the drug.

Contact the Pre-Service Department first
When you plan to administer a drug on the list, please request prior authorization using the downloadable Pre-Service Injectable Authorization form under Provider Materials on the PHP Website at http://positivehealthcare.net/california/php/for-providers/publications.

Information required
Our goal is to give you and your patient the most accurate answer possible the first time, rather than to tie you up with a series of requests for information. To that end, please be sure that your request includes the appropriate diagnosis code and patient identification, as well as the patient's age, weight, gender, lab values, co-morbidities, and outcomes of other treatment regimens.

How long will the review take?
Routine review will take no longer than 14 days from the date request is received and an expedited review no longer than 72 hours provided all necessary clinical information is received.

Will patients already receiving coverage be re-evaluated?
Yes, each request will be evaluated for medical necessity.

What if the physician doesn't get authorization before administering the drug?
When a retrospective claim is received, Pharmacy Services will contact your office to get the clinical information regarding the patient. If the criteria are met, Pharmacy Services will notify the UM Department to approve the authorization. The Claims Department will then proceed with payment. If the criteria are not met, you will receive notice the claim is denied and instructions to appeal our decision if you choose.

How do clinicians check the status of a request or get more information?
You may call the Pharmacy Technical Help Desk at (888) 554-1334 or the Utilization Department at (866) 990-9322.

Provider Referral Tracking System

Providers may track and monitor referrals requiring prior authorization. Staff model Providers may access the electronic medical records, which contains in detail the status of the referral. Contracted Providers may contact the UM/Care Management Department directly at (800) 474-1434.

Section 13: Admission Review

The Utilization Management representative obtains either telephonic or on-site medical record review within 24 hours of notification of admission (or next business day) to ensure the admission to an acute care hospital is appropriate/medically indicated in accordance with the illness or condition and confirm information obtained during prior authorization of elective admissions. Admission review is also required on all emergency admissions to determine medical necessity and appropriateness.

Notification of Admissions

All elective and emergency inpatient admissions must be reported to PHP within 24 hours of the admission (or the next business day). Notifications should be submitted by faxing the patient's admission face sheet to PHP, Utilization Management (UM)/Care Management Department at (866) 990-9322.

Concurrent/Continued Stay Review

Concurrent/continued stay review is a process coordinated by the Utilization Management (UM) representative during a member's course of hospitalization to assess the medical necessity and appropriateness of continued confinement at the requested level of care. Hospital UM staff should fax the following clinical documentation to support the continued stay:

- Emergency Room notes
- Progress notes
- Lab Values
- Diagnostic test
- Procedures

Clinical updates should be faxed daily to the Utilization Management Department at (888) 272-7656.

Discharge Planning Review

Discharge planning begins within 24 hours of notification of the inpatient admission. Such planning is designed to identify quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, PHP UM staff, including its Medical Director, ancillary providers, and community resources to coordinate care and services.

Retrospective Review of Inpatient Stay

Retrospective review is a review process performed by the PHP UM staff and Medical Director, after services have been rendered, to determine:

- If unauthorized services were medically necessary/appropriate
- If services were rendered at the appropriate level of care and in a timely manner
- If any quality-of-care issues exist

The attending physician, and/or hospital/facility are notified in writing of the claim payment determinations via the "Explanation of Benefits."

Ancillary Services (Home Health, Durable Medical Equipment, Hospice)

Referrals for any ancillary services including home health and durable medical equipment require prior-authorization from the Utilization Management (UM)/Care Management Department.

Skilled Nursing or Rehabilitation Facility Review

When a member is transferred or admitted to a skilled nursing facility (SNF) or rehabilitation facility, PHP uses Title 22 SNF criteria and guidelines to determine appropriate level of care. All admissions to SNF and Rehab facilities require prior authorization by the Utilization Management (UM)/Care Management Department.

Section 14: Continuity of Care

PHP and its contracted Providers must ensure that members receive medically necessary health care services in a timely manner without undue interruption.

The cornerstone of continuity of care is the maintenance of a single, confidential medical record for each patient. This record includes documentation of all pertinent information regarding medical services rendered in the primary care provider's (PCP) office or other settings, such as, hospital emergency departments, inpatient and outpatient hospital facilities, specialist offices, the patient's home (home health), laboratory and imaging facilities.

Providers must have systems in place to ensure the following:

- Maintenance of a confidential medical record
- Monitoring of patients with ongoing medical conditions
- Appropriate referral of patients in need of specialty services
- Documentation of referral services in the member's medical record
- Forwarding of pertinent information or findings to specialist
- Entering findings of specialist in the member's medical record
- Documentation of care rendered in the emergency or urgent care facility in the medical record
- Documentation of hospital discharge summaries and operative reports in the medical record
- Coordination of post-hospital follow-up, discharge planning, and after-care

Medical Care Management Program

PHP provides comprehensive medical care management to all members. Medical care management focuses on procuring and coordinating the care, services, and resources needed by members with complex issues throughout the continuum of care.

Medical care management is individualized to accommodate a member's needs. In collaboration with and approval by the member's primary care provider (PCP), the PHP RN Care Manager will arrange individual services for members whose needs include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services. The PHP RN Care Manager is responsible for assessing all members and notifying the PCP of the evaluation results, as well as making recommendation for a treatment plan.

The RN Care Manager works in conjunction with the PCP, the member, the member's family, other Providers, etc. to coordinate and implement the individualized treatment plan of members.

PHP adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines in its execution of the program. It does not delegate case management services to medical groups.

The Medical Care Management Program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of health care and services, to increase continuity of care and efficiency, and to improve health outcomes.

Unlike many other member case management models, referral by PCPs is not required for enrollment into PHP Medical Care Management Program - membership is automatic. All members are assessed to determine their level of acuity and appropriateness for Medical Care Management interventions.

The member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the member. The PCP participates in the development of the member's individualized treatment plan. The PHP RN Care Manager provides the PCP with reports, updates, and information regarding the member's progress in their treatment plan(s) and ensures that the Member is linked to the appropriate community resources.

Both the RN Care Manager and PCP are responsible for coordinating their efforts in a chronic care model delivery approach to PHP members.

Section 15: Medical Records

Medical Record Documentation Standards

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. Medical records are the data source that document the services provided to PHP members to enable the verification of the quality of health care provided by participating practitioners. Medical record standard requirements include:

1. Organization of the medical records
2. Organized medical record keeping system
3. Confidentiality of the medical record
4. Availability of medical records
5. Quality of medical record keeping
6. Appropriate evaluation and management coding, and documentation of professional services provided to the member

As an accredited organization, PHP ensures that its Provider network maintains electronic and/or paper, clinical records and a health information system from which information can be retrieved promptly. Clinical records maintained by its Provider network are complete, comprehensive, legible, documented accurately in a timely manner, and readily accessible to health care professionals within the Provider network.

Practitioner medical record documentation must, at a minimum, meet the 80% practice specific performance standards. PHP documentation standards were developed using the NCQA Medical Record Guidelines, the AAAHC Medical/Clinical Record Review Guidelines, and Centers for Medicare & Medicaid Services (CMS) guidelines. Medical Record review elements include:

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical data include the name, date of birth, gender, race/ethnicity, address, employer, telephone numbers (home, work and cell), and marital status/domestic partnership status as applicable.
3. Primary language of the member and interpretation and/or translation needs or any communication assistance needs.
4. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier.
5. All entries are dated.
6. The record is legible to someone other than the writer.

7. The use of abbreviations should be limited to those approved for use by The Joint Commission (http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf).
8. Significant illnesses and medical conditions are indicated on the problem list.
9. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
10. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
11. Social history will be documented in the medical record
12. The record reflects a current review and update at each visit of all individual patient medications, including over-the-counter products and dietary supplements when information is available to Provider.
13. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).
14. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
15. Laboratory and other studies are ordered, as appropriate.
16. Consultation, lab, and imaging reports filed in the chart are initialed by the PCP to signify review.
    a. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
    b. Review and signature by professionals other than PCPs, such as nurse practitioners and physician assistants, do not meet this requirement.
    c. Providers will establish a timely response policy for patient results within their practice site. This policy and procedure will address what action(s) should be taken when significant problems and/or abnormal laboratory or radiological findings have been identified.
    d. If the reports are presented electronically, or by some other method, there is also representation of physician review.
17. Working diagnoses are consistent with findings.
18. Treatment plans are consistent with diagnoses.
19. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.

20. Unresolved problems from previous office visits are addressed in subsequent visits.
21. Review for under-utilization and over-utilization of consultants.
22. If a consultation is requested, there is a note from the consultant in the record.
23. Evidence of continuity of care between Plan PCP and specialists and documentation of all referral services
24. For members referred to behavioral health services, there is documentation of patient-approved exchange of information between PCP and Behavioral Health practitioners/providers.

There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

25. History of Emergency/Hospital services with appropriate discharge diagnosis and follow-up will be documented
26. Significant medical advice provided by telephone, including after-hours or telephone triage services will be documented in the medical record and appropriately signed or initialed.
27. Immunization records for children are up-to-date, or an appropriate history has been made in the medical record for adults.
28. Evidence that preventive screening and services are offered in accordance with Medicare's preventive health services and practice guidelines.
29. Advance Directive information is offered and documented in the medical record.
30. All invasive procedures will have signed informed consent
31. Appropriate documentation of post-hospital and post skilled nursing transition of care visits.
32. Providers will provide summaries of past and current diagnoses, problems, and past surgical procedures in the event a member has had three or more visits/admissions, or the clinical record is complex and lengthy.

Medical records for PHP members should be retained for a minimum of ten years following the last date of service or entry.

Medical Record Policy and Procedure Requirements

All participating Providers must implement and maintain a written policy and procedure that will guard against disclosure of any protected health information (PHI) to unauthorized persons in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Policies and procedures governing the confidentiality of medical records and the release of PHI must address the following elements, including, but not limited to:

1. Employees with access to medical record information must have confidentiality statements on file.
2. Medical records are to be stored in a location secure from public access.
3. Assurance that staff is trained with respect to HIPAA privacy requirements and related policies.
4. Written authorization obtained from the member, or his/her legal representative, before medical records are made available to anyone not directly concerned with his/her care: except where otherwise permitted or required by law
5. All signed authorizations for release of medical information must be carefully reviewed for authorization information and for any limitations to the release of medical information.
6. Each medical record should be reviewed prior to making it available to anyone other than the member or legal representative of the member.
7. Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the member's medical records.
8. Any portion of the medical record not indicated by the authorization will be omitted.

All Providers must maintain a proper release of medical information form for each record request within the member's medical records.

Availability

Members' medical records must be available at the time of an appointment. Medical record documentation facilitates communication, coordination, and continuity of care, which promotes the most efficient and effective treatment of the member.

The medical records of PHP members must be made available to the Plan's representatives upon request. In addition, members may access their medical records at any time by contacting their health care provider.

Transfers

If a member requests copies of medical records to be sent to another medical professional because of a transfer to another primary care provider (PCP), there will be no charge to the member.

When a member, or the member's representative, presents a written request to a Provider's office requesting copies of medical records *for reasons other than*

stated above, the office may charge a fee not to exceed the amount allowed by state law.

In addition to assuring medical records are maintained in a confidential manner, members' medical records must also be available at the time of an appointment. Medical record documentation facilitates communication, coordination, and continuity of care, which promotes the most efficient and effective treatment of the member.

Medical Records Copies

The primary care provider (PCP) office bears the cost of duplicating and shipping the member's medical records when referring the member to a consulting physician. The Provider's office will not charge the member for the cost of copying medical records that will be used during the member's course of treatment with a referral Provider.

Section 16: Provider Notification Requirements

Office Relocation

All Provider changes must be submitted in writing to PHP Provider Relations Department 60 days in advance for the following:

Primary care providers changing office locations require a facility site review. Once the site is approved, the Provider's address is updated and members are transferred to the new site. If the PCP moves outside of PHP geographic service area, PHP will reassign the members to the PCP of the member's choosing within the service area.

Written notification must be submitted to the Provider Relations Department for all telephone, fax number and tax identification number changes.

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address
- Tax identification number or entity affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number

Leave of Absence

Primary care providers (PCPs) must provide adequate coverage for leave of absence or vacation. Absences more than 90 days require transfer of members to another PHP PCP.

Specialty care providers must provide a written notification to PHP Provider Relations Department for absences more than 30 days.

Provider Termination

Providers must send written notification to PHP Provider Relations Department 180 days in advance of a withdrawal or termination. For continuity of care, PHP reserves the right to obligate the Provider to provide medical services for existing members until the effective date of termination according to the terms of your contract with PHP.

PHP may administratively suspend or terminate a Provider for reasons such as, but not limited to:

- No response to inquiries regarding the expiration of license, malpractice or other credentialing requirements
- Excluded from participation in Medicare, Medicaid and all other Federal health care programs as reported by the Office of Inspector General (OIG).
- Deficiencies in quality of care.

PHP will provide at least 60 days written notification of an administrative suspension or termination. A Provider may be terminated immediately in cases in which a member's health is subject to imminent danger or a Provider's ability to practice medicine is impaired. PHP is responsible for transitioning member care for all terminated Provider s. Provider Fair Hearing and Appeal Rights will be issued at the time of termination.

In addition to the Provider termination information included in your Provider Agreement with the Plan, you must adhere to the following items:

- Any contracted Provider must ensure at least written notice before "without cause" termination of a contracted Provider's participation. Please refer to your contract for the details regarding specific required days for providing termination notice.
- Unless otherwise provided in the termination notice, termination occurs on the last day of the month. For example: required notice in 60 days; a termination letter dated October 15; since required notice is 60 days, the effective date of termination is December 31.

Providers who receive a termination notice from the Plan may submit an appeal.

PHP will notify all appropriate agencies and/or members in writing of a Provider termination as required by regulations and statutes.

Section 17: Provider Services

Provider Network Oversight

PHP selects Providers who deliver the highest quality care and service to our members. Once a Provider is contracted with PHP, he or she must comply with specific contractual obligations.

PHP monitors the Provider network to identify deficiencies in each service area. All efforts are made to obtain Provider contracts that complete gaps in the network to ensure the Plan's members have reasonable access to all required specialties.

- PHP establishes and maintains primary care provider (PCP) panels to ensure members have an option to select and/or change their PCP without interference
- PHP contracts with specialists in more than 40 specialties, including mental health, dental, vision and ancillary providers
- PHP also contracts with general acute care hospitals for inpatient services, skilled nursing facilities, durable medical equipment suppliers, home health agencies, home infusion agencies and other Provider types

Provider Relations Department

The Provider Relations Department acts as the liaison between PHP and the external Provider network to promote positive communication, conduct trainings, facilitate the exchange of information and seek efficient resolution of Provider issues.

Provider Rights

Providers who treat PHP members have the right to:

- Be informed of participating contractual obligations placed on the provider by the Health plan and the sponsoring government agency.
- File a grievance or complaint about the program and/or any associated functions of the Health plan.
- An overview of the PHP and AIDS Healthcare Foundation.
- Contact information for Plan departments.
- Give feedback on the program, including participation in any activity soliciting provider input or feedback as to provider satisfaction and/or Plan performance surveys.
- Receive current HIV/AIDS treatment guidelines from nationally accepted sources.
- View applicable assessments and plans of care upon request.
- Member information obtained through the program in the coordination of disease management services for clinical decisions, as applicable.
- Respectful and courteous interactions with Health plan staff.

- Collaboration with other HIV/AIDS primary care providers and specialists who work with the Health plan for support when interacting with their patients to make decisions about their healthcare.

Provider Manual

A Provider manual is distributed to all new contracted Providers upon execution of an agreement with PHP. PHP will request and maintain documented receipt of all Provider manuals distributed. The Provider manual is also available on our website at http://positivehealthcare.net/california/php/for-providers/publications.

Training and Education

Provider Relations representatives will conduct Provider orientations to educate new Providers on PHP guidelines, policies and procedures. Contracted Providers may request additional training by scheduling an in-service from the Provider Relations Department. Call (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Provider orientations and in-services include, but are not limited to, the following:

- Administration overview and contact information
- Enrollment and eligibility
- Quality management and access standards
- Authorizations and referrals
- Utilization management and care management
- Chronic Care Program including Model of Care
- Claim submission and payment guidelines
- Health education
- Credentialing and Provider services
- Grievances and appeals
- Pharmacy and formulary
- Fraud, waste and abuse

Provider Directory

The PHP Provider Directory is printed at least annually and is updated as necessary. The directory is solely used as a member handbook referencing participating primary care providers, specialists, hospitals, ancillary, vision and dental providers. All Providers are encouraged to review their information in the directory and are responsible for submitting any changes to PHP Provider Relations Department. The Provider Directory is also available on our website http://positivehealthcare.net/california/php/for-providers/publications.

Section 18: Provider Grievances and Appeals

Any Provider who renders service to PHP enrollees may file a grievance about any aspect of the Plan's operations and performance, or behavior of its members or staff within 365 calendar days from the date of the incident that precipitated the dissatisfaction. Note that grievances/disputes regarding claims are addressed in Section 26 (Claim Submission and Payment Guidelines), section "Provider Claim Disputes."

To submit a grievance, Providers should complete a Provider Grievance Form and submit it to the Plan. A Provider Grievance Form is included in Section 36 (Forms) of this manual. The form is also available on the Plan's website at http://positivehealthcare.net/florida/php/for-providers/publications. PHP also accepts grievances over the telephone. Call Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Upon receipt of a grievance in writing or over the telephone, the Plan sends written acknowledgement of the grievance within five (5) business days to the submitting Provider. The Plan resolves grievances within 30 calendar days from the date of receipt of the grievance and sends a resolution letter to the Provider who submitted the grievance.

If a Provider is dissatisfied with the Plan's resolution to his or her grievance, he or she may submit an appeal within 180 calendar days from receipt of the Plan's resolution letter. A Provider may also file an appeal if PHP fails to resolve his or her grievance with the 30-day timeframe described above.

To submit an appeal, a Provider should submit the following documentation to the Plan. Appeal submissions must be in writing.

1. Letter requesting appeal and/or review of the grievance resolution
2. Copy of the Provider Grievance Form or letter used to submit the grievance to the Plan, if the grievance was submitted in writing
3. Copy of the documents submitted with the grievance if applicable
4. Copy of the Plan's grievance resolution letter, if applicable
5. Copy of any other correspondence between PHP and the Provider

Upon receipt of an appeal, the Plan sends written acknowledgement of the appeal within 15 calendar days to the Provider who submitted it. The Plan sends a written report of its investigation and conclusions to the appeal within 45 business days of receipt of the appeal.

Grievances and appeals should be faxed to (888) 235-7695 or mailed to:

Attention: Provider Relations
PHP
1001 N. Martel Ave.
Los Angeles, CA 90046

Section 19: Provider Marketing Activities

Carefully read the following **"Dos" and "Don'ts"** related to provider marketing activities for Medicare beneficiaries. This list is a summary of Provider -related marketing guidelines that are published by the Centers for Medicare & Medicaid Services (CMS) in its Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manuals).

- Providers may display health-plan specific materials in their own offices
- Providers cannot orally or in writing compare benefits or Provider networks among health plans, other than to confirm health plan network participation
- Providers may not direct, urge or attempt to persuade beneficiaries to enroll in a specific Plan based on financial or any other interests
- Providers may announce a new affiliation with a health plan or give a list of health plans with which they are affiliated to their patients
- Providers may co-sponsor events, such as health fairs, and advertise with the health plan in indirect ways such as through television and radio commercials, posters, fliers and print advertisements
- Providers shall not furnish lists of their Medicare recipients to health plans with which they contract, or any other entity, nor can Providers furnish other health plans' membership lists to any other health plan
- Providers cannot assist with health plan enrollment or accept enrollment applications
- Providers may not offer anything of value to induce Plan enrollees to select them as their Provider
- Providers may not offer inducements to persuade beneficiaries to enroll in a particular Plan or organization
- Providers may not conduct health screenings when distributing information to patients, as health screening is a prohibited marketing activity
- Providers may not accept compensation directly or indirectly from the Plan for beneficiary enrollment activities
- Providers may provide information and assistance to beneficiaries in applying for the low income subsidy
- Providers may print out and share information with patients from the CMS website (www.cms.gov).

Section 20: Delegated Entities

All participating Providers or entities delegated for network management and network development should meet all applicable standards and are held to the same standards whether delegation of these functions have occurred to Providers or entities or is retained by the Plan. Reviews are performed on delegated entities and compliance is monitored on a regular basis. If you would like a copy of all applicable standards, please contact our Provider Relations Department at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. Credentialing and re-credentialing standards are outlined in Section 27 (Credentialing and Re-credentialing).

Section 21: Members with Special Health Care Needs

Members with special needs are defined as adults, children and adolescents who face physical, mental or environmental challenges daily that place their health at risk and ability to fully function in society. They include for example:

- Members with mental retardation or related conditions
- Members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders
- Members with disabilities resulting from years of chronic illness, such as arthritis, emphysema or diabetes; and adults, children and adolescents with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care

The following is a summary of responsibilities specific to Provider s who render services to PHP members identified as having special health care needs:

1. Assess the member and develop a plan of care for those members determined to need a course of treatment or regular care;
2. Coordinate a treatment plan with member's family or close friend and specialist caring for the member;
3. Ensure the plan of care adheres to community standards and any applicable agency quality assurance and utilization review standards;
4. Allow the members needing a course of treatment or regular care monitoring to have access through standing referrals or approved visits, as appropriate for the member's condition or needs;
5. Coordinate with the health plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
6. Members may request a specialist as primary care provider (PCP) through PHP Member Services Department. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Member Services Department.
7. Coordinate services with other managed care organizations to prevent duplication of services.

Section 22: Member Rights and Responsibilities

You should be aware of PHP member rights and responsibilities. Members have the right to expect a certain level of service from the Provider s of their health care. Members are also responsible for cooperating with Providers when obtaining health care services. PHP notifies its members annually of their rights and responsibilities through the Evidence of Coverage (EOC) publication. Members who have questions regarding their rights and responsibilities should be directed to the EOC and/or Member Services at (800) 263-0067, Monday through Friday, 8:00 a.m. to 8:00 p.m. TTY users should call 711.

Member Rights

PHP member rights as published in the Evidence of Coverage (EOC) are as follows:

- To provide information about the Plan in a way that works for members, i.e., languages other than English that are spoken in the Plan service area, large print, or other alternate formats
- To be treated fairly and with respect at all times
- To get timely access to covered services and drugs
- To protect the privacy of members' personal health information
- To receive information about the Plan, its network of Providers, and covered services
- To make decisions about care, including the right to give instructions about what is to be done if members are not able to make medical decisions for themselves, i.e., Advance Directive
- To make complaints and to ask us to reconsider decisions we have made
- To make an informed decision to participate, or refuse to participate, in a research-based initiative or clinical/drug study or trial

Member Responsibilities

PHP member responsibilities as published in the Evidence of Coverage (EOC) are as follows:

- Become familiar with the Plan's covered services and the rules members must follow to get these covered services
- Advise the Plan if members have any other health insurance coverage or prescription drug coverage besides PHP
- Tell their Providers that they are enrolled in the Plan by showing their member ID card whenever members get health care services of Part D prescription drugs

- Give their Providers health information and ask questions, and follow through on their care.
- Be considerate when seeing Providers or visiting Provider facilities
- Pay what they owe for services
- Tell the Plan if they move
- Call Member Services if members have any questions or concerns about the Plan or services provided through the Plan

Member Confidentiality

PHP members have the right to full consideration of their privacy concerning their medical care. They are entitled to confidential treatment of member communications and records. Care discussion, consultation, examination, and treatment are confidential and should be conducted with discretion. Written authorization from the member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or necessitated by the administration of the health plan and in accordance with all state and Federal laws

Advance Directives

Every competent adult has the fundamental right to make decisions about his or her own health, including the right to choose or refuse medical treatment. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

To ensure that such right is not lost or lessened if a patient becomes physically or mentally incapacitated, California law establishes Advance Directives procedures that allow patients to sign a document or orally designate another person to direct the course of their medical treatment if they can no longer do so. Their Advance Direction can include instructions to their physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another person to make these important decision for them if they cannot.

A health care facility must provide each patient with written information concerning Advance Directives, and about the health care facility's policies respecting the implementation of such rights. A health care provider or health care facility may not require patients to waive their Advance Directive rights, nor can it require patients to execute an Advance Directive or to execute a new Advance Directive using the facility's or Provider's forms. Instead, patients' Advance Directives will travel with them as part of their medical record.

PHP provides its members with Advance Directive forms at the time of enrollment. The Plan will also provide a form upon request. Members should call Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week, to request a form. Forms are available in English and Spanish.

Resources for Advance Directive services are available from PHPs Health Education Department. Please contact Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. for more information.

Americans with Disabilities Act (ADA) and Impact to Your Practice

The Americans with Disabilities Act (ADA) ensures that all public services & facilities provide full access to individuals covered under the Act so they can lead full and productive lives. In order to accomplish this goal, the ADA has requirements and responsibilities for medical practices. These requirements and responsibilities cover the following areas:

- Physical access;
- Employment; and
- Adequate access to healthcare services, free from barriers and discrimination.

Scope of ADA Coverage

ADA states "an individual is considered to have a 'disability' if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. Persons with HIV disease, either symptomatic or asymptomatic, have physical impairments that substantially limit one or more major life activities and thus are protected by the ADA." (taken from ADA.gov)

Statute and proposed revisions to the law list some examples of covered conditions, including limited mobility, vision, hearing, speech and thinking, however physiological diseases and other impactful ailments may also be covered.

Physical Access

Title III of the ADA requires places of public accommodation to ensure that patients, clients and visitors with disabilities have full access to facilities and

services. This includes medical practices. Medical practices need to make certain that policies & procedures provide for reasonable access to their services and take into consideration the person's disability. It is recommended that any accommodation policy you have in place is well understood by practice personnel and applied consistently with your patients, and others who enter into your practice environment.

All medical practices are required to comply with physical access requirements of the ADA. Buildings are required to follow specifications for access guidelines that address a variety of areas, including parking, ramps, door widths, restroom facilities and other features that affect accessibility.

Communication

Clear and effective communication and understanding are essential for the safe provision of healthcare services. Medical practices must be prepared to provide assistance to individuals who have difficulty with hearing or speech. The ADA has requirements for the provision of assistive communication devices and translation services for patients who need them. Cost and inconvenience to a medical practice are not sufficient reasons to fail to provide the necessary accommodation. Please keep in mind the needs of patients who are visually impaired by having written materials or forms in large print or another form to ensure patients who can use these have full access to information they need in a form that they can utilize.

Employment

Title I of the ADA prohibits medical practices with 15 or more employees from discriminating against people with disabilities in employment matters. If an applicant is otherwise qualified, a person's disability cannot be used as a basis for adverse action in hiring, promotion, working conditions, compensation or other aspects of employment.

The same consideration that is given to patients or visitors to a medical practice related to accommodation to a disability is also applicable to an employee. Every reasonable accommodation is expected, but a medical practice is not required to make accommodations that would place an undue burden on the business and its staff.

Section 23: Member Satisfaction

PHP uses several mechanisms to measure member satisfaction with the Plan, Providers, care and service such as:

- Satisfaction Surveys – PHP conducts an annual assessment of member satisfaction. Members rate their satisfaction in multiple areas including perceptions of the health plan, health care, providers, access, referral process, specialty care, benefits, and customer service.
- Grievances – PHP codes all complaints received from members, both oral and verbal, and enters the information into a centralized system to identify trends and opportunities for improvement related to care and service.
- Client Advisory meetings – held routinely throughout the year, these meetings are attended by members and Plan staff to discuss the member experience and identify what's working as well as opportunities to provide improved service.

Section 24: Member Grievances and Appeals

This section describes what steps members may take to file a grievance or to appeal a decision, i.e., organization determination or coverage determination, made by the Plan. Members who have questions, concerns or complaints about the health Plan should call Member Services at (855) 318-4387, 8:00 a.m. to 8:00 p.m., and seven days a week. TTY users should call 711.

A "grievance" is an expression of dissatisfaction about any matter. For example, member would file a grievance if he or she has a problem with issues such as:

- The quality of care
- Waiting times for appointments
- Waiting time to be seen while in a doctor's office
- The way a doctor or his or her staff behave
- Unable to reach a Provider or the health plan by phone
- Inability to receive the information you need
- Cleanliness or condition of a Provider's office.

An "organization determination" is the denial or limit by the Plan of services requested by member or Provider. Examples of an organization determination are:

- Changing level of service, i.e., outpatient instead of inpatient hospital care
- Reduction, suspension or termination of a service that was already authorized for you
- Denial of all or part of the payment for a service or failure to provide the service in a timely manner

A "coverage determination" is the denial or limit by the Plan of a prescription drug requested by member or Provider.

An "appeal" is a request for a review of an organization or coverage determination. For example:

- If PHP refuses to cover or pay for services member thinks the health plan should cover, he or she may file an appeal
- If the health plan or one of its contracted Providers refuses to give member a service he or she thinks should be covered, he or she may file an appeal
- If the health plan or one of its contracted Providers reduces or cuts back on services member has been receiving, he or she may file an appeal

- If member thinks PHP is stopping his or her coverage of a service too soon, he or she may file an appeal

With member's permission, a Provider may also file an appeal on behalf of a member.

The health plan is required to keep track of all appeals and grievances so it can report data to the State on a quarterly and annual basis. This information is also used to improve the Plan's service to its members.

Filing a Grievance

If member is dissatisfied with PHP for any reason he or she can file grievance. Member cannot be dis-enrolled or penalized in any way if he or she files a grievance.

Member may file grievance by calling Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., and seven days a week. TTY users should call 711.

Member may also file a grievance in writing. The grievance should explain in detail what happened to make member dissatisfied, the names and titles of people involved, and the date, time and location of the incident(s). When filing a grievance, member should include his or her name, his or her PHP ID number, and current address, and telephone number. Grievances go to:

Attn: Member Services
PHP
P.O. Box 46160
Los Angeles, CA 90046

With a member's written permission, a Provider may also file a grievance on behalf of the member.

PHP will send each member who files a grievance a letter stating that the health plan received the grievance. The health plan must resolve the grievance within 30 calendar days from receipt. Member may file a grievance any time up to one (1) year following the date of an incident. Member or his or her Provider may request an extension, if necessary; if this is in his or her best interest. An extension can be made for up to 14 days.

PHP is required to send each member who files a grievance a written response to his or her grievances within 90 calendar days from the date it was filed. The

resolution letter will tell the member what actions the health plan took to address his or her grievance, and what additional steps he or she can take.

PHP members should call the Member Services Department if they have questions or need any help with grievances. They can also call Member Services if they have more information to add about grievances after they filed them. Member Services can be reached at (800) 263-0067, 8:00 a.m. to 8:00 p.m., and seven days a week. TTY users should call 711.

Coverage Decisions

PHP will make initial coverage determinations and organization determinations within 14 days after it receives a member's request or a request made by a Provider on behalf of a member. The Plan may take up to 14 additional days to make an initial decision if it requires additional information that will benefit the member, or if the member or Provider requires more time to submit information to support the request.

A member or Provider acting on behalf of a member may request an expedited determination for medical care or prescription drugs that the member has not yet received. The Plan must render a decision within 72 hours under an expedited decision request.

If a Provider requests an expedited decision, PHP will automatically agree to render its decision within the expedited decision deadline. If a member requests and expedited decision, the Plan will determine, based in medical necessity, if an expedited decision is appropriate.

Filing an Appeal

Members may file an appeal of an organization or coverage determination by PHP within 60 calendar days of receipt of the health plan's notice to him or her about its determination.

Members or Providers acting on behalf of a member may file an appeal orally or in writing. Contact Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., and seven days a week. TTY users should call 711. To file an appeal in writing, submit detail to support member's appeal to:

Attn: Member
Services PHP
P.O. Box 46160
Los Angeles, CA 90046

PHP will resolve appeals within 30 calendar days from the date the health plan received the appeal request, unless an expedited appeal is requested. The Plan will process expedited appeals within 72 hours. This timeframe can be extended up to 14 calendar days if requested by member. The timeframe may also be extended if PHP finds there is a need for additional information, and the delay is in member's best interest. PHP will notify member in writing within five (5) business days if it needs an extension. The health plan will notify member within two (2) weeks of the decision.

If the decision to an appeal is in member's favor, PHP will provide the services as quickly as conditions require. If the Plan's appeal decision is not in the member's favor, it will send the member a written denial notice and send the appeal to the Independent Review Organization.

Section 25: Eligibility

A member's eligibility status can change at any time; therefore, all Providers should consider requesting and copying a member's identification card, along with additional proof of identification, such as a photo ID, and file them in the patient's medical record.

Primary care providers (PCPs) receive a list of eligible members at the beginning of each month who have chosen or been assigned to the PCP as of that date.

Providers should call PHP Member Services Department at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week, to verify member eligibility.

Section 26: Claim Submission and Payment Guidelines

This section of the Provider manual describes PHP requirements for Provider claims settlement practices and Provider disputes applicable to claims.

Claim Definitions

"Clean Claim" is defined as a claim for services submitted by a practitioner that is complete and includes all information reasonably required by PHP, and as to which request for payment there is no material issue regarding PHP obligation to pay under the terms of a managed care Plan.

"Received Date" is the oldest PHP date stamp on the claim. Acceptable date stamps include any of the following:

- PHP Claims department date stamp
- Primary payer claim payment/denial date

Initial Claim Submission

Claims for services provided to members can be submitted electronically. PHP's clearinghouse vendor is Emdeon and its electronic submitter I.D. is 95411.

Claims can also be submitted on the appropriate billing form (CMS1500, UB04, etc.) within 90 calendar days from the date of service, or as stated in the written service agreement with PHP. The Provider is responsible to submit all claims to PHP within the specified timely filing limit. PHP may deny any claim billed by the Provider that is not received within the specified timely filing limit. Claims submitted electronically will be adjudicated significantly quicker than paper claim submissions. Please check with Claims to get the electronic clearinghouse ID for PHP to be used for electronic billing. Claims telephone is (888) 662-0626.

The following information must be included on every claim:

1. Provider name
2. Provider address
3. Name
4. Date of birth
5. ID
6. Date(s) of service
7. All ICD10 diagnosis code(s) present upon visit
8. Revenue, CPT, HCPCS code for service or item provided
9. Billed charges

10. Place of service or UB04 bill type code
11. Tax ID number
12. NPI number
13. Name and state license number of rendering provider

Claims that do not meet the criteria described above will be returned to the Provider indicating the necessary information that is missing. PHP will process only legible claims received on the proper claim form that contains the essential data elements described above.

Only current standard procedural terminology is acceptable for reimbursement per the following coding manuals:

- Current Procedural Terminology (CPT) for physician procedural terminology
- International Classification of Diseases (ICD10-CM) for diagnostic coding
- Health Care Procedure Coding System (HCPC)

CMS-1500 paper claim submissions must be submitted on form OMB-0938-0999(08-05) as noted on the document's footer. The Plan accepts the revised CMS-1500 and UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink.

When appropriate, PHP requires adequate and appropriate documentation to be submitted with each claim filed.
Documentation required with a CMS1500 or UB04 claim form:

Documentation	Applies to
Other coverage explanation of benefits	All Providers
Dialysis log	Dialysis Service
Doctor's orders, nursing or therapy notes	Home Health
Full medical record with discharge summary	Hospital
Consult, procedures report	Physician
Emergency room report	Emergency Medicine Physician
Operative report	Surgeon
Minimum Data Set (MDS) Assessment	Skilled Nursing Facility

Standard Code Sets

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All Providers are required to submit claims and encounters using current HIPAA compliant codes, which include the standard CMS codes for ICD10, CPT, HCPCS, NDC and CDT, as appropriate.

Coding Accuracy and Specificity

Correct and accurate coding leads to better patient care and improved Provider reimbursements with claims submissions. Providers should use codes at the highest level of diagnosis specificity. Accurate diagnosis codes can be found at the following website:
www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx

Information for Obtaining an NPI

To obtain a National Provider Identifier (NPI) you may:

- Telephone: (800) 465-3203 or TTY: (800) 692-2326
- E-mail customerservice@npienumerator.com
- Mail to NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059
- Answers to frequently asked questions regarding NPI are available at www.cms.gov

Claims Submission Protocols and Standards

Paper claims should be submitted to the address listed on the back of the members' ID cards or to:

Attn: Claims
PHP
P.O. Box 7490
La Verne, CA 91750

For claim payment inquiries and information regarding electronic claim submission, please contact PHP Claims Department at (888) 662-0626 or via fax (888) 235-9274.

Claims Receipt Verification and Status

For verification of claims receipt by PHP, please contact the Claims Department at (888) 662-0626.

Claims Processing

Claims will be paid to contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract and/or by applicable Florida State or Federal law. Unless the subcontracting Provider and contractor have agreed in writing to an alternate payment schedule, claims will be adjudicated as follows:

- For clean claims, expect reimbursement within 14 days of PHP receipt of the claim if submitted electronically
- For clean claims, expect reimbursement within 45 days of PHP receipt of

the claim if submitted on paper
- You will receive an Explanation of Benefits (EOB) that details how each service is paid
- You will receive an Explanation of Payment and Recovery Detail (EOPRD) when PHP identifies a previous claim overpayment

Coordination of Benefits

Coordination of Benefits (COB) is the process of determining if a member has more than one health insurance plan for medically necessary care. If so, PHP will make a determination as to which insurance company bears the primary responsibility and which company has secondary responsibility (paying only balances after the primary's payment). Subrogation procedures are used when a member has an illness or injury that is caused by a third party. PHP has the legal right to recover any claims payments from the responsible party or their insurance company.

The COB claims filing limit is established as the 90 calendar day period, or as defined in the written service agreement between the date of payment or denial by the primary payer and the date by which the Plan must first receive the claim. PHP may deny any claim billed by the Provider that is not received within the specified timely filing limit.

Medicaid Coverage for PHP Members

Generally speaking, PHP covered benefits are the financial responsibility of PHP primarily. The Plan's members who are eligible for Medicaid do retain some Medicaid benefits separately and apart from PHP benefit package. Examples include certain Medicare Part D excluded drugs.

It is the responsibility of both the Provider and PHP to determine whether the member may be covered by another payer such as Medicaid when coverage through the Plan is not available, or where Medicaid will take secondary financial responsibility for a Medicaid covered service.

Prohibition of Billing Plan Members

Your agreement with PHP requires Providers to accept payment directly from the health plan. Payment from the health plan constitutes payment in full, with the exception of applicable co-payments and any other amounts listed as member responsibility on the Explanation of Benefits/Provider Remittance Advice.

This means Providers cannot bill PHP members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the Provider fails to notify the health plan of a service that required prior authorization – payment for that service will be denied
- Covered services that were not medically necessary, in the judgment of the health plan, unless prior to rendering the service the Provider obtains the member's informed written consent and the member receives information that he/she will be financially responsible for the specific services.

Provider Claim Disputes

A Provider dispute is a Provider's written notice challenging, appealing or requesting reconsideration of a claim, (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract disputes or disputing a request for reimbursement of an overpayment of a claim.

Each Provider claim dispute must contain the following information at a minimum:

1. Provider's name
2. Provider's identification number
3. Provider's contact information
4. If the Provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from PHP to a Provider, the request must include:
    a. A clear identification of the disputed item
    b. The date of service
    c. A clear explanation of the basis upon which the Provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

Providers may submit disputes on a Provider Dispute Resolution Form, which is included in Section 36 (Forms) of this manual. The form is also available on the Plan's website at http://positivehealthcare.net/california/php/for-providers/publications.

Providers may initiate a claims dispute no later than 365 days from the date of the Plan's action on a claim.

PHP sends written acknowledge of receipt of a Provider claim dispute within 15 business days for hard copy submission, and two (2) business days for electronic submission.

The Plan returns Provider claim disputes to submitting Providers that do not include the required information as described on the previous page. Providers have 30 calendar days from receipt of a returned Provider claim dispute to submit an amended dispute. If a Provider does not submit an amended Provider claim dispute within the 30-day timeframe, the Plan closes the dispute.

PHP issues a written determination regarding a Provider claim dispute within 30 calendar days after receipt of the dispute. For those Provider claim disputes that require amending by the Provider, the Plan issues a written determination within 30 calendar days after receipt of an amended dispute.

Provider claim disputes and appeals should be mailed to:

Attn: Claims
PHP
P.O. Box 7490
La Verne, CA 91750

Overpayment of Claims

If PHP determines that a claim was overpaid, then the health plan will notify the Provider in writing within 365 calendar days of the date of the payment. Notification of an overpaid claim to the Provider requires the following information:

1. Name and ID number
2. Date of service
3. An explanation why PHP believes the claim was overpaid

The Provider has 30 working days to dispute an overpayment notification, which then becomes a Provider dispute and follows the applicable procedures listed above under Provider Disputes.

Section 27: Quality Improvement Program

Quality Improvement Requirements

PHP monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to Plan members. This occurs through many QI activities including but not limited to:

- Chronic Care Improvement Program: PHP and its Providers participate in the Million Hearts™ initiative, which is a nationwide coalition of public and private sector organizations working towards the goal to prevent one million heart attacks and strokes in the next five years.
- Quality Improvement Project: Reducing Plan All Cause Readmissions is a three year QIP undertaken to the meet CMS requirement to implement actions to reduce readmissions over the next three years.
- Other improvement projects - Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes & member satisfaction. These include quality and performance improvement projects.
- Medical record audits - Annual medical record review to evaluate the quality outcomes concerning timeliness of and member access to covered services
- Performance measures - Data on patient outcomes as defined by the Healthcare Effectiveness Data & Information Set (HEDIS) or otherwise defined by CMS.
- Surveys – on an annual basis, PHP administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and Health Outcomes Survey (HOS) and uses the results to improve care and service.
- Peer Review - Conducted by the Plan to review a Provider's practice patterns & appropriateness of care.

Quality Improvement Overview

PHP is committed to providing quality health care to its members. The health plan deploys a comprehensive Quality Improvement Program (QI Program) built on the concept of continuous quality improvement and incorporates clinical care and service activities. The QI Program is developed with practitioner, Provider, and member input to address the specific needs and demographics of the enrolled population. The health plan requires contracting Providers to participate and cooperate in the quality improvement program emphasizing change through education, and practice management. Active involvement includes, but is not limited to, participating on committees, collecting data and providing access to

medical records, identifying barriers when opportunities for improvement are identified, and implementing targeted interventions.

Clinical Performance Measures

PHP reports clinical performance measures annually to the National Committee for Quality Assurance (NCQA), CMS and other agencies. Some of these clinical performance measures may include but are not limited to the following:

Clinical Performance Measures	Description
1. Breast Cancer Screening (BCS)	Percent of women between 40 and 69 years old who had a least one mammogram in the past two (2) years.
2. Follow-Up after Hospitalization for Mental Illness (FUH)	Percent of enrollees six (6) years and older who were hospitalized for a mental health diagnosis and were discharged to the community from an acute care facility and were seen on an outpatient basis by a mental health practitioner within seven (7) days and within 30 days.
3. Antidepressant Medication Management (AMM)	Percent of enrollees who were diagnosed with a new episode of major depression and received: *Effective Acute Phase Treatment*: Were treated with an antidepressant medication and remained on the antidepressant drug during the entire 84-day Acute Treatment Phase. *Effective Continuation Phase Treatment*: Were treated with an antidepressant medication and remained on the antidepressant drug for at least 180 days.
4. Controlling High Blood Pressure (CBP)	Percent of hypertensive adults ages 18 to 85 whose blood pressure was controlled. Adequate control is defined as a blood pressure reading less than 140/90 mmHg during the past year.

Clinical Performance Measures	Description
5. Comprehensive Diabetes Care (CDC)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following. • HbA1c testing • HbA1c result > 9.0 = poor control • HbA1c result < 8.0 = good control • LDL-C • LDL-C result < 100 • Retinal eye exam (REE) • Nephropathy screening test or evidence of nephropathy • Blood pressure collected as 2 measures < 140/90 < 140/80
6. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Percent of persons age 18 and older hospitalized for a heart attack who received beta blockers medication through 6 months period post event.
7. Adult BMI Assessment (ABA)	Percent of enrollees 18–74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented.
8. Cholesterol Management for People with Cardiovascular Conditions (CMC)	Patients who were discharged alive for any of the following: • Acute myocardial infarction • Coronary artery bypass graft • Percutaneous coronary interventions Or who had: • Diagnosis of ischemic vascular disease Who had each of the following during the measurement year. • LDL-C screening • LDL-C control (<100 mg/dL).

Clinical Performance Measures	Description
9. Annual Monitoring for Patients on Persistent Medications (MPM)	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Four rates are reported separately and as a total rate. Annual Monitoring for members on: • angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • digoxin • diuretics • anticonvulsants
10. Use of High-Risk Medications in the Elderly (DAE)	The percentage of Medicare members 65 years of age and older who: • received at least one high-risk medication. • received at least two different high- risk medications
11. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)	The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, concurrent with or after the diagnosis.
12. Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported. (Dispensed a systemic corticosteroid within 14 days of the event and Dispensed a bronchodilator within 30 days of the event).
13. Medication Reconciliation Post-Discharge (MRP)	The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

Clinical Performance Measures	Description
14. Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).
15. Colorectal Cancer Screening (COL)	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.
16. Care for Older Adults (COA)	The percentage of adults 66 years and older who had each of the following during the measurement year. • Advance care planning • Medication review • Functional status assessment • Pain screening
17. Glaucoma Screening (GSO)	The percentage of Medicare members age 65 years and older who received a glaucoma exam by an eye care professional for early identification of glaucomatous conditions.
18. Osteoporosis Management in Women Who Had a Fracture (OMW)	The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.
19. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
20. Frequency of HIV Disease Monitoring Lab Tests - (CD4 and VL)	The frequency of HIV disease monitoring lab test for CD4 and viral load performed in a calendar year.

PHP requires access to all primary care provider (PCP) medical records for the purpose of collecting and reporting data to NCQA, CMS and other agencies regarding performance in these measures. PHP will coordinate any necessary medical record reviews with PCP's office.

Section 28: Credentialing and Re-credentialing

Credentialing Program

PHP has a comprehensive credentialing program that has been established in accordance with the standards of the National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC) and applicable state, and Federal regulatory requirements that are reviewed and revised at least annually. Additionally, since PHP is a Medicare Advantage special needs plan there are specific requirements relating to HIV/AIDS training and experience.

PHP maintains the confidentiality of all information obtained about physicians and other practitioners in the credentialing/re-credentialing process as required by law.

Criteria for Practitioner Selection

All practitioners who fall under the scope of the PHP Credentialing Program must meet the following minimum credentials, qualifications and criteria as applicable.

1. For physicians, graduation from a school of medicine, or osteopathy, that is accredited by the Liaison Committee on Medical Education and completion of a residency. Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or must have completed a fifth pathway. For other practitioners, graduation from an appropriate accredited professional school and/or completion of a formal training program.
2. A current valid unrestricted state license to practice his or her specialty in the state in which the applicant will provide services. For categories of practitioners for which licensure is not required by any state board/agency, PHP Credentialing Committee and/or Medical Director will review the education, training and additional criteria to verify practitioner competence.
3. A current valid Drug Enforcement Agency (DEA) certificate.
4. For physicians, board certification by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in physician's practicing specialty. If the physician states that he or she is board-certified on the application, or, for those physician applicants who are not board certified, evidence that the applicant has completed required residency/fellowship programs that meet all ABMS or AOA

training prerequisites to be considered "board eligible" in practicing specialty.

5. Current and unrestricted clinical and admitting privileges in good standing at a PHP contracted hospital, or evidence and Medical Director approval that the applicant does not require hospital privileges in order to deliver satisfactory professional services. For PCPs without hospital privileges at a contracted facility, the physician must provide a mechanism for continuity of care. Physicians who do not have hospital privileges must have a formal inpatient coverage arrangement through a physician with clinical and admitting privileges at a PHP-contracted hospital and who is a PHP participating practitioner.
6. Current professional liability insurance that meets or exceeds PHP minimum limits for each type of practitioner.
7. Absence of a history of involvement in a malpractice suit, arbitration, or settlement; or, in the case of applicant with such history, evidence that the history does not demonstrate probable future sub-standard professional performance.
8. Must demonstrate continuous personal development.
9. Primary care providers must demonstrate experience as an HIV-qualified Provider. A Provider should show continuous professional development through clinical, behavioral or case management of at least 20 HIV-infected patients in the last two (2) years with a minimum of eight (8) contact hours annually of HIV-specific continuing medical education (CME) that includes information on the use of antiretroviral therapy.
10. Absence of a history of denial, suspension, restriction, or termination of hospital privileges; or in the case of an applicant with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted or does not demonstrate probable future substandard.
11. Absence of a history of disciplinary actions affecting applicant's professional license, DEA or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant's license, DEA, or any other required certification.
12. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant's current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future substandard care.
13. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history,

evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any Federal or state sponsored programs.

14. Absence of a history of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.
15. Absence of a physical or mental health condition that would impair or would be likely to impair applicant's ability to competently and safely perform the professional duties for which applicant is contracted and that could not be reasonably accommodated without undue hardship to PHP.
16. Evidence of the capability to provide 24 hour coverage as required by PHP.
17. Ability to work cooperatively with others.
18. Appropriate and complete work history for at least the past five (5) years.
19. Successful completion of an office survey, which includes a structured review of the office site and evaluation of the medical record keeping practices.

Credentials Documentation

The applicant must provide a completed, signed and dated credentialing application to PHP and any additional information requested by the health plan in order to properly verify and evaluate the practitioner's qualifications. All questions listed on the application must be answered, and explanations given for all "yes" answers. The credentialing application requests documentation of the following information from the practitioner:

1. A valid state professional license number;
2. Clinical privileges in good standing at a PHP-contracted hospital(s) designated by the practitioner as the primary admitting facility, as applicable;
3. A valid Federal Drug Enforcement Agency (DEA) number or certificate and whether such certificate has ever been suspended, revoked or limited;
4. Graduation from professional school and completion of a formal residency or fellowship-training program, as applicable;
5. Board certification, if the practitioner states that he or she is board certified on the application (American Board of Medical Specialties or American Osteopathic Association for physicians);
6. Work history for at least the past five (5) years. Work history will be verified by review of the Provider's Curriculum Vitae and application. Any gaps exceeding one year will be verified in writing; six (6)months for non-

physicians;

7. Current, adequate malpractice insurance in the minimum amounts required by PHP;
8. Professional liability claims history for, at a minimum, the past seven (7) years, with details of any claims/lawsuits that resulted in settlements or judgments paid by or on behalf of the practitioner, as well as the outcome (if the suit or claim has been resolved);
9. A statement by the practitioner regarding lack of a physical or mental health condition that would substantially impair the practitioner's ability to competently and safely carry out the scope of his or her duties on behalf of PHP, and a statement by the practitioner regarding lack of impairment due to chemical dependency/substance abuse;
10. A statement by the practitioner regarding history of loss or limitation of professional license and/or felony convictions;
11. A statement by the practitioner regarding history of loss or limitation of privileges or disciplinary activity;
12. One peer-reference verification letters is required and must come directly from the source. The letter will be placed in the credentialing file;
13. A signed and dated consent and release form completed by the applicant authorizing PHP to obtain confidential information for credentialing purposes.
14. A. signed and dated PHP Designation of HIV Specialist Credentialing and Re-credentialing Verification and Qualifications Annual Attestation Form to be completed by all PCPs.

Copies of the following documents must accompany the application:

1. Valid, current and unrestricted professional license;
2. Evidence of current malpractice coverage (face sheet) at PHP required limits;
3. Evidence of board certification, if applicable, or certificate of completion of a formal residency or fellowship training program;
4. Current Federal DEA;
5. Evidence of eligibility for payment under Medicare.

Other documents may be required for certain types of practitioners to meet specific license-type requirements and documents relating to the education, experience, prior training and ongoing training regarding HIV/AIDS.

The applicant must submit a signed and dated attestation certifying the correctness and completeness of the information provided on and with the application. This attestation must be signed within 30 days of receipt of application by PHP.

Re-credentialing

Every three (3) years, a re-credentialing application will be sent to the practitioner. The re-credentialing application will request that the practitioner update the same information as was required on the initial credentialing application form. If applicable, a site review and medical records review will be completed during the course of the re-credentialing process.

Section 29: Cultural and Linguistic Competency

PHP is committed to be respectful of and responsive to the cultural and linguistic needs of our members. The US Department of Health & Human Services, Office of Minority Health, has issued national culturally and linguistically appropriate services (CLAS) standards. PHP is committed to a continuous effort to perform according to those standards.

PHP uses Language Line for interpreter services as needed to communicate with members who have limited English proficiency. Providers are expected to have access to interpreter services to accommodate their non-English speaking patients. If you do not have access to interpreter services to accommodate a non-English speaking patient who is a member of the Plan, PHP will provide such access. Please contact Member Services at (800) 263-0067to request assistance.

Providers may request a "Self-Assessment Checklist for Personnel Providing Primary Health Care Services," from PHP to assess their cultural competency in the delivery of health care services. The checklist is also available online: http://nccc.georgetown.edu/documents/Checklist%20PHC.pdf

Cultural competency training modules for clinical staff working with people living with HIV/AIDS are available on the PHP website: http://positivehealthcare.net/california/php/for-providers/publications. The health plan will arrange for follow-up assistance and/or training to Providers who report a need for technical assistance.

If PHP receives any member grievance related to the delivery of culturally or linguistically appropriate care by Providers, it will immediately assess the Provider's competency and require corrective action where necessary.

Contracted Providers are expected to provide services in a culturally competent manner that includes, but is not limited to, removing all language barriers to service, and accommodating the special needs of the ethnic, cultural, and social circumstances of the patient. Providers must also meet the requirements of all applicable state and Federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

PHP operates the health plan pursuant to a Cultural and Linguistic Competency Plan. To obtain a copy of the plan at no charge, you may request one by calling Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. The plan is also available at http://positivehealthcare.net/california/php/for-providers/publications.

Section 30: Compliance and Regulations

Provider Contract Requirements

PHP contracts with physicians, facilities and ancillary Providers to provide health care services to its members. PHP Provider contracts or subcontracts must include the following provisions:

1. Utilization/Medical Management Policies and Procedures. All parties contracted directly or indirectly with PHP must abide by the health plan's Utilization Management Department's policies and procedures.
2. Quality Management Compliance. PHP requires that all Providers participate in periodic audits and/or site surveys for evaluating compliance with PHP quality management standards and regulatory requirements, i.e., National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC) Healthcare Effectiveness Data and Information Set (HEDIS). These audits include, but are not limited to, site review and medical record reviews.
3. Medical Records. Contracted Providers must provide the PHP Medical Director or designee access to all Plan member charts and medical records for the purpose of determining or resolving eligibility, liability or appropriate care issues. Providers, as prescribed by State and Federal law, will maintain confidentiality of this information at all times. In addition, a random sampling of medical records for all primary care providers (PCPs) with more than 50 members will be reviewed for compliance with NCQA standards every two (2) years.
4. No Billing of Members. PHP contracted Provider s agree not to impose any charges on any Plan member for covered benefits. Further, contracted Providers agree to accept the PHP payment as payment in full and agree not to seek compensation from a PHP member for services provided to that member, even in the event of non-payment by the health plan.
5. Retention of Records. Contracted Providers agree to retain financial and medical records relating to PHP members for a period of 10 years from the termination of the contract or such time period as may be required by applicable law, regulation or customary practice.
6. Liability Coverage. PHP requires all contracted Providers to maintain professional liability insurance and primary general liability coverage in the minimum amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate.
7. Non-Solicitation of Members. During the initial and any succeeding term of a Provider contract and one (1) year following the termination date of

the contract, a contracted Provider agrees not to knowingly advise a PHP member to dis-enroll from PHP and will not solicit any member or employer to seek enrollment with any other health maintenance organization or Provider of health services. Further, the contracted Provider will not make any derogatory remarks regarding PHP to any member.

8. No Contact with Members. All contracted Providers acknowledge that PHP has expended significant time and resources in developing its business and enrolling members. Therefore, the PHP eligibility list is an important corporate asset containing valuable proprietary information. All contracted Providers agree to rely exclusively on the health plan's communication to its members regarding changes in the contractual relationship between PHP and the Provider.
9. Use of the Plan's Trade Secrets. A trade secret refers to information, including but not limited to programs, techniques and processes that has independent economic value by not being generally known to either the public or to other persons or parties who could obtain economic value from its disclosure or use. PHP contracted Providers agree not to use or divulge PHP trade secrets to anyone.
10. Contact with Members. PHP and its participating Providers shall maintain a physician-patient relationship with each member. Nothing contained in the agreement is intended to interfere with such physician-patient relationship. Nothing in the agreement should be interpreted to discourage or prohibit participating physicians from discussing treatment options or providing other medical advice or treatment deemed appropriate by the participating physician. The participating physician shall have the sole responsibility for the medical care and treatment of members. PHP contracts or subcontracts could also include additional sections or provisions not discussed in this section. In addition, the description of the contract provisions listed in this section does not constitute a complete disclosure of all requirements placed on Providers contracted with PHP. Contracted Providers should refer to their PHP contract for further information.

In the event a Provider fails to comply with AHF contract requirements, or other conditions of participation in the network, corrective action may be necessary to obtain compliance. Provider Relations works closely with other AHF departments when reports of an issue are made. PR will solicit information and coordinate findings with other stakeholders. Depending on the issue, a decision will be made as to what corrective action is needed. This is reported by AHF to the

Provider. Corrective action may take a number of forms, but can include, but not be limited to, ongoing monitoring for resolution, Provider education, and possibly termination if the failure to achieve compliance constitutes a serious situation. The Plan makes every effort to satisfactorily resolve any Provider issue, but will take more structured action, via corrective measures, if a Provider struggles to comply with Plan requirements associated with participation in the network.

Section 31: Fraud, Waste and Abuse Program

PHP is committed to conducting its business ethically and lawfully, and with integrity. It has created a compliance program as an expression of its commitment to ethical behavior, which operates in accordance with Federal law and the health plan's policies and procedures. The health plan's Compliance Officer, Compliance Committee, and a Compliance hotline are available to Providers and their employees, agents, and contractors to receive reports of suspected violations and when, appropriate, oversee corrective actions.

As a Provider in PHP network, you and, as applicable, your employees, agents, and contractors, have a duty to act ethnically and lawfully when rendering services to health plan members. In carrying out those duties, you are required take measures to prevent, detect, report, and correct fraud, waste, and abuse.

Fraud

Fraud, generally involves a person's or entity's intentional use of false statements or fraudulent schemes, such as kickbacks, to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a Federal health care program. Some examples of fraud are:

- Billing for services not furnished
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Violations of the physician self-referral ("Stark") prohibition
- Using an incorrect or inappropriate Provider identifier in order to be paid, i.e., using a deceased individual's Provider identifier
- Signing blank records or certification forms that are used by another entity to obtain Medicare or Medicaid payment
- Selling, sharing, or purchasing Medicare/Medicaid Health Insurance Claim (HIC) numbers in order to bill false claims to the Medicare/Medicaid Program
- Offering incentives to Medicare/Medicaid beneficiaries that are not offered to other patients, i.e., routinely waiving or discounting Medicare/Medicaid deductibles, coinsurance, or co-payments
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government or its agents
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished
- Consistently using billing or revenue codes that describe more extensive services than those actually performed (up coding)

- Misrepresenting himself or herself as a Medicare/Medicaid beneficiary for the purpose of securing Medicare/Medicaid payment for their health care by presenting a Medicare/Medicaid health insurance card or Medicare/Medicaid HIC number that rightfully belongs to another person.

Waste

Waste involves using or expending carelessly, extravagantly, or to no purpose.

Abuse

Abuse may be intentional or unintentional, and directly or indirectly results in unnecessary or increased costs to the Medicaid Program.

Some of the significant anti-fraud, waste, and abuse laws are:

- The False Claims Act (31 USC §§ 3729-3733) prohibits knowingly presenting (or causing to be presented) to the Federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the Federal government or its agents, like a carrier, other claims processor, or state Medicaid program. Because your payments from PHP ultimately derive from Federal funds, you may not submit any false or fraudulent claims or other records to PHP for payment or approval. If you find that a claim you originally believed was correct was not, you have a continuing obligation to disclose that to PHP.

- The Anti-Kickback Statute (42 USC § 1320a-7b) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal health care programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

- The Physician Self-Referral ("Stark") Statute (42 USC §1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Florida also has state-law counterparts to these laws, which prohibit similar conduct as it relates to state-regulated government healthcare programs. Penalties for violating these state or Federal laws can be significant – for example, $10,000 per violation and exclusion from Federal health care programs, including Medicare and Medicaid.

Education and Training

Additionally, as a person who contracts with PHP, you and, as applicable, your employees, agents, and contractors must comply with CMS education and training requirements related to fraud, waste, and abuse ("FWA"). (See 42 CFR §§ 422.503(b)(4)(vi)(C) and 423.504(b)(4)(vi)(C).) You are required to maintain evidence of your education and training (i.e., training materials, logs, and sign-in sheets) and provide certifications of completion to PHP upon request.

You may fulfill your FWA training requirements by either (a) using materials provided by PHP (such as this section of the Provider manual, or other materials that may be made available from time to time), (b) using your own FWA materials, or (c) taking training from Medicare Plan or organization, as long as the training program complies with Federal and state guidelines.

If you have contracted with other entities or persons to provide health and/or administrative services for PHP beneficiaries, you will need to obtain attestations from those entities that they have completed FWA training and copies of their training logs.

Reporting Fraud, Waste and/or Abuse

If you or, as applicable, your employees, agents, or contractors identify potential fraud, waste, or abuse, contact the Plan's Compliance Hotline at (800) 243-7448, or by writing to:

Attn: Compliance Officer
PHP
1001 N. Martel Ave.
Los Angeles, CA 90046

As situations require, we may also refer the case to Centers for Medicare and Medicaid Services (CMS), appropriate law enforcement and Federal or state agencies.

Anti-Retaliation Policy

PHP has a strict policy against retaliating against anyone who, in good faith, makes a report, complaint, or inquiry regarding a compliance issue. Providers must follow this same policy with respect to their employees. Under the Whistle Blower or qui tam provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. Government and may share a percentage of the recovery realized from a successful action.

Section 32: Infection Prevention and Control

PHP is committed to minimizing the risk of infection and to the safety of patients. It is essential that all aspects of infection control best practices be comprehensively covered, documented, and shared with all persons in your practice environment. Adherence to infection prevention and control best practices promotes optimal safety for both patients and staff. All PHP participating provider s must have policies that address the following areas:

1. Standard precautions (based on CDC & OSHA guidelines)
    a. Hand washing procedures
    b. Protective clothing (if appropriate)
    c. General dress code
    d. Handling and disposal of healthcare waste including sharps and single use-devices
2. If medical procedures are conducted within the practice environment, policies should address proper infection control procedures, including but not limited to: venipuncture/lab draws; urine specimens; vaccinations; and microbiological swabs or smears. Proper handling of specimens needs to be clearly identified and the correct process implemented consistently.
3. Recommendations on the preferred methods for cleaning, disinfection and sterilization of patient-care medical devices and for cleaning and disinfecting the healthcare environment.
4. Thorough knowledge of incident reporting to proper authorities
    a. Internal – Office Administrator or Nurse Manager
    b. External – State and Federal agencies, when required to do so

All policies and procedures must be part of routine staff training with completion of the training well documented to ensure all staff understand and comply with the required policies.

Web addresses for **CDC** and **OSHA** are supplied for your use.

Centers for Disease Control
www.cdc.gov

Occupational Safety & Health Agency
www.osha.gov

Section 33: Environmental Safety

Safety Program

The Occupational Safety & Health Administration (OSHA) states that people have the right to a safe work environment, and employers must take the proper precautions to maintain safety in the workplace. Equally important is the right that patients have to receive their care & treatment in a safe environment. Practicing safety in a medical office begins with defining safety as it relates to the work environment. Safety management protocols should take into account potential risks and threats in the environment to minimize and eliminate those potential risks. PHP network providers are responsible to develop and maintain a safety plan that addresses the following areas.

1. **Environmental safety** –includes making sure that all areas in your practice location are: free from hazardous materials, compliant with all required and current fire safety codes, and compliant with all licensing regulations, such as appropriate needle disposal and proper sterilization of medical instruments, equipment and rooms.
2. **Medication handling and storage**- includes prevention of unauthorized access, labeling and logging practices, and of drug dispensing according state regulations and laws.
3. **Safe patient handling** –includes training for prevention of musculoskeletal injuries for staff and patients due to falls and lifting, and use of proper assistive devices.
4. **Exposure control and sharps injury prevention** – includes proper sharps disposal and handling, safety systems to minimize staff risk for exposure to blood and body fluids, policy outlining procedure in the event of a breach in safe handling.
5. **Security** –includes security both in entering and exiting the practice location, safety from hazards within the practice location, and instruction on handling a patient that becomes threatening or unauthorized entry of persons in your practice location.

Emergency and Disaster Preparedness

Internal Emergencies

Preparation is essential for medical emergencies in your practice environment. A well - documented plan, with advance instruction and training with your staff is essential in the event of a real emergency. PHP network providers are responsible to ensure patients, staff, and visitors to their practice are in well-

trained hands in the event of an emergency. An emergency preparedness program should include the following:

1. Purchase of emergency equipment and medications that reflect the spectrum of anticipated emergencies in their patient populations
2. Maintenance of current certification in basic life support (minimum) or advanced life support courses for all office staff
3. Creation of a written emergency protocol that outlines the steps to be followed in the event of a medical office emergency
4. Periodic staff training in the proper use of emergency, safety and fire-extinguishing equipment

The most common office emergencies Provider offices should be prepared for are below. Emergency conditions by setting type are listed in order of incidence.

Primary Care	Child Care
Asthmas exacerbation	Asthmas exacerbation
Psychiatric	Severe respiratory distress
Seizure	Meningitis/sepsis
Hypoglycemia	Seizure
Anaphylaxis	Apnea
Impaired consciousness	Anaphylaxis
Shock	Shock
Poisoning	Obstructed airway
Drug overdose	Probable epiglottis
Cardiac arrest	Cardiac arrest

PHP primary care offices should maintain emergency supplies including the following. Specialty care offices can adapt this list to meet the needs of their patient population.

Equipment	Medications
Bag mask ventilator (two sizes, three mask sizes)	Acetaminophen (rectal suppositories)
Blood pressure cuff (all sizes)	Albuterol (Proventil)
Glucose meter	Aspirin
Intra-osseous needle (18 & 16 gauge)	Ceftriaxone (Rocephin)
Intravenous catheter/butterfly needles (24 to 18 gauges)	Corticosteroids, parenteral
IV tubing – extension & T-connector	Dextrose, 25%

Nasal airways (one set)	Diazepam, parenteral (Valium)
Nasogastric tube	Diphenhydramine, oral & parenteral (Benadryl)
Nebulizer or metered dose inhaler spacer & face masks	Epinephrine (1:100, 1:10,000)
Non-rebreather (three sizes)	Flumazenil (Romazicon)
Oxygen mask (three sizes)	Lorazepam, sublingual (Ativan)
Oxygen tank & flow meter Portable suction device & catheters, or	Morphine (MS Contin) Nitroglycerine spray
bulb syringe	
Pulse oximeter for child & adult usage	

Resuscitation tape – color-coded	Saline, normal
Universal precautions (latex-free gloves, mask, eye protection)	

Disaster Preparedness & Readiness

Each area of the country has its own potential for a natural disaster, whether it is flooding, earthquakes, tornadoes or hurricanes. PHP providers need to recognize and plan for the potential disasters that may occur and make sure staff is also ready to respond. All PHP providers are responsible to ensure the following processes and regulations are met in accordance with Federal, state, and local regulations and laws.

1. Evidence of staff safety training and policies and procedures for the following: fire safety and prevention, site evacuation, clear emergency lighting, exit signs, emergency power capabilities, and unobstructed and safe evacuation routes.
2. Data back-up plans including your billing, electronic health record, and accounting systems.
    a. If still using paper records, implement the "three lock" rule – that is securing your charts in a storage unit and room that is rated for fire, smoke, and water resistant.
3. State and local building code compliance

Physician & Staff Training

Staff education and training is critical for the effective response to any medical emergency or disaster preparedness. PHP network provider office staff must undergo basic life support training, including CPR. Additional training may be indicated for other staff in the setting and should be consistent with national standards of care and congruent with the professional skills of the trainee.

Emergency Drills

The best way to make sure everything goes as planned in an emergency is to make sure everyone is clear on their assignment and that emergency drills such as fire and CPR are scheduled annually so everyone has the chance to practice the plan you have in place. Drills in non-emergent situations allow you to practice and see what works well and what needs attention. You want your staff well-trained and responding appropriately in a real emergency and practicing is the best way to ensure everyone is prepared when it counts.

Section 34: Definitions

The following are definitions that are specific this publication:

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, (whether statutory or as recognized by the courts of the State) relating to the provision of health care when the individual is incapacitated.

AIDS —The Centers for Disease Control and Prevention (CDC) definition of Acquired Immune Deficiency Syndrome includes all HIV-infected persons who have been less than 200 CD4+ T-lymphocytes/uL (or CD4+ T-lymphocytes/uL percentage of total lymphocytes of less than 14) or one of the clinical conditions as provided in the CDC's most currently published Classification System for HIV Infected and Expanded Surveillance Case Definition for AIDS that can be found at www.cdc.gov/hiv.

Appeal — A request for review of an Action, pursuant to 42 CFR 438.400(b).

Benefits — A schedule of health care services to be delivered to member covered by the health plan set forth in Part 4 (Covered Services) in this publication.

Children/Adolescents — Members under the age of 18.

Clinical Guidelines for HIV/AIDS Care – The latest anti-retroviral regimen and treatments recommended by the U.S. Department of Health & Human Services. To receive a copy of the guidelines contact the DOH, Bureau of HIV/AIDS at (800) 245-4334, or www.aidsinfo.nih.gov/guidelines.

CMS – The Centers for Medicare & Medicaid Services, which oversees Medicare and shares responsibility with states for Medicaid.

Demonstrated Experience in the Treatment of HIV/AIDS – To demonstrate experience as an HIV-qualified Provider a person should show continuous professional development through clinical, behavioral or case management of at least 20 HIV-infected patients in the last two (2) years with a minimum of eight (8) contact hours annually of HIV specific continuing medical education (CME) that includes information on the use of antiretroviral therapy.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

With respect to a pregnant woman:

- That there is inadequate time to affect safe transfer to another Hospital prior to delivery;
- That a transfer may pose a threat to the health and safety of the patient or fetus;
- That there is evidence of the onset and persistence of uterine contractions or rupture other membranes

Emergency Services and Care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services and Care includes the care or treatment that is necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the facility.

Member — A Medicare Recipient currently enrolled in the health plan.

Expanded Services — A health plan covered service for which it receives no direct payment from the Agency.

External Quality Review (EQR) — The analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that are furnished to Medicare recipients by a health plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in Federal regulation

42 CFR 438.354, and performs EQR, other related activities as set forth in Federal regulations or both.

Grievance — A grievance is any complaint or dispute (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its Providers, regardless of whether remedial action is requested.

Health Plan — An entity that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of Providers, which deliver services and frequently shares financial risk. For the purposes of this Contract, a health plan has also contracted with the Centers for Medicare & Medicaid Services (CMS) to provide healthcare to Medicare beneficiaries.

HIV/AIDS Specialist Physician — A physician who is licensed in the State of California and who meets any one of the following criteria: (1) Is credentialed as an AAHIVM HIV Specialist by the American Academy of HIV Medicine; (2) Is board certified in the field of infectious diseases and, if not certified in the last year through the American Board of Medical Specialties, has clinically managed a minimum of 25 patients in the preceding 12 months, as well as successfully completed a minimum of 10 hours of continuing medical education (CME) with at least five (5) hours related to antiretroviral therapy in the last year; and (3) meets the criteria of an HIV-qualified physician as defined by the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America.

HIV Infected Member — All eligible members who are HIV-positive but asymptomatic; individuals with symptomatic HIV disease; and individuals with CDC-defined AIDS.

Licensed — A facility, equipment, or an individual that has formally met state, county, and local requirements, and has been granted a license by a local, state or Federal government entity.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

Medicaid Recipient — Any individual whom DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to Federal and State law, to receive medical or allied care, goods or services for which the

Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medical Record — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

Medically Necessary or Medical Necessity — Services that include medical or allied care, goods or services furnished or ordered that must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
3. Be consistent with the generally accepted professional medical standards as determined by the Medicare program, and not be experimental or investigational;
4. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the Provider.

Medically Necessary or Medical Necessity for those services furnished in a Hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a Provider has prescribed, recommended or approved medical or allied goods, or a service does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Medicare — The Federal medical benefits program authorized by Title XVIII of the Social Security Act.

Medicare Beneficiary — Any individual whom the Social Security Administration determines is eligible, pursuant to Federal and State law, to receive medical or

allied care, goods or services for which the Administration may make payments under the Medicare program, and who is enrolled in the Medicare program.

Non-Covered Service — A service that is not a Covered Service/Benefit.

Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a twenty-four (24) hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with the health plan to provide specialized medical services to the health plan's members.

Primary Care — Comprehensive, coordinated and readily-accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Provider (PCP) — A health plan staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioners, physician assistants or other specialty approved by the Agency, who furnishes Primary Care and patient management services to an member.

Prior Authorization — The act of authorizing specific services before they are rendered.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity that has a Medicare Provider agreement in effect with the Centers for Medicare & Medicaid Services (CMS), and a contractual agreement with the health plan.

Provider Contract — An agreement between the health plan and a health care provider as described above.

Quality —The degree to which a health plan increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Improvement (QI) — The process of monitoring and assuring that the delivery of health care services are available, accessible, timely, medically necessary, and provided in sufficient quantity, of acceptable quality, within established standards of excellence, and appropriate for meeting the needs of the members.

Quality Improvement Program (QIP) — The process of assuring the delivery of health care is appropriate, timely, accessible, available and medically necessary.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Subcontract — An agreement entered into by the health plan for provision of administrative services on its behalf.

Subcontractor — Any person or entity with which the health plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

Transportation — An appropriate means of conveyance furnished to a member to obtain Medicare-authorized/covered services.

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or do substantially restrict a member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Well Care Visit — A routine medical visit for one (1) of the following: routine follow-up to a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.

Part 35: Community Based Resources

PHP Florida has a network of information and referral organizations linking members to appropriate assistance in their community. Providers and members are encouraged to access the resources below or contact PHP Florida's Utilization Management/Case Management Department for further assistance with member specific resource needs at (866) 990-9322, Monday through Friday, 8:30 am to 5:30 p.m.

Resource	Contact Information	Description
California's Smokers' Helpline	(800) NO BUTTS (800) 662-8887	This toll-free cessation hotline is a service of the CA Department of Health. It provides county-specific resources around the State to assist in smoking cessation.6
Women, Infants and Children (WIC)	(800) 342-3556	A nutrition program for women, infants and children.
Healthy Start Program	(800) 451-2229	A program for women and teenagers to obtain medical services, social services and instructional support in the areas of pregnancy, family planning, substance abuse, mental health and counseling.
National Domestic Violence Hotline	(800) 799-7233	A 24-7 hotline that provides facts and information about domestic violence.
Los Angeles, CA Elder/Senior Housing Placement and Referral Agency	www.carewatchers.org 24 Hour hot line (800) 564-8185	An area guide to senior residences and care options.

Resource	Contact Information	Description
Community And Senior Services: Aging & Adult Services-Information And Referral – Los Angeles County 3333 Wilshire Blvd Ste 1000 Los Angeles, CA 90010	(877) 477-3646	A website that provides information on domestic violence, mental health, substance abuse, grief, pregnancy, crisis, housing assistance, disability, cancer and HIV.
HIV/AIDS Treatment Guidelines	www.aids.gov www.cdc.gov/hiv www.aidsinfo.nih.gov www.mentalhealth.samhsa.gov/cmhs/HIVAIDS www.floridashealth.com/Disease_ctrl/aids/index.html	

Section 36: Forms

These forms follow:

1. Authorization Request Form
2. Prescription Drug Authorization Request Form
3. Provider Dispute Resolution Form
4. Provider Grievance Form

The forms are available in the Provider section of the Plan website found at:
www.positivehealthcare.org

Authorization Request Form

Authorization Request

Instructions

Prior authorizations are required for all procedures and medical services listed in the table below, and for any specialist visits beyond initial and follow-up appointments. **Providers and facilities must be in network.** Complete this form in its entirety, include supporting clinical documentation and fax it to Utilization Management at (888) 272-7656. Routine authorization requests are processed within 14 calendar days for PHP and 5 business days for PHC and Medically Expedited Requests within 72 hours for both PHP and PHC. Patient eligibility should be verified at time of service. Please call (800) 474-1434 for authorization status. Claim(s) will be paid if a prior authorization has been granted and member is eligible. Approved authorizations are valid up to 90 days. After that time, a new request will need to be submitted along with updated supporting documentation when applicable. Inpatient Acute, Psychiatric and Skilled Nursing Facility (SNF) authorizations are subject to concurrent review.

MEDICALLY EXPEDITED/URGENT REQUESTS: THE DEFINITION OF URGENT/EXPEDITED SERVICE REQUEST DESIGNATION IS WHEN THE TREATMENT REQUESTED IS REQUIRED TO PREVENT SERIOUS DETERIORATION IN THE MEMBER'S HEALTH OR COULD JEOPARDIZE THE ENROLLEE'S ABILITY TO REGAIN MAXIMUM FUNCTION. REQUESTS OUTSIDE OF THIS DEFINITION SHOULD BE SUBMITTED AS ROUTINE/NON-URGENT. URGENT/EXPEDITED REQUESTS THAT DO NOT MEET MEDICAL CRITERIA WILL BE DOWNGRADED TO A STANDARD REQUEST.

Eligibility Verification: For **PHP California (HMO SNP)** (Medicare Advantage Part D plan) and **PHC California** (Medi-Cal HMO plan) eligibility verification, please call (800) 263-0067.

Specialty Services Requiring Prior Authorization

- All inpatient care (acute, subacute, SNF, and long-term)
- Home health care, including skilled nursing, rehab, and home infusion
- Imaging studies (excluding mammography, x-ray and ultrasounds or single/flat view studies) and nuclear medicine
- Interventional radiology
- Outpatient surgery, rehabilitation including PT/OT/ST and chemotherapy
- Photo and radiation therapy
- Wound care
- Injectables (Part B) administered in physician's office other than immunizations administered by a PCP
- Durable medical equipment (DME)
- Dialysis in service area
- Colonoscopy and endoscopy
- EMG, nerve conduction studies
- Hearing aids
- Orthotics and prosthetics
- Cardiac testing (excluding EKG) and catheterization

Date of Request: _____ ☐ Medically Expedited (subject to review)

Patient Information

_____
Patient Name

Select Plan Option:
☐ PHP (Medicare)
☐ PHC (Medi-Cal)

_____ _____
Member ID Number Birth Date

_____ _____ _____ _____
Primary Care Provider Name Contact Phone Fax

Referring Provider Information

_____ _____ _____ _____
Provider Name Person Filling out this Form Direct Phone Direct Fax

Indication for Referral

Diagnosis(es)/Code(s) _____

CPT Code(s) _____

List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data _____

_____

Requested Consultation or Service _____

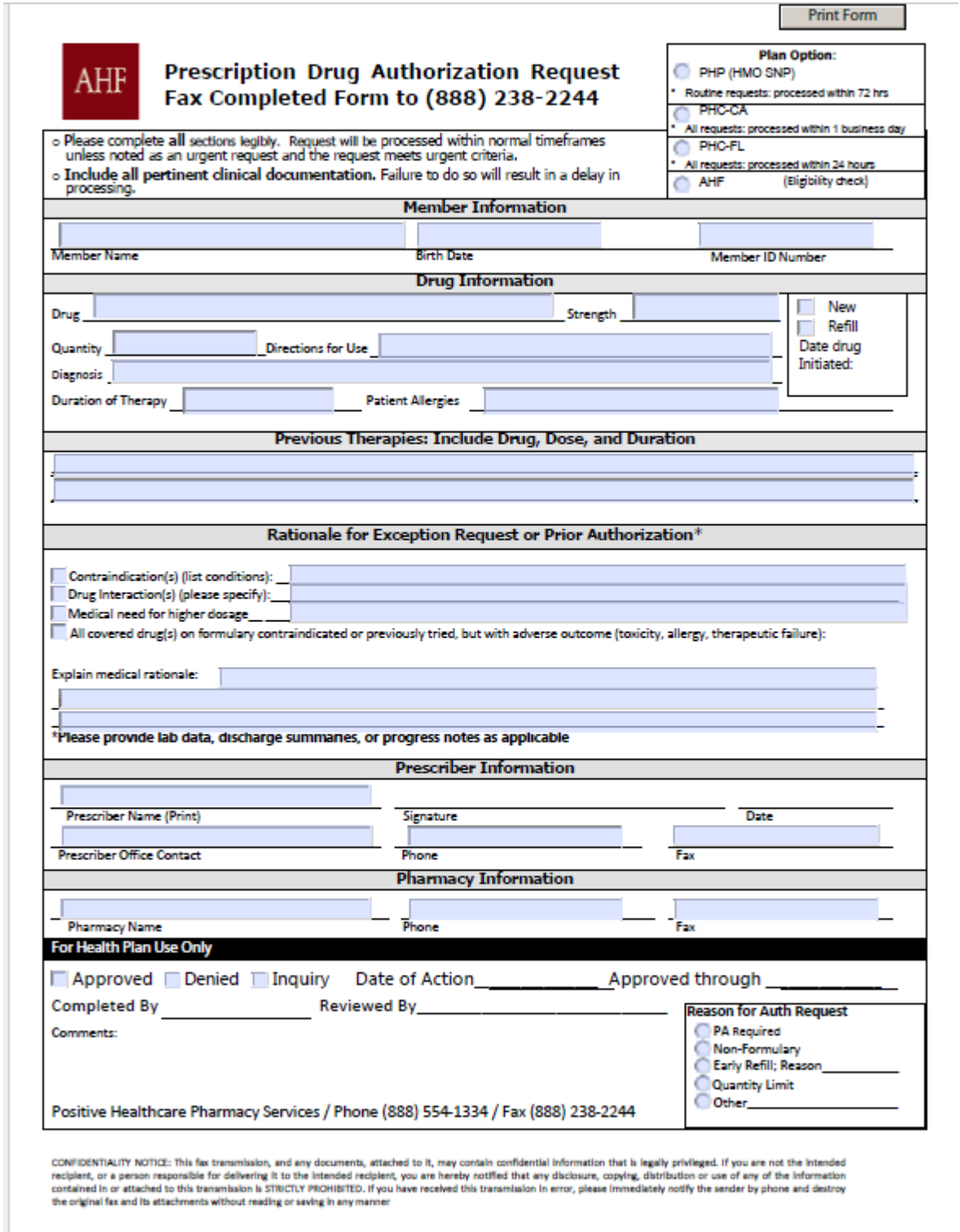
Requested (Refer to) Provider Information

_____ _____ _____
Requested Provider/Facility Name Phone Fax

Fax authorization requests to Utilization Management at (888) 272-7656. Routine authorization requests are processed within 14 Calendar days for PHP and 5 Business days for PHC. Please call (800) 474-1434 for authorization status.

Rev. 04102017

Prescription Drug Authorization Request Form



Print Form

AHF

Prescription Drug Authorization Request
Fax Completed Form to (888) 238-2244

Plan Option:
- PHP (HMO SNP) — * Routine requests: processed within 72 hrs
- PHC-CA — * All requests: processed within 1 business day
- PHC-FL — * All requests: processed within 24 hours
- AHF (Eligibility check)

- Please complete **all** sections legibly. Request will be processed within normal timeframes unless noted as an urgent request and the request meets urgent criteria.
- **Include all pertinent clinical documentation.** Failure to do so will result in a delay in processing.

Member Information

Member Name | Birth Date | Member ID Number

Drug Information

Drug | Strength | New | Refill | Date drug Initiated:

Quantity | Directions for Use

Diagnosis

Duration of Therapy | Patient Allergies

Previous Therapies: Include Drug, Dose, and Duration

Rationale for Exception Request or Prior Authorization*

- Contraindication(s) (list conditions):
- Drug Interaction(s) (please specify):
- Medical need for higher dosage
- All covered drug(s) on formulary contraindicated or previously tried, but with adverse outcome (toxicity, allergy, therapeutic failure):

Explain medical rationale:

***Please provide lab data, discharge summaries, or progress notes as applicable**

Prescriber Information

Prescriber Name (Print) | Signature | Date

Prescriber Office Contact | Phone | Fax

Pharmacy Information

Pharmacy Name | Phone | Fax

For Health Plan Use Only

Approved | Denied | Inquiry | Date of Action | Approved through

Completed By | Reviewed By

Comments:

Reason for Auth Request
- PA Required
- Non-Formulary
- Early Refill; Reason
- Quantity Limit
- Other

Positive Healthcare Pharmacy Services / Phone (888) 554-1334 / Fax (888) 238-2244

CONFIDENTIALITY NOTICE: This fax transmission, and any documents, attached to it, may contain confidential information that is legally privileged. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify the sender by phone and destroy the original fax and its attachments without reading or saving in any manner

Provider Dispute Resolution Forms

PROVIDER DISPUTE RESOLUTION FORM

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please [indicate whether your organization uses a Claims Follow-Up Form or indicate how providers should inquire on claims status, e.g., customer service phone number].
- Mail the completed form to: PHP
  P.O. Box 7490
  La Verne, CA 91750

*PROVIDER NAME:	*PROVIDER TAX ID # / NPI #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims:*___

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED ____ NON-CONTRACTED ____

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Page _____ of _____

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)

Provider Grievance Form

Provider Grievance Form

Provider Name:	Date of Complaint:
Address:	Complaint Filed by:
	Member Information (if applicable):
Telephone:	Member Name: ID#: DOB:
Fax:	

Description of the Grievance/Complaint:

Action Requested by Provider:

Supporting Documentation:

Provider or Representative Signature:	Date:

Submit form to Provider Relations, Positive Healthcare Partners, 110 SE 6th St., Ste. 1960, Ft. Lauderdale, FL 33301, or fax to Provider Relations at (954) 522-3260.

PHPFL 062310