FirstChoice VIP CARE PLUS
by Select Health of South Carolina

Healthy Connections PRIME

Provider Manual

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Welcome

Welcome to First Choice VIP Care Plus by Select Health of South Carolina, headquartered in Charleston, South Carolina. Select Health is a member of the AmeriHealth Caritas Family of Companies, a mission-driven managed care organization that has served its members for over thirty (30) years. The First Choice VIP Care Plus product is available to qualified residents of South Carolina who are enrolled in Medicare and South Carolina Healthy Connections Medicaid.

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

No content found in this publication or in the First Choice VIP Care Plus participating network provider agreement is intended to be interpreted as encouraging providers to restrict medically- necessary covered services or limit clinical dialogue between providers and their patients.
Regardless of benefit coverage limitations, providers should openly discuss all treatment options that are available.

This *Provider Manual* may be changed or updated periodically. Revisions will be posted on our website

Table of Contents

I. FIRST CHOICE VIP CARE PLUS OVERVIEW

Who We Are

Select Health of South Carolina has partnered with the Centers for Medicare and Medicaid Services (CMS) and the State of South Carolina to support the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Prime demonstration to integrate Medicaid and Medicare services for dual-eligible South Carolina residents. Select Health was selected by the SCDHHS as one of four Coordinated and Integrated Care Organizations (CICO).

Select Health is proud to partner with the CMS and SCDHHS to offer this plan – First Choice VIP Care Plus.

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

About Our Programs

Healthy Connections Prime was created for dual eligible members to better coordinate the care and services they receive from the Medicare and Healthy Connections Medicaid programs. The Medicare program is administered through CMS. South Carolina's Healthy Connections Medicaid program is administered through SCDHSS. Select Health will be providing all covered Medicare and Healthy Connections Medicaid services for its members who are enrollees of Healthy Connections Prime in South Carolina.

Program Eligibility

Members are eligible to enroll in First Choice VIP Care Plus if they are:

- Age 65 or older at the time of enrollment; and
- Entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D, and receiving full Healthy Connections Medicaid benefits.
- Individuals, who meet the above criteria and enrolled in the following programs are eligible to enroll:
    - Community Choices Waiver
    - HIV/AIDS Waiver
    - Mechanical Ventilation Waiver

Plan Overview

First Choice VIP Care Plus is contracted to provide Medicare Hospital (Part A), Medical (Part B) services and Prescription Drug Coverage (Part D) and Healthy Connections Medicaid services in the State of South Carolina**.** Members must live in the State of South Carolina to join the plan.
Please refer to Section III of this *Provider Manual* for a full description of Plan benefits including supplemental benefits.

Member Enrollment

First Choice VIP Care Plus accepts members with dual Medicare and Healthy Connections Medicaid eligibility.

First Choice VIP Care Plus accepts all members who voluntarily enroll and members who are assigned without restriction through the SCDHHS state enrollment broker, and in the order in which they

enroll. First Choice VIP Care Plus will work with CMS and SCDHHS to utilize the state enrollment broker, South Carolina Healthy Connections Choices, as defined by CMS and SCDHHS.

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

First Choice VIP Care Plus members may change plans or opt out of the demonstration from month to month. Members may call the enrollment broker, South Carolina Healthy Connections Choices, at 1-(877)-552-4642 to make these changes. First Choice VIP Care Plus will work with South Carolina Healthy Connections Choices as directed by the state.

Role of the Healthy Connections Prime Enrollment Broker

South Carolina Healthy Connections Choices will employ Enrollment Counselors who will assist people in reviewing, completing, and submitting Healthy Connections Prime enrollment materials if an individual asks for assistance with or information about enrolling, opting-out, or switching plans. Enrollment counselors will review all CICO plan options with individuals and provide unbiased information to the enrollee. Enrollees may be referred to Enrollment counselors from a variety of sources including First Choice VIP Care Plus member services.

Primary Care Selection & Assignment

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

- Match of member's language preference (if available)
- Existing provider relationships including Home and Community Based Services (HCBS)
- Selection of a PCP closest to the member's residence based on zip code

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

- The member's name and Member ID number
- First Choice VIP Care Plus's name, mailing address and member services number

First Choice VIP Care Plus Integrated Care Member ID card

Member Identification and Eligibility Verification

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

Eligibility may be checked by:

- Visiting the provider area of the First Choice VIP Care Pluswebsite, www.firstchoicevipcareplus.com, to access a free, web-based application for electronic transactions and information through NaviNet, a multi-payerportal.
- Calling Provider Services at 1-(888)-978-0862.
- Using First Choice VIP Care Plus's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- The Web Tool available through SCDHHS – Result will show whether an individual is eligible for Healthy Connections Prime and which plan they are enrolledwith
- CMS Eligibility will result in the Contract Number H8213 which denotes Select Health of South Carolina's First Choice VIP Care Plus.
- Asking to see the member's Plan ID card. Members are instructed to keep the ID card with them at all times. The member's ID card includes:
  - The member's name, First Choice VIP Care Plus ID number, and the Plan's name, address and Member Services telephone number.

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

Member Rights and Responsibilities

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

Member Rights

- To be treated with dignity and respect.
- To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting medical care.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To have their medical records remain private, according to HIPAA rules.
- To have access to services, both clinical and non-clinical, regardless of whether a member has limited English proficiency or reading skills, has a diverse cultural and ethnic background, or a physical or mental disability.

- To receive free translation services as needed, including help with sign language, if hearing impaired.
- To participate in making decisions about their own medical care, including the right to refuse treatment.
- To receive a full, clear and understandable explanation of treatment options and the risks of each option in order to make an informed decision, regardless of cost or benefit coverage.
- Female members have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.
- Members have the right to designate a participating and willing specialist as their PCP.
- To refuse treatment or care. Refusal of treatment is not considered a reason to request disenrollment of the member from a physician's practice.
- To have access to medical records in accordance with applicable Federal and State of South Carolina laws.
- To choose a PCP from First Choice VIP Care Plus' list of providers.
- To change a PCP and choose another one from First Choice VIP Care Plus' list of providers.
- To voice his or her complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the First Choice VIP Care Plus Member Handbook or other procedures adopted by First Choice VIP Care Plus for such purposes.
- To be provided good quality care without unnecessary delay.
- To inform contracted providers that he or she refuses treatment, and to expect to have such providers honor his or her decision if he or she chooses to accept the responsibility and the consequences of such a decision. In this event, members are encouraged (but not required) to:
    - Complete an advance directive, such as a living will and provide it to contracted plan providers.
- To receive a copy of the *Member Handbook*.
- To continue in current treatment until a new treatment plan is in place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of incentive plans for First Choice VIP Care Plus's practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.
- To receive a copy of First Choice VIP Care Plus's prescription drug formulary.
- To receive a copy of First Choice VIP Care Plus's "Dispense as Written" policy for *prescription* drugs.
- To receive information about First Choice VIP Care Plus, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To seek a second opinion from a qualified health care professional. To be informed of any cost-sharing obligations upon becoming a Plan member and at least 30 days prior to any change.
- To be informed about how and where to access any benefits that are available under the Healthy Connections Prime program but are not covered by First Choice VIP Care Plus.
- First Choice VIP Care Plus members have the right to receive non-emergency transportation to get health care services 24 hours a day, 365 days a year.
- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).
- To request information on the structure of First Choice VIP Care Plus.

- To be treated no differently by providers or by First Choice VIP Care Plus for exercising the rights listed here.
- To call or write First Choice VIP Care Plus any time with comments, questions, and observations regarding positive or constructive comments. Members may also make recommendations about the members' rights and responsibilities.
- To change plans or opt out of the demonstration.

Member Responsibilities

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

Members should consult their Member Handbook for more information on their rights and responsibilities.

Plan Privacy and Security Procedures

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

II. Provider and Network Information

This section provides information for obtaining and maintaining network privileges and sets forth expectations and guidelines for Primary Care Providers (PCPs), Specialists and Facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is also provided in the "Behavioral Health Care" section of this *Provider Manual*.

Becoming a Plan Provider

Health care providers are invited to participate in the First Choice VIP Care Plus network based on their qualifications and an assessment and determination of the network's needs. Providers must be enrolled in Medicare and Healthy Connections Medicaid in order to be credentialed with First Choice VIP Care Plus.

Provider Credentialing and Re-credentialing

First Choice VIP Care Plus is responsible for credentialing and re-credentialing its network of providers. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is provided in the "Behavioral Health Care" section of this *Provider Manual*.

Hospital-based physicians are not required to be independently credentialed if those providers serve First Choice VIP Care Plus members only through the hospital and those providers are credentialed by the hospitals.

First Choice VIP Care Plus maintains criteria and processes to credential and re-credential the following practitioners:

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

First Choice VIP Care Plus maintains criteria and processes to credential and re-credential the following provider types:

- Hospitals – Acute Care and Acute Rehabilitation
- Ancillary Facilities
- Home Health Agencies/Home Health Hospice
- Skilled Nursing Facilities

- Skilled Nursing Facilities, Providing Sub-Acute Services
- Nursing Homes
- Free-Standing Surgical Centers
- Sleep Center/Sleep Lab - Freestanding
- Durable Medical Equipment (DME) Suppliers
- Clinical laboratories (a CMS-issued CLIA certificate (or waiver) or a hospital- based exemption from CLIA)
- Free Standing Imaging Centers
- Providers of outpatient diabetes self-management training
- Providers of ESRD services
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Providers of Long-Term Support Services (home-delivered meals, home modification, etc.)

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

First Choice VIP Care Plus's credentialing/re-credentialing criteria and standards are consistent with the Centers for Medicare and Medicaid Services and the State of South Carolina's requirements and NCQA standards. Practitioners and facility/organizational providers are re- credentialed every three years.

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

Through CAQH, providers submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. First Choice VIP Care Plus's goal is to have all providers enrolled with CAQH. There is no charge to providers to submit applications and participate in CAQH. Providers not already registered for CAQH may do so via a link from www.firstchoicevipcareplus.com.

Providers may access credentialing requirements and all the required documents via First Choice VIP Care Plus's website at www.firstchoicevipcareplus.com and submit to First Choice VIP Care Plus as follows:

- Send CAQH ID number along with additional required documents to First Choice VIP Care Plus via email, fax, or mail to the Provider Network account executive. Visit the provider area of our website at www.firstchoicevipcareplus.com for the most current credential checklist, required documents, and contact information.
- Providers who are not affiliated with CAQH or who prefer a paper credentialing process may contact their First Choice VIP Care Plus Provider Network account executive for assistance or visit the provider area of our website at www.firstchoicevipcareplus.com for the most current checklist, required documents, and contact information. Paper applications may be emailed, faxed, or mailed to the Provider Network account executive.

Credentialing/Re-Credentialing Criteria and Standards

First Choice VIP Care Plus applies credentialing and re-credentialing criteria for all professional providers that, at a minimum, meet all applicable federal and state requirements.

To that end First Choice VIP Care Plus's criteria include:

1. Current unrestricted professional licensure;
2. No revocation or suspension of the provider's State license by the applicable State licensing board;
3. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106);
4. Proof of the provider's professional school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training;
5. Evidence of specialty board certification, if applicable;
6. Evidence of the provider's professional liability insurance coverage, and claims history;
7. Satisfactory review of any sanctions imposed on the provider by Medicare or Healthy Connections Medicaid;
8. The provider's Medicare identification number, Healthy Connections Medicaid ID number, Healthy Connections Medicaid provider registration number or documentation of submission of the Healthy Connections Medicaid provider registration form whenever applicable. Plan laboratory providers will provide Clinical Laboratory Improvements Amendments (CLIA) certification (or waiver).
9. The provider has not opted out of Medicare.

In addition, First Choice VIP Care Plus's credentialing and re-credentialing processes include verification of the following additional requirements for physicians:

1. For primary care physicians and specialists–privileges in good standing at a participating hospital designated by the practitioner. If the provider does not have admitting privileges, the provider must submit in writing the name of the participating provider with whom the provider has an arrangement for admitting the provider's patients;
2. Valid Drug Enforcement Administration (DEA) certificate, where applicable;
3. Current State Controlled Substance Certificate (CDS).

As part of the application process First Choice VIP Care Plus will**:** Request information on provider sanctions prior to making a credentialing or re-credentialing decision. Information is sought from the National Practitioner Data Bank (NPDB), and the HHS Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Federation of Chiropractic Licensing Boards (CIN-BAD), System for Award Management (SAM) and Healthy Connections Medicaid Excluded Provider List.

Initial Site Visit Review

As part of First Choice VIP Care Plus's credentialing process, new practitioners (and new practice locations) are required to meet minimal criteria for office settings and medical record keeping in order to be considered for inclusion in the provider network. These initial site visit

requirements also apply to practitioners joining previously surveyed locations, as well as the new practice locations of previously surveyed practitioners.

To address any areas of deficiency identified on the initial visit, First Choice VIP Care Plus requires a corrective action plan be submitted to the Plan within one week of the visit. Re-survey of the site will occur within thirty (30) calendar days to ensure standards have been met.
Practitioners not meeting the minimal performance standard threshold of 85% will be reviewed by the First Choice VIP Care Plus Medical Director and Credentialing Committee for recommendation.

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

Site Visits Resulting from Receipt of a Complaint and/or On-going Monitoring

Member Dissatisfaction Regarding Office Environment

1. The Provider Services department or Provider Network Management department may identify the need for a site visit due to receipt of an issue with member dissatisfaction regarding the provider's office environment.
2. At the discretion of the Provider Network Account Executive, a site visit may occur to address the specific issue(s) raised by a member. Follow-up site visits are conducted as necessary.
3. These focused site visits, where a full site visit evaluation is not performed, do not count toward the three-year site visit requirements.

Communication of Results

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

Follow-Up Procedure for Initial Deficiencies

1. The Provider Network Account Executive requests a corrective action plan from the office contact person. The corrective action plan must be submitted to First Choice VIP Care Plus within one (1) week of the visit.
2. Each follow-up contact and visit is documented in the provider's electronic file.
3. The Provider Network Account Executive schedules a re-evaluation visit with the provider office within thirty (30) calendar days of the initial site visit to review the site and verify that the deficiencies were corrected.
4. The Provider Network Account Executive reviews the corrective action plan with the office contact person.
5. The Provider Network Account Executive reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact person.
    - If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office contact person.

- If the site does not meet and/or exceed the passing score the Provider Network Account Executive follows the procedures outlined below for follow-up for secondary deficiencies.

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

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

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

Re-Credentialing

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

- Application – South Carolina Managed Care Provider Credentials Update Form or Practitioner CAQH ID Number
- Office Hours / Service Addresses
- Supporting Documents – State Professional License, Federal DEA Registration (if applicable), State-Controlled Substance Certificate (if applicable), Malpractice Face Sheet and Clinical Laboratory Improvement Amendments (CLIA) Certificate (if applicable)

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

Facility Credentialing Criteria

First Choice VIP Care Plus's credentialing criteria for facilities include:

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

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

Practitioner Credentialing Rights

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

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

Questions regarding the status of a credentialing application may be directed to the First Choice VIP Care Plus Credentialing department by calling Provider Services at 1-(888)-978-0862.

Standards for Participation

By agreeing to provide services to First Choice VIP Care Plus members, providers must:

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

Access to Care

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

First Choice VIP Care Plus endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. First Choice VIP Care Plus establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are convenient to First Choice VIP Care Plus members and that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply

with the access standards defined below. The standards below apply to medical care services and medical providers; please refer to the "Behavioral Health Care" section of this *Provider Manual* for the standards that apply to behavioral health care services and behavioral health providers.

First Choice VIP Care Plus monitors the following access standards on an annual basis per the South Carolina Department of Health and Human Services. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at this toll-free number: 1-(888)-978-0862.

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

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for the missed appointment. The medical record should reflect any reasons for delays in providing medical care as a result of missed appointments, and should also include any refusals by the member. Providers are encouraged to advise First Choice VIP Care Plus's Care Management team at 1-(888)-244-5440 if outreach assistance is needed

when a member does not keep an appointment and/or when a member cannot be reached during an outreach effort.

After-Hours Accessibility

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

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

Monitoring Appointment Access and After-Hours Access

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

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

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

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

Panel Capacity/Not Accepting New Patients and Notification

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

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

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

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

Practitioner and Provider Responsibilities

Responsibilities of All Providers

First Choice VIP Care Plus is regulated by the South Carolina Department of Health and Human Services, the South Carolina Department of Insurance, and a number of Federal laws and regulations. Providers who participate in First Choice VIP Care Plus have responsibilities, including but not limited to:

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

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

Primary Care Provider (PCP) Responsibilities

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

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

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

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

All new First Choice VIP Care Plus members with a newly-assigned PCP (one who has not previously cared for the member) must receive a comprehensive initial examination and a screening for mental health and substance abuse. Members must also be screened for additional long term support services. The PCP must report the determination of support needs to the First Choice VIP Care Plus Care Management Team at 1-(888)-244-5440. For on-going care, the mental health and substance abuse screening must also be administered as a routine part of every preventive health examination.

First Choice VIP Care Plus PCPs are also expected to assist members with accessing substance abuse and mental health services, as needed. The First Choice VIP Care Plus Care Management team is available to members and providers to support care coordination and access to services. Members and providers may request Care Management support by calling 1-(888)-244-5440.

In addition, the PCP is responsible for:

- Providing covered services to all First Choice VIP Care Plus assigned members and complying with all requirements for referral management and prior authorization.
- Providing First Choice VIP Care Plus assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services and other communitybased agency services.
- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the medical care of a member with a participating specialist(s), and/or behavioral health provider;
- Early identification of all members with special health care needs and notification to the First Choice VIP Care Plus Care Management team regarding any such identification as soon as possible;
- Collaboration with First Choice VIP Care Plus's Integrated Care Management programs to facilitate member care;
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets First Choice VIP Care Plus's Medical Record Documentation Requirements;
- Providing follow-up services for members who have been seen in the Emergency Department;
- Promptly and accurately reporting all member encounters to First Choice VIP Care Plus;
- Releasing medical record information upon written consent or request of the member;
- Providing preventive healthcare to members according to established preventive health care guidelines; and
- Advising First Choice VIP Care Plus's Care Management team at 1-(888)-244-5440 if outreach assistance is needed when a member does not keep an appointment and/or when a member cannot be reached during an outreach effort.

First Choice VIP Care Plus Specialist Responsibilities

A First Choice VIP Care Plus specialist is responsible for:

- Providing specialty care as indicated by a referral;
- Verifying a member's eligibility and reviewing a referral prior to the provision of services.

- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner via the referral;
- Documenting all care rendered in a complete and accurate manner, including maintaining a current medical record for Plan members that meets First Choice VIP Care Plus' Medical Record Documentation Requirements, as described in the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*; and
- Refraining from referring members to other specialists without the intervention of the member's PCP.

Provider Directory Responsibilities

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

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

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

- Contacting the Provider Network Account Executive
- Calling Provider Services at 1-(888)-978-0862

Compliance Responsibilities

First Choice VIP Care Plus providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities. Although not an exhaustive list, the primary areas of compliance with policies and laws/regulations for Plan providers are:

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

Americans with Disabilities Act (ADA) and Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require First Choice VIP Care Plus' providers to make their services and facilities accessible to all individuals. First Choice VIP Care Plus expects its network providers to be familiar with the requirements of the Rehab

Act and the ADA and to fully comply with the requirements of these statutes. All providers are required to provide First Choice VIP Care Plus an attestation of accessibility for each of their physical locations.

Health Insurance Portability and Accountability Act (HIPAA)

First Choice VIP Care Plus is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Fraud, Waste and Abuse (FWA)

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

Fraud

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

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

Waste

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

Abuse

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

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

False Claims Act

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

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

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

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

Reporting and Preventing FWA

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

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

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

Below are examples of information that will assist First Choice VIP Care Plus with an investigation:

- Contact information (i.e. name of individual making the allegation, address, telephone number)

- Name and identification number of the suspected individual
- Source of the complaint (including the type of item or service involved in the allegation)
- Approximate dollars involved(if known)
- Place of service
- Description of the alleged fraudulent or abuse activities
- Timeframe of the allegation(s)

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

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

Attorney General's Healthy Connections Medicaid Fraud Unit at: (803) 734-3660 or call toll- free: 1-888-NO-CHEAT (1-888-662-4328).

Reporting Abuse, Neglect and Exploitation

All First Choice VIP Care Plus providers are required to identify, prevent and report abuse, neglect and exploitations of enrollees in compliance with the Omnibus Adult Protection Act. As soon as a provider suspects that abuse is occurring, they are required to call the South Carolina Adult Protective Services. South Carolina provides a 24/7 toll free hotline in each county of South Carolina. Providers may find their specific counties number at the South Carolina Department of Social Services Website at:

https://dss.sc.gov/content/customers/protection/aps/index.aspx

Providers are also required to alert the First Choice VIP Care Plus Case Manager within 24 hours of making a report to South Carolina Adult Protective Services.

Advance Directives

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

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

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient

at the time of the first home visit, as long as the information is furnished before care is provided.

- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

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

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

Provider Marketing Activities and Compliance

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

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

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

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

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

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

- Offer sales/appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade members to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of plan sponsors

Offer anything of value to induce plan enrollees to select them as their provider

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

Provider Affiliation Information

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

Providers may make new affiliation announcements within the first thirty (30) days of the new contract. An announcement to patients of a new affiliation which names only First Choice VIP Care Plus may occur only once when such announcement is conveyed through direct mail, e- mail, or phone and must include the following disclaimer – "Other <Pharmacies/ Physicians/ Providers> are available in our network.". Additional direct mail and/or e-mail communications from providers to their patients regarding affiliations must include a list of all plans with which the provider contracts.

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

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

Prohibition on Payments to Excluded/Sanctioned Persons or Services

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

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

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

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

No payment shall be made for items or services in accordance with the Assisted Suicide Funding Restriction Act of 1997.

Provider Support and Accountability

Provider Network Management

First Choice VIP Care Plus's Provider Network Account Executives function as a provider relations team to advise and educate First Choice VIP Care Plus providers. Provider Network Account Executives assist providers in adopting new business policies, processes and initiatives or adapting existing ones in order to facilitate compliance with First Choice VIP Care Plus policies and procedures. From time to time, providers will be contacted by First Choice VIP Care Plus representatives to participate in meetings that address topics including, but not limited to:

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

New Provider Orientation

Upon completion of the First Choice VIP Care Plus contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all First Choice VIP Care Plus providers to online resources, including First Choice VIP Care Plus provider orientation and training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this *Provider Manual* by contacting the Provider Services department toll-free at 1-(888)-978-0862.

Ongoing Training and Education

First Choice VIP Care Plus's training and development are fundamental components of continuous quality and superior service. First Choice VIP Care Plus offers on-going educational opportunities for providers and their staff. Provider training and educational programs are based on routine assessments of provider needs. First Choice VIP Care Plus has a commitment to provide all appropriate training and education to help providers comply with First Choice VIP Care Plus standards, and federal and state of South Carolina regulations. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed training information is available in the Provider area of the First Choice VIP Care Plus website at www.firstchoicevipcareplus.com. Plan providers also have access to the Provider Services department toll-free at 1-(888)-978-0862 and their Account Executive for questions.

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

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

Model of Care Training

The Model of Care (MOC), described more fully in Section IV, is a high quality, patient-centric medical care delivery system for dual eligible Medicare-Medicaid members and is designed to maintain the member's health and encourage their involvement in their health care. As a Medicare-Medicaid Plan, First Choice VIP Care Plus is required by the Centers for Medicare and Medicaid Services (CMS) to provide training of its MOC to providers. MOC training is also a First Choice VIP Care Plus contractual requirement for all participating providers.

This required training can be accessed in any of the following ways:

- An online interactive Model of Care training module on our website, www.firstchoicevipcareplus.com, under the Provider Training and Education link.

- In person from a First Choice VIP Care Plus Account Executive or training seminar.

- Receive or request electronic or printed MOC training materials from Provider Services at 1-(888)-978-0862 or call the First Choice VIP Care Plus Account Executive.

The MOC may be revised from time to time, based on performance improvement activities. More information regarding the Model of Care is also provided in section four of this *Provider Manual*.

Annual Fraud Waste and Abuse Training

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

Provider Specific On-Going Training

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

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

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

Plan-to-Provider Communications

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

- Provider portal
- Provider manual
- Provider newsletters
- Website updates and information
- Provider letters and announcements
- Surveys
- Faxes
- E-mails
- Miscellaneous other materials

Provider Complaint System

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

Providers may call Provider Services toll-free at 1-(888)-978-0862 to notify First Choice VIP Care Plus of a complaint.

Provider Contract Terminations

First Choice VIP Care Plus provider agreements specify termination provisions. Provider terminations are categorized as follows:

- Provider Initiated
- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"
- Mutual

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

Provider Initiated

- The provider must provide written notice to First Choice VIP Care Plus if intending to terminate from the Plan network. Written notice must be provided at least sixty (60) days before the termination date. The provider's contract with First Choice VIP Care Plus may require longer notice. Neither the provider nor First Choice VI P Care Plus may terminate a provider contract without cause. Written notice must be delivered in accordance with the method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
- If the provider is a PCP, First Choice VIP Care Plus will send a written notification to the members who have chosen the provider as their PCP no less than fifteen (15) calendar days after receipt of the termination notice or at least thirty (30) days prior to the termination date, whichever issooner.
- If a First Choice VIP Care Plus member has special health care needs and his or her treating provider gives notice of termination to the Plan, First Choice VIP Care Plus Member Services and/or Case Management staff will personally contact the member by telephone and in writing to provide assistance in securing a new provider.

First Choice VIP Care Plus Initiated "For Cause"

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

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

First Choice VIP Care Plus Initiated "Without Cause"

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

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

Mutual Terminations

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

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

Continuity of Care

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

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

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

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

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

III. Provision of Services

First Choice VIP Care Plus offers an integrated care plan that combines a member's Medicare and Healthy Connections Medicaid benefits into one plan for improved coordination of benefits.

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

For detailed information about Medicare basic benefits please refer to www.Medicare.gov. For detailed information about Healthy Connections Medicaid basic benefits, please refer to the Healthy Connections Medicaid State Plan, available online at https://www.scdhhs.gov/provider.

Medicare and Healthy Connections Medicaid Program Summary of Covered Services

Medicare/Healthy Connections Medicaid Program Physical Health Services
The following physical health services represent First Choice VIP Care Plus Medicare/Healthy Connections Medicaid program's benefit package:

- Physician services including nurse practitioner services and certified nurse midwife services
- Laboratory, X-rays and radiology services
- Inpatient hospital services (other than service in an institution for mental diseases)
- Outpatient hospital services (preventive, diagnostic, therapeutic, rehabilitative or palliative services)
- Outpatient prescription drug coverage, in accordance with the First Choice VIP Care Plus drug formulary
- Emergency and urgent care services
- Chiropractic services
- Federally Qualified Health Center (FQHC) services
- Renal Dialysis
- Kidney disease education services
- Podiatry services
- Therapy services (physical therapy, occupational therapy and speech therapy);
- Durable medical equipment and medical supplies, including orthotics and prosthetics
- Vision services
- Diabetes self-management training
- Home health services
- Private duty nursing services
- Personal care services

- Nursing facility services
- Tissue and transplant services
- Emergent transportation
- Non emergent transportation to an adult day program
- Home and community based services
- Long term care
- Caregiver training
- Environmental Modification/Assistive Technology
- Minor Household Repairs (Contact First Choice VIP Care Plus for details)
- Supplemental Roads to Community Living
- Adult wellness
- Medicare covered Dental services
- Audiology services
- 24/7 Nurse Call Line

Medicare/Healthy Connections Medicaid Program Behavioral Health Services

The following behavioral health services are also included in the First Choice VIP Care Plus Medicare/Healthy Connections Medicaid program's benefit package:

- Diagnostic and assessment services
- Physician and mid-level practitioner visits
- Crisis services
- Inpatient hospitalization and emergency services
- Partial Hospitalization Program
- Inpatient psychiatric and substance abuse facility services
- Inpatient and Outpatient Substance Abuse services

Please refer to the "Behavioral Health Care" section of this *Provider Manual* for additional information on the provision of behavioral health care services.

Health Management Program

First Choice VIP Care Plus cares about our members' health and wellness. To help our members stay healthy and improve their quality of life, First Choice VIP Care Plus has special programs available for members to address heart disease, diabetes and asthma, and can provide information about health education and wellness services such as our smoking cessation program. We also have a nurse hotline, 1-(877)-693-8275 where members can get personalized help from a registered nurse.

Medicare/Healthy Connections Medicaid Program Non-Covered Services

The First Choice VIP Care Plus Integrated Care program will refer members to local resources for services that are not covered by First Choice VIP Care Plus, as appropriate. Providers may contact the First Choice VIP Care Plus Care Management team at 1-(888)-244-5440 for assistance with coordination of non-covered services.

Private Pay for Non-Covered Services

Providers are required to inform members about the costs associated with services that are not covered under the First Choice VIP Care Plus plan, prior to rendering such services. Should the member and provider agree the services would be rendered under a private pay arrangement, the provider must then request a prior authorization and an organizational determination will be made. An integrated denial notice will be sent to the member and the provider, informing the member of his/her appeal

rights. Upon a final unfavorable appeal determination or the member forgoes their appeal rights, the provider may obtain a signed document from the member to validate the private payment arrangement. First Choice VIP Care Plus providers may not use the CMS Advanced Notice of Non Coverage or the Advanced Beneficiary notice to fulfill this requirement.

Emergency Services

First Choice VIP Care Plus ensures the availability of emergency services and care 24 hours a day, seven days a week (24/7).

First Choice VIP Care Plus is responsible for coverage and payment of emergency services and post-stabilization care services for First Choice VIP Care Plus members regardless of whether or not the provider who furnishes the services has a contract with First Choice VIP Care Plus. First Choice VIP Care Plus coverage responsibility for post-stabilization care that has not been pre- approved ends when:

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

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

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

Out-of-Network Use of Non-Emergency Services

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

IV. Model of Care and Integrated Care Management

The following information is in regard to First Choice VIP Care Plus's Integrated Care Management (ICM) and Model of Care, which includes Case & Disease Management and Care Coordination for physical and mental health services provided to First Choice VIP Care Plus members.

Integrated Care Management Overview

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

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

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

Integrated Care Management Components

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

- Model of Care
- Multidisciplinary Team
- PCP/Medical Home
- Chronic Care Programs
- Clinical Practice Guidelines
- Care Management

Model of Care

First Choice VIP Care Plus has created a Model of Care (MOC) that addresses the physical, mental, and external needs of the dual eligible population in South Carolina. The MOC takes into consideration medical conditions, challenges presented by the members' social conditions, limitations in activities of daily living, and the potential health status of the population eligible to enroll in the First Choice VIP Care Plus plan. First Choice VIP Care Plus assists the Multidisciplinary Team in creating the best plan of care and quality management for each member.

Multidisciplinary Team

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

PCP/Medical Home

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

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

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

Chronic Care Improvement Programs

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

Clinical Practice Guidelines

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

Care Management

This team is designed to address the needs of members and to support providers and their staff. The team is composed of registered nurses, social workers as well as non-clinical staff including community health navigators and personal care connectors. Together, this team performs three functions on behalf of First Choice VIP Care Plus members and providers: receiving inbound calls, conducting outbound outreach activities and providing care management and care coordination support.

Members and providers may request Care Management support by calling 1-(888)-244-5440.

Seamless Transition

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

First Choice VIP Care Plus Staff

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

PCP

- Contact admitting physician to coordinatecare
- Review and reconcile medications after discharge
- See the member at officevisit post-discharge.

Hospital

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

Care Coordination with the PCP

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

Care Coordination with Other Providers

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

Integrating Mental and Physical Health Care

Members with mental health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both mental and physical health conditions. First Choice VIP Care Plus understands that coordination of care for these members is imperative.

Plan staff work with the appropriate primary care and mental health providers to develop an integrated

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

Individualized Care Plans

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

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

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

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

Model of Care Evaluation

Data Sources

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

Methods of Communicating Updates and Outcome

- First Choice VIP Care Plus Provider Portal - NaviNet
- The First Choice VIP Care Plus website – Quality and Satisfaction Updates
- Member News Bulletin
- Provider News Bulletin
- Provider Workshops – presentations are interactive via the website, face-to-face workshop presentations, as well as provider site visits

All communications are available via the Plan's website at www.firstchoicevipcareplus.com

Providers may also contact the Provider Services department at 1-(888)-978-0862 or your Account Executive for assistance with questions.

V. Utilization Management

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

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

This includes:

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

Referrals

Referrals from PCPs to participating specialists for office visits are not required under First Choice VIP Care Plus. Referrals from participating providers are required for Opioid Treatment Programs, Outpatient Blood and Medicaid only covered Outpatient Mental Health Services under the First Choice VIP Care Plus (no official, plan-issued or electronic referral required).

Certain Long Term Services and Supports (LTSS) under the First Choice VIP Care Plus plan require referrals or prior authorizations. These services include:

- Skilled Nursing Facility Services
- Home health Services
- Durable Medical Equipment
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private duty nursing services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Personal emergency response
- Environmental modifications
- Companion Services
- Palliative Care
- Residential Personal Care

- Nursing Home Transition
- Telemedicine
- Adult Day Care
- Respite

For more information please see the Services Requiring Prior Authorization or LTSS sections in this manual.

Prior Authorization

Prior authorization is required for services provided by non-participating physicians and providers, with the exception of emergency services. The First Choice VIP Care Plus UM department hours of operation are 8 a.m. to 6:00 p.m. Eastern Time, Monday through Friday. The general UM department telephone number is 1-(888)-244-5410. The general UM department fax numbers is 1-(888)-257-7960.

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

Providers may request prior authorization by:

- Calling the general UM number or calling Provider Services and selecting the option for prior authorization/case management.
- Faxing a request for prior authorization.
- You may also submit a prior authorization request via NaviNet. Select the **Medical Authorizations** option, which is a robust, intuitive, and streamlined online authorizations workflow.

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

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

Providers will receive notification of organizational determination for all non-emergency behavioral health inpatient admissions verbally within 2 hours of notification of admission and in writing with 24 hours following admission.

Services Requiring Prior Authorization

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

www.firstchoicevipcareplus.com.

- Elective/Non-Emergent Air Ambulance Transportation
- All Out-of-Network Services (except emergency services)
- Inpatient Services
    - All Inpatient Hospital Admissions (including medical, surgical and rehabilitation)
    - Inpatient Medical Detoxification
    - Elective Transfers (for inpatient and/or outpatient services between acute care facilities)
- Home Health Services
- Therapy and Related Services
    - Speech Therapy, Occupational Therapy and Physical Therapy
      Cardiac Rehabilitation
- Transplants (including transplant evaluations)
- All DME Rentals
- DME Purchases (for allowable charges $500 and over, including prosthetics and orthotics)
- Hyperbaric Oxygen
- Implants (for allowable charges over $500)
- Medications: All infusion/injectable medications listed on the Medicare Professional Fee Schedule. (Injectable Medications not listed on the Medicare and Healthy Connections Medicaid Fee Schedule are not covered by First Choice VIP Care Plus)
- Surgical Services that may be considered cosmetic, including:
    - Blepharoplasty
    - Mastectomy for Gynecomastia
    - Mastoplexy
    - Maxillofacial
    - Panniculectomy
    - Penile Prosthesis
    - Plastic Surgery/Cosmetic Dermatology
    - Reduction Mammoplasty
    - Septoplasty
- Cochlear Implantation
- Gastric Bypass/Vertical Band Gastroplasty
- Hysterectomy
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks
- Radiology Outpatient Services, including but not limited to:*
    - CT Scan
    - MRI
    - MRA
    - MRS
    - PET scan
    - SPECT scan
    - Nuclear Cardiac Imaging
- All miscellaneous/unlisted or not otherwise specified codes
- All services that may be considered experimental and/or investigational
- Long Term Support Services/ Home and Community Based Services
- Behavioral Health
    - Mental Health Partial Hospitalization Program
    - Inpatient Detoxification Admissions
    - Mental Health IP Inpatient Admissions

- Neuropsychological Testing
- Psychological Testing
- Developmental Testing
- Behavioral Health & Substance Abuse Day Treatment
- Mental Health & Substance Abuse Residential Treatment
- Electroconvulsive Therapy
- Targeted Case Management
- Substance Abuse Intensive Outpatient Program
- Vivitrol Injection (via pharmacy)

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

***All requests for services are subject to Medicare and* Healthy Connections *Medicaid coverage guidelines and limitations.*

Services that Do Not Require Prior Authorization

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

- Emergency Services
- Women's Health Specialist Services (to provide women's routine and preventive health care services)
- Low-level plain films
- EKGs
- Post Stabilization Services (in-network and out-of-network)
- Imaging procedures related to emergency room services, observation care and inpatient care
- Outpatient Behavioral Health & Substance Abuse Therapy
  - Behavioral Health Outpatient Services
  - Substance Abuse Outpatient (Level I) Services

Services that Require Notification

- All Admissions (elective admissions require pre authorization)
- Medicaid-Sponsored Long-Term Care Stay (initial placement and every 365 days)

Organization Determinations

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

- Payment for emergency services, post-stabilization care or urgently needed services;
- Payment for any other health service furnished by a non-contracted provider where the member believes;
  - The services are covered under Medicare or Healthy Connections Medicaid; or
  - If not covered under Medicare or Healthy Connections Medicaid, should have been furnished, arranged for or reimbursed by First Choice VIP Care Plus
- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the member believes should be furnished, arranged

for or reimbursed by First Choice VIP CarePlus;
- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or
- Failure of First Choice VIP Care Plus to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of themember.

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

Standard Process

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

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

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

Expedited Process

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

If First Choice VIP Care Plus decides to expedite the request, Plan staff will render a decision as expeditiously as the member's health condition requires but no later than seventy two (72) hours after receiving therequest.

If First Choice VIP Care Plus requires medical information to make the determination, there is a requirement to request the information within twenty-four (24) hours and to respond to the member within seventy two (72) hours of receiving the request.

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

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

First Choice VIP Care Plus will provide an expedited organization determination if the member's physician indicates, either verbally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If First Choice VIP Care Plus denies the request for an expedited determination, we will:

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

Medical Necessity Standards

Medically Necessary or Medical Necessity - Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Healthy Connections Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. §1395y. In accordance with Medicaid law and regulations, and per Healthy Connections Medicaid, services must be those medical services which:

- Are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Healthy Connections Medicaid member;
- Are provided at an appropriate facility or by an appropriate contracted provider and at the appropriate level of care for the treatment of the Healthy Connections Medicaid member's medical condition; and,
- Are provided in accordance with generally accepted standards of medical practice.

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

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

InterQual

- Adult ISD (Intensity of Service, Severity of Illness and Discharge Screens)
- Outpatient therapy
- Home care
- Radiologic procedures
- DME

American Society of Addiction Medicine (ASAM) Criteria

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

- Member Considerations

- Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.

- Local Delivery System
  - Availability of sub-acute care facilities or home care in the First Choice VIP Care Plus service area for post-discharge support,
  - First Choice VIP Care Plus benefits for sub-acute care facilities or home care where needed,
  - Ability of local hospitals to provide all recommended services within the estimated length of stay.

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

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

First Choice VIP Care Plus will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or verbal authorization from First Choice VIP Care Plus or an agent of First Choice VIP Care Plus, unless there was material misrepresentation or fraud in obtaining the authorization. Upon request by a member or practitioner/provider, the criteria used for medical necessity decision making in general, or for a particular decision, is provided in writing by the First Choice VIP Care Plus medical director or designee. First Choice VIP Care Plus will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member.

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

Notice of Adverse Determination

If First Choice VIP Care Plus decides to deny authorization for services or payments, in whole or in part, or discontinues/reduces a previously authorized ongoing course of treatment, then

it will give the member a written notice of its determination. First Choice VIP Care Plus will provide notice using the most efficient manner of delivery to ensure the member receives the notice in time to act (e.g., via fax, hand delivery, or mail). If the member has a representative, the representative will be given a copy of the notice.

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

- Informs the member of the right to file an expedited grievance if he or she disagrees with First Choice VIP Care Plus' decision not to expedite a coverage determination;

- Informs the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically;and

- Provides instructions about the expedited grievance process and its time frames.

Peer to Peer Review

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

Reconsideration

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

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

Post-Service Reviews

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

service review may be performed in the following circumstances:

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

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

VI. Grievances, Appeals and Fair Hearings

Standard and Expedited Grievances (Complaints)

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

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

First Choice VIP Care Plus will contact the member within five (5) business days of reporting the grievance. First Choice VIP Care Plus will investigate the grievance and send a decision letter within thirty (30) calendar days of receiving the grievance. Members also have the ability to file an expedited grievance whenever First Choice VIP Care Plus extends the time frame to make an organization determination or reconsideration or First Choice VIP Care Plus refuses to grant a request for an expedited determination or reconsideration. First Choice VIP Care Plus is required to resolve the member's expedited grievance within twenty-four (24) hours of the member's request for an expedited grievance.

Quality of Care Grievances

For grievances pertaining to quality of care, members may register their complaint either through First Choice VIP Care Plus, which will follow the same process as all other grievances, or through The Carolinas Center for Medical Excellence, an independent organization under contract to the Federal Government to monitor and improve the care given to Medicare members (the "Quality Improvement Organization" or "QIO").

Filing a Grievance

To file a grievance, the member, or the member's physician or other representative, may call Member Services for First Choice VIP Care Plus at 1-(888)-978-0862 or write to:

First Choice VIP Care Plus
Attn: Appeals and Grievances Department
P.O. Box 80109
London, KY 40742-0109

To file a quality of care grievance with the QIO, the member, the member's physician, or the member's representative may contact: The Carolinas Center for Medical Excellence for an independent review through their website at www.ccmemedicare.org or at 1-(800) 922-3089.

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services toll free at 1-(888)-978-0862**.**

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

Appeals

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

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

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

Standard Appeal Process

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

First Choice VIP Care Plus must issue a resolution to a standard appeal request within fifteen (15) calendar days from the date it received the request or as expeditiously as the member's health requires. This time frame may be extended up to fourteen (14) calendar days by First Choice VIP Care Plus if First Choice VIP Care Plus justifies a need for additional information and documents how the delay is in the interest of the member. However, the extended time frame cannot delay the decision beyond thirty (30) calendar days of the request for appeal, without the informed consent of the member. In all circumstances, the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Plan receives the appeal request.

Expedited Appeal Process

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

First Choice VIP Care Plus will issue a resolution within seventy-two (72) hours of receiving the request. First Choice VIP Care Plus can also have an additional fourteen (14) days if First Choice VIP Care Plus documents that additional information is needed and the delay is in the member's best interest. If First Choice VIP Care Plus needs more time, the member will be informed of the reason for the extension in writing.

Steps Following First Choice VIP Care Plus Appeal Decisions

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

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

i. For Healthy Connections Medicaid-only services, information on the member's right to submit an appeal to the SCDHHS Division of Appeals and Hearings and how to do so.
ii. For Medicare-only service appeals, notice that the appeal will be automatically forwarded to the CMS Independent Review Entity (IRE)
iii. For Medicare/Healthy Connections Medicaid cross over services, notice that the appeal will be automatically advanced to the CMS Independent Review Entity (IRE). Members may also submit an appeal to the SCDHHS Division of Appeals and Hearings. Except for Medicare-only appeals, the communication will include information on the member's right to receive benefits while the review is pending and the timeframe the member has for seeking continuation of benefits.
iv. Except for Medicare-only appeals, the communication will inform the member that the member may be held liable for the amount the Plan pays for services received while the appeal or State Fair Hearing is pending, if the

final decision of the appeal upholds the Plan's action.

Filing an Appeal

To file an appeal or for more information regarding the appeals process, you or the member may call Member Services at for First Choice VIP Care Plus at 1-(888)-978-0862 or TTY/TDD 1- (866)-428-7583 or fax appeal information to 1-(855)-221-0046 or write to:

First Choice VIP Care Plus
Attn: Appeals and Grievances Department
P.O. Box 80109
London, KY 40742-0109

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

Interpreter services are free of charge to the member

Provider Administrative Rights and Responsibilities

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

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

Appeal for a Request for Payment of Denied Claims
Contracted providers do not have rights to appeal for the payment of denied claims. Denied claims for any reason, including lack of authorization, may be reviewed through the claims dispute process (see the Claims section).

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Member Appeals telephone line at 1-(888)-978-0862.

VII. Quality Assurance and Performance Improvement Program

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

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

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

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

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

Quality Management Activities

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

- Every provider in the First Choice VIP Care Plus provider network is required by contract to cooperate with and participate in First Choice VIP Care Plus' quality management/quality assessment & performance improvement (QM/QAPI) program. We rely on your cooperation and participation to meet our own state and federal obligations as a Medicare-Medicaid CICO.

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

Quality Assessment Performance Improvement Committee

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

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

Quality of Service Committee – Responsible for the review and monitoring of clinical care services and outcomes such as utilization management, integrated care management, chronic care management and clinical appeals. Monitors performance and quality improvement activities related to First Choice VIP Care Plus services; reviews, approves and monitors action plans created in response to identified variances.

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

Credentialing Committee – Reviews practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the First Choice VIP Care PlusNetwork.

Practitioner Involvement

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at 1- (888)-978-0862 or toll-free at 1-(866)-428-7583 or their Provider Network Account Executive.

QAPI Activities

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

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

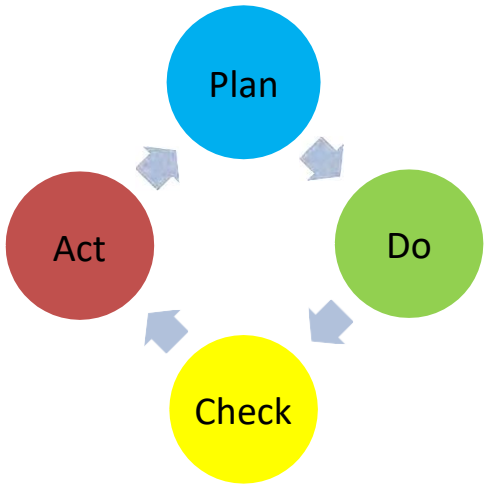

Figure 2: PDCA Quality Process

Practitioners and providers agree to allow First Choice VIP Care Plus to use their performance data as needed for the organization's QI activities to improve the quality of care and services, and the overall member experience. On-going QAPI activities include:

Quality Improvement Projects

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

Health Status – Prevalence Documentation and Baseline Assessment

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

Ensuring Appropriate Utilization of Resources

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

Chronic Care Improvement Programs

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

Measuring Member and Provider Satisfaction

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

Participant and Provider Dissatisfaction

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

Member Safety Programs

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

Preventive Health and Clinical Guidelines

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

Health Care Equity

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

- Collect and analyze practitioner race/ethnicity and language data to determine if the network is responsive to the needs of the membership
- Develop a plan to address network race/ethnicity and language gaps
- Support practitioners in providing appropriate language services
- Conduct baseline assessment of performance on chronic care and preventive care outcome measures by race and ethnicity subgroups; identify and prioritize opportunities to reduce disparities

Credentialing Program

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

Availability and Accessibility Audits

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

Medical Record Requirements

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

Providers are required by contract to make medical records accessible to the State of South Carolina Department of Health and Human Services, the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), First Choice VIP Care Plus and their respective designee. Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Health care education provided to patients, family members or designated caregivers is noted

in the record and periodically updated, as appropriate.

- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- An immunization record is up to date or an appropriate history has been made in the medical record.
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.

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

Medical Record Audits

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

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

Adverse Action Reporting

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

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

Reporting & Managing Unusual Occurrences

Critical Incidents, Sentinel Events and Never Events

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

Important definitions include:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.
- **Critical Incident** – Retrospective identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. Critical incidents differ from sentinel events only in terms of the timeframe in which they are identified.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above. For the purposes of First Choice VIP Care Plus never events include, but are not limited to:
    - Deaths (unexpected, suicide, or homicide);
    - Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function);
    - Infectious disease outbreaks;
    - Pressure ulcers that are unstageable or are Staged III and IV;
    - Traumatic injuries (including third degree burns over more than ten percent(10%) of the body) that result in death, require hospitalization, or result in a loss of function;
    - Restraints, both chemical and physical, use that results in death, hospitalization, or loss of function;
      All elopements in which a member with a documented cognitive deficit is missing for twenty-four (24) hours or more;
    - Suspected physical, mental or sexual abuse and/or neglect; and
    - Media-related event. First

Choice VIP Care Plus' goals are to:

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

Managing Unusual Occurrences

Providers are expected to report unusual occurrences, as described above and including near misses, to First Choice VIP Care Plus in real time. First Choice VIP Care Plus recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore,
allowance is made for the stabilization of the member prior to reporting. All unusual occurrences must be reported to the Plan within twenty-four (24) hours of occurrence. Reports may be made to the First Choice VIP Care Plus Care Manager by calling 1-(888)-978-0862 or toll-free at 1-(866)-428-7583.

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

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

1. The First Choice VIP Care Plus Medical Director is notified of the event via an incident report, telephone, email or personal visit as soon as reasonably possible after identification of the occurrence.
2. The First Choice VIP Care Plus Medical Director will collaborate with the Medical Management, Quality and Compliance departments and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All unusual occurrences require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance. A multidisciplinary team led by the Medical Director will perform all root cause analysis.
5. As appropriate, issues are identified for correction and corrective action plans are developed to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the actions.
6. Confirmed critical incidents and sentinel events will be reported to the South Carolina State Department of Health and Human Services and the Contract Administrator within twenty-four (24) hours of occurrence or as soon as a determination is made that the occurrence is a critical incident or sentinel event. Additionally, First Choice VIP Care Plus will report all critical incidents and sentinel events, as well as actions taken, to the South Carolina State Department of Health and Human Services and the Contract Administrator on a quarterly basis.
7. As appropriate, other agencies will also be notified of confirmed critical incidents and sentinel events.
8. As appropriate, information from the investigation of unusual occurrences will be provided to the Credentialing Committee to support the re-credentialing process and to the QAPIC on a quarterlybasis.

Provider Preventable Conditions

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

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

- Foreign Object Retained After Surgery

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

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

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

Reporting Provider Preventable Conditions

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

Potential Quality of Care Concerns

Potential quality of care concerns are investigated by First Choice VIP Care Plus.

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

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

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

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

- Requiring the practitioner/provider to submit a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record audit.

- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by First Choice VIP Care Plus to ensure that adverse events do not continue. This requirement will be documented in writing. A corrective action plan may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.
- Implementing formal sanctions, including termination from the First Choice VIP Care Plus network if the offense is deemed an immediate threat to the well-being of First Choice VIP Care Plus members. First Choice VIP Care Plus reserve the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

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

Formal Sanctioning Process

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

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

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

Notice of Hearing

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

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

Conduct of the Hearing and Notice

The hearing will be held before:

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

Practitioner/Provider's Hearing Rights

The practitioner/provider has the right to:

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

Appeal of First Choice VIP Care Plus Quality of Care Decision

The practitioner/provider may request an appeal of a quality of care adverse decision after the final decision of First Choice VIP Care Plus.

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

The written quality of care appeal will be reviewed and a decision rendered by First Choice VIP Care

Plus QAPIC within forty-five (45) days of receipt of the notice of the appeal.

Summary Actions Permitted

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

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

VIII. Cultural Competency Program and Requirements

Introduction

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

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

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

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

planning services that respond to the cultural and linguistic characteristics of our service area.

- First Choice VIP Care Plus is committed to both community and member involvement in designing and implementing CLAS-related activities by our Community Advisory Committee.
- First Choice VIP Care Plus's grievance and appeals process is culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by members.
- First Choice VIP Care Plus publicizes information regarding our progress and success in implementing CLAS standards and also provides public notice regarding the availability of this information.

Providers may request more information on the Cultural Competency Program by contacting Provider Services toll-free at 1-(888)-978-0862.

Cultural and Linguistic Requirements

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

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

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

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

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

Providers should discourage members from using family or friends as verbal translators. Members should be advised that translation services from First Choice VIP Care Plus are available. Providers are required to:

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

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

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

First Choice VIP Care Plus contracts with a competent telephonic interpreter service provider. If you need more information on using this telephonic interpreter service, please contact Provider Services toll-free at 1-(888)-978-0862.

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact First Choice VIP Care Plus Member Services at 1- (888)-978-0862 (TDD/TTY: 1-(866)-428-7583), and a representative will help locate a professional interpreter to communicate in the member's primary language.

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

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

Disability Competency

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

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

In all cases, First Choice VIP Care Plus requires that all members are provided with reasonable accommodations in the following areas: communication with First Choice VIP Care Plus, communication with the member's providers, and physical access to provider offices and equipment.

First Choice VIP Care Plus will inform members of providers who meet ADA compliance for communications and physical access in the online provider directory or by calling Member Services at 1-(888)-667-0318.

First Choice VIP Care Plus members may submit a request for reasonable accommodation for either communication or physical access if the member believes that his/her needs are not being met. The member or member's representative may request that a reasonable accommodation be made by First Choice VIP Care Plus or a provider by submitting a request orally or in writing to

the member's Case Manager. First Choice VIP Care Plus will use clinical information, state and federal laws or regulations as applicable to evaluate the need and reasonableness for the requested accommodation.

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

IX. Claims Submission Protocols and Standards

Encounter Reporting

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

Completion of Encounter Data/ Claim Submission

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

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

First Choice VIP Care Plus can accept claim submissions via paper or electronically (EDI). **.** In order to support timely statutory reporting requirements, we encourage all providers to submit claims within 30 days of the visit. However, all claims must be submitted within 365 days from the date services were rendered or compensable items were provided.

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

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

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

First Choice VIP Care Plus monitors encounter data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to First Choice VIP Care Plus**.** Network providers may also be subject to sanctioning by First Choice VIP Care Plus for failure to submit accurate Encounter data in a timely manner.

The Provider Services Department at First Choice VIP Care Plus at 1-(888)-978-0862 can address questions concerning claims submission.

Presence of Referring/ Ordering Physician NPI on Claims Submissions

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

General Procedures for Claim Submission

First Choice VIP Care Plus is required by the State of South Carolina and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

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

Claims filed with First Choice VIP Care Plus are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under First Choice VIP Care Plus during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of- network provider has received authorization to provide services to the eligible member.
- Verification that an authorization or referral has been given for services that require prior authorization or referral by First Choice VIP Care Plus.
- Verification of whether there is any other third-party resources and, if so, verification that

First Choice VIP Care Plus is the "payer of last resort" on all claims submitted to First Choice VIP Care Plus Plan.

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

Electronic Claims Submission (EDI)

First Choice VIP Care Plus encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare's Provider Support Line at 1-(877)-363-3666 for more information.

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

Providers interested in sending claims electronically may contact the EDI Technical Support Hotline at 1-(877)-363-3666 to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare at 1-(877)-363-3666 to inform them you wish to initiate electronic claim submissions to First Choice VIP Care Plus.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

  First Choice VIP Care Plus EDI
  Payer ID#: **77009**

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

https://legacy.changehealthcare.com/

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

SNIP Level 4

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

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification of electronic claims against 837 edits at Change Healthcare™.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.

- ***All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN and Location Numbers).***

Submission of Electronic Documentation (275 Transactions)
The 275 transaction functionality expands the options for providers to provide supplemental documents providing additional patient medical information that cannot be accommodated

within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries, and operative reports to support health care claims adjudication.

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

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

Paper Claim Mailing Instructions

Please submit paper claims to the appropriate address below:

First Choice VIP Care Plus
Claims Processing Department
P.O. Box 7106
London, KY 40742-7106

Claim Filing Deadlines

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

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

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

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

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

Common Causes of Claim Processing Delays, Rejections or Denials

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

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

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

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

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

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

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

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

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

Highlighted Claim Fields – (See "Illegible Claim Information")

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prospective Claims Editing Policy

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

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

Claims Inquiry

If a provider does not receive payment for a claim within forty-five (45) days of submission to First Choice VIP Care Plus or has concerns regarding any claim issue, claims status information is available by:

- Visiting the Provider area of First Choice VIP Care Plus' website, www.firstchoicevipcareplus.com, to access a free, web-based solution for electronic transactions and information through a multi-payer portal called NaviNet.
- Calling Provider Services at 1-(888)-978-0862

Balance Billing Members

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

Under the requirements of the Social Security Act, all payments from First Choice VIP Care Plus to participating Plan providers must be accepted as payment in full for services rendered. This means for First Choice VIP Care Plus Healthy Connections Prime members, providers **may not bill and/or collect** any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the remittance advice, as they are not the member's responsibility. **Please be advised that it is unlawful for providers to "balance bill" any patient who is a member of First Choice VIP Care Plus for any covered services.**

First Choice VIP Care Plus members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports as determined by SCDHHS.
- Medicaid copay for Medicaid only covered Durable Medical Equipment (DME) items.

How First Choice VIP Care Plus resolves balance billing issues with the provider:

- First Choice VIP Care Plus informs the provider that the member has been inappropriately balance billed and educates the provider on balance billing.
- If First Choice VIP Care Plus reimbursed the member for an inappropriately balance billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If after outreach and education efforts to the provider, First Choice VIP Care Plus identifies ongoing inappropriate balance billing activities, First Choice VIP Care Plus may take disciplinary action up to and including termination of the Provider Agreement.

All providers are encouraged to use the claims inquiry processes to resolve any outstanding claims payment issues.

First Choice VIP Care Plus
Attn: Claims
P.O. Box 7106
London, KY 40742-7106

For more information regarding balance billing, please refer to CMS' balance billing prohibition notice at this link (https://msp.scdhhs.gov/SCDue2/press-release/prohibition-balance-billing- healthy-connections-prime-members-0) on the Healthy Connections Prime website.

Claim Disputes

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

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

If you believe the payment amount you received for treating our member is less than the expected payment, you have the right to dispute that payment. Requests for a claims dispute may be submitted by calling Provider Services at (888) 978-0862 or in writing within one hundred eighty (180) calendar days of the date of the initial remittance advice from First Choice VIP Care Plus using the Provider Claims Dispute form which is available on our website. If the form is not used you must include the following:

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

Mail your claims dispute to:

First Choice VIP Care Plus
Attn: Claim Disputes
P.O. Box 7106
London, KY 40742-7106

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

Refunds or Recoveries for Improper Payment or Overpayment of Claims

If a First Choice VIP Care Plus provider identifies improper payment or overpayment of claims from First Choice VIP Care Plus, the improperly paid or overpaid funds must be returned to the Plan. Providers are required to return the identified funds to First Choice VIP Care Plus by submitting a refund check directly to the appropriate claims processing department:

First Choice VIP Care Plus
Attn: Provider Refunds
P.O. Box 7106
London, KY 40742-7106

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

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

If you…	**Then…**
Agree with the overpayment notice	• The provider does not need to do anything. • The claims will be reprocessed and all overpayments will be recovered from future payments
Have questions regarding the recovery or the calculation of the overpayment amount	• Contact Provider Claim Services 1 -888-978-0862 • Refer to the **Project Number** from the letter when calling or sending an e-mail.

Do not agree with our findings and would like to dispute the overpayment notice	**The provider must notify us in writing.** The letter should include the following: • A copy of the letter the provider received from us with the Project Number • The reason for the dispute with our findings • Supporting documentation for the dispute including claims information Send correspondence to: First Choice VIP Care Plus P.O. Box 7 106 London, KY 40742-7106
Would like to send a check for the recovery amount	The provider submit a check **AND** a copy of the letter the provider received from us with the Project Number to the following address: First Choice VIP Care Plus 200 Stevens Dr. Attn: CRRU CC286 Philadelphia, PA 19113

Program Integrity

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

- **Prospective (Pre-claimspayment)**
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services (“CMS”), the American Medical Association (“AMA”), state regulatory agencies or First Choice VIP Care Plus medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - *Please note: Claims requiring itemized bills or medical records will be denied if the*

supporting documentation is not received within the requested timeframe.

- Coordination of Benefits ("COB") - Process to verify third party liability to ensure that First Choice VIP Care Plus is only paying claims for members where First Choice VIP Care Plus is responsible, i.e. where there is no other health insurance coverage.
- Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

- **Retrospective (Post-claims payment)**

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

    - *Please note if medical records are not received within the requested timeframe, First Choice VIP Care Plus will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*

- **Credit Balance Issues**

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

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

Prior authorization is not a guarantee of payment for the service authorized. First Choice VIP Care Plus reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided

Readmission Review Program

First Choice VIP Care Plus's readmission review program involves the retrospective review of a patient's subsequent admission to the same acute, general, short-term hospital or hospital system

within thirty (30) calendar days of discharge for the same diagnoses-related group (DRG). This applies to acute inpatient admissions only and neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred. Although First Choice VIP Care Plus is not a Quality Improvement Organization (QIO), First Choice VIP Care Plus is following CMS guidelines on readmission reviews in the Medicare Quality
Improvement Organization (QIO) Manual (Chapter 4, Section 4240 Readmission Review), as a means to monitor the quality of care delivered to our members.

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

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

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

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

First Choice VIP Care Plus has contracted with a third party vendor to assist us with the readmission review process. This vendor will be responsible for the initial review of the claim, to determine if it meets the criteria of a readmission; for requesting medical records and conducting a review to determine if the readmission was clinically related to the first admission,

and to help determine if it was a potentially preventable admission. If all criteria are met, the vendor will send the findings to First Choice VIP Care Plus's Medical Director for review and validation. If the review findings are validated, the vendor will send a denial notice to the hospital on behalf of First Choice VIP Care Plus. The denial will result in the full take back of claim payment for the readmission claim; however, the Provider may then submit a replacement claim combining the two admissions into one claim. Providers have the right to appeal this determination as noted in this Provider Manual. Results of First Choice VIP Care Plus's review of readmissions may also result in a referral of a potential quality of care concern to First Choice VIP Care Plus'sQuality department.

Third Party Liability/Subrogation

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

Additional Information for Electronic Billing

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to First Choice VIP Care Plus must first pass Change Healthcare HIPAA edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted with all necessary and valid data elements within the required filing deadline of 365 days from the date the initial date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor in order to identify and re-submit these claims accurately.

Monitoring Reports for Electronic Claims

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

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

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

Plan-Specific Electronic Edit Requirements

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

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

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

Electronic Billing Exclusions

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

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

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

Common Rejections

Invalid Electronic Claim Records – *Common Rejections from Change Healthcare*
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.).
Claims without member ID numbers
Invalid Electronic Claim Records – *Common Rejections from First Choice VIP Care Plus (EDI Edits within the Claim System*)
Claims received with invalid provider numbers (including NPI and Taxonomy, or Plan ID, as applicable).
Claims received with invalid member ID numbers
Claims received with invalid member date of birth.

Rejected Claims

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

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

Corrected or Replacement Claims

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

- In cases where resubmission serves to correct a claim that has already been denied/paid, the claim must be clearly identified as a corrected claim and resubmitted within 365 days from the date of service.
- If there is an identified overpayment beyond 365 days from date of service, please contact Provider Services to arrange repayment. You may either send a refund check with documentation directly to the First Choice VIP Care Plus, P.O. Box 7106, London, KY 40742-7106, or arrange to have the repayment withheld from future payments.
- Corrected claims may be submitted electronically through Change HealthCare or NaviNet, or on paper submission to First Choice VIP Care Plus, P.O. Box 7106, London, KY 40742-7106.
- Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original First Choice VIP Care Plus claim number.
    - You can find the First Choice VIP Care Plus claim number on the 835 ERA, the paper Remittance Advice, or from the claim status search in NaviNet.
    - If you do not have the First Choice VIP Care Plus claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the First Choice VIP Care Plus claim number.

How to Submit Corrected or Replacement Claims

- Corrected/replacement and voided claims may be sent electronically or on paper.
    - If sent electronically, the ***claim frequency code*** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement (correction) of a prior claim or '**8**' for the Void of a prior claim. The value '**6**' should no longer be used.
    - In addition, you must also provide the original claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated *HIPAA Version 5010 Implementation Guide*.
    - If the corrected claim is submitted on paper, the claim must have the following in order to be processed:

- On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" and the Plan's original claim number must be in Field 22.
- On an Institutional UB04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the Plan's original claim number must be in Form Locator 64A Document Control Number.

Reminders:

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

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically…	Contact Change Healthcare: 1-(877)-363-3666
If you have general EDI questions …	Contact EDI Technical Support: 1-(877)-363-3666
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports…	Contact your EDI software vendor or call the Change Healthcare Provider Support Line: 800-845 -6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services: 1-(888)-978-0862
If you have questions about claims that are reported on the remittance advice…	Contact Provider Claim Services: 1-(888)-978-0862
If you need to know your provider NPI number…	Contact Provider Services: 1-(888)-978-0862
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information OR For questions about changing or verifying provider information…	Please Contact Provider Services: 1-(888)-978-0862
If you would like information on the 835 remittance advice…	Contact your EDI vendor or call Change Healthcare: 1-(877)-363-3666
Check the status of your claim…	Review the status of your submitted claims on NaviNet at www. NaviNet.net.
Sign-up for the Provider Portal…	Go to www. NaviNet.net or contact NaviNet Customer Service: 1-(888)-482-8057
Sign-up for Electronic Funds Transfer…	Contact Change Healthcare: 1-(877)-363-3666

PROVIDER PREVENTABLE CONDITIONS

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

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

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

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

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

Mandatory Reporting of Provider Preventable Conditions

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

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

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a “Present on Admission” indicator
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; First Choice VIP Care Plus will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA

(surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the diagnosis codes, such as Y 65.51, Y65.52, or Y 65.53 for ICD-10 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

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

- Wrong surgery on correct patient Y 65.51 (ICD-10)
- Surgery on the wrong patient, Y65.52 (ICD-10)
- Surgery on wrong site Y 65.53 (ICD-10)
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Inpatient Claims

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

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

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

Indicating Present on Admission (POA)

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

Valid POA Indicators Include:

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

X. Behavioral Health Care

Credentialing of Behavioral Health Providers

First Choice VIP Care Plus will assure access to the full scope of care and service resources within the established CMS standards of access and choice for all members. All network providers, including behavioral health providers are credentialed and re-credentialed to provide clinical care and services. First Choice VIP Care Plus has formally assigned responsibility for the credentialing and re-credentialing review function to the Credentialing Committee. The Credentialing Committee a multi-disciplinary committee that performs the review of behavioral health provider credentials for credentialing and re-credentialing and makes recommendations accordingly.

The following types of individual providers, facilities and provider organizations fall under the authority of the behavioral health credentialing/re-credentialing process:

a. Licensed Physicians (psychiatrists and addictive medicine physicians)
b. Licensed Psychologists
c. Licensed Behavioral Health Clinicians (LPC, LMFT, LISW-CP)
d. Stand Alone Behavioral Health Hospital/Inpatient Facilities
e. Medicare Enrolled Community Partial Hospitalization Programs
f. Rehabilitative Behavioral Health Services (RBHS)

First Choice VIP Care Plus strives to offer a provider network that provides the highest level of quality, as well as adequate choices and convenience to members.

Behavioral Health Practitioner / Provider Credentialing Rights

Right to Review Information Submitted

Behavioral health providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently First Choice VIP Care Plus does not require peer references. In addition, behavioral health providers have the right to be notified if information received during the credentialing process is substantially different than what was reported by the provider. Practitioners will be notified of this right in the credentialing decision notification letter.

Right to Correct Erroneous Information

Behavioral health providers have the right to correct erroneous information submitted by another party. Corrections must be submitted in writing to the credentialing staff identified in the decision notification letter within ten (10) business days of notification. Corrections or information received will be reviewed and documented in the practitioner's file. Practitioners will also be notified of this right in the credentialing decision notification letter.

Right to be Informed of Application Status

Behavioral health providers may request information about the status of the application they submitted at any time during the process. Such requests must be made to the Credentialing department, which will provide information about the status of the application, including whether it is scheduled to be presented to the Credentialing Committee, etc.

Behavioral Health Provider Application Process

Individual Provider Application

First Choice VIP Care Plus credentials at the practitioner level to meet CMS requirements for all services provided outside the auspices of a hospital inpatient setting. The application process for individual behavioral health practitioners requires submission of a completed application.
The application must include evidence of meeting credentialing criteria, such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc.

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

Through CAQH, providers submit credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. First Choice VIP Care Plus' goal is to have all providers enrolled with CAQH. There is no charge to providers to submit applications and participate in CAQH. Providers not already registered for CAQH may do so via a link from www.firstchoice vipcarePlus.com.

Providers may access credentialing requirements and all the required documents via First Choice VIP Care Plus' website at www.firstchoicevipcareplus.com and submit to First Choice VIP Care Plus as follows:

g. Send CAQH ID number along with additional required documents to First Choice VIP Care Plus via email, fax, or mail to the Provider Network account executive. Visit the provider area of our website at www.firstchoicevipcareplus.com for the most current credential checklist, required documents, and contact information.
h. Providers who are not affiliated with CAQH or who prefer a paper credentialing process may contact their First Choice VIP Care Plus Provider Network account executive for assistance or visit the provider area of our website at www.firstchoicevipcareplus.com for the most current checklist, required documents, and contact information. Paper applications may be emailed, faxed, or mailed to the Provider Network account executive.

Following the primary source verification process, the First Choice VIP Care Plus Credentialing Committee will make a determination regarding network participation.

Professional Provider Organization and Facility Application Process

Facility and professional provider organizations must complete a facility application. The following types of organizations are considered facilities:

i. Hospitals
j. Free Standing Psychiatric Facilities
k. Chemical Dependency Treatment Centers Intensive/Outpatient
l. Partial Hospitalization Programs

Applications may be requested by contacting the Provider Services department at 1-(888)-978- 0862.

Credentialing Site Visit

Following receipt and review of the facility application, a Provider Network Account Executive will schedule a site visit if the facility is not accredited by Joint Commission (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or if the provider is anticipated to be a high volume provider. The credentialing site visit includes a tour of all program areas of the organization, interview with senior administrative, clinical and direct care staff and review of additional written material and documentation. The on-site documentation review may include:

m. Policy and procedure manuals
n. Licensing documentation
o. Accreditation documentation
p. Program, treatment or other service protocols
q. Program schedules
r. Quality Improvement/Assurance Plan and reports
s. Discussion about medical record documentation practices, review of a blind treatment record and review of documentation policy and procedure

A score of 85% on the site visit is required. The Account Executive will assist the provider to the extent practical and appropriate relative to improvement. The Account Executive will provide a report with recommendations for improvement to the provider and will re-visit the site within six (6) months to assess progress. Assistance will be documented in the provider's file and will include the dates and the types of assistance provided. This will continue until the provider meets the site visit standards or declines further participation in the process.

The application and site visit report are reviewed by the Credentialing Committee for an approval/disapproval determination regarding the organization's/facility's network participation.

Credentialing Committee Decision

First Choice VIP Care Plus does not make credentialing/re-credentialing decisions based on applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, First Choice VIP Care Plus strives to meet the cultural and special needs of members.

Applicants are notified of their initial credentialing approval within 60 days of the Credentialing Committee's recommendation. Should the Credentialing Committee elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Re-credentialing

Re-credentialing involves periodic review and re-verification of clinical credentials of network providers. The First Choice VIP Care Plus Credentialing department maintains an active file of all credentialing decisions. A reminder system ensures each provider organization, facility and individual behavioral health practitioner is re-credentialed as scheduled. As part of this process, First Choice VIP Care Plus periodically reviews provider information from the National Practitioner Data Bank (NPDB) as well as the Office of Inspector General list of individuals who have been excluded from participation in Medicare and Medical Assistance Programs. Providers are required to disclose, at the time of discovery, any criminal convictions of staff members related to the delivery of medical care or services under the Medicare, Medicaid, or Title XX Social Service programs. Such information must also be reported at the time of application for

or renewal of network participation (Credentialing and Re-Credentialing). Providers are also obligated to provide such information to First Choice VIP Care Plus at any time upon request.

At a minimum the re-credentialing process occurs every three years. The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

t. Member complaints and grievances
u. Results of quality indicator monitoring and evaluating activities
v. Care Management Provider profiles, asavailable
w. Utilization Management Provider profiles, as available
x. Member satisfaction surveys, asavailable
y. Re-verification of licensure standing
z. Re-verification of hospital privileges
aa. Review of incident reports

Adding a New Site or Service

When a high volume provider relocates or opens a new site, First Choice VIP Care Plus must evaluate the new site. Providers are contractually bound to report changes that affect referrals. Non-accredited, high volume or potential high volume providers require a site visit prior to seeing members so please plan accordingly. While the definition may vary from time to time, currently, a high volume provider is one who sees 200 or more unique members in a 12 month period.

Providers who are adding a new service or site must contact the designated Account Executive. The Account Executive will notify you if a site visit is necessary.

Address Changes

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from First Choice VIP Care Plus.

Contracting and Rate Notices

Contracts

If an entity provides both behavioral health and physical health services, contracts for each specific service will be maintained. The Behavioral Health Account Executive will include the appropriate staff as needed from First Choice VIP Care Plus to assist and answer any questions. The First Choice VIP Care Plus contract is generally used for freestanding behavioral health entities and individual / group practices that exclusively provide behavioral health services.
First Choice VIP Care Plus uses a standard Provider Agreement that is approved by all the appropriate local authorities. Provider Agreements automatically renew each year.

Rate Notices and Fee Schedules

Payment is made based on the Medicare fee schedule. Rates will adjust in conjunction with rate changes from CMS.

Covered Behavioral Health Services

The following behavioral health services are included in the Plan's benefit package.

bb. Diagnostic and assessmentservices

cc. Physician and mid-level practitioner visits
dd. Individual counseling, group counseling, family counseling and Federally Qualified Health Center (FQHC) services
ee. Medication Management
ff. Inpatient acute psychiatric hospitalization andemergency services
gg. Partial hospitalization services
hh. Behavioral Health and Substance Abuse Outpatient Services
ii. Targeted Case Management
jj. Behavioral Health and Substance Abuse Residential Services
kk. Inpatient Detoxification Admissions

Access to Behavioral Health Care

Providers are required to maintain hours sufficient to meet the demand of the practice. If a provider site cannot meet a member's need within the specified timelines for emergent, urgent, or routine care, as indicated below, the provider must inform the member so that he or she can contact the Member Services department to obtain additional provider options. The member has the right to choose to wait for the next available appointment; however this must be clearly documented in the member's medical record.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below.

The standards below apply to behavioral health care services and behavioral health providers; please refer to the "Provider and Network Information" section of this *Provider Manual* for the standards that apply to medical care services and medical providers.

Access to Behavioral Health Care	
Life Threatening Emergencies ***Definition of Life Threatening Emergency:*** A situation requiring immediate care to a member to prevent death, serious injury or deformity of the member.	Providers must ensure that members receive an appointment within **one hour** of the request for services.
Non-Life Threatening Emergencies ***Definition of Non-Life Threatening Emergency:*** A behavioral health condition where the member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within six hours.	Provider must ensure that members receive an appointment within **six hours** of the request for services.

Urgent ***Definition of Urgent:*** The diagnosis and treatment of medical conditions that are serious or acute but pose no immediate threat to life and health, but which require medical attention within **24 hours.**	Providers must ensure that members receive an appointment within **twenty-four (24) hours** of the request for services.
Routine Mental Health Services ***Definition of Routine:*** Routine services are those services not deemed emergent or urgent.	Providers must ensure that members receive an appointment within **21 business days** of the request for services.
Waiting Time in a Provider Office	Not to exceed 45 minutes
Use of Free Interpreter Services	As needed upon member request during all appointments

Behavioral Health Services Requiring Prior Authorization

The following is a list of behavioral health services requiring prior authorization review for medical necessity and place of service. Prior Authorization may be requested by contacting Provider Services at 1-(888)-978-0862

- Mental Health and Substance Abuse Partial Hospitalization Program
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Residential Treatment
- Inpatient Detoxification Admissions
- Mental Health Inpatient Admissions
- Neuropsychological Testing
- Psychological Testing
- Electroconvulsive Therapy

Behavioral Health Services that Do Not Require Prior Authorization

- Outpatient Behavioral Health Counseling and Therapy
- Outpatient Evaluation
- Outpatient Medication Management Services
- Outpatient Nursing Services

Billing for Behavioral Health Care Services

Behavioral health providers will follow the same billing procedures as medical health care providers. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information on how to submit claims for covered behavioral health care.

Behavioral Health Provider Contract Terminations and Formal Sanctioning

See the section above called "Provider and Network Information" for information about contract terminations and sanctioning.

XI. HCBS Providers

Introduction

The information contained in this section of the *Provider Manual* applies to providers who are contracted with First Choice VIP Care Plus to provide covered home and community based services (HCBS). Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including HCBS providers, unless otherwise indicated in this section or specified via later communications. For more information, please contact Provider Services at 1-888-978-0862.

First Choice VIP Care Plus is responsible for ensuring that services are provided in a manner that helps maximize community placement and participation for members that require HCBS. The South Carolina Department of Health and Human Services (SCDHHS) Division of Community Long-Term Care (CTLC) is dedicated to serving individuals in the communities of their choice with the resources available through section 1915(c) Home and Community-Based Waivers. First Choice VIP Care Plus supports and enhances this type of member-centered care. When members reside in nursing facilities, these facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs. Members residing in these facilities receive additional care management and quality oversight from First Choice VIP Care Plus. When members with health and long-term care needs live in their own homes or other community-based residential settings, First Choice VIP Care Plus will develop a comprehensive care plan to address their care and treatment needs, including HCBS, provide assurances for health and safety, and proactively address risks to support a members' desire to live as independently as possible.

HCBS Provider Standards

First Choice VIP Care Plus HCBS providers are required to follow standards that are set by SCDHHS. They are also held to the same standards as all First Choice VIP Care Plus providers. All HCBS providers should review all sections of the manual to ensure that they are compliant with quality standards, cultural competency requirements and more. This HCBS section of the First Choice VIP Care Plus manual covers items that are specific to the HCBS provider but does not stop the other standards and requirements of the First Choice VIP Care Plus provider manual from applying to HCBS providers.

Overview of Home and Community Based Services (HCBS)

The SCDHHS Division of CLTC operates several waiver programs, including the Community Choices, HIV/AIDS, and Mechanical Ventilator Dependent waivers. The mission of HCBS is to provide a cost-effective option to institutional placement for eligible clients with long-term care needs, if they choose, allowing them to remain in a community environment. HCBS are a variety of services and supports that help eligible individuals meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. HCBS are provided over an extended period in homes and community residences.

Member Eligibility/Referral to Program

To be eligible for HCBS benefits, as a Healthy Connections Prime First Choice VIP Care Plus member, individuals must meet all of the following criteria:

- Age 65 and older at the time of enrollment; and

- Entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D, and receiving full Medicaid benefits
- Enrolled in the Community Choices Waiver, HIV/AIDS Waiver or Mechanical Ventilator Dependent Waiver or
- Not currently enrolled in one of the three (3) designated waiver programs, but it is determined these services are necessary to avoid or delay nursing home placement, may also be eligible for HCBS waiver services.

A referral to SCDHHS for a Long Term Care (LTC) assessment and a verification of eligibility by SCDHHS is necessary for HCBS waiver eligibility. Additional information about the requirements for a nursing home level of care is referenced in Section IV, Model of Care and Integrated Care Management, of this manual.

It is the responsibility of the Provider to verify the individual is a member of First Choice VIP Care Plus before services are covered by First Choice VIP Care Plus. Enrollment in First Choice VIP Care Plus can be verified through the South Carolina Healthy Connections Phoenix Care Call System. While First Choice VIP Care Plus maintains eligibility information as determined by SCDHHS, SCDHHS maintains final decision-making authority for determining eligibility for enrollment in this plan and eligibility to receive waiver covered services. Loss of eligibility or disenrollment from First Choice VIP Care Plus may not affect the member's waiver eligibility and they may be able to continue their waiver services. First Choice VIP Care Plus will notify providers when services are no longer covered by First Choice VIP Care Plus.

Provider Contracting

To support HCBS providers, First Choice VIP Care Plus uses a Medicaid Home and Community Based Services (HCBS) Provider Agreement. Provider Agreements automatically renew each year. The Provider Agreement may be amended from time to time as necessary to reflect the addition or removal of services due to a change in the South Carolina Healthy Connections Medicaid program.

Credentialing/Recredentialing

First Choice VIP Care Plus relies on the credentialing/re-credentialing of HCBS providers by SCDHHS under the Healthy Connections Prime program. Providers are required to maintain all necessary licenses and/or certifications, registrations and permits that are required to provide covered services, and must otherwise be credentialed without restriction by SCDHHS.

Benefits/Services

First Choice VIP Care Plus members who are in a waiver program will receive all Medicare parts A, B, and D benefits and South Carolina Healthy Connections Medicaid benefits, in addition to the HCBS benefits as outlined below.

Community Choices Waiver

The Community Choices Waiver is designed to serve First Choice VIP Care Plus members who are age 65 or older and have long-term care needs. To avoid or delay costly nursing home admission, clients are able to access the services necessary to receive care at home through careful assessment, service planning, care coordination, and monitoring. Covered benefits/services include:

- Adult Day Health Care Transportation

- Adult Day Health Care and Nursing
- Attendant Care
- Bath Safety Equipment
- Case Management
- Companion
- Environmental Modifications
- Enhanced Environmental Modifications
- Home delivered *M*eals
- Institutional Respite Care
- Limited Durable Medical Equipment
- Nursing Home Transition Service
- Nutritional Supplements
- Personal Care (I and II)
- Personal Emergency Response System
- Respite in Community Residential Care Facility
- Tele-monitoring

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver

The HIV/AIDS Waiver is designed to serve First Choice VIP Care Plus members who are age 65 or older who choose to live at home but have long-term care needs and are at risk for hospitalization. Covered benefits/services include:

- Adult Companion Care
- Attendant Care
- Bath Safety Equipment
- Case Management
- Environmental Modifications
- Enhanced Environmental Modifications
- Home Delivered Meals
- Nutritional Supplements
- Personal Care (I and II)
- Pest Control
- Additional Prescription Drugs
- Private Duty Nursing

Mechanical Ventilator Dependent Waiver

The Mechanical Ventilator Dependent Waiver is designed to serve First Choice VIP Care Plus members who are age 65 or older who are dependent on mechanical ventilation and have long- term care needs. Clients are able to receive services to supplement care in their home through careful assessment, service planning, and service coordination. Covered benefits/services include:

- Attendant Care
- Bath Safety Equipment

- Case Management
- Environmental Modifications
- Enhanced Environmental Modifications
- Home Delivered Meals
- Institutional Respite Care
- In-Home Respite Care
- Personal Care (I and II)
- Personal Emergency Response System
- Pest Control
- Additional Prescription Drugs
- Private Duty Nursing
- Specialized Medical Equipment and Supplies

Other Benefits/Services:

- Incontinence Supplies
- Oral Nutritional Supplements
- Miscellaneous Supplies and Equipment

Known as Supplemental or Flexible Benefits, members who are not eligible for one of the three (3) waiver programs listed above may be eligible for "waiver-like" services, when the First Choice VIP Care Coordinator determines that the services are necessary to avoid or delay nursing home placement as identified through an assessment conducted by the care coordinator or by physician recommendation/order.

For additional details on all covered waiver services and requirements, providers may also access the Phoenix Care Call system for the Scope of Services found under the help tab.

Non-covered Benefits/Services

First Choice VIP Care Plus will refer members to local resources for services that are not covered by First Choice VIP Care Plus, such as supportive, affordable housing, and other social services that maximize community integration, as appropriate. Providers may contact the First Choice VIP Care Plus Care Management team at 1-888-244-5440 for assistance with coordination of non-covered services.

Care Coordination

The First Choice VIP Care Plus care team includes a Care Coordinator and a Community Health Navigator who work in collaboration with HCBS providers as part of the Multidisciplinary Team (MT). The MT also includes the member, the member's primary care physician and other health care providers, other individuals who play an important role in the member's health care, and the HCBS Waiver Case Manager. Working with the MT, the Care Coordinator conducts a comprehensive assessment of the member in order to develop a person-centered plan, called the Individual Care Plan (ICP), which includes all needed services including physical health, mental health, and home and community-based services. A copy of the ICP is available to the provider(s) in the Phoenix Care Call system and copy is also given to the member. For more details on care coordination and our Model of Care, please see Section IV, Model of Care and
Integrated Care Management, of this provider manual.

Responsibilities of Home and Community Based Services Providers

First Choice VIP Care Plus is regulated by the South Carolina Department of Health and Human Services, the South Carolina Department of Insurance, and a number of Federal laws and regulations. Providers who participate in First Choice VIP Care Plus have responsibilities which are detailed in Section II, Provider and Network Information, of this provider manual.
Additionally, HCBS providers are required to participate in the Model of Care process, as described in Section IV, Model of Care and Integrated Care Management, of this provider manual.

Continuity of Care

Upon initial enrollment to our Plan, First Choice VIP Care Plus is required to offer a 180-day transition period for all members. Members will be allowed to maintain all direct care waiver services with providers who are not in our network at the current authorization levels unless major changes have occurred and are documented during the Long Term Care Level of Care Assessment. The 180-day transition period begins at the member's effective date of enrollment. This includes, but is not limited to:

- Adult Day Health
- Home Delivered Meals
- Personal Care Level 1 and 2
- Respite Care
- Waiver Nursing

Prior Authorizations

Prior authorization is required for ALL home and community based services and for all services provided by non-network HCBS providers, with the exception of emergency services.

Prior authorizations are initiated in the following ways:

- Through the care coordinator.
- Through the Multidisciplinary Team.
- Providers contacting the member's care coordinator to request authorizations at 1-(888)-978-0862
- Through the Phoenix Care Call system

Access to HCBS Care

First Choice VIP Care Plus and HCBS providers must meet standard guidelines as outlined in this provider manual to help ensure our members have timely access to HCBS care. First Choice VIP Care Plus encourages and supports comprehensive and consistent access standards for members to assure member accessibility to health care services. First Choice VIP Care Plus has established tools for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than standard business hours of operation for that type of service or business.

The standards below apply to HCBS providers. Please refer to the Provider and Network Information, Section II, of this Provider Manual for the standards that apply to all other health care services and medical providers

HCBS Access Standards	
HCBS Providers	Access standards are based on those required by SCDHHS for each covered HCBS waiver service, as described in the scope of services section of the Phoenix Care Call system.
Non-Network Providers	In the event that no participating provider can meet program standards, First Choice VIP Care Plus will extend authorization of home and community based services to an out-of-network provider to ensure continuity of care.
Distance	Transport distance to licensed Adult Day Care providers should not to exceed 15 miles one-way.

Billing and Reimbursement

HCBS providers should continue to submit claims for reimbursement through the South Carolina Healthy Connections Phoenix Care Call System. First Choice VIP Care Plus is responsible for payment to the HCBS providers within seven (7) days of submitted waiver services. Contact First Choice VIP Care Plus Provider Services at 1-(888)-978-0862 for any questions related to the status of your payment.