

PROVIDER MANUAL



VillageCareMAX Managed Long Term Care (MLTC)

VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)

VillageCareMAX Medicare Total Advantage MAP Plan (HMO D-SNP)

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Provider Quick Reference Guide



Quick Reference Guide for Providers

The VillageCareMAX Provider Portal

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status, and much more. The portal is available 24 hours a day, 7 days a week and can be

accessed by visiting https://vcm.guidingcare.com/AuthorizationPortal.				
Department	Contact Information	Hours of Operation	Information	
Member Enrollment & Eligibility Verifications	EMEDNY toll-free: 1-800-997-1111 Member Services Fax: 212-337-5711* * Any member or provider communication other than authorization, grievance and appeals	24 hours / 7 days Mon-Fri, 9 am - 5 pm	Verify VCMAX Enrollment on EMEDNY: MLTC Plan Code: VL MA Plan Code: VM To facilitate care management, VCM requests notification to UM of all hospital admissions in accordance with the following timeframes: -Elective: 5 days prior to admission but no later than 1 business day after admission -Emergent: within 1 business day of emergent admission	
Claims/ Provider Services	Tel: 855-769-2500	Mon – Fri 9 am to 5 pm		
Authorizations	Tel: 800-469-6292		All Fax Numbers should be used for requests related to authorizations including authorization changes, authorization corrections, authorization modifications, clinical & supporting documentation, and prior authorization forms.	
» Inpatient Admissions	Fax: 212-402-4468		Inpatient admissions; UR requests, Clinical, Discharge Summaries.	
» Outpatient Services	Fax: 978-367-1872		Outpatient Services (CHHA, In-Home & Outpatient OT, PT, ST, Nursing Services, Home Infusions) including New & Continuing Service Requests.	
» LHCSA/CDPAS/Personal Care	Fax: 646-618-8997	7 days/week 8 am - 8 pm	PCA and CDPAS including Overtime Requests.	
» Long Term Support Services	Fax: 646-362-2004	ο απι - ο ρπι	SADC, ADHC, PERS, Home-Delivered Meals, and Home Modifications.	
» DME	Fax: 718-517-2709		Requests for all new & existing DME/ Medical Necessity, Prescriptions.	
» Grievance and Appeals	Fax: 347-226-5180		All requests related to grievance and appeals.	
» Part B	Fax: 917-243-9997		All requests related to authorizations for Part B Drugs, including New & Continuing Service Requests.	
» Skilled Nursing Facility Admissions	Fax: 978-967-8030		All information regarding Skilled Nursing Facility Admissions, including: PRI and Short Term Rehab Requests, Clinicals, Discharge Summaries, Requests for Continuity of Care, etc.	
Pharmacy Services » MedImpact Pharmacy Benefits Manager	Tel: 888-807-6806, TTY 711.	Mon - Fri, 8 am - 8 pm	-VCMAX MLTC members obtain prescription drugs through their Medicare Prescription Drug Plan (Part D) and/or NYS MedicaidVCMAX MA and MAP members obtain prescription drugs through the VCMAX plan. Pharmacy network and prescription drug benefits are administered by MedImpact -The formulary (including prior authorization and other requirements) as well as a listing of participating providers and pharmacies can be found via www.villagecaremax.org.	

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Dental Services » LIBERTY Dental Benefits Manager	Tel: 833-276-0853	Mon - Fri, 8 am - 8 pm	
Transportation Services (non-emergency)			
Sentry Management Solutions	Tel: 844-573-6879	Mon – Sat, 7 am - 9 pm Sun, 8 am - 5 pm	
Optometry/Vision Services » Superior Vision (Versant)	Tel: 866-819-4298	Mon - Fri, 8 am - 8 pm	
Audiology/Hearing Services » HearUSA (audiology)	Tel: 855-898-1320	Mon - Fri 8 am - 8 pm	
Laboratory Services 1. Bio-Reference Laboratories 2. LabCorp 3. Accu Reference Medical Laboratory 4. Centers Laboratory 5. Lenco Lab	1. Tel: 800-229-5227 2. Tel: 800-222-7566 3. Tel: 877-733-4522 4. Tel: 718-837-5222 5. Tel: 866-98-LENCO (866-985-3626)	 24 hours /7 days Mon – Fri 8 am to 5 pm Mon – Fri, 8am-5pm, Sat – Sun, 10 am to 4 pm Mon- Sun, 9 am to 5 pm Mon - Sat 8 am to 5 pm 	

Prior Authorization List

The following services require prior authorization (contact Utilization Management). For a complete list of services with additional details, please see the VillageCareMAX Provider Manual, Section 10. For a complete list of DME codes that require prior authorization, please see Appendix 10 in the Provider Manual.

Frequently utilized MLTC Services		Frequently utilized MA & MAP Services	
>>	DME	>>	DME
»	Nursing Home Care	>>	Hospital admissions
»	Home Health Care	>>	Skilled Nursing Facility admissions
»	Adult Day Health Care & Social Day Care	»	Surgeries
»	Non-emergency Transportation	>>	Outpatient Behavioral Health services
>>	Rehabilitation Therapy (PT, OT, ST)		» Auth required after 20 visits for non-physician services
»	Respiratory Therapy	>>	Alcohol and Substance Abuse services
»	Nutrition	»	Rehabilitation Therapy (PT, OT, ST, Cardiac & Pulmonary)
>>	Social and Environmental Supports		» Auth required for all visits- change in 2022
»	Home Delivered & Congregate Meals	»	Home Health Care
»	Private Duty Nursing	>>	Organ Transplant
»	Community-based Long-Term Services and Supports (LTSS)	>>	Chiropractic services
>>	Respite services	>>	Diagnostic Services (MRI/MRA, EMG, PET Scan, Nuclear Medicine,
»	Tele-Monitoring		Discogram/Myelogram)
>>	Home Infusion	>>	Mobile Radiology
l		>>	Acupuncture visits for lower back pain
l		»	Acupuncture "Supplemental Benefit" - change in 2022
			» MAP: limit 5 visits/month -max 50/year
			» DSNP: limit 4 visits/month -max 34/year

Claims

Mail paper claims (CMS-1500 or UB-04) and claims correspondence, including Claims Appeals to: ILS - VillageCareMAX

P.O. Box 21516 • Eagan, MN 55121

Electronic claims submissions: Use VillageCareMAX Change HealthCare payer ID: 26545

- For MLTC claims, if VillageCareMAX is not primary, submit the claim within 90 days of the date on the Explanation of Payment (EOP)/Remittance Notice and include EOP with your claim.
- For MAP claims, VillageCareMAX is the payer for all covered services.
- For MA claims, VillageCareMAX is the primary payer.
- NPI and Tax ID must be included on all claims.

🏏 🛐 🔼 www.villagecaremax.org

Provider Portal Quick Reference Guide



VillageCareMAX Managed Long Term Care (MLTC)
VillageCareMAX Medicare Health Advantage Plan (HMO SNP)
VillageCareMAX Medicare Total Advantage MAP Plan (HMO SNP)



PROVIDER PORTAL

Quick Reference

Guide

The VillageCareMAX Provider Portal

The VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more. The portal is available 24 hours a day, 7 days a week. Providers must complete the registration process to receive access to the portal. All provider information will be verified by the plan before user account can be activated. This verification process may take up to 72 hours to complete.

How do I sign up?	Registration is quick and easy! Visit www.villagecaremax.org (or use the direct link https://secure.healthx.com/villagecareprovider) Click on the "For Providers" tab Click on Provider Login link located on the homepage On the right side of the web portal homepage, click Provider User Account Sign-Up and follow the step by step instructions to complete your one time registration.		
Once registered, providers have instant access to • Member/Participant Eligibility Status • Authorization Status • Claims Status • Claim inquiry request			
Using the Eligibil	ity, Benefits, Claims, and Prior Authorizations Searches		
How do I verify eligibility? Click on the Eligibility & Benefits link. Here, you may search member eligibility, which may be downloaded to your company to the company of			
How do I check claim status?	Click on the Claims link. Here you may search for a member's claim by entering their Member ID. To narrow your search, enter the Member ID, start and end dates of service. Once you locate your claim, select to view the claim details (date claim received, payee name, payment address, bulk check amount and more).		
How do I check authorization status?	Click on the Prior Authorizations link. Here you may search for member's authorizations by entering their Member ID. To narrow your search, enter the Member ID, start and end dates.		
How do I submit a claim inquiry?	You can also submit a claim inquiry by simply clicking on "click here to ask a question about this claim" at the top of Claim Detail screen. Your inquiry will be reviewed and responded to by the Provider Services Claims Department within the required timeframes.		

If you have any questions, please call the Provider Services Claims Department at 1-855-769-2500

Provider Authorization Portal Quick Reference Guide





PROVIDER AUTHORIZATION PORTAL QUICK REFERENCE GUIDE

VillageCareMAX-Altruista Health Provider Authorization Portal

The Provider Authorization Portal integrates with GuidingCare Care Management and is a tool for providers to electronically submit authorizations, step through criteria and receive automated responses and real-time updates. Providers can check on the status of authorizations, add supporting documentation for authorizations, update authorizations with discharge information and submit appeals on authorizations in one easy-to-use interface.

submit appeals on authorizations in one easy-to-use interface.				
How do I sign up?	Visit https://vcm.guidingcare.com/AuthorizationPortal/ Click Request Access link to display Provider Portal Registration page. Select ID type from drop-down list, Enter ID in text field, and click Search. Enter Provider First and Last Name, User Name, Password, and Email, then Click Register.			
Features of the Portal	Once registered, providers will be able to do the following electronically: » Request new authorizations, and check status of all authorizations. » Update, add additional info, discharge info, request extensions, withdraw, or appeal authorization requests. » View messages regarding authorizations.			
Access full use	er guide: https://vcm.guidingcare.com/AuthorizationPortal/Account/DownloadGuide			
Request Authorization	 From Home page, under Start a New Request, click New Inpatient Request or New Outpatient Request, and the Member Search page displays. Search by 1) Member ID or by 2) First and Last Name, and Date of Birth, then Find Member. Select Member from list, then Member Eligibility from the Authorization Basics page (click Show Active drop-down to see active eligibilities only). Select Authorization Type/Priority, enter Provider information, and select or enter authorization info, as applicable e.g. Admission/Discharge Date and Time, Type/Place of Service, Diagnosis/Procedure Descriptions, Codes, Modifiers, Service Start/End Dates, Units, and Notes (for text or images). Click Add Attachments if applicable, and click Submit. Message will appear with system-generated authorization number and status. Service Authorization Timeframes: Standard within 3-14 calendar days; Expedited within 72 hours. For Home Health Care requests, Initial visit must occur within 24 hours of request. For Social Adult Day Care requests, placement must occur within 14 days of request. 			
Check Authorization Status	From Home page, you can see the count of in-progress authorizations. Click Inpatient or Outpatient Auth in Progress or View All Inpatient or Outpatient Authorizations to view your Authorization List . Use Member ID field to filter list.			
Add Discharge Planning Details	Option available when inpatient authorization is in any status except NIA. Click blue circle with arrow to expand authorization, click +Discharge Information, select Discharge Date, location to Discharge To, and click Submit to save.			
Add Additional Option available for authorizations with statuses of Approved, Pending, or Appeal Overturned from the Authorization List or Messages. Expand authorization, click +Additional Information, and Enter Note or Add Attachments. Click Submit to save.				
Request an Authorization Extension	Option available for authorizations with statuses Approved or Appeal Overturned . Expand authorization and dick +Extension . Select requested end date from Extend Start Date and Extend End Date calendars. If Unit Type is Days , Total Extended Units auto-populates, but if Unit is anything other than Days , you need to calculate and manually enter. Click Submit to save.			
Messaging Center	From Home page, click envelope icon on left menu to view Messages from reviewers to providers. Unread messages we have a red indicator with count of unread messages on icon. Click message on left to open full text in reading pane on right. Auth ID link opens additional information.			
Appeal an Authorization Determination	To submit an appeal, contact us by calling 1-800-469-6292, or contact us in writing by mailing your request to VillageCareMAX, 112 Charles Street, New York, NY 10014.			

For authorization questions, please call 1-800-469-6292.
For Assistance or Training of Provider staff on using Portal, please email ProviderRelations@villagecare.org or call 718-517-2783.

Revised:4/2022

Section 2: VillageCareMAX Overview

VillageCareMAX Overview

Village Senior Services Corporation d/b/a VillageCareMAX is a New York not-for-profit corporation licensed by the New York Department of Health pursuant to Article 44 of the Public Health Law. The sole corporate member of VillageCareMAX is Village Care of New York, Inc., ("VCNY") a New York not-for-profit corporation that provides management and administrative services to VillageCareMAX and other VCNY affiliates and subsidiaries (collectively, "VillageCare").

The mission of VillageCare is to promote healing, better health and well-being to the fullest extent possible by providing a caring and supportive environment where all those we serve, along with their families and partners, are respected for their uniqueness and are encouraged to treat themselves and others with kindness and respect.

VillageCare has been providing quality health care to older adults and to those with other chronic diseases and conditions, including HIV/AIDS, who are in need of continuing care and rehabilitation services. VillageCare is a pioneering and innovative continuing care organization that offers post-acute care, community services and managed care options to people living in New York City.

Currently, VillageCareMAX offers three (3) managed care products to individuals in the Bronx, Kings, New York and Queens counties in New York:

- VillageCareMAX MLTC Plan provides Medicaid-covered services only. These include, but are not limited to, long term care services such as Personal Care, Home Health Care, rehabilitation therapies, care in a Skilled Nursing Facility, Personal Emergency Response System (PERS), Home Delivered Meals, and Social & Environmental Supports.
- VillageCareMAX Medicare Health Advantage Plan provides Medicare-covered services only. These include all Medicare Part A & B services, and Part D prescription drugs. Providers must bill New York State directly for Medicaid cost sharing and services covered through Medicaid/Medicare Fee for Service (FFS). In addition, members receive supplemental benefits not covered by Medicare or Medicaid such as over-the-counter health related items and acupuncture.
- VillageCareMAX Medicare Total Advantage provides all Medicare-covered and Medicaid-covered services. These include all Medicare Part A & B services, Part D prescription drugs; and all Medicaid-covered services, including community-based long term care. Providers must bill New York State directly for Medicaid cost sharing and services covered through Medicaid/Medicare Fee for Service (FFS). In addition, members receive supplemental benefits not covered by Medicare or Medicaid such as over-the-counter health related items and acupuncture.

VillageCareMAX is designed to coordinate healthcare services for chronically ill adults who wish to remain in their own home and communities for as long as possible.

Section 2: VillageCareMAX Overview

- Member's healthcare needs are coordinated by a dedicated Care Manager in collaboration with an Interdisciplinary Team (ICT). The ICT is led by the Care Manager and may include Primary Care Provider (PCP), Behavioral Health Professional, Member's family and caregivers, Member's personal care aide, and other service Providers and individuals as requested by the Member. The ICT works together to develop a plan of care consisting of covered and non-covered services designed specifically to meet the Member's healthcare needs.
- All Members enrolled in VillageCareMAX must have a physician who is willing to collaborate with VillageCareMAX. Collaboration by a physician means that the physician is willing to write orders for covered services and non-covered services, to refer to VillageCareMAX's Participating Providers and to work with the VillageCareMAX Interdisciplinary Care Team to coordinate all care.

Section 3: Enrollment Eligibility Criteria

VillageCareMAX MLTC Enrollment Eligibility

To be eligible for enrollment in the VillageCareMAX MLTC Plan, an individual must:

- 1. Be 18 years of age or older
- 2. Be a resident of Bronx, Brooklyn, Manhattan or Queens
- 3. Have full Medicaid coverage as determined by the Local Department of Social Services (in New York City, this is the Human Resources Administration known as "HRA")
- 4. Show a need and require one of the following Community Based Long Term Care Services (CBLTCS) for more than 120 days from the effective date of enrollment.
 - 1. Nursing services in the home
 - 2. Therapies in the home (physical, occupational or speech therapies)
 - 3. Health aide services in the home
 - 4. Personal care services in the home
 - 5. Consumer Directed Personal Assistance Services (CDPAS)
 - 6. Adult day health care
 - 7. Private duty nursing
- 5. For persons with Medicaid only or those with Medicare and Medicaid who are 18 to 20 years old, he/she must be assessed as eligible for nursing home level of care, at the time of enrollment, as determined by the New York State assessment tool, and need CBLTCS for more than 120 days as listed in #4 above.

VillageCareMAX MLTC Members <u>usually</u> need help with two or more of the following:

Grooming	Bathing	 Ambulation
 Dressing Upper Body 	 Dressing Lower Body 	 Toileting
• Eating	 Transferring 	 Housekeeping
 Transportation 	 Laundry 	 Light Meal Prep
• Shopping	Using the Telephone	

VillageCareMAX MLTC Members <u>often</u> also have one or more chronic medical and/or psychiatric conditions and/or cognitive impairments.

Section 3: Enrollment Eligibility Criteria

VillageCareMAX Medicare Health Advantage Enrollment Eligibility

To be eligible for enrollment in VillageCareMAX Medicare Health Advantage Plan, an individual must:

- 1. Be eligible for both Medicare Part A and Medicare Part B
- 2. Be eligible for full Medicaid benefits or a Medicare Savings Program
- 3. Be a resident of Bronx, Brooklyn, Manhattan or Queens
- 4. A United States citizen or lawfully present in the United States
- 5. Not have End-Stage Renal Disease (ESRD) at the time of enrollment

VillageCareMAX Medicare Total Advantage Enrollment Eligibility

To be eligible for enrollment in VillageCareMAX Medicare Total Advantage, an individual must:

- 1. Be 18 years of age or older
- 2. Have full Medicaid benefits as determined by the Local Department of Social Services (in New York City, this is the Human Resources Administration known as "HRA")
- 3. Be eligible for both Medicare Part A and Medicare Part B
- 4. Be a resident of Bronx, Brooklyn, Manhattan or Queens
- 5. Be a United States citizen or lawfully present in the United States
- 6. Be eligible for nursing home level of care
- 7. Be able to stay safely at home and in the community at the time of enrollment
- 8. Show a need and require community-based or facility-based Long Term Services and Supports (LTSS) for more than 120 days from the effective date of enrollment; or nursing facility clinically eligible and get facility-based LTSS. Community-based LTSS include:
 - 8. Nursing services in the home
 - 9. Therapies in the home (physical, occupational or speech therapies)
 - 10. Health aide services in the home
 - 11. Personal care services in the home

Section 3: Enrollment Eligibility Criteria

- 12. Consumer Directed Personal Assistance Services (CDPAS)
- 13. Adult day health care
- 14. Private duty nursing
- 9. Not have End-Stage Renal Disease (ESRD) at the time of enrollment
- 10. Enroll in the Medicare Advantage plan under VillageCareMAX Medicare Total Advantage

If you have a patient who you believe is eligible and may benefit from one of the VillageCareMAX plans, refer the person to us and we will tell them about our program and initiate the enrollment process.

To refer a patient, please:

- » Complete VillageCareMAX Lead Form*
- » Complete Form and email to SalesOps@villagecare.org, or
- » E-Fax Form to (978) 967-2879

^{*}Please refer to Appendix 1 for the VillageCareMAX Lead Form to submit referrals to the plan.

Section 4: Enrollment Eligibility Verification

Eligibility Verification

Providers are responsible for verifying Member eligibility prior to every encounter. Eligibility can be verified through EMEDNY – NY State Medicaid Eligibility Verification System at any time.

- VillageCareMAX MLTC Plan
 » ePACES Plan Code: VL
 » Provider Number: 03420399
 VillageCareMAX Medicare Health Advantage
 » CMS Contract ID: H2168 001
 VillageCareMAX Medicare Total Advantage
 » ePACES Plan Code: VM
 » CMS Plan ID: H2168 002
 » Provider Number: 04682248
 - EMEDNY toll-free 1-800-997-1111

For instructions, see the following web site:

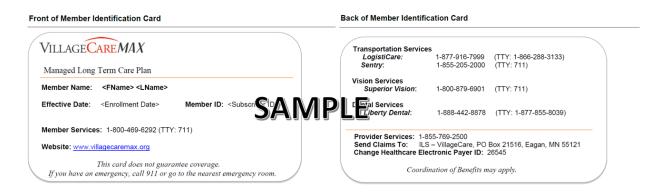
https://www.emedny.org/providermanuals/5010/MEVS/MEVS_DVS_Provider_Manual_(5010).pdf

Providers may also call Provider Services during normal business hours at 1-855-769-2500 with any questions.

Section 4: Enrollment Eligibility Verification

Member ID Cards

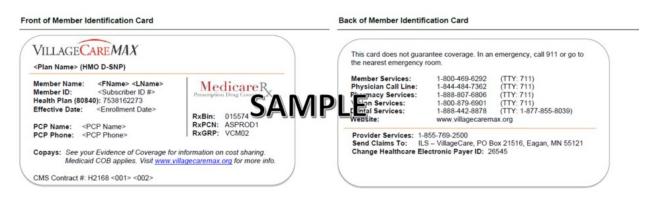
VillageCareMAX MLTC Member ID Card



VillageCareMAX Medicare Health Advantage Member ID Card



VillageCareMAX Medicare Total Advantage Member ID Card



H2168 MBR21-50 C

List of Covered Benefits for VillageCareMAX Managed Long Term Care Plan (MLTC), Medicare Health Advantage Plan (D-SNP), and Medicare Total Advantage Plan (MAP).

The complete listing of benefits and description for all plans can be viewed in the Evidence of Coverage or Member Handbook located at http://www.villagecaremax.org/.

KEY

X = Covered Benefit

NC = Not Covered

X* =*This service may only be partially covered under this Plan. Providers may contact Utilization Management at 1-800-469 6292 or visit our website at http://www.villagecaremax.org for more information.

Benefits	MLTC	MAP	D-SNP
24/7 Physician Hotline	NC	Χ	X
Acupuncture	NC	Χ	X
Adult Day Health Care	X	Χ	NC
Ambulatory Surgery Center	NC	Χ	X
Anesthesia	NC	Х	X
Angiograms and Embolization	NC	Χ	Х
Audiology Services (Exam)	X	Χ	X
Basic Radiology Services	NC	Χ	X
Blood Transfusion	NC	Χ	X
Cardiac Rehabilitation Services	NC	Χ	X
Chemotherapy	NC	Х	X
Chiropractic Services	NC	Χ	X
Consumer Directed Personal Assistance Services (CDPAS)	X	Χ	NC
CT Scan	NC	Χ	X
Dentistry ¹	X	Χ	X
Diabetes Programs and Supplies	X	Χ	X
Diagnostic Services	NC	Χ	X
Dialysis	NC	Χ	X
Discogram/Myelogram	NC	Χ	X
Durable Medical Equipment (DME)	X	Χ	Х
Electromyogram (EMG)	NC	Χ	X
Emergency Ambulance Services	NC	Х	Х
Emergency Care	NC	Х	X
Hearing Aids / Batteries ²	X	Χ	X

¹ See Appendix 13 for updated NYS Medicaid program dental policy notice.

² Hearing Aid Batteries do not require prior authorization.

Benefits	MLTC	MAP	D-SNP
Home Delivered and Congregate Meals	X	Х	X*3
Home Health Care	X	Χ	X
Home Infusion Services	X*	Χ	X
Hospital Services	NC	Х	Х
Immunizations	NC	X	X
Infusion	X*	Х	Х
Inpatient Bariatric Surgery	NC	Χ	X
Inpatient Hospital Care	NC	Х	Х
Inpatient Mental Health Care	NC	X	X
Inpatient Organ Transplants	NC	Х	Х
Inpatient Reconstructive Surgery	NC	X	X
Inpatient Skilled Nursing Facility	X	Χ	Х
Inpatient Substance Abuse and Rehab	NC	X	Х
Lab Services	NC	Χ	X
Medical Social Services	X	Χ	X*
Mental Health Care	NC	Х	Х
Mobile Radiology (EKG and X-Rays)	NC	X	X
MRI/MRA	NC	Х	Х
Nerve block/Epidurals	NC	Χ	X
Non-Emergency Transportation / Ambulance Services	X	Х	Х
Nuclear Medicine	NC	X	X
Nurse Practitioner	NC	Χ	Х
Nutrition	X	Χ	X*
Occupational Therapy ⁴	X	Х	Х
Orthopedic Footwear	X	Χ	X
Part B Drugs (when billed by a physician or facility)	NC	Χ	X
Partial Hospitalization	NC	X	Х
Personal Care Services	X	Х	NC
Personal Emergency Response Services (PERS)	X	Х	NC
Pet Scan	NC	Х	Х
Physical Therapy ⁺	X	Х	Х
Physician Assistant	NC	Х	Х
Physician Specialist Services	NC	Х	Х

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³ Effective January 1, 2022, Home Delivered/Congregate Meals will be a supplemental benefit for the D-SNP Plan. ⁴⁺Effective January 1, 2020 VillageCareMAX MLTC and MAP Plans removed service limits on Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST). VillageCareMAX MLTC and Total Advantage Plans covers medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. PT visits must have been recommended by a physician or other licensed professional in following settings: prviat practitioenrs' offices, certified hospital out-patient departments, and diagnostic & treatment centers (free-standing clinics). If not POS 12: GP, GN, GO modifier needed.

Benefits	 VILTC	MAP	D-SNP
Podiatry Services	Χ	Χ	Х
Primary Care Physician Services	NC	Χ	X
Private Duty Nursing	Χ	Χ	NC
Prosthetics/ Medical Surgical Supplies	Χ	Χ	X
Psychiatry	NC	Χ	Χ
Pulmonary Rehabilitation Services	NC	Χ	X
Respiratory Therapy	Χ	Χ	Χ*
Social and Environmental Supports	Χ	Χ	NC
Social Day Care	Χ	Χ	NC
Speech Therapy ⁺	Χ	Χ	X
Substance Abuse Care	NC	Χ	X
Telehealth	Χ	Χ	Χ
Tuberculosis screening & clinical management	NC	Х	Х
Ultrasound	NC	Χ	Χ
Urgent Care	NC	Х	Х
Vision Services – Eye Exam and Eyewear	Χ	Х	Х
Worldwide Emergency/Urgent Care	NC	Х	Х

KEY

 $\overline{X} = \overline{C}$ overed Benefit

NC = Not Covered

 X^* = Service may only be partially covered under this Plan. Providers may contact Utilization

Management at 1-800-469-6292 or visit our website at http://www.villagecaremax.org for more information.

2022 Supplemental Benefits Comparison

VillageCareMAX Medicare Health Advantage - Plan 001 (D-SNP)				
Benefit	Vendor	2021 Benefit/Coverage Limit	2022 Benefit/Coverage Limit	Type of change
Over-the-Counter (OTC) items	InComm	\$140 per month for approved items	Same	No change
Comprehensive Dental	Liberty Dental Plan	\$2,000 limit for comprehensive dental services	Same	No change
Preventive Dental	Liberty Dental Plan	1 oral exam, 1 cleaning, 1 fluoride treatment, 1 dental X-ray every 6 months	Same	No change
Vision	Versant/Superior Vision	Annual eye exam and \$350 per year for eyewear	Same	No change
Transportation	Sentry	18 one-way trips every 6 months with a maximum of 36 one-way trips per year	36 one-way trips per year	Changed limit to per year
Acupuncture	N/A	48 visits per year	Up to 4 visits per month, with maximum of 34 visits per year. (up to \$80 limit per visit)	Reduced number of visits and added \$ limit per visit.
Hearing	HearUSA network	Annual hearing exam. \$750 per ear every year with a maximum of up to \$1,500 for 2 hearing aids.	Same	No change
Fitness Membership	Silver&Fit	Monthly membership to participating fitness locations and in-home fitness programs/kits.	Same	No change
Therapeutic Shoes	N/A	additional pair of diabetic shoes for individuals with diabetes and severe diabetic foot disease.	Same	No change
Worldwide Coverage	N/A	Worldwide Emergency/Urgent Care coverage limited to \$50,000 per year	Worldwide Emergency/Urgent Care/ Emergency Transportation Ucoverage limited to \$50,000 per year	Added Emergency transportation.
Physician Call Line	United Concierge Medicine (UCM)	24/7 phone and video access to speak to physicians about health related concerns	Same	No change
Meals (immediately following surgery or inpatient hospitalization)	TBD	Not covered	2 meals per day for 4 weeks (2 x 28 days = 56 meals total)	New benefit

VillageCareMAX Medicare Total Advantage - Plan 002 (MAP)				
Benefit	Vendor	2021 Benefit/Coverage Limit	2022 Benefit/Coverage Limit	Type of change
Over-the-Counter	InComm	\$185 per month for approved	\$225 monthly limit combined for both OTC	Combined limit for OTC and Food
(OTC) items		items	items and Food & Produce	& Produce
Food & Produce	InComm	\$40 per month for grocery items	\$225 monthly limit combined for both OTC	Combined limit for OTC and Food
			items and Food & Produce	& Produce
Comprehensive	Liberty Dental	Prosthodontics & Endodontic	Same	No change
Dental	Plan	services not covered by Medicaid		
Vision	Versant/Superior	Annual eye exam and \$350 per	Same	No change
	Vision	year for eyewear		
Acupuncture	N/A	50 visits per year	Up to 5 visits per month, with maximum	Added monthly limit and \$ limit
			of 50 visits per year (up to \$80 limit per	per visit
			visit)	
Fitness	Silver&Fit	Monthly membership to	Same	No change
Membership		participating fitness locations and		
		in-home fitness programs/kits.		
Physician Call Line	United Concierge	24/7 phone and video access to	Same	No change
	Medicine (UCM)	speak to physicians about health		
		related concerns		
Worldwide	N/A	Worldwide Emergency/Urgent	Worldwide Emergency/Urgent Care /	Added Emergency transportation.
Coverage		Care coverage limited to \$50,000	Emergency Transportation coverage	
		per year	limited to \$50,000 per year	

Please refer to the VillageCareMAX website for official Annual Notice of Change documents:

-Health Advantage:

 $\frac{https://d2mcoh0vajf3v0.cloudfront.net/production/public/files/docs/DSNP/2022/ANOC/MKT22_05_M_2022_ANOC_MHA_En_glish%20v2.pdf$

-Total Advantage:

 $\underline{https://d2mcoh0vajf3v0.cloudfront.net/production/public/files/docs/MAP/2022/ANOC/MKT22_06_M_2022_ANOC_MAP_Eng_lish.pdf$

Section 6: Model of Care

VillageCareMAX Model of Care

VillageCareMAX has implemented an evidence-based model of care (MOC) for its health plans. Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve and sustain Member health outcomes across the care continuum in accordance with the requirements set forth by the CMS and DOH.

MOC elements include:

- Description of the plan-specific target population
- Measurable goals;
- Staff structure and care management goals;
- Interdisciplinary Care Team (ICT);
- Provider network having specialized expertise and use of clinical practice guidelines and protocols;
- MOC training for personnel and provider network;
- Health risk assessment;
- Individualized care plan;
- Integrated communication network;
- Care management for the most vulnerable subpopulations;
- Performance and health outcomes measurement; and
- Education, monitoring and evaluation of self-direction.

MOC goals are:

- Improve access to essential services such as medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve seamless transitions of care across healthcare settings, providers, and health services;
- Improve access to preventive health services;
- Ensure appropriate utilization of services; and
- Improve beneficiary health outcomes as selected by the plan.
- Ensure appropriate use of clinical practice guidelines that meet the unique needs of members.

Section 6: Model of Care

Care Manager and Interdisciplinary Care Team

Each VillageCareMAX Member is assigned to a Care Manager and Interdisciplinary Care Team that will include health care professionals (Member's primary care provider, nurses, social workers, psychologists or therapists, other specialists as appropriate) and a Member Services Representative. The Interdisciplinary Care Team has ongoing responsibility for ensuring that the Member's health risks are identified on ongoing basis and that the Member's healthcare needs and risks are appropriately addressed by the plan of care.

As the primary coordinator of care, the Care Manager's responsibilities include:

- Ensuring the ongoing identification of health risks Developing a plan of care for the Member and facilitating authorization of covered benefits;
- Implementing the Member's plan of care and coordinating services across the continuum of services:
- Monitoring the delivery of services for quality and effectiveness;
- Integrating feedback, observations, and recommendations of other professionals involved in managing the care of the Member, including Participating Providers, PCPs, Specialists and Providers of non-covered services; and
 - Collaborates with discharge planners and transition of care staff to coordinate discharge planning from hospital or nursing home stays and facilitate transitions of care. Subject to any limitations imposed by applicable law or program requirements, VillageCareMAX may, at any time, request that Provider transfer a Member to another provider or discharge the Enrollee to his/her home when VillageCareMAX determines that such transfer or discharge would be in the best interests of the Member. Neither VillageCareMAX or its affiliates, nor the Member shall have any liability for any charges or fees of Provider incurred after the date on which such transfer or discharge reasonably could have been effectuated.

Member Services Representatives

Member Services Representatives serve as liaisons between the Member and their Care Manager, and assist in facilitating communication across the Interdisciplinary Care Team. Member Services Representatives provide information about VillageCareMAX policies, available services, and Participating Providers, make and confirm service arrangements, and answer questions and resolve problems presented by Members.

Section 6: Model of Care

Health Risk Assessment

VillageCareMAX uses the Universal Assessment System (UAS) to conduct evaluations of the Member's medical history, clinical issues, diagnoses, functional status, psychosocial issues and cognitive status, and potential health risks that may be amenable to intervention, such as tobacco use, obesity and decreased medication adherence. The information collected using UAS is the basis for development of the individualized plan of care, including the identification of Memberspecific problems and goals. In addition to the UAS, the plan conducts a home safety evaluation and completes a personal care tasking tool. The plan conducts an assessment upon enrollment and every 6 months and whenever there has been a significant event (e.g., hospitalization, a fall, etc.).

Individualized Care Plan

Based on the results of the assessments, each Member is assigned a Care Manager (CM), who is either a registered nurse or a certified social worker. Care Managers working with the Member, his/her caregivers and the ICT, develop a Person-Centered Service Plan. A Person-Centered Service Plan is a written description in the care management record of Member-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a Member in order to achieve such goals.

Performance and Health Outcome Measurement

VillageCareMAX continuously reviews the progress that has been made toward meeting the goals of its Model of Care, and issues related to the MOC structure, provider network, and communications mechanisms. The Plan will review the results of its performance measures to assure that we continue to promote, improve and sustain Member health outcomes.

Please refer to <u>Appendix 15</u> to review the VillageCareMAX Special Needs Plan Model of Care Training.

Responsibilities of All Participating Providers

Participating Providers are responsible for providing care, the coordination of benefits and, depending of the program in which the Member is enrolled, for maximizing a Member's Medicare, Medicaid or other primary insurance sources.

Participating Providers must comply with all New York State Department of Health and/or CMS requirements regarding physician's orders. Authorization from VillageCareMAX does not exempt a Participating Provider from being required to obtain physicians orders. This includes but is not limited to services provided by licensed home care agencies and providers of personal care services, home care services, rehabilitation therapies, Durable Medical Equipment, Prosthetics, Orthotics, and supplies.

Members of VillageCareMAX lines of business are responsible for their cost-sharing amounts when they receive services covered by VillageCareMAX. For VillageCareMAX MLTC members, VillageCareMAX will be the last entity to be billed. The Member's primary insurance or Medicare will be billed first, followed by Medicaid or any other insurance that a member has.

Care coordination and management is critical to the health and well-being of VillageCareMAX Members. Participating Providers agree to fully cooperate with VillageCareMAX Care Management and Quality Management activities. Participating Providers agree to this even in those cases where the service is covered entirely by a primary payer, such as Medicare, and there is no payment from VillageCareMAX because the primary coverage pays for the service in its entirety.

All Participating Providers are responsible for effectively communicating with the Care Manager/Interdisciplinary Care Team, along with the Member Services staff regardless of primary payer, in order to ensure health risks are identified and addressed, to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, access appropriate reimbursement sources for services, increase continuity of care and progress toward goal achievement. Participating Providers should notify VillageCareMAX Care Management immediately upon learning of changes in the Member's condition, including hospitalizations, falls and other health or social/environmental risks.

In case of an Emergency, Provider shall refer the Enrollee to an appropriate provider of Emergency Services. As soon as possible, but in no event later than one (1) business day after making such referral, Provider shall notify VillageCareMAX of such referral by emailing vcmaxrefer@villagecare.org, calling 1-800-4MY-MAXCARE (1-800-469-6292) or faxing referral to 1-347-226-5181 using the form designated in the Provider Manual

If Provider cannot provide a Member with any covered or authorized service, Provider shall immediately notify VillageCareMAX by calling 1-800-4MY-MAXCARE (1-800-469-6292) to notify the VillageCareMAX Program Physician on call, and Provider shall promptly send to

VillageCareMAX written notification setting forth the date of such verbal notification and the name of the VillageCareMAX Program Physician notified. In addition, Provider shall cooperate with the Member and VillageCareMAX in obtaining appropriate care for such Member.

A Member may refuse care that has been specified in his/her plan of care. If this happens, Providers should notify VillageCareMAX immediately. VillageCareMAX will not place or terminate services that the Member refuses until after the Member, their family or authorized representative has been fully informed of the health risks and consequences involved in such refusal and the Member, upon being fully informed, continues to refuse care. All Participating Providers must notify VillageCareMAX immediately if a Member refuses an authorized service.

All contracts with providers of covered services (including management agreements, if applicable), shall include the following provisions:

- Any services or other activities performed by a provider in accordance with a subcontract between the provider and VillageCareMAX will be consistent and comply with the VillageCareMAX's obligations under the Agreement and applicable state and federal laws and regulations.
- A provision that VillageCareMAX will provide, no less than thirty (30) days prior to implementation, any new rules or policies and procedures regarding quality improvement, service authorizations, Enrollee appeals and grievances and provider credentialing, or any changes thereto, to a provider of covered services that is a subcontractor.
- No provision of the Provider Contract is to be construed as contrary to the provisions of PHL Article 44 and implementing regulations to the extent they do not conflict with federal law and 42 CFR Parts 434 and 438.
- Specific delegated activities and reporting responsibilities, including the amount, duration and scope of services to be provided.
- Satisfactory remedies, including termination of a Provider Contract when the Department or the Contractor determines that such parties have not performed adequately which includes but is not limited to egregious patient harm, significant substantiated grievances, submitting claims to VillageCareMAX for services not delivered, and refusal to participate in the plan's quality improvement program.
- Provision for ongoing monitoring of the provider's compliance with the Provider Contract by VillageCareMAX. Such monitoring provision shall specify requirements for corrective action, revocation of the Provider Contract or imposing sanctions if the provider's performance is inadequate.
- A procedure for the resolution of disputes between VillageCareMAX and its providers. Any and all such disputes shall be resolved using the Department's interpretation of the terms and provisions of the Agreement and portions of provider contracts executed hereunder that relate to services pursuant to the Agreement. If a Provider Contract provides for arbitration or

mediation, it must expressly acknowledge that the Commissioner of the Department of Health is not bound by arbitration or mediation decisions. Arbitration or mediation must occur within New York State, and the Provider Contract must provide that the Commissioner will be given notice of all issues going to arbitration or mediation and copies of all decisions.

- A provision specifying how the provider shall participate in the VillageCareMAX's quality assurance, service authorization and grievance and appeals processes, and the monitoring and evaluation of the VillageCareMAX's plan.
- A provision specifying how the provider will ensure that pertinent contracts, books,
 documents, papers and records of their operations are available to the Department, OMIG,
 DHHS, the Comptroller of the State of New York and the Comptroller General of the United
 States and the New York State Office of the Attorney General and/or their respective
 designated representatives, for inspection, evaluation and audit, through ten (10) years from
 the final date of the Provider Contract or from the date of completion of any audit, whichever
 is later.
- A provision specifying how the subcontractor will ensure that pertinent contracts, books, documents, papers and records of their operations are available to the Department, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.
- A provision that the statutes, rules and regulations, and applicable Medicaid Updates of the Medicaid program and of the Department related to the furnishing of medical care, services, or supplies provided directly by, or under the supervision of, or ordered, referred, or prescribed by Participating Providers enrolled in VillageCareMAX's MLTCP, apply to such Participating Providers and any subcontractors, regardless of whether the Participating Provider or subcontractor is an enrolled Medicaid provider, including 18 NYCRR 515.2, except to the extent that any reference in the regulations establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by VillageCareMAX.
- Any Value Based Payment (VBP) arrangements, as applicable to the Provider Contract.
 VillageCareMAX Provider Relations department will secure contracts aligned with the DOH VBP roadmap to improve outcomes for members/populations and reward the delivery of high value care by providers in the hopes of increasing long-term sustainability.
- A provision that the New York State Office of the Attorney General (OAG), the Department, OMIG and the Office of the State Comptroller (OSC) have the right to audit, investigate or review the provider or subcontractor and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. and to bring criminal prosecutions.

- A provision that the provider or subcontractor shall provide the New York State Office of the Attorney General, the Department, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider's subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to VillageCareMAX performance under the Agreement for the purposes of audit, inspection, evaluation and copying. The provider shall give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules, or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider.
- A provision requiring that the provider or subcontractor promptly report to VillageCareMAX after it identifies any overpayment related to performance under the Agreement.

All Participating Providers are required to:

- Comply with all regulatory and professional standards of practice and are responsible to
 acquire physician orders whenever required by regulation or local, state or federal law as
 well as for determination of medical necessity and/or third party reimbursement. The
 Care Manager/Interdisciplinary Care Team may assist in obtaining orders if the
 Participating Provider has been unsuccessful; however, obtaining orders is the
 responsibility of the Participating Provider.
- Collaborate with Care Management and participate in the care planning processes.
 - VillageCareMAX's Care Manager will authorize and coordinate the provision of services rendered under the Participating Provider Agreement. This responsibility includes authorizing the specific amount of services that will be utilized by the Enrollee, including the number of units of service to be provided, as outlined in Exhibits A of the Agreement, and the authorized time period during which these services are to be provided.
- Follow evidence-based clinical practice standards when providing care.
- Notify VillageCareMAX immediately whenever there is identification of a clinical, social, or environmental issue of serious concern, change in Member status, refusal of service, inability to access a Member's home or inability to provide service for any reason
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member.
- Cooperate with VillageCareMAX on any grievance, or appeal as required. Incident reports must be submitted to VillageCareMAX within ten (10) working days of request.
- Communicate to VillageCareMAX any complaint made by or on behalf of the Member.
- Cooperate with VillageCareMAX Quality Assurance Department and quality improvement programs as needed.

- Assure that all Participating Provider's employees and agents involved in direct contact with Members carry proper identification.
- Notify VillageCareMAX of the provision of any services normally requiring prior authorization but which were provided on an urgent basis (before authorization could be obtained) within forty-eight (48) hours.
- Cooperate with VillageCareMAX credentialing and recredentialing processes.
- Participate in all required VillageCareMAX training programs including physical accessibility, which is defined in accordance with the US Department of Justice ADA guidance for providers, in the following areas:
 - Provision of reasonable accommodations to Members with hearing, vision, cognitive and psychiatric disabilities
 - Utilizing waiting room and exam room furniture that meets the needs of all Members, including those with physical and non-physical disabilities
 - o Accessibility along public transportation routes and/or providing enough parking
 - Utilizing clear signage and way finding (e.g. color and symbol signage) throughout facilities; and
 - o Any other requirements included in the ADA Accessibility Attestation Form.
- Check governmental exclusion lists on a monthly basis, including the U.S. Dept. of Health and Human Services Office of the Inspector General ("OIG") List of Excluded Individuals and Entities and the NY Office of the Medicaid Inspector General ("OMIG") List of Exclusions to ensure that no employee/staff is excluded from participation in government programs.

Roles and Responsibilities of PCPs, Specialists and Covering Physicians/Providers

Primary Care Physicians

Primary Care Physicians (PCPs) provide comprehensive primary care services to VillageCareMAX Members without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

The PCP's role and scope of responsibilities include:

- Develop Member's care and treatment plans, including preventive care
- Coordinate, monitor and supervise the delivery of primary care services to each Member
- Follow evidence-based clinical practice standards when providing care, if such standards exist for the services the Member's needs
- Maintain Member's current medical records, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the Provider contract and Section 8 of the Provider Manual
- Refer Members for specialty care when appropriate

- Coordinate with specialty providers when appropriate
- Coordinate and communicate with Care Manager and participate in ICT meetings.
- Provide complete information about proposed treatments and prognosis for recovery to our Members or their appointed representatives
- Ensure that Member's medical and personal information is kept confidential, as required by state and federal laws
- Provide or arrange for coverage of services, twenty-four (24) hours per day, seven (7) days per week.
- To ensure PCPs meet accessibility and availability requirements, PCPs must provide the following:
 - o A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP;
- Participate in all required training programs, including those that are specific to PCPs including:
 - o How to identify behavioral health needs;
 - o How to assist the Member in obtaining behavioral health services;
 - How to identify community-based and facility-based Long Term Care Services and Supports (LTSS)
 - o How to assist the Member in obtaining community-based and facility-based LTSS

Providers are required to inform VillageCareMAX of any changes to their practice, including, but not limited to changes in:

- Professional business ownership/ TIN changes
- Business address or the location where services are provided
- Specialty

Covering Physicians/Providers

In the event that a participating provider is temporarily unavailable to provide care to VillageCareMAX Members, the participating provider should make arrangements with another qualified provider to provide services on their behalf, unless there is an emergency.

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists diagnose and treat conditions specific to their area of expertise. Referrals to In-Network Specialists are not required.

Home Care Provider Responsibilities

In addition to the above, All Home Care Participating Providers are responsible for:

- Obtaining physician orders. (CDPAP/ Fiscal Intermediaries are not responsible for obtaining MD orders)
- Providing aide clinical supervision visits as required by law.
- Developing the home aide plan of care for requested services and maintaining duty sheets. For split shifts, the day and night duty sheets should be maintained.
- Ensuring that family members of VillageCareMAX Members who are aides are not assigned to handle the care of their family member.
- Notifying Members in advance of the name of assigned staff. Members should be notified before 3:00 pm on the day prior to the provision of services.
- Notifying Members in advance of the need for replacement staff and the name of replacement staff. Members should be notified before 3:00 pm on the day prior to the receipt of services from replacement staff. If the staff change will be permanent, providers need to notify VillageCareMAX of the staffing change.
- Confirming the daily attendance of staff. To assure the safety of our Members, VillageCareMAX recommends that all Home Care Participating Providers implement an electronic attendance program in addition to other manual random verifications. Agencies not utilizing electronic attendance programs must verify attendance of staff daily for all VillageCareMAX Members for whom they serve. Agency protocols on aide attendance verification must be available to VillageCareMAX upon request. Agencies should begin calling to verify staff attendance within 15 minutes of his/her start time. If the aide is not on site, the agency should notify VillageCareMAX within 15 minutes of receipt of this information.
- Submitting evaluation and progress notes within one business days of the request by VillageCareMAX for authorization purposes and within 5 business days of the request for quality assurance purposes.
- Cooperating fully with the VillageCareMAX Care Management Department, verbally or in writing regarding the Member's progress even if the episode of care does not result in any payment by VillageCareMAX to the Participating Provider.

• Notice of Medicare Non-Coverage (NOMNC):

- Effective January 1, 2022, per Chapter 10 of the Medicare Claims Processing Manual, Medicare requires Certified Home Health Agency (CHHA) to submit a one-time Notice of Admission (NOA) instead of the former Request for Anticipated Payment (RAPs).
- o If VillageCareMAX denies a concurrent CHHA request, the Participating CHHA shall distribute the Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) to the Member which includes verbiage that grants Members the right to appeal and request a review by the Quality Improvement Organization (QIO).

Please see Appendix 7 for the LHCSA Operational Guidelines.

Behavioral Health Provider Responsibilities

VillageCareMAX provides our Members with coverage for mental health and substance abuse programs with access to a full continuum of mental health and substance abuse services through our network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. VillageCareMAX expects that Members will receive timely access to clinically appropriate behavioral health care services, in order to achieve improved outcomes for our Members.

Participating providers will provide treatment that is medically necessary exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, disease or its symptoms, where treatment is in accordance with generally accepted standards and practices that are clinically appropriate, with regard to type, frequency, extent, site and duration. The practitioner will take into consideration the Member's cultural background and language.

Individual behavioral health professionals caring for VillageCareMAX Members are required to:

- Coordinate and communicate with the Member's Care Manager and
- Participate in the Interdisciplinary Care Team (ICT) if they wish to do so, and if the Member has approved his/her participation on the ICT. Please see Section 5 for more information about the VillageCareMAX interdisciplinary care team.

Certain behavioral and mental health providers are required to maintain a system of 24-hour oncall services for Members in active treatment. VillageCareMAX expects all providers who are required to meet this regulatory requirement, or those providers who offer this service through best practice, to ensure that all Members in treatment are aware of how to contact the treating or covering provider after-hours and during provider vacations.

<u>Crisis intervention services:</u> Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a Member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.

Participating provider can be an individual practitioner, private group practice, community based organization, licensed outpatient agency, or facility that has been credentialed by VillageCareMAX and agrees to provide mental health and/or substance abuse services to Members, to accept reimbursement directly from VillageCareMAX according to the contracted rates. Participating providers must maintain approved credentialing status to remain active network participants.

See Section 9 "Authorization Requirements" for additional information.

Residential Health Care Facility (RHCF) Provider Responsibilities

For short term stay:

- Determining the type of health insurance coverage, the prospective resident has and whether or not the RHCF is authorized to serve the Member.
- Submitting initial evaluations, assessments and plan of care (including short and long term goals) within 1 week of admissions. Subsequent progress notes and/or plan of care updates are submitted at least weekly / or within 5 days of admission to VillageCareMAX for authorization purposes.
- Obtaining authorization for any covered service outside of the daily rate.
- Assisting in the Medicaid recertification process.

For long term placement:

- Determining eligibility for Institutional Medicaid and other third party coverage and whether or not the RHCF is authorized to serve the Member.
- Submitting conversion applications for Members placed for long-term care.
- Identifying the admission as a MLTC admission.
- Collecting the Net Available Monthly Income (NAMI will be deducted from payments).
- Submitting resident monthly summaries to the VillageCareMAX Care Manager.
- Including the VillageCareMAX Care Manager in case conferences.
- Obtaining authorization for any covered service outside of daily rate.
- Assisting in the Medicaid recertification process.

As long as we are responsible for charges, monthly status updates will be requested.

<u>Note:</u> VillageCareMAX Members must be eligible for Institutional Medicaid to remain in an RHCF for long term care.

Adult Day Health Care Provider Responsibilities

- Clinic visits defined as care or an occasion of service of less than three hours duration; or
- Part day care, defined as clinic care extending for more than three hours, but less than five hours; or
- Full day care, defined as clinic care extending for more than five hours, but less than 24 hours; or
- Evening care, defined as clinic care provided after 5 p.m. but not including an overnight stay; or
- Night care, defined as clinic care for less than 24 hours in a day in a residential health care facility and including, as a minimum, an overnight stay in the facility.

Adult Day Health Care Providers are also required to:

- Arrange for the indirect or direct provision of the following services to Members:
 - Medical services including admission and medical history, physical examinations, consultations by medical specialists when needed, and necessary orders for medication, diet, physical therapy, occupational therapy, and supportive services;
 - Nursing services, under the direct supervision of a registered professional nurse, based on periodic and continuing evaluations of each Member's need for nursing care;
 - o Dental care, services provided in accordance with State guidelines for dental care;
 - o Rehabilitation therapy and speech-language pathology services, including the arrangement of transportation;
 - o Pharmaceutical services, with supervision in taking prescribed drugs and in administering medication, as appropriate;
 - o Supportive services, including laboratory, X-ray, and other such services.
 - o Placement of the services listed above must occur within fourteen (14) days of the request.
- Develop or arrange for the development of a written review and evaluation plan within thirty (30) days for each Member.
- Review and evaluation no less than yearly and more often as indicated by changes in the conditions or circumstances of the Member.
- Develop and maintain a health record for each Member that records current health reports and information pertaining to a Member's care with planning promptly entered, dated, and signed by the individual providing the information or prescribing the service and kept in a place convenient for use by authorized staff.

Social Day Care Provider Responsibilities

- Complying with New York State Office of Aging Social Adult Day Care Regulations.
 Please contact the plan or the New York State Office of Aging website to obtain a copy of these requirements.
- Assessing client functional capability and impairment.
- Reassessing functional capacity when appropriate including when there is a question of the client's capacity to no longer participate safely in the program.
- Developing individual service plans with consumers as well as caregivers or informal supports. The service plans should:
 - o Be developed within 30 days;
 - o Be reviewed at least annually;
 - o Promotes the highest functional level possible;
 - Builds on existing capabilities or development of new capabilities or compensating;
 - o Specify outcomes expected

- Providing services to functionally impaired individuals that must include: socialization, supervision, and personal care assistance. Optional services may include transportation.
- Providing nutritious meals for members who are attending the program at normal meal times and includes offering snacks and liquids for all members at appropriate times.
- Requiring and maintaining accurate attendance records which require separate sign-ins by members for inbound transportation, outbound (return home) transportation, and attendance at the Social Adult Day Care program.
- Plan of care signed by the member or member's representative.

Podiatry Provider Responsibilities

Podiatry Participating Providers are responsible for:

- Providing services only by a qualified licensed and currently registered podiatrist.
- Making appointments within seven (7) days of the date of the call to make the appointment; twenty-four (24) hours in the case of emergency.
- Providing services and supplies as medically needed and as an integral part of comprehensive medical care.
- Providing services only upon referral by physician, physician's assistant, nurse practitioner or nurse midwife.
- Ordering or arranging for clinical laboratory necessary for the diagnosis or treatment of conditions of the foot.
- Assuring covered services do not include routine hygienic care of the feet in the absence of pathology.

DME and Medical Supply Provider Responsibilities

- Verifying primary payer coverage and eligibility prior to delivery.
- Acquiring physician orders whenever required by regulation or local, state or federal law and/or third party reimbursement.
- Exhausting all other payment sources prior to billing VillageCareMAX.
- Timely delivery of requested products.

Note: It is the responsibility of the Participating Provider to determine whether Medicare covers the item or service being billed if a member has coverage with another plan that is primary to VillageCareMAX. If the service or item is covered or if the Participating Provider does not know if the service or item is covered, the Participating Provider must first submit a claim to Medicare, as VillageCareMAX is always the payer of last resort if a member has coverage with another plan that is primary to VillageCareMAX. If the item is normally covered by Medicare but the Participating Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the VillageCareMAX Care Manager prior to delivery.

Section 7: Participating Provider Responsibilities

Home Delivered Meals Provider Responsibilities

Home delivered meals providers are responsible for:

- Providing nutritionally balanced meals that meet one-third of the daily Recommended Dietary Allowance (RDA). The program will provide a variety of hot and frozen meals that can be re-heated in the home.
- Making meal deliveries each weekday except for agreed upon holidays, or as specified in contract. Monitoring home-delivered meal clients. Meal deliverers have direct, face-to-face contact with the client at the time of delivery.
- Communicating with case manager or caseworker about changes in need or when a client suspends service due to hospitalization, or an extended visit away from home.
- Serving a variety of appealing foods and making approved menus available to clients. Clients have the opportunity to offer input on meal planning and meal service.
- Delivering meals within the timeframe stated to clients. Explaining the agency's policies and procedures to clients.
- Having emergency procedures (i.e. weather or vehicular breakdown). Clients are notified when meals cannot be delivered or cannot be delivered on time.
- Having deliverers who are appropriately trained and supervised.
- Preparing food according to principles of nutritional health and safety standards.

Transportation Provider Responsibilities

- Arriving within thirty (30) minutes of the requested pick up time.
- Providing all requested in and out of borough transportation requests, including special needs transports.
- Assuring that all transportation is to medical appointments unless specifically noted in the authorization.
- Notifying VillageCareMAX when a requested trip is to a non-medical destination.
- Notifying VillageCareMAX when a Member cancels or does not show for a pick up.
- Notifying VillageCareMAX when it is determined, upon arrival, that the driver is unable to transport a Member safely.
- Obtaining documentation for each trip provided, including the following:
 - o Member's name and VillageCareMAX identification number,
 - o Date of transport
 - o Pick-up address and time of pick-up
 - o Drop-off address and time of drop-off
 - o Vehicle license plate number, and
 - o Full name of the driver (printed, not signature)

Section 7: Participating Provider Responsibilities

VillageCareMAX requires that all Ambulette and Car Service Participating Providers follow the safety criteria in accordance with the New York City Taxi and Limousine Commission Safety and Emissions Division when transporting Members, including the following securement systems:

- Four (4) tie down straps for each wheelchair position.
- A passenger seat belt and shoulder harness shall also be provided for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device, which secures the mobility aid itself.

Additional Transportation Requirements:

Each vehicle must be equipped (installed) with the following:

- Body fluid/spill kit reflector triangle kit (three (3) triangles).
- First aid kit.
- Fire extinguisher.

Section 8: Appointment Availability Standards

Appointment Service Standards

Participating Providers shall provide service to Members in accordance with the standards set by VillageCareMAX, except when a longer timeframe is required by the Member. These standards are outlined below:

- 1. Primary Care Physicians must:
 - Maintain office hours not less than two days per week, eight hours per day, at each primary care office.
 - Notify VillageCareMAX Provider Relations of changes to office hours within ten (10) days.
- 2. PCPs and OB/GYNs must provide 24 hours a day 7 days a week access to services and instruct Members on what to do to obtain services after business hours and on weekends.
- 3. Waiting time for an appointment: Not more than one (1) hour.
- 4. **Specialist referrals (not urgent):** Within two (2) to four (4) weeks of request.
- 5. **Emergency services**: upon presentation at a service delivery site.
- 6. <u>Urgent services</u>: appointment within twenty-four (24) hours of request.
- 7. **Non-urgent "sick" visit**: appointment within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- 8. Routine non-urgent, preventive appointment: within four (4) weeks of request.
- 9. Mental Health and Substance Abuse:
 - Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a participating Provider: within five (5) days of the request, or as clinically indicated.
 - Non-urgent mental health or substance abuse visits with a participating provider: within two (2) weeks of request.
 - Mental Health Clinic must provide a clinical assessment within five (5) days for individuals within the following designated groups:
 - o Individuals in receipt of services from a mobile crisis team not currently receiving treatment.
 - o Individuals in domestic violence shelter not currently receiving treatment.

Section 8: Appointment Availability Standards

- o Homeless individuals and those present at NYC homeless shelters who are not currently receiving treatment.
- o Individuals aging out of foster care who are not currently receiving treatment.
- o Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment.
- o Individuals referred by rape crisis centers.
- o Individuals referred by the court system.
- 10. <u>Participating Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a Member's ability to perform work:</u> Within ten (10) days of request
- 11. **Home Health Care:** Initial visit must occur within twenty-four (24) hours of request.

12. Audiology:

- Appointments within seven (7) days of request;
- Emergency within forty-eight (48) hours of request

13. **Optometry**:

- Appointments within seven (7) days of request
- Emergency within twenty-four (24) hours

14. **Dental**

- Routine Appointments within twenty-eight (28) days of request
- Emergency within twenty-four (24) hours of request

15. Podiatry:

- Appointments within seven (7) days of request
- Emergency within twenty (24) hours
- 16. Adult Day Health Care: Placement must occur within fourteen (14) days of request.
- 17. Social Day Care: Placement must occur within fourteen (14) days of request.
- 18. <u>**DME and Medical Supply:**</u> Delivery must occur within seventy-two (72) hours of request, unless custom ordered.
- 19. **Prosthetics and Orthotics:** Measurement within fourteen (14) days of request.
- 20. <u>Social and Environmental Support:</u> Delivery within fourteen (14) days of request unless custom ordered.

Section 8: Appointment Availability Standards

- 21. <u>Meals (Home and/or Congregate)</u>: Provided on the date and time requested by VillageCareMAX.
- 22. <u>Skilled Nursing Facility</u>: Placement of any medically necessary admission appropriate to the facility within twenty-four (24) hours of the submission of all required documentation.
- 23. Nutritional Counseling: Service must be provided within fourteen (14) days of request.
- 24. **Physical, Occupational & Speech Therapy (not in home):** Initial visit within seven (7) days of request.
- 25. <u>Physical, Occupational & Speech Therapy (in home):</u> Initial visit must occur within seventy (72) hours of request.
- 26. **Social Work:** Services must be provided within fourteen (14) days.
- 27. Respiratory Therapy: Initial visit must occur within forty-eight (48) hours of request.
- 28. <u>Transportation</u>: Pick up within thirty (30) minutes of scheduled time.
- 29. <u>Personal Care initial visit:</u> Must occur on the date and time requested by VillageCareMAX.
- 30. **Private Duty Nursing**: Date and time as requested by VillageCareMAX.
- 31. Clinical notes: Submitted within forty-eight (48) hours of any assessment visit.
- 32. <u>Progress notes and summaries:</u> Submitted every two (2) weeks thereafter unless otherwise requested or there is a change in Member health status.

Prior Authorization

Member is not required to get a referral in order to access covered services. However, prior authorization rules apply to some services. You should always check with VillageCareMAX regarding authorization rules prior to providing a service. Please see the "Prior Authorization Process" described below for information on how to request a prior authorization.

It is important to note that New York State Medicaid coverage limits apply to services covered by VillageCareMAX. Please see the New York State EMEDNY Provider Manuals and CMS Medicare Coverage Manuals for more information on coverage limits.

A Service Authorization Request (coverage decision request) is when a Member or Provider on Member's behalf requests approval of a treatment or service. To get a service authorization request, you may call our toll-free Member Services number at 1-800-469-6292 or send your request via Fax to 718-517-2709. We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**. Please refer to grid below for Service Authorization Timeframes.

A **Prior Authorization** (approval in advance) is a request by the Member or Provider on the Member's behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period. Some covered services require Prior Authorization before a Provider you provide them to our Members. Please refer to Section 10 for Services that require Prior Authorization. You can also contact Utilization Management at 1-800-469-6292 to confirm if a service requires Prior Authorization.

A Concurrent Review is a request for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission. Sometimes we will do a review on the care a Member is receiving to determine if the Member still requires the care. We may also review other treatments and services Members already received (retrospective review).

Medically Necessary means services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap.

A **Request for Service** is a request from a Member, representative, or Provider on a Member's behalf for:

- A new service: or
- A continuation, increase or extension of a service (more of the same) during a current authorization period.

An **Action** is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

Provider Authorization Portal

Effective early 2022, VillageCareMAX launched a new authorization portal that allows providers to submit authorization requests and track status for authorizations in real-time. This provides a streamlined approach in initiating requests rather than sending documentation and requests by fax. This portal provides enhancements, including:

- Ability to submit requests for new authorizations.
- Update authorization requests with additional information, such as clinical documents, notes, prescriptions, discharge plans, and information, etc.
- 2-way messaging between providers and the VillageCareMAX UM team.
- View and print authorizations.
- Access authorization letters, notes, and guidelines.
- Initiate requests for concurrent services.
- Withdraw requests for services.
- Submit appeals on authorizations.

See Section 1 Provider Authorization Portal Quick Reference Guide for more information.

Process to Request Prior Authorization

Providers can request a prior authorization electronically via the Provider Authorization Portal or by calling: 1-800-4MY-MAXCARE (1-800-469-6292).

Authorization for payment of services, revised authorizations and authorization terminations are faxed to all Providers. Each authorization will have the following information:

- Authorization or request number;
- Authorization effective and expiration date;
- Name, address, and VillageCareMAX Member identification number;
- Service code and description of service;
- Amount, frequency and duration of service;
- Name and address of the Provider to be authorized payment;
- The name of the Member Services staff person entering authorization.

Additional information will be documented in the "Notes" section of the authorization. This information would include relevant clinical information and the reason for the authorization to the Provider

In addition, if the request is unusual, time sensitive, especially complicated or requires a particular customization, additional written or verbal communication with the Provider will take place.

Providers should review the authorization to confirm the Provider name, date(s) of service, service code and number of units authorized. If any of these fields do not match the service/item requested, call VillageCareMAX immediately and request a corrected authorization.

Services that require authorization must have an authorization on record in order for services to be paid. If the service is requested outside of business hours, an authorization should be requested on the next business day. See sample authorization in Appendix 2.

VillageCareMAX's Utilization Management process consists of the ongoing evaluation of the use of covered benefits to assure that Members receive the appropriate services of the highest quality and most cost effective care possible.

VillageCareMAX provides coverage for appropriate and medically necessary services to Members, and responds to requests for new or additional services in compliance with Article 49, 10 NYCRR Part 98, and VillageCareMAX's contract with the New York State Department of Health and / or the Centers for Medicare and Medicaid Services.

Any Action taken by VillageCareMAX regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL§4900(2)(a).

Adverse determinations, other than those regarding medical necessity or experimental/investigational services, must be made by a licensed, certified or registered health care professional when such determination is based on an assessment of the Member's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit (where coverage is dependent on an assessment of the Member's health status) and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals and out-of-network services.

VillageCareMAX has established written criteria and ensures that staff utilizes criteria consistently in responding to requests for service. VillageCareMAX provides information about criteria upon request at no charge to Members, their representatives and providers.

To facilitate care management, VillageCareMAX requests notification to Medical Management of all hospital admissions in accordance with the following timeframes:

• Urgent Admissions: Any time prior to the admission but not later than 1 business day

after admission

• Emergent Admission: Within 1 business day of the emergent admission

Service Authorization Timeframes

Service Authorization Timeframes	MLTC	Health Advantage (DSNP)	Total Advantage (MAP)	
Standard Determination	14 Calendar Days 14 Calendar Days		14 Calendar Days	
Standard Determination with	Additional 14	Additional 14 Additional 14		
Extension	Calendar Days	Calendar Days Calendar Days		
Expedited Determination	72 hours	72 hours	72 hours	
Expedited Determination	Additional 14	Additional 14	Additional 14	
with Extension	Calendar Days	Calendar Days	Calendar Days	

<u>VillageCareMAX MLTC, Health Advantage & Total Advantage Prior Authorization Timeframes</u>

Standard Determination: When a request for a service is made, VillageCareMAX will inform the Member or their designee and the Member's health care Provider of the decision by phone and in writing as fast as the Member's condition requires but within three (3) business days of receipt of all necessary information and no later than fourteen (14) days from receipt of the request.

Standard with Extension: Upon request from the Member or his/her Provider, or if VillageCareMAX can justify a need for additional information and document how the delay is in the interest of the Member, VillageCareMAX may extend the time frame by up to an additional fourteen (14) calendar days from the date the extension notice is sent and within three (3) business days of receipt of all necessary information. If the extension is initiated by VillageCareMAX, the Member will be notified in writing about the reason for the delay.

Expedited Determination - Automatic: VillageCareMAX will automatically expedite any request by a Physician to expedite the determination. VillageCareMAX will make the determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, but no later than three (3) business days after receiving the request.

Approved Expedited Requests: If a Member or his/her Provider requests an expedited determination, without physician support, VillageCareMAX will determine if the decision should be expedited. The decision will be based on whether applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If the Member's request for an expedited decision is approved, VillageCareMAX will make the

determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, within one (1) business day of receipt of necessary information but no later than three (3) business days after receiving the request.

Denied Expedited Requests: If the Member or his/her Provider's request for an expedited determination is denied, the Member will be informed verbally and in writing within three (3) business days of receipt of the request and the request will be transferred to a standard time frame of fourteen (14) days.

Reduction, Termination or Suspension of a Previously Authorized Service Within a Service Authorization Period

When VillageCareMAX intends to reduce, suspend or terminate a previously authorized service, the Member will receive a written notice at least ten (10) days prior to the intended action (the notice will be generated and mailed fifteen (15) days prior to the intended action to assure sufficient delivery time of the notice).

In the event of Member fraud, the Member will receive a written notice at least five (5) days prior to the intended action (the notice will be generated and mailed ten (10) days prior to the intended action to assure sufficient delivery time of the notice).

VillageCareMAX may mail a written notice no later than the date of the Action in the event of:

- Death of the Member
 - o If the provider learns of a VillageCareMAX Member's death, please contact the plan. VillageCareMAX will cancel any authorizations currently in place for the Member.
 - o If VillageCareMAX learns of a Member's death, we will contact the Member's providers and cancel any authorizations that are currently in place.
- A signed written request from the Member requesting service termination or giving information requiring termination or reduction of services;
- The Member's admission to an institution where the Member is ineligible for services;
- The Member's address is unknown or mail is returned as undeliverable:
- The Member has been accepted for Medicaid services by another jurisdiction; or
- The Member's physician prescribes a change in the level of medical care.

Services Fully or Partially Covered by Medicare or Other Primary Insurance

Participating providers are responsible for:

- Verifying Primary Payer Insurance coverage and eligibility and
- Acquiring any needed Physician orders

VillageCareMAX MLTC participating providers should exhaust all other payment sources prior to billing VillageCareMAX.

In the event that a VillageCareMAX MLTC Participating Provider has knowledge that a Medicare covered service has already been obtained through Medicare, or other payer, and the allowable time period for replacement has not expired, the VillageCareMAX MLTC Participating Provider must contact the VillageCareMAX Care Manager prior to any reorder.

Authorization Fax Numbers

VillageCareMAX launched a new Care Management System in the first quarter of 2022 and created service-specific fax numbers to improve the way Providers send documents and manage Member authorizations.

The new system provides enhancements that will make it easier to fax documents directly to the team responsible for processing requests. To do this, VillageCareMAX has updated and created fax numbers intended for different areas. Please review the tables below that provide information regarding the fax numbers and what type of requests and/or documents that should be sent to each number. The new fax numbers are live effective January 1, 2022, and Providers may start using them right away.

See Section 1 Provider Authorization Portal Quick Reference Guide for more information.

Hospitals			
Fax Line Name	Fax #	Description	
Inpatient Admissions	212-402-4468	This fax number should be used for all information regarding inpatient admissions, including: UR Hospitalization Request, Clinicals, Discharge Summaries, etc.	
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals	
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals	

LHCSA Providers			
Fax Line Name Fax # Description			
Personal Care Services	646-618-8997	This fax number should be used for all requests related to authorizations for Personal Care and Consumer Directed Personal Assistant Services, including: Authorizations Changes,	

		Authorization Corrections, Authorization Modifications, Overtime Requests
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals

Primary Care (PCP) / Specialist Providers				
Fax Line Name	Fax #	Description		
Durable Medical Equipment	718-517-2709	This fax number should be used for all requests related to authorizations for Durable Medical Equipment, including: New & Continuing Service Requests, Authorizations Changes, Authorization Corrections, Authorization Modifications, Prescription and/or Clinical & Supporting Documentation, Letters of Medical Necessity, Prior Authorization Forms.		
Outpatient Services	978-367-1872	This fax number should be used for all requests related to authorizations for Outpatient Services (Radiology Services, Acupuncture, Ambulatory, etc.), including: New & Continuing Service Requests, Authorizations Changes, Authorization Corrections, Authorization Modifications, Clinical & Supporting Documentation, Prior Authorization Forms.		
Part B	917-243-9997	This fax number should be used for all requests related to authorizations for Part B Drugs, including: New & Continuing Service Requests, Authorizations Changes, Authorization Corrections, Authorization Modifications, Clinical & Supporting Documentation, Prior Authorization Forms.		
Personal Care Services	646-618-8997	This fax number should be used for all requests related to authorizations for Personal Care Services, Consumer Directed Personal Assistant Services, and Home Health Attendant Services, including: Letters of Medical Necessity.		
Long Term Support Services	646-362-2004	This fax number should be used for all requests related to authorizations for Social Day Care, Adult Day Health Care, Personal Emergency Response Systems, Home Delivered Meals, and Home Modifications, including: Authorizations Changes, Authorization Corrections, Authorization Modifications, Clinical & Supporting Documentation, Prior Authorization Forms.		

Grievance and Appeals	347-226-5180	All requests related to grievance and appeals
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals

DME Providers			
Fax Line Name	Fax #	Description	
Durable Medical Equipment	718-517-2709	This fax number should be used for all requests related to authorizations for Durable Medical Equipment, including: New & Continuing Service Requests, Authorizations Changes, Authorization Corrections, Authorization Modifications, Prescription and/or Clinical & Supporting Documentation, Letters of Medical Necessity, Prior Authorization Forms.	
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals	
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals	

Outpatient / CHHA / PT, OT, ST Providers			
Fax Line Name	Fax #	Description	
Outpatient Services	978-367-1872	This fax number should be used for all requests related to authorizations for Outpatient Services (Certified Home Health Agency Services, In-home & Outpatient Occupational, Speech, Physical Therapy, and Nursing Services and Home Infusions), including: New & Continuing Service Requests, Authorizations Changes, Authorization Corrections, Authorization Modifications, Clinical & Supporting Documentation, Prior Authorization Forms.	
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals	
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals	

Meals/PERS/SADC/ADHC Providers			
Fax Line Name	Fax #	Description	
Long Term Support Services	646-362-2004	This fax number should be used for all requests related to authorizations for Social Day Care, Adult Day Health Care, Personal Emergency Response Systems, Home Delivered Meals, and Home Modifications, including: Authorizations Changes, Authorization Corrections, Authorization Modifications, Clinical & Supporting Documentation, Prior Authorization Forms.	
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals	
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals	

Skilled Nursing Facilities			
Fax Line Name Fax # Description			
Skilled Nursing Facility Admissions	978-967-8030	This fax number should be used for all information regarding Skilled Nursing Facility Admissions, including: PRI and Short Term Rehab Requests, Clinicals, Discharge Summaries, Requests for Continuity of Care, etc.	
Grievance and Appeals	347-226-5180	All requests related to grievance and appeals	
Member Services	212-337-5711	Any member or provider communication other than authorization, grievance and appeals	

The complete listing of services that require prior authorization for all plans can be viewed in the Evidence of Coverage or Member Handbook located at www.villagecaremax.org.

VillageCareMAX Managed Long Term Care Plan (MLTC), Medicare Health Advantage Plan (D-SNP), and Medicare Total Advantage Plan (MAP) Prior Authorization Grid

Disclaimer: Prior authorization is not a guarantee of payment. Benefits are determined by the member's eligibility. Policies are subject to change. Please note there are exceptions for certain services as outlined below.

Key

X= Prior authorization required

NA= Covered-no Prior Authorization required

NA*= Covered but Prior Authorization may be required for some services, see footnote.

NC= Not Covered

Services	MLTC	MAP	DSNP
24/7 Physician Hotline	NC	NA	NA
Acupuncture ⁵	NC	NA*	NA*
Adult Day Health Care	X	X	NC
Ambulatory Surgery Center	NC	X	X
Assistive Technology (AT)	X	Χ	NC
Audiology Services (Hearing Exam)	NA	NA	NA
Cardiac Rehabilitation Services	NC	Х	X
Chiropractic Services	NC	Χ	X
Community Transitional Services (CTS)	X	Χ	NC
Consumer Directed Personal Assistance Services (CDPAS)	X	Х	NC
Dentistry	NA	NA	X
Diabetes Programs and Supplies	NA	X	X
Diagnostic Services ⁶	NC	X	X
Discogram/Myelogram	NC	Χ	Х
Durable Medical Equipment (DME) / Medical Supplies ⁷	X	Χ	X
Electromyogram (EMG)	NC	Χ	Χ
Environmental Modifications (EMods)	X	X	NC
Hearing Aids ⁸	Χ*	Χ*	Χ*

⁵ Effective January 1, 2022, see below <u>Medicare Benefit Grid</u> for all Rehab, including Acupuncture services, that require prior authorization.

⁶ Effective January 1, 2022, see below <u>Medicare Benefit Grid</u> for Diagnostic Services that require prior authorization.

⁷ See Appendix 10 for a list of DME services that do **not** require prior authorization.

⁸ Effective January 1, 2022, no prior authorization required for the following Monaural Codes: V5090, V5241, V5246, V5247, V5256 and V5257. Any requests for Binaural Hearing Aids require prior authorization.

Home Delivered and Congregate Meals	Х	Х	X ⁹
Home Health Care	X	X	X
Home Infusion Services	X	X	X
Infusion	X	X	X
Inpatient Bariatric Surgery	NC	X	X
Inpatient Hospital Care	NC	X	X
Inpatient Mental Health Care	NC NC	X	X
•	NC	X	X
Inpatient Organ Transplants Inpatient Reconstructive Surgery	NC NC	X	X
	X	X	X
Inpatient Skilled Nursing Facility			
Inpatient Substance Abuse and Rehab	NC	X	X
Lab Services (Molecular Pathology, Cryptogenic studies and Genomic Sequencing Procedures)	NC	Х	Х
Lab Services (All other services)	NC	NA	NA
Medical Social Services	NA	X	X
Mobile Radiology (EKG and X-Rays)	NC	NA	NA
Mobile Radiology (All other services)	NC	X	X
Moving Assistance (MA)	Х	X	NC
MRI/MRA	NC	Х	Х
Non-Emergency Transportation / Ambulance Services	Х	X	Х
Nuclear Medicine	NC	X	Х
Nutrition	Х	Х	Х
Occupational Therapy	Х	Х	Х
Orthopedic Footwear	Х	Х	Х
Part B Drugs (when billed by a physician or facility)	NC	Х	Х
Partial Hospitalization	NC	Х	Х
Personal Care Services	Х	X	NC
Personal Emergency Response Services (PERS)	Х	X	NC
Pet Scan	NC	Х	Х
Physical Therapy	Х	Х	Х
Private Duty Nursing	Х	X	NC
Pulmonary Rehabilitation Services	NC	Х	Х
Respiratory Therapy	Х	X	Х
Skill Acquisition Maintenance and Enhancement (SAME)	Х	Х	NC
Social and Environmental Supports	Х	Х	NC
Social Day Care	Х	Х	NC
Speech Therapy	Х	Х	Х
Substance Abuse Care	NC	Х	Х

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⁹ Effective January 1, 2022, VillageCareMAX implemented a supplemental meals benefit for the D-SNP Plan.

Telehealth	X	Х	Х
Vehicle Modifications (VMods)	Х	Х	NC
Vision Services - Eye Exam and Eyewear	NA	NA	NA
Worldwide Emergency/Urgent Care	NC	NA	NA

<u>Key</u> X= Prior authorization required

NA= Covered-no Prior Authorization required

NA*= Covered but Prior Authorization may be required for some services, see footnote.

NC= Not Covered

VillageCareMAX Medicare Health Advantage Plan (D-SNP), and Medicare Total Advantage Plan (MAP) Medicare Benefit Grid

Benefit	Par/In-Network Providers	Non-Par/Out- of Network Providers	Exceptions to Authorizations
Acupuncture for chronic low back pain: Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually	Yes	Yes	Not Applicable
Acupuncture *Supplemental Benefit*: Plan covers acupuncture as a supplemental benefit: Covered for up to 34 treatments (for DSNP) and 50 treatments (for MAP) per year when provided by a certified and licensed provider in the VillageCareMAX network. For DSNP, Limited to up to \$80 per visit and 4 visits per month with a maximum of 34 visits per year.	No	Yes	Not Applicable

For MAP, Limited to up to \$80 per visit			
and 5 visits per month with a maximum of			
50 visits per year.	V	V	Niet Austriania
Ambulatory Surgery Center (ASC):	Yes	Yes	Not Applicable
The facility services furnished in			
connection with covered surgical			
procedures provided in an ASC			
Diagnostic Services	No (some exclusions	Yes	1 - Par = Basic
-CT scans, EKGs and X-rays when a	apply):		Diagnostic do not
provider orders them as part of treatment	Basic Diagnostic: EKG's,		require prior Auth
for a medical problem	Ultrasound, CT Scan (see		
-Radiation (radium and isotope) therapy,	CT exclusions below) &		2 - Par = All
including technician materials and	XRAY		Advanced
supplies			diagnostics
-Surgical supplies, i.e. dressings	Yes: all advanced		require prior Auth
-Splints, casts, and other devices used for	diagnostics i.e. PET Scan,		
fractures and dislocations	MRI/MRA, Nuclear		3- Non-Par = All
-Medically necessary clinical lab services	Studies,		diagnostics
and tests ordered by a provider to help	Discogram/Myelogram,		Services require
diagnose or rule out a suspected illness or	and CT Exclusions (CTA,		prior Auths
condition	Total Body CT, and		
-Blood, including storage and	Codes: 73706, 75571,		
administration	75574, 75635, 76376,		
-Other outpatient diagnostic tests	76377)		
Outpatient Physical Therapy (PT)	Yes	Yes	Not Applicable
	163	163	Not Applicable
Medically necessary therapeutic activities	163	ies	Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified	163	163	Not Арріісавіе
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include	les	ies	ног друпсаше
Medically necessary therapeutic activities and/or treatments provided by a qualified	les	ies	ног друпсаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve,	les	ies	нос дрисаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical	ies	ies	нос дрикаве
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve,	ies	ies	нот дрикаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical		ies	нот дрикаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or		ies	нот дрикаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic		TES	нот дрикаше
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital	No	Yes	Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries.			
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services			
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by			
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist	No	Yes	Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS Code C9507) for use in outpatient setting	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS Code C9507) for use in outpatient setting effective on or after 12/28/2021	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS Code C9507) for use in outpatient setting	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS Code C9507) for use in outpatient setting effective on or after 12/28/2021 For members that are duals, having both Medicaid and Medicare coverage,	No No	Yes	Not Applicable Not Applicable
Medically necessary therapeutic activities and/or treatments provided by a qualified practitioner. Restorative services include diagnostic evaluation and therapeutic intervention designed to improve, develop, correct, or rehabilitate physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital abnormalities, or injuries. Physician Specialist Services Consultation, diagnosis, and treatment by a Specialist Preventive Services COVID-19 convalescent Plasma (HCPCS Code C9507) for use in outpatient setting effective on or after 12/28/2021	No No	Yes	Not Applicable Not Applicable

See <u>Appendix 16</u> for VillageCareMAX Medicare Health Advantage and Medicare Total Advantage Specialist Services that do not require Prior Authorization in an Office Setting only.

Participating Providers must inform VillageCareMAX of any changes in Tax ID, corporate name and/or addresses as soon as they are known. Please fill out the **Provider Information Change** Form (See Appendix 8), and please allow thirty (30) days for record updates.

Please note the following General Claims Timeframes below. <u>Please refer to your contract to confirm specific timeframes as they may differ from below.</u>

Line of Business	Timely Claim Submission within	Processing Times (within)	Reconsideration/ Appeal of Claim (within)	Reconsideration/ Appeal Processing Times (within)
MLTC	90 days	30 (Eclaims); 45 (Paper)	45 days	60 days
DSNP	90 days	30 (Eclaims); 45 (Paper)	60 days	60 days
MAP	90 days	30 (Eclaims); 45 (Paper)	60 days	60 days

Electronic Submission of Claims

Participating Providers may submit electronic claims. Use VillageCareMAX Change Health Care Payer ID/Submitter ID: <u>26545</u>. Electronic Claims must be submitted in 837I or 837P format. Please refer to Appendix 3 for information on implementing EFT and ERA.

All Claims must include:

- Member name and VillageCareMAX Member ID number.
- Provider Name, Tax ID Number and NPI number.
- Valid ICD-10 Diagnosis Codes.
- A date of service that falls within the effective and expiration date printed on the authorization.
- The Service Code.
- The number of units (cannot exceed the total units or units per day on the authorization).
- Copy of the Primary Payer EOB for coordinated claims.

Paper Claims and Claims for Services Covered in Part by Primary Payer

Claims for authorized services must be submitted to VillageCareMAX *generally* within ninety (90) days from the date of service, but providers should always review their contracts for the specific timely filing timeframes indicated in the provider contract.

All paper claims, correspondence, and Claims Disputes and Appeals should be submitted to:

ILS - VillageCareMAX P.O. Box 21516 Eagan, MN 55121

If you have any questions, please call Provider Services at 1-855-769-2500.

In addition, the VillageCareMAX Provider Online Portal is a great resource for providers to review claims statuses, authorization statuses, and Member Eligibility statuses. Please visit our portal at: https://vcm.guidingcare.com/AuthorizationPortal

All covered Dental claims should be submitted as follows:

Claims DOS on or after January 1, 2021
LIBERTY Dental Plan
Attn: Claims Department
PO Box 401086
Las Vegas, NV 89140
Tel: 833-276-0853
Monday – Friday, 8:00am – 8:00pm

All covered routine Vision claims should be submitted as follows:

Claims DOS on or after November 1, 2020
Superior Vision/Versant Health
Attn: Claims Department
PO Box 967
Cordova, CA 95670
Tel: 866-819-4298
Monday – Friday, 8:00am – 8:00pm

VillageCareMAX may pay claims denied for untimely filing where the Participating Provider can demonstrate that a claim submitted after the date specified in their provider contract resulted from an unusual occurrence.

VillageCareMAX MLTC claims for services partially covered by Medicare or another Primary Payer, must be accompanied by a Medicare or other Primary Payer EOB and cannot be submitted electronically.

Authorizations are not needed for Secondary claims submissions. Secondary claims are processed according to the EOB provided with the claim submission. If an EOB is not attached and an authorization is on file, the claim will be processed as primary.

Paper claims must be submitted in one of the following formats:

- **1. CMS-1500 Form:** The CMS-1500 claim for is used to bill for most non-facility services including, but not limited to:
 - Ambulatory Surgery Centers
 - DME and Medical Supplies
 - Individual Practitioners
 - Home-Delivered/Congregate Meals
 - Laboratories
 - Physician/Professional Services
 - Personal Electronic Response Systems (PERS)
 - Rehabilitation Therapy in an Outpatient Clinic Setting
 - Rehabilitation Therapy home or private office setting
 - Social & Environmental Supports
 - Transportation Providers

Note: All fields must be completed including Place of Service and Valid Diagnosis Code.

CMS publishes a guide to help providers complete the CMS-1500 form. Please see the following website for more information - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

- **2. UB-04 Form:** The UB-04 claim form is used by institutional providers to bill for all hospital inpatient, outpatient and emergency room services including, but not limited to:
 - Adult Day Health Care
 - Home Care Agencies
 - Hospitals
 - Skilled Nursing Facilities
 - Social Adult Day Care
 - Other Facilities (including but not limited to Diagnostic & Treatment Centers, Federally Qualified Health Centers, etc.)

CMS publishes a guide to help providers complete the UB-04 form. Please see the following website for more information - http://www.cms.gov/Regulations-and-guidance/Manuals/downloads/clm104c25.pdf

Prompt Payment of Claims

Electronic claims will be paid within thirty (30) days of receipt. Paper claims will be paid within forty-five (45) days of receipt.

Electronic Funds Transfer

Please complete the form in <u>Appendix 3</u> to have payments deposited directly into your bank account.

Balance Billing

In no event can a Provider bill VillageCareMAX Members for any balance remaining on a claim.

Claim Service Code Guidelines

An important element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is required for accurate reimbursement. Please refer to your current CPT, ICD or HCPCS code books for specific code descriptions.

Please Note the following:

- All codes are subject to change based on regulatory requirements.
- ICD-10 diagnosis codes must be included on all medical claims.
- NYS DOH standard universal billing codes must be included on all claims for home care and adult day health care services.

Pharmacy Prescription Drug Claims

According to the Federal Deficit Reduction Act, VillageCareMAX MLTC is required to obtain National Drug Codes on all claims for certain physician administered drugs for the purpose of billing manufactures for Medicaid Drug Rebates.

Any claims for drugs or vaccines that are not administered in a pharmacy must include the NDC code in additional to any CPT or HCPCS codes. The claim will be rejected without this code.

Please note that NDCs should be collected and reported where HCPCS (J0000-J9999) and BETOS (01E/O1D) codes are billed for these Categories of Service.

NOTE: Drug encounters with a "UD" procedure code modifier (340B purchased drug) are exempt from NDC reporting requirements.

01 – Physician Services 41 – Nurse Practitioner/Midwives

03 – Podiatry 75 – Clinical Social Worker

04 – Psychology 85 – Freestanding Clinic

06 – Rehabilitation Therapy 87 – Hospital OP/ER Room

07 - Nursing

Claims Inquiry

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, verify authorization status and much more as indicated below. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting https://vcm.guidingcare.com/AuthorizationPortal.

- The status of a claim for which no payment or denial of payment has been received within 45 days;
- Payment missing on the Explanation of Payment for claim or claim line submitted via batch;
- You were denied payment for a claim and subsequently realized that there was an error on the authorization;
- Provision of a service is different from the service requested (changed hours or days, completed visit after expiration date, etc.);
- Denials or partial payments due to authorization issues;
- Member status; and
- Fee schedule issues

Please Note: VillageCareMAX is not required to change an authorization if a different service was provided.

Services that Require Prior Authorization

Services that require authorization must have a valid authorization on record in order for services to be paid. If the service is requested outside of business hours, an authorization should be requested on the next business day. Please see <u>Section 10</u> to verify if a covered service requires authorization. You may contact 1-800-469-6292 to obtain all necessary authorizations.

Changes to an Authorization or Retroactive Authorizations

Changes or retroactive authorizations will only be considered if there is documentation that VillageCareMAX intended to authorize the service provided. If your claim matches the authorization, compare all fields of the claim line printed on the Explanation of Payment to your claim. If any of the fields (date of service, service code, amount charged, etc.) are not the same as what you submitted on your claim, call Provider Services at 1-855-769-2500. Provide the claim number and the information that was entered incorrectly.

Common Reasons for Claims Denial

PAY CODE	PAY CODE DESCRIPTION
11	Timely Filing Limit Exceeded
16	Dup Claim Previous Paid or Service in Global Surgery Package
14	Denied – Please See Detailed Message Code
17	Required Notification, Referral, Authorization not on File or Denied
41	Member Not Effective On This Date of Service – Please Verify Coverage
31	Denied – See Detailed Message Code
35	Service Exceeds The Authorized Number of Units or Days
94	Please Resubmit with HIPAA Valid Procedures and Diagnosis Code(s)
93	Claim Unprocessable Required Date Elements Missing or Invalid
13	Benefit Limit Maximum Reached
96	Member Is Not On File
44	Date of Service After The Member's Date of Death
46	No Allowable Amount in the Fee Schedule
32	Duplicate Claim
95	Please Resubmit with Physician Indicated

NOTE: A corrected authorization does not automatically reprocess denied claims. You must also submit a corrected claim.

The New York State Office of the Attorney General (OAG), the Department, OMIG and the Office of the State Comptroller (OSC) have the right to audit, investigate or review the provider or subcontractor and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. and to bring criminal prosecutions.

OMIG or the Department shall have the right to request that VillageCareMAX recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its Participating Provider consistent with the requirements of Insurance Law § 3224-b. In such cases OMIG or the Department may charge the Participating Provider a collection fee as set forth in State Finance Law, in an amount to be determined by OMIG or the Department in its sole discretion. VillageCareMAX shall remit, on a monthly basis, to the Department all amounts collected from the Participating Provider. Upon collection of the full amount owed to the Medicaid program, the Contractor may retain the collection fee to account for VillageCareMAX's reasonable costs incurred to collect the debt. VillageCareMAX shall report the amounts recovered in its Quarterly Provider Investigative Report in accordance with Section F(3)(t) of Article VIII of the Agreement. OMIG will only request that VillageCareMAX recover an overpayment, penalty or other damage where there has been a final determination. For purposes of this section, a final determination is defined as:

- a. a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 515;
- b. a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516;
- c. a Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517;
- d. a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or
- e. an Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519; however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision.

Consistent with 18 NYCRR § 517.6(g) OMIG may enter into an agreement with VillageCareMAX to conduct a combined audit or investigation of VillageCareMAX's Participating Provider, Non-Participating Provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between VillageCareMAX and OMIG as provided for in the combined audit or investigation agreement. In no event shall VillageCareMAX share in any

recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.

The provider or subcontractor must promptly report to VillageCareMAX after it identifies any overpayment related to performance under the Agreement. VillageCareMAX shall require and have a mechanism in place for Providers to report to VillageCareMAX when the Provider has received an overpayment, to return the overpayment within 30 days of the date of the identification of the overpayment, and to notify VillageCareMAX in writing of the reason for the overpayment.

Other than recovery for duplicate payments, VillageCareMAX will give Providers thirty (30) days written notice before seeking recovery of the overpayment of claims. Providers shall have thirty (30) days from the date of the written notice to challenge the recovery of the overpayment. The provider's challenge must include the specific grounds on which the challenge is based. If the Provider does not respond within thirty (30) days from the date of the written notice, VillageCareMAX will act to recover the funds from future claims payment.

The parties agree that where VillageCareMAX has previously recovered overpayments, by whatever mechanism utilized by VillageCareMAX, from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by the agencies listed in Section 22.7bF(8) of Article VII of the Agreement.

The parties agree that where VillageCareMAX has recovered overpayments from a Participating Provider, VillageCareMAX shall retain said recoveries, except where such recoveries are made on behalf of OMIG or the Department as provided in Section F(6) of Article VII, or pursuant to a combined audit as provided in Section F(7) of Article VII of the Agreement.

VillageCareMAX will not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by the provider. However, no such time limit will apply to overpayment recovery efforts that are:

- Based on a reasonable belief of fraud or other intentional misconduct, or abusive billing;
- Required by, or initiated at the request of, a self-insured plan; or
- Required or authorized by a state or federal government program or coverage that is provided by this state to its residents.

Abusive billing is defined as billing practice that results in the submission of claims that are not consistent with sound fiscal, business or medical practices and at such frequency and for such a period of time that reflects a consistent course of conduct.

Notwithstanding the time limitations stated above, in the event that a Provider asserts that VillageCareMAX has underpaid a claim, VillageCareMAX may set off the assertion of

underpayment based on overpayments going back in time as far back as the claimed underpayment.

This process applies to all health care professionals licensed, registered or certified pursuant to PHL 28, 36 or 40 or Mental Hygiene Law Articles 19, 31 and 32.

Claim Appeals

The following timely filing guidelines are general for the MLTC, Health Advantage, and Total Advantage lines of business; however, providers should always refer to their contracts for exact timeframes.

If your claim was processed and you disagree with how it was processed, you may submit a claim appeal electronically through the VillageCareMAX Provider Portal, which can be accessed by visiting https://vcm.guidingcare.com/AuthorizationPortal. All claim appeals generally must be submitted within forty-five (45) days of receipt of a claim determination for MLTC and within sixty (60) days of receipt of a claim determination for Health Advantage & Total Advantage and must include the following information:

- Claim number
- Authorization number
- Member name
- VillageCareMAX Member ID number
- Exact date(s) of service (do not give range)
- Codes billed
- Units billed
- Amount billed
- Reason for appeal
- Supporting documentation to support your appeal i.e. liability waiver, medical record documentation to support services provided

To submit a correction to a previously processed electronic claim using a HCFA 1450/UB-04 claim form (or equivalent), use bill type (XX7). HCFA 1500 Claim Form, please use resubmission code 7.

To submit a correction to any other previously processed claim, send the corrected paper claim to the Correspondence Department at the following address:

ILS - VillageCareMAX Provider Services Department P. O. Box 21516 Eagan, MN 55121

Time Frames for Claim Submission & Reconsideration of Claim

Timely Claim Submission: Generally, providers must submit all claims within ninety (90) days from the date of service for prompt adjudication and payment. Please refer to your contract for exact timeframes.

However, claims for services that are submitted later than the time period set forth in the provider's agreement with VillageCareMAX will not be paid. In no event will VillageCareMAX pay claims submitted more than one hundred eighty (180) days after the date of service.

Late Claim Submissions: Please note that claims that were denied or returned to the provider for additional information when re-processed are adjudicated according to the original date of service. Having submitted a claim that was not clean does not constitute an exception to the timely filing requirements listed above. Late claim submission will be reviewed by management only in cases where timely submission was outside of provider's control. Any requests for consideration must follow the claim reconsideration process and documentation requirements listed below.

Reconsideration of a Claim: At times, a provider may be dissatisfied with a decision made by VillageCareMAX regarding a claim determination. Some of the common denials and reasons for reconsideration include incorrectly processed or denied claim, incorrect paid amount, late claim submission, or failure to obtain prior authorization. Providers who are dissatisfied with a claim determination made by VillageCareMAX must submit a written request for review and reconsideration with all of the supporting documentation to VillageCareMAX within forty-five (45) calendar days of receipt of a claim determination for MLTC and within sixty (60) calendar days of receipt of a claim determination for Health Advantage and Total Advantage.

Claim Reconsideration/Appeals must be in writing and should be sent to:

ILS - VillageCareMAX Provider Services Department P. O. Box 21516 Eagan, MN 55121

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- Provider's name, address, and telephone number
- Provider's identification number
- Member's name and VillageCareMAX identification number
- Date(s) of service
- VillageCareMAX claim number
- A copy of the original claim or corrected claim, if applicable
- A copy of the VillageCareMAX EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification
- Evidence that initial claim was submitted on time
- A written statement explaining why you disagree with VillageCareMAX's claim determination.

VillageCareMAX will investigate all written requests for Review and Reconsideration, and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld, generally within sixty (60) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

VillageCareMAX will not review or reconsider claims determinations which are not submitted according to the procedures set forth above. If a provider submits a request for review and reconsideration after the forty- five (45) calendar day time frame for MLTC or the sixty (60) calendar time frame for Health Advantage and Total Advantage, the request is deemed ineligible and will be dismissed.

Regardless of the outcome of the claims review, in all cases, providers may not bill members for services rendered.

VillageCareMAX will not accept appeals from providers that are not made in writing and that fail to address the reason for the appeal.

If VillageCareMAX is instructed by the New York State Department of Health (DOH) or the New York State Office of the Medicaid Inspector General (OMIG) to withhold payments due to a pending investigation, VillageCareMAX will:

• Provide notice to the provider of the withhold within five (5) days of taking such action unless requested in writing by a law enforcement organization to delay such notice. The

notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation

• Withhold all pending and future payments until such time as DOH or OMIG approve their release

In such cases, the provider should direct questions and appeals to:

Office of the Medicaid Inspector General Office of Counsel 800 North Pearl Street Albany, New York 12204 ATTN: Withhold Appeal

Claim Contacts

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, and much more. The portal can be accessed by visiting https://vcm.guidingcare.com/AuthorizationPortal

Section 13: Adverse Reimbursement Change

Adverse Reimbursement Change to Health Care Professionals Agreement

An adverse reimbursement change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional."

VillageCareMAX health care professionals will receive notice from VillageCareMAX at least ninety (90) days prior to an adverse reimbursement change to a health care professional's agreement (check your provider contract). A health care professional for purposes of this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.

If the health care professional objects to the change that is the subject of the notice, the health care professional may give written notice to VillageCareMAX to terminate the agreement effective upon the implementation of the adverse reimbursement change. Providers should review the terms of their contract, but most health care professionals are required to provide written notice to VillageCareMAX within 30 days of the date the notice was received. The above paragraph will not apply when the adverse reimbursement change is:

- Otherwise required by law, regulation or applicable regulatory authority;
- Required due to changes in fee schedules, reimbursement methodology or payment
 policies by the State or Federal government or by the American Medical Association's
 Current Procedure Terminology (CPT) Codes, Reporting Guidelines and Conventions;
 and
- Provided for in the Participating Provider agreement between VillageCareMAX and the participating provider or a participating IPA and the participating provider through the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a health care professional relative to this provision.

Section 14: Medicaid Surplus and NAMI

Medicaid Surplus and NAMI

VillageCareMAX assumes responsibility for billing Medicaid spend-down amounts for community based VillageCareMAX Members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Participating Providers shall not bill or collect such amounts from the Member.

The Residential Health Care Facility or Skilled Nursing Facility is responsible for collecting the Net Available Monthly Income (NAMI) from Members that are designated to be in permanent placement. A Member deemed to be in permanent placement when the Member and the plan agree that the Member will not be returning to the community. VillageCareMAX will deduct the Member's NAMI from the payment to the facility for services provided and billed to the plan.

VillageCareMAX Medicare Health Advantage (HMO D-SNP) participating providers are not responsible for billing Medicaid spend-down amounts for members enrolled in this plan.

As of January 1, 2017, the New York State Department of Health revised the requirements for reporting Nursing Home encounters. Nursing Home Providers are now required to report the NAMI amount on the claim. VillageCareMAX will continue to deduct NAMI from the claims prior to release of payment to the provider.

NAMI should be reported as 'Recurring Monthly Income', using a value code of '23', with the amount reported in the 'Value Amount' section, Field 39, 40 or 41 on the Institutional Claim form as indicated below:

- Value Code:
 - Code 23 should be used to indicate that the member's NAMI amount is entered under Amount.
- Value Amount:
 - o Enter the NAMI amount determined by the local district.
 - o In cases where the member's budget has increased, the new amount, rather than the current budgeted amount, should be entered.
 - o If billing occurs more than once a month, enter the full NAMI amount on the first claim submitted for the month.
 - For retroactive NAMI changes, an adjustment to the previously paid claim needs to be submitted. These adjustments can only be submitted when approval for a budget change has been received from the local district.

Please note that claims without accurate NAMI will be denied.

Participating Providers are required to bill Medicare for MLTC members or any other third party insurance that is primary to Medicaid.

Section 15: Third Party Insurance

Medicare and Other Primary Payer Services

VillageCareMAX MLTC Participating Providers:

VillageCareMAX Members will continue to access their services fully or partially covered by Medicare through fee for service Medicare or another Medicare plan that the Member may be enrolled in. Participating Providers may bill VillageCareMAX for any required secondary payments not covered by other insurance as stipulated in the Participating Provider Agreement.

VillageCareMAX is the payer of last resort. It is the Participating Provider's responsibility to determine Primary Payer coverage and eligibility. Co-insurance claims do not require authorization. A copy of the primary and secondary insurers Explanation of Payment must accompany all co-insurance claims. Claims with applicable Coordination of Benefits (COB) must be submitted within 90 days of COB determination.

Section 16: Marketing Guidelines

Marketing Guidelines: Participating Providers and VillageCareMAX

VillageCareMAX is subject to the contractual terms and conditions of both the New York State Department of Health and Centers for Medicare and Medicaid Services (CMS), including their marketing guidelines. The information below is a general guideline to help participating providers meet the requirements of these regulatory agencies.

Permitted Marketing Activities

Participating Providers

- Participating Providers who wish to communicate with their patients about managed care
 options must direct patients to the State's Enrollment Broker for education on all plan
 options. Participating Providers shall not advise patients in any manner that could be
 construed as steering towards any Managed Care product type.
- The provider is required to provide patients with a list of all the plans he/she/it has contracts with.

VillageCareMAX

• May conduct marketing activities at a Participating Provider's site with the permission of the Participating Provider. Marketing activities can only take place in areas where direct services to the beneficiaries are not provided (see below).

Prohibited Marketing Activities

Participating Providers

Plan Members often look to their health care professionals for information and advice about their health care choices. To the extent that a participating provider can help a Member with an objective assessment of their health care needs, providers are encouraged to do so. However, participating providers should remain neutral when assisting Members with enrollment decisions. When providing this information to beneficiaries, the provider should inform the beneficiary of all the plans in which he/she participates.

Section 16: Marketing Guidelines

In addition, participating providers must not:

- Offer sales/appointment forms to Members
- Accept HMO D-SNP or MLTC enrollment applications
- Make phone calls or direct, urge or attempt to persuade a Members to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of VillageCareMAX
- Offer anything of value to induce members to select an individual as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from VillageCareMAX for Member enrollment activities
- Distribute materials/applications within an exam room setting
- Develop or use any marketing materials that have not been approved by VillageCareMAX
- Distribute brochures provided by VillageCareMAX

Guidelines associated with provider marketing activities and additional information can be found in the Medicare Marketing Manual located on the CMS website - https://www.cms.gov.

VillageCareMAX:

- Will not market in hospital emergency rooms, treatment rooms, patient rooms, skilled nursing facility or adult care facility patient rooms, medical professional offices, adult day health care and social day care sites.
- Will not use "Cold Call" telephoning and door-to-door distribution of material. Solicitation is not permitted.
- Cannot offer monetary incentives to the Participating Providers to market VillageCareMAX services or refer prospective Members to VillageCareMAX.

Provider Affiliations

VillageCareMAX may allow contracted providers to announce new or continuing relationships with the plan. New affiliation announcements are for those contracted providers that have entered into a new contract with VillageCareMAX. Contracted providers can announce a new affiliation agreement within the first 30 days of the new contract agreement with VillageCareMAX. New contracted providers can communicate once through direct mail, email or a phone announcement that lists only one plan. However, in future direct mail or email

Section 16: Marketing Guidelines

communications, contracted providers must include a list of all the plans with which they contract.

Any piece of affiliation communication material that describes VillageCareMAX in any way (e.g. benefits or formularies) must be approved by CMS and/or DOH, and must include the appropriate disclaimer found in Section 50 of the Medicare Marketing Guidelines. VillageCareMAX is responsible for ensuring that all Plan marketing materials are compliant and approved by CMS.

Participating providers should contact VillageCareMAX for more information about the plans we offer. We can provide you with information about our plan options, eligibility requirements and covered benefits.

Section 17: Member Confidentiality

Confidentiality of Member Information

Participating Providers shall ensure the confidentiality of all Member related information by maintaining all Member specific information and Member records in accordance with New York State Public Health Law and the New York State Social Services Law and HIPAA (Health Insurance Portability Accountability Act). Member information shall be used or disclosed by a Participating Provider only with the Member's consent unless otherwise required by law and only for purposes directly connected with Participating Provider's performance and obligations under VillageCareMAX Participating Provider Agreement.

Participating Providers will inform and train their employees and other workers to comply with the confidentiality and disclosure requirements of New York State statutes and HIPAA.

Member authorization for disclosure is not required for access to health information by:

- Medicare or CMS;
- The New York State Department of Health;
- Accreditation surveyors; and
- Federal, State and Local government agencies authorized to conduct investigations of Medicaid Managed Long Term Care or Medicare Advantage HMO D-SNP plans.

VillageCareMAX MLTC Member Rights

Participating Providers will uphold the Member's rights and responsibilities as outlined below.

As a Member of VillageCareMAX, the Member has the right to:

- Receive medically necessary care;
- Privacy about the Member's medical record and treatment;
- Timely access to care and services;
- Receive information on available treatment options and alternatives presented in a manner and language understood by Member;
- To receive information in a language the Member understands; oral translation services must be free of charge;
- Receive information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Receive a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to receive the services they need from VillageCareMAX, including how they can receive covered benefits from Non-Participating Providers if they are not available in the Participating Provider Network;
- Complain to VillageCareMAX, the Centers for Medicare and Medicaid Services, the New York State Department of Health or the New York City Human Resources Administration, the right to use the New York State Fair Hearing System or in some instances request a New York State External Appeal;
- Appoint someone to speak for them about their care and treatment; and
- Make advance directives and plans about their care.

VillageCareMAX Medicare Health Advantage and VillageCareMAX Total Advantage Plan Member Rights

As a Member of VillageCareMAX Medicare Health Advantage and VillageCareMAX Total Advantage, Participating Providers will uphold the Member's rights and responsibilities as outlined below. Specifically, each Member must be guaranteed the right:

- To request and receive written and oral information about the Plan, its network providers, covered services and the Member's rights and responsibilities in a manner the Member understands.
- To receive materials and/or assistance in a foreign language and in Alternative Formats, such as Braille or large print if necessary.
- To be treated with fairness and respect at all times.
- To get timely access to a Member's covered services and drugs
- To protect the privacy of a Member's private health information
- To the support of the plan regarding a Member's right to make decisions about his/her care.
- The right to make complaints and to ask the plan to reconsider decisions made by the plan.
- To get information about what a Member should do if he/she believes they have been treated unfairly or a Member feels his/her rights have not been respected.
- To get more information about a Member's rights

Member Responsibilities

VillageCareMAX MLTC Members, VillageCareMAX Medicare Health Advantage Members and VillageCareMAX Total Advantage members are responsible to:

- Use Participating Providers who work with VillageCareMAX;
- Become familiar with the plan's covered benefits and rules to be followed in order to get these covered benefits
- Tell VillageCareMAX if they have any other health insurance coverage or prescription drug coverage in addition to the plan in which they are enrolled.
- Tell their doctor or other health care provider that they are enrolled in a VillageCareMAX plan.
- Help their doctor and other providers by giving them information, asking questions and following through on their care.
- Be considerate.
- Call VillageCareMAX Member Services with any questions or concerns.
- Receive authorization from their Physician, Care Manager or Interdisciplinary Care Team before receiving a covered service requiring such authorization;
- Tell VillageCareMAX about their care needs and concerns and work with the VillageCareMAX Care Management Department in addressing them;
- Notify VillageCareMAX when they go away, move or are out of town;
- Make all required payments to VillageCareMAX; and
- Cooperate with any requests for documentation related to maintaining Medicaid eligibility.
- In no event can a Provider bill VillageCareMAX Members for any balance remaining on a claim.

Cultural Competency

VillageCareMAX is committed to providing the healthcare service needs of all Members, regardless of their ethnic, cultural or religious beliefs or language spoken. This includes:

- Being familiar and understanding of other cultures and ethnic groups,
- Understanding the communication styles of different ethnic groups, and
- Facilitating communication with individuals who require translation and translated materials.
- Acceptance of different perceptions and views about health care.

To facilitate cultural competency, VillageCareMAX provides training to both our staff and participating providers.

VillageCareMAX works with providers to share information and education about cultural competency. VillageCareMAX will offer ongoing programs in cultural competency requirements during provider orientation, scheduled training sessions and updates as necessary. Participating providers are required to work with VillageCareMAX to meet this requirement.

VillageCareMAX serves a diverse population. To meet the needs of our Members, VillageCareMAX provides access to interpreter services and assistance to Members with a visual or hearing impairment. Members are encouraged to use the interpreter services to best understand their health care needs.

Members who require interpreter services should call Member Services at 1-800-469-6292. Our hours are 8:00 am to 8:00 pm, 7 days a week. Members with a hearing or speech impairment should call 711 for assistance. 711 is the New York Relay Service where a specially training operator will connect the Member to the person he/she is calling and assist with the communication. Providers can use the 711 phone number to communicate with their patients.

VillageCareMAX can link providers to translation services, through bilingual Member services staff and a telephonic translation service. Providers can access this by calling the main Member Services phone number listed above.

Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face, by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

The VillageCareMAX MLTC handbook is available in English, Spanish and Chinese. The VillageCareMAX Medicare Health Advantage (HMO D-SNP) Evidence of Coverage is available

in English, Spanish, Chinese and Korean. The VillageCareMAX Total Advantage Evidence of Coverage is available in English, Spanish and Chinese.

Members should call Member Services if they need a handbook in different languages, large print or Braille.

Provider Culturally and Linguistically Appropriate Services ("CLAS") Training

The CLAS Training Program is required by VillageCareMAX per the Office for Minority Health (OMH) at the U.S Department of Health and Human Services (HHS). The purpose of the Program is to communicate with providers the 15 National CLAS Standards broken up into four (4) categories: Principal Standard; Governance, Leadership and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability.

To ensure the cultural competence of our provider network, all VillageCareMAX contracted/participating providers are required to complete this CLAS Training Program and must certify, on an annual basis, completion of the state-approved cultural competence training curriculum for all participating providers' staff who have regular and substantial contact with Members/Enrollees. Providers' completed Attestation Forms will ensure VillageCareMAX remains compliant with OMH and HHS.

Please refer to VillageCareMAX website for CLAS Training, Notice, and Attestation: https://www.villagecaremax.org/providers#clas

The New York State Department of Health has also approved the cultural competence training offered by the HHS OMH education program, **Think Cultural Health**. The training can be accessed at https://hclsig.thinkculturalhealth.hhs.gov

Upon completion of training, all contracted/participating providers are required to share certification with VillageCareMAX. Providers should complete the attestation form (See <u>Appendix 18</u>) and send to their Provider Relations Account Manager, or submit to the Provider Relations Team via email <u>ProviderRelations@villagecare.org</u> or via fax: (718) 517-2698.

For questions, please contact the Provider Relations Department at (718) 517-2783.

VillageCareMAX Grievances and Appeals

LINE OF BUSINESS	CATEGORY	TIME FRAMES
MLTC	 Expedited Same day Standard Grievance Extension Grievances Appeals 	Expedited: Resolved within 48 hours from the receipt of all necessary information, but no later than 7 calendar days from the receipt of the grievance. Same Day: Resolved same day/within 24 hours to the Provider's or member's satisfaction
		Standard Grievance: 45 calendar days to resolve a standard grievance. An Acknowledgement letter is sent to the Provider or member within 15 days of the received of the grievance and a Resolution is send to the Provider or Member within 45 calendar days from receipt of all necessary information. Grievance Extension: If additional information is required to make a
		determination, the Plan, Provider, or the Member can request an extension, which will allow an extra 14 calendar days.
		Grievances Appeal: If a Provider or Member is not satisfied with the Plan's decision about a grievance, the Provider or Member can request a second review by filing a grievance appeal. VCMAX has 30 business days to complete an appeal and an acknowledgement is sent to the member within 15 days of the received of the grievance. A Provider or Member can also request an Expedited appeal which will need to be resolved within 2 Business days
DSNP and MAP	ExpeditedStandardGrievance Extension	Expedited Grievance: Resolved within 24 to 48 hours after receipt of all necessary information but no later than 7 calendar days

LINE OF BUSINESS	CA	TEGORY	TIME FRAMES
	•	Grievances Appeals	Standard Grievances: Must be resolved within 30 calendar days. An acknowledgement letter is sent to the Provider or Member within 15 business days of the receipt of the grievance.
			Grievance Appeal and Grievance Extension is the same as the MLTC Program

Grievances

A grievance is any communication by a Provider or Member to VillageCareMAX about dissatisfaction with the care and treatment received from VillageCareMAX staff or Providers of covered services, which does not amount to a change in scope, amount, and duration of service or other actionable reason.

A Member or a Provider on the Member's behalf may make a grievance verbally or in writing. Members are advised of their right to file a grievance at the time of enrollment and are advised of their rights and responsibilities annually. Members are advised as to how to file a grievance, and of their ability to receive assistance from VillageCareMAX staff, if necessary. All grievances will be resolved without disruption to the Member's plan of care. Members will be free from coercion, discrimination or reprisal in response to a grievance.

All grievances (both same day and non-same day resolution) are logged, tracked and reported. VillageCareMAX will designate appropriate personnel who were not involved in the previous level of decision-making to review grievances in supervisory capacity and on grievance appeal. If the grievance or grievance appeal relates to clinical matters, the personnel assigned to process them will include duly registered health professionals.

Grievances (non-same day resolution) can be standard or expedited. Standard grievances, including both those reported verbally or written, are acknowledged in writing within fifteen (15) business days of receipt of the grievance or less by VillageCareMAX. Grievances are addressed as quickly as required by the Member's condition. A standard determination is to be made within forty-five (45) calendar days of the receipt of all necessary information and no more than sixty (60) calendar days from receipt of a grievance. The standard grievance decision will be communicated by telephone and in writing within three (3) business days of the decision. The review period for VillageCareMAX grievance determination can be increased by an additional fourteen (14) calendar days if it is in the Member's best interest. The Member, the Provider on the Member's behalf, or VillageCareMAX may request the extension. The reason for the extension must be documented. When the extension is initiated by VillageCareMAX, a notice

will be sent to the Member or the Provider advising of the extension, the reason for the extension and specify how it is in the best interest of the Member. If a decision on the grievance is reached before the written acknowledgement was sent, VillageCareMAX will send the written acknowledgement with the grievance determination. A VillageCareMAX decision to initiate an extension is made when it is established that inadequate information is available to make an informed decision.

If the standard response time to the grievance would seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, VillageCareMAX will expedite the grievance. The Member or the Provider may request that a grievance be expedited. If VillageCareMAX agrees to expedite the grievance, the expedited grievance determination will be made within forty-eight (48) hours of receipt of all necessary information and no more than seven (7) calendar days from receipt of the grievance. The expedited grievance decision will be communicated by telephone and in writing within three (3) business days of the decision.

If the expedited grievance decision is made before the written acknowledgement is sent, both the acknowledgement and expedited grievance decision will be combined. If the Member or the Provider on the Member's behalf, requests that the grievance be expedited and VillageCareMAX does not agree, VillageCareMAX will notify the Member or the Provider verbally within two (2) days and in writing within fifteen (15) days that the grievance decision was not expedited and the grievance will be handled within the standard grievance decision timeframes.

The plan will use grievance data to an identify trends and opportunities for program improvement. VillageCareMAX will review the grievance data that includes Provider type, specific Providers, and VillageCareMAX staff identified as responsible parties in the grievance.

VillageCareMAX shall, upon contracting with a Participating Provider or subcontractor, provide the following information about the grievance and appeal system to Participating Providers and subcontractors:

- a. the right of the enrollee, or, with the enrollee's written consent, a provider or an authorized representative, to file grievances and appeals;
- b. the requirements and timeframes for filing a grievance or appeal;
- c. the availability of assistance in the filing process;
- d. the right to request a State fair hearing after the Contractor has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- e. the fact that, when requested by the enrollee, benefits that VillageCareMAX seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

Medicare Health Advantage & Medicare Total Advantage

VillageCareMAX provides meaningful procedures for timely hearing and resolving both standard and expedited grievances between providers or enrollees and the Medicare health plan or any other entity or individual through which VillageCareMAX provides health care services.

VillageCareMAX procedures include the following:

- Ability to accept any information or evidence concerning the grievance orally or in writing no later than 60 calendar days after the event;
- Ability to respond within 24 hours to a provider's or an enrollee's expedited grievance whenever:
 - VillageCareMAX A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
 - VillageCareMAX A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration;
- Prompt, appropriate action, including a full investigation of the grievance as expeditiously as the provider's or enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written request is received, unless extended as permitted under 42 CFR 422.564(e)(2);
- Timely transmission of grievances to appropriate decision-making levels in the organization;
- Notification of all concerned parties upon completion of the investigation, as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 calendar days from the date the grievance is filed.
- Prompt notification to the provider, enrollee, or their representative regarding an organization's plan to take up to a 14 calendar day extension on a grievance case;
- Documentation of the need for any extension taken (other than one requested by the provider or enrollee) that explains how the extension is in the best interest of the enrollee; and
- Procedures for tracking and maintaining records about the receipt and disposition of grievances. VillageCareMAX discloses grievance data to Medicare beneficiaries upon request and is able to log or capture enrollees' grievances in a centralized location that is readily accessible.

Appeals of Grievances

A grievance appeal is a written communication from the Member that the Member disagrees with the decision of VillageCareMAX in response to the grievance filed. Once the Member files a grievance appeal, VillageCareMAX must look again at the determination to decide if the decision was the correct one.

Members are instructed during enrollment of their right to appeal a grievance determination if the Member is dissatisfied with the determination of a grievance. Member are advised how to file a grievance appeal and if needed, told how to obtain assistance from VillageCareMAX staff. VillageCareMAX staff will review the grievance appeal with no disruption in the Member's care and Members will be free from coercion, discrimination or reprisal by the program.

The Member has the right to present their reasons for the grievance appeal both in person and in writing during the grievance appeal process. The Member has the right to examine all records that are part of the grievance appeal process. The Member has the right to have a designated representative.

There are two (2) types of grievance appeal processes. They are:

- Standard grievance appeal decisions which are made within thirty (30) business days of the date of receipt of necessary information.
- Expedited grievance appeal decisions (if the Member, Provider on behalf of the Member or VillageCareMAX feel that the time interval for a standard grievance appeals process could result in serious jeopardy to the Member's health, life or ability to attain, maintain or regain maximum function) are made within two (2) business days of receipt of all necessary information.

For both the standard and expedited process, the Member must submit a written grievance appeal form request within sixty (60) business days from the receipt of the initial grievance decision. The appeal request form is sent with all notices of action, denial of service requests or grievance determinations not made in the Members favor. Members may request an appeal verbally and VillageCareMAX staff will complete the appeal request form on the Member's behalf.

VillageCareMAX MLTC: Appeals of Actions and Adverse Determinations

An **Appeal** is a request for the plan to review the reason for an action in order to decide if the action was correct. An appeal of an action can be made orally or in writing.

Adverse determination means a determination by the plan that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

Representative: An individual appointed by the Member or other party, or authorized under State or other applicable law, to act on behalf of a Member or other party involved in the appeal. A Member may appoint any individual (such as a relative, friend, advocate, an attorney or any physician).

Overview

A Member, their Representative or a provider on the Member's behalf may appeal within forty-five (45) days of the date of VillageCareMAX action. The Member Handbook contains descriptions of the appeals procedures to ensure that Members are fully informed of their right to file an appeal. Members are informed of their appeal rights in writing annually, upon request and every time a service is denied or services are terminated, reduced or suspended. There will be no change in a Member's services or in the way VillageCareMAX staff or providers treat a Member because he/she makes an appeal. VillageCareMAX will not retaliate or take any action against a Member for requesting an appeal.

During VillageCareMAX review, the Member or their Representative may give us information in writing or in person, and may see the Member's record at VillageCareMAX. Upon request, VillageCareMAX will give the Member the chance to discuss their appeal in their own language.

The review will be conducted by an individual who is qualified to render a decision and is not the original decision maker. Appeals regarding clinical matters will be decided by persons qualified to review the appeal, including licensed, certified or registered health care professionals who were not involved with prior determinations and are not subordinate to the person who made the initial adverse determination or action.

The Member or their representative may request a standard or expedited appeal in writing or verbally. If VillageCareMAX upholds its initial adverse organization determination, either in whole or in part, or VillageCareMAX fails to provide the Member with a decision on the appeal within the relevant time frame, the Member has the right to continue an appeal by asking for a New York State External Review if the reason VillageCareMAX denied coverage was that it was not medically necessary, or it was experimental or investigational.

Before a Member may make an External Appeal to New York State:

- The Member must file a Standard Appeal with VillageCareMAX and get VillageCareMAX final adverse determination; or
- If the Member had an Expedited Appeal and is not satisfied with VillageCareMAX decision, the Member can choose to file a Standard Appeal with VillageCareMAX or go directly to a NYS external appeal; or

• The Member and VillageCareMAX may agree to skip VillageCareMAX appeals process and go directly to a NYS External Appeal.

The Member may also ask for a New York State Medicaid Fair Hearing if an appeal is denied. The Member may ask for both a NYS External Appeal and a NYS Medicaid Fair Hearing. However, if the Member asks for both, it will be the decision of the Fair Hearing officer that counts

The Member may be able to continue receiving previously authorized services while waiting for a NYS Fair Hearing decision if the Member asks for a New York State Fair Hearing within ten (10) days from the date the Member received our decision about the appeal; or by the date the change in care or services is scheduled to occur. If the Fair Hearing decision is not in the Member's favor, the Member may have to pay the costs of any continued benefits received solely as a result of requesting a Fair Hearing about those benefits.

MLTC Appeal Timeframes

Appeals must be received by VillageCareMAX within forty-five (45) days of VillageCareMAX action. If the request is made after forty-five (45) days, the appeal will not be considered.

1. Standard Appeal of an Action for Denial of Service:

- VillageCareMAX will acknowledge the Provider's or Member's appeal in writing within 15 days of receipt of the appeal.
- VillageCareMAX will make a determination and notify the Provider or Member of the decision verbally and in writing as expeditiously as the Member's health requires, but no later than thirty (30) calendar days after VillageCareMAX receives the appeal.
- Standard with Extension: VillageCareMAX may extend this time frame by up to fourteen (14) calendar days upon request by the Provider or Member or if there is a need for additional information and the extension of time benefits the Member.
- If VillageCareMAX overturns the initial adverse organization determination, the requested service will be authorized as expeditiously as the Member's health requires, but no later than thirty (30) calendar days of the date the request for reconsideration was received (or no later than upon expiration of an extension).

2. Expedited Appeal – Request for Service:

- Automatic Expedited Appeal: VillageCareMAX will automatically expedite a request for appeal:
- If the appeal request is for a concurrent authorization.
- Upon request by a physician to expedite the determination.
- Expedited Request Approved: If a Member requests an expedited appeal, without physician support, VillageCareMAX will determine whether applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum

function. If the Member's request for an expedited appeal is approved or automatically given as above, VillageCareMAX will make the determination and notify the Member verbally and in writing as expeditiously as the Member's condition warrants, but no later than two (2) business days of receipt of all necessary information and no later than three (3) business days after receiving the request

- Expedited Request Denied: If the Member's request for an expedited determination is denied, the Member will promptly be informed verbally and in writing within three (3) business days, and the request will be transferred to a standard time frame (30 days). The Member will be informed of the right to file an expedited grievance if the Member disagrees with the denial of an expedited appeal decision
- If VillageCareMAX overturns the initial adverse determination, the Member will be verbally notified promptly on the day of the determination and will be sent written notification within two (2) business days of the decision
- VillageCareMAX must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's service authorization request, appeal, or grievance.

3. Appeal of an Action to Terminate, Reduce or Suspend Service:

- A Member may request that aid continue while an appeal is being reviewed. The request must be made prior to the effective end date of services on the Member's written notification terminating, reducing or suspending services
- Services will be continued:
 - Until the appeal is withdrawn by the Member or
 - Until ten (10) days after an appeal decision is mailed if the decision is not in the Member's favor unless a New York State Fair Hearing has been requested.

4. NYS External Appeal:

If a Member is not satisfied with VillageCareMAX decision, the Member may appeal using the NYS External Appeals process by requesting an appeal within forty-five (45) days of VillageCareMAX decision on their appeal.

The NYS External Appeal will be decided in thirty (30) days from the date the State Insurance Department receives the application. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information.

- a. The Member and VillageCareMAX will be told the final decision within two (2) days after the decision is made.
- b. The Member can get a faster decision if the Member's doctor says that a delay will cause serious harm to the Member's health. The external appeal reviewer will decide an expedited appeal in three (3) days or less.

5. Fair Hearing

The Member must request a Fair Hearing within sixty (60) days of VillageCareMAX decision to uphold the denial.

- a. The Member may be able to continue receiving previously authorized services while waiting for a New York State Fair Hearing decision if the Member asks for a NYS Fair Hearing:
 - Within ten (10) days from the date the Member received our decision about the appeal; or
 - By the date the change in care or services is scheduled to occur
- 2. The Fair Hearing officer will notify the Member and VillageCareMAX of the decision within one (1) day of making the decision.

VillageCareMAX Medicare Health Advantage Plan (D-SNP) and Medicare Total Advantage Plan (MAP).

Type of Request	Who May Request
Standard Pre-Service Reconsideration	 An enrollee An enrollee's representative The enrollee's treating physician acting on behalf of the enrollee or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider). Any other provider or entity (other than VillageCareMAX) determined to have an appealable interest in the proceeding.
Expedited Reconsideration	 An enrollee An enrollee's representative Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the enrollee.
Standard Payment Reconsideration	 An enrollee An enrollee's representative Non-contract provider that completes a Waiver of Liability (WOL) statement which indicates that he/she will not bill the enrollee regardless of the outcome of the appeal The legal representative of a deceased enrollee's estate or Any other provider or entity (other than the MA Plan) determined to have an appealable interest in the proceeding.

^{*}Please refer to your contract to confirm specific language.

1. Plan Internal Appeal (Level 1 Appeal)

Members, their providers, and their representatives have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. The appeal must be requested within 60 calendar days of postmark date of Notice of Action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 calendar days of the notice's postmark date or by the intended effective date of the Action, whichever is later.

VillageCareMAX will send a written acknowledgement of appeal to the Member within 15 calendar days of receipt unless a decision is reached sooner. The Plan will make a decision on appeal and notify the Member of its decision as fast as his/her condition requires, but no later than within 72 hours of the receipt of the expedited appeal and no later than 30 calendar days from the date of the receipt of the standard appeal. Benefits will continue pending an appeal if requested within 10 calendar days of the Action notice's postmark date or by the intended effective date of the Action, whichever is later.

VillageCareMAX, Members or providers may take up to 14-calendar day extension, if the Plan can justify the need for additional information and if the extension is in the Member's interest, or if Member or provider requests it. In all cases, the extension reason must be well-documented, and when the Plan requests the extension it must notify the Member in writing of the reasons for delay and inform the Member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

VillageCareMAX will notify Members orally of expedited appeal decision and send written notice within 2 calendar days of its decision for standard and expedited appeals.

2. Independent Review Entity (Level 2 Appeal)

Any adverse decision in whole or in part by VillageCareMAX is automatically forwarded to the Independent Review Organization (IRE). This is an independent organization that is hired by Medicare to review our decision for the Level 1 appeal.

VillageCareMAX will send Acknowledgement of Automatic Level 2 appeals. If the appeal request was a "fast" appeal at Level 1, the plan will automatically process the request as a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives the appeal. If the appeal request was a "standard" appeal at Level 1, the plan will automatically process the request as a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 days of it receives your appeal. However, if the Independent Review Organization needs to gather more information, it can take up to 14 additional calendar days. The Independent Review

Organization shall issue a written decision that explains the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other requirements.

3. Administrative Law Judge or Attorney Adjudicator (Level 3 Appeal)

If the Independent Review Entity upholds the decision, you have the right to a Level 3 Appeal. However, in order to make an appeal at Level 3, there is a minimum amount requirement. If the dollar value of the coverage you are requesting is too low and doesn't meet a certain minimum, the decision at Level 2 is final.

- If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - o If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - o If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.
 - o If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - o If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

4. The Medicare Appeals Council (Level 4 Appeal)

The Medicare Appeals Council will review the appeal and give its decision; The Council is a part of the Federal government.

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - o If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - o If we decide to appeal the decision, we will let you know in writing.
- If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.

- o If you decide to accept this decision that turns down your appeal, the appeals process is over.
- o If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

5. Federal District Court (Level 5 Appeal)

A judge at the Federal District Court will review your appeals. This is the last step of the appeals process

VillageCareMAX Medicare Health Advantage Plan (D-SNP) and Medicare Total Advantage Plan (MAP) Plan Part D Coverage Determinations, Appeals and Grievances

Coverage Determinations

Coverage determination is a decision by VillageCareMAX/ MedImpact to pay or cover a prescription drug. Coverage determinations include exception requests; such as request to cover a non-formulary drug. An exception request must be accompanied by a supporting statement from the prescribing provider.

VillageCareMAX strongly encourages and recommends that a prescribing provider review the current Plan formulary to identify the drugs that are covered for VillageCareMAX Members. The plan formulary can be found at www.villagecaremax.org. The formulary can help a provider identify the therapy or therapies that will be least expensive. In general, the lower the drug tier the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that are preferred by the Plan. The formulary was developed by a Pharmaceutical and Therapeutics (P&T) Committee comprised of a national panel of clinicians. The formulary can help providers understand the VillageCareMAX strategy for managing the pharmacy benefit. We recognize that sometimes this strategy may not align with a provider's treatment criteria.

The Plan requires a Member or his or her provider to request prior authorization for certain drugs. This means the Member must obtain prior approval for a prescription from the Plan before the prescription is filled. If approval is not obtained, VillageCareMAX may not cover the drug. For certain drugs, VillageCareMAX limits the amount of the drug that is covered. This is called Quantity Limit. In some cases, the VillageCareMAX Medicare Part D Plan requires a Member to first try certain drugs to a medical condition before we will cover another drug for that condition, this requirement is called Step Therapy.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact MedImpact.

CALL: MedImpact -1-888-807-6806 **FAX:** MedImpact - 1-858-790-6060

WRITE: MedImpact Healthcare Systems, Inc.

Attention: Prior Authorization Department

10181 Scripps Gateway Court

San Diego, CA 92131

Medicare Part D Appeals

The Member's appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A Member may appeal an adverse coverage determination.

A Member has a right to appeal if he or she believes that VillageCareMAX / MedImpact decided not to cover a drug, vaccine, or other Part D benefit; decided not to reimburse a Member for a part D drug that he/she paid for; asked for payment or provided reimbursement with which a Member disagrees; denied the Member's exception request; made a coverage determination with which the Member disagrees.

Appeals for Part D Prescription Drugs

CALL: MedImpact at 1-800-807-6806

FAX: MedImpact at 1-858-790-6806

WRITE: MedImpact Healthcare Systems, Inc.

Attention: Appeals/Grievance Department

10181 Scripps Gateway Court

San Diego, CA 92131

If MedImpact fails to meet coverage determination or redetermination time frames, it must automatically forward the Member's request(s) to the Independent Review Entity (IRE) contracted by CMS. If the IRE upholds the Plan's adverse coverage determination, the IRE will notify the Member in writing and explain further appeal options that may be available to the Member.

Time Frames for Coverage Determinations and Appeals

VillageCareMAX is required to make coverage determinations and process appeals as expeditiously as the Member's health status requires but no later than is indicated in the following chart:

Medicare Prescription Drug (Part D) Time Frames					
Type of Appeal	STANDARD*	EXPEDITED*			
Pharmacy Coverage	72-hour time limit	24-hour time limit			
Determinations (Initial					
Decision)					
1st Level - Part D	7-day time limit	72-hour time limit			
Redetermination Appeal					
2 nd Level - IRE (Independent	7-day time limit	72-hour time limit			
Review Entity) Review					

3rd Level (Office of	Administrative Law Judge	Administrative Law Judge
Medicare Hearings and	Standard Decision	Expedited Decision
Appeals)	90-day time limit	10-day time limit
For amounts in controversy ≥		
\$140		
4 th Level (Medicare Appeals	Standard Decision	Standard Decision
Council – MAC)	90-day time limit	10-day time limit
5 th FINAL Level - Judicial	Federal District Court	
Review		
(Federal District Court) For		
amounts in controversy ≥		
\$1,400		

Section 20: Dispute Resolution

Claim Issues

Discrepancies between a claim and VillageCareMAX authorization will be processed as follows:

- If the claim processing vendor denies a claim due to a discrepancy between VillageCareMAX authorization record and the claim, or for any other problem with the claim or authorization, the Participating Provider may submit a corrected claim within forty-five (45) days of the denial or follow the claim inquiry procedures outlined in this Participating Provider Manual.
- If the designated claim inquiry staff decides against the Participating Provider, the Participating Provider can appeal to the Provider Services at 1-855-769-2500.
- The Participating Provider will be notified in writing of the decision.
- If the Participating Provider wishes to pursue the discrepancy further, the discrepancy becomes a dispute and is adjudicated through the dispute resolution process.

If a dispute arises out of, or relates to, the Participating Provider's agreement with VillageCareMAX, and the dispute cannot be resolved by the parties within a reasonable time of either parties notice to the other party of the dispute, the dispute shall be resolved by arbitration, unless otherwise stipulated. Arbitration shall be conducted pursuant to the agreement between VillageCareMAX and the Participating Provider. Arbitration decisions shall be final and binding.

Provider Credentialing

The VillageCareMAX Provider Relations Department maintains credentialing files for each Participating Provider and ensures timely credentialing. Organizational Providers and Individual Providers must submit information and documentation required by VillageCareMAX to validate the Provider's qualifications to provide services to VillageCareMAX Members.

VillageCareMAX has a formal process for credentialing providers on a periodic basis (initially and not less than once every three (3) years) and for monitoring provider performance. This shall include, but not be limited to, requesting and reviewing any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last time VillageCareMAX credentialed the Participating Provider. For providers that are not subject to licensure or certification requirements (other than Social Day Care), VillageCareMAX shall establish alternative mechanisms to ensure the health and safety of Enrollees which could include such activities as criminal background checks or review of abuse registries. VillageCareMAX shall enter into contracts only with providers who are in compliance with all applicable state and federal licensing, certification, and other requirements; and are generally regarded as having a good reputation; and have demonstrated capacity to perform the needed contracted services. All provider contracts must meet the requirements of the Agreement and applicable state and federal laws and regulations.

Organizational Credentialing criteria include:

- Completed and signed Participating Provider application;
- All regulatory licenses, registrations and certifications;
- Evidence of insurances, as applicable, e.g. general liability, automobile insurance, etc.,
- NPI (National Provider Identifier Number):
- MMIS and Medicare Provider numbers for all Medicaid and Medicare Providers;
- Valid Drug Enforcement Agency and/or Controlled Substance Certificate, (if applicable).
- A copy of an accreditation certificate or a copy of the most recent federal or state regulatory body site visit report (with a letter if appropriate of the acceptance of a plan of correction).

VillageCareMAX includes review of compliance with the American with Disabilities Act of 1990 (ADA) as part of its credentialing and recredentialing process. To be fully compliant with ADA requirements, participating providers must attest that the following standards are in place.

Provider sites at which Members receive services are required to be compliant with the ADA. A self-assessment questionnaire is included as part of the initial credentialing process. Compliance with ADA accessibility requirements includes, but is not limited to the following:

- Wheelchair accessible office, doorways, waiting rooms, examination rooms, lavatories, etc.
- Elevator controls (if applicable) and light switches for lavatories reachable by someone in a wheelchair
- Assistance available for those who may need sign language interpretation and other special needs

If an organization has not been accredited and has not had a recent, favorable regulatory site visit, then VillageCareMAX will conduct a quality assessment which may include a site visit.

Individual Credentialing (medical providers including MDs, DOs, DPMs, DCs, ODs, NPs, PTs and behavioral health care providers, including Psychiatrists, Psychologists, PhDs and Social Workers) Criteria includes, but is not limited to:

- An active license in New York State
- An active Drug Enforcement Agency ("DEA") certification if a prescribing practitioner)
- Controlled substance registration
- An active MMIS number in New York State
- An acceptable 5-year work history for initial credentialing
- Acceptable malpractice claims history
- Current malpractice insurance coverage in accordance with contractual provisions (if applicable)
- Appropriate training and board certification
- Clinical privileges in good standing (as applicable)

Note: Providers who are sanctioned or excluded from participation with Medicare and/or New York State Medicaid Program will be excluded from participation. Medicare Opt Out providers cannot participate in MA-PD plans.

Practitioners who *do not need* to be credentialed:

- 1. Practitioners who practice exclusively within the inpatient setting and who provide care for organization Members only as a result of Members being directed to the hospital or another inpatient setting; and/or covering Primary Care Provider (PCP) who works less than 16 hours per week.
- 2. Practitioners who practice exclusively within free-standing facilities and who provide care for organization Members only as a result of Members being directed to the facility
- 3. Covering practitioners (e.g., locum tenens). Locum tenens who do not have an independent relationship with the organization are outside the scope of credentialing

Providers applying for Initial Credentialing are required to complete a credentialing application along with documents specified on the application. VillageCareMAX will inform the Provider

of any deficiencies or missing documents. If the Provider cannot correct deficiencies or provide timely submission of documents, processing of the provider's application will cease and the provider will be informed that participation with the plan will not proceed within no more than 90 days after the application is received. Providers being considered for Recredentialing will be afforded the same opportunities to correct deficiencies and/or submit documents. However, should a provider fail to comply with recredentialing activities, the provider will be terminated from participation with VillageCareMAX. Termination for non-compliance with recredentialing does not afford appeal rights, but does not preclude the provider from applying for Initial Credentialing once again.

VillageCareMAX may conduct a site survey of the Provider's premises when services are to be rendered on site at the Provider's facility. VillageCareMAX will consider the results of the site survey in determining whether to contract with a Provider, and in determining whether to renew an agreement with a Participating Provider.

Recredentialing Criteria

VillageCareMAX requires all providers to undergo recredentialing at least every three (3) years. Providers must maintain the same minimum qualification requirements as applicable for the Initial Credentialing. In addition, the recredentialing process will factor in the following elements when evaluating each practitioner:

- Access/availability
- Under/over utilization data
- Quality of care
- Primary and secondary prevention
- Disease management
- Member satisfaction
- Site/medical record audit scores
- Member concerns
- Peer review
- Continuity of care

All of the credentialing and recredentialing decisions are made by the VillageCareMAX Credentialing Committee. The Credentialing Committee can approve, pend for additional information, or deny the applicant. The provider's effective date is the date the Credentialing Committee approved the provider's application. Providers will be notified of their status within 60 days of a Credentialing Committee's decision date, as per New York State Public Health Law (PHL 44). In some cases, credentialing has been delegated to a hospital system, Independent Practice Association (IPA) or other Credentials Verification Organization (CVO). On an annual basis, the Credentialing Policy shall be reviewed and approved by the VillageCareMAX Board of Directors or a designated Board committee.

Monitoring of Participating Providers

To insure that Participating Providers comply with the terms of provider contracts and provide the most cost effective, quality care for Members, VillageCareMAX audits and monitors Participating Providers on a regular and ongoing basis. Participating Providers who are found to have performance issues will be required to take corrective actions that will demonstrate improved performance. If corrective action is not taken or fails to produce improved results over an acceptable period of time, the Participating Provider will be evaluated for possible termination of their agreement.

Monitoring Process

- The Assistant Vice President of Quality Assurance or designee reviews Member satisfaction surveys and Member complaint logs.
- The Quality Assurance and Provider Relations Departments meet as needed to review Member complaints.
- Repeated complaints regarding a particular Participating Provider are followed up by the Provider Relations Department and the Quality Assurance Department when applicable.
- The Provider Relations Department, or Quality Assurance staff where quality of care issues are involved, will contact the Participating Provider to discuss complaints and request a plan of action.
- If repeated issues that are identified through Member satisfaction surveys and complaint logs cannot be remedied, the Provider Relations Department will commence agreement termination procedures.

Pursuant to 42 CFR 455.436 and 42 CFR 438.610, VillageCareMAX reviews governmental sanction databases and the Medicare Opt-Out Provider list to confirm the identity and determine the exclusion status of new Participating Providers, re-enrolled Participating Providers, and all current Participating Providers to ensure Providers are eligible to serve Members, including:

- New York State Education Department Office of the Professions Enforcement Actions
- New York State Office of the Medicaid Inspector General (OMIG) -Terminations and Exclusions List
- U.S. Dept. of Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals and Entities
- U.S. General Services Administration System for Award Management (SAM)

Any disciplinary action taken against a Participating Provider will be reviewed by the Credentialing Committee and appropriate action will be taken.

Section 22: Participating Provider Audits

VillageCareMAX will annually review a sampling of Participating Provider records documenting evidence of service delivery to determine compliance with State and local laws, contract terms and verify claims accuracy and any patterns of error. Audits will be based upon a sampling of paid claims for a specific time frame. Participating Provider selection will be rotated based on utilization. A statistically significant number of claims will be reviewed.

Documents Collected During Provider Audit

The data to be collected will depend on the specific audit being performed. The following list includes an example of documents to be collected during audits:

- Medical record notes;
- Doctor's orders;
- Plan of care;
- RN Supervision notes and proof of visit;
- Attendance/ Duty sheets;
- Home health aide certification;
- Last annual physical examinations and health status assessment;
- Evidence of participation in 6 hours of in-service education per year;
- Annual assessment of performance of home health aide, including at least one in-home visit to observe performance;
- Results of NYS criminal history record check for required staff;
- Evidence of verification against government exclusion lists including date and proof of screening for each aide in the audit sample;
- Policy and procedure that describes how provider conducts Medicaid/Medicare exclusion/sanction list verifications for all new and existing employees and contractors;
- Activity records;
- Time slips, Sign in logs and attendance sheets;
- Durable Medical Equipment delivery tickets;
- Trip verification;
- Monitoring Reports from Participating Providers
- Documentation related to ADA compliance
- Payroll documentation to verify compliance with Wage Parity

Retrospective Claims Audit Process

• Upon ten (10) days' notice to a Participating Provider, VillageCareMAX will give the Participating Provider a list of claim numbers, Member names and service dates as applicable.

Section 22: Participating Provider Audits

- Participating Providers will submit documentation of service records for VillageCareMAX to review against paid claims.
- VillageCareMAX will compile data into a report indicating number of Participating Providers audited, number of claims, and number of errors, if any, found.
- Participating Providers showing a pattern of errors (in excess of five percent (5%) will be notified, and corrective action requested.
- Additional audits of these Participating Providers will be conducted quarterly.
- If no corrective action is taken to improve the results, VillageCareMAX Provider Relations will be notified and agreement termination procedures will be initiated.

VillageCareMAX reserves the right to audit participating providers as required by law and Participating Provider Agreement.

Section 23: Termination of Participating Providers

Participating Provider Termination

VillageCareMAX may terminate its agreement with a Participating Provider pursuant to the provisions of the VillageCareMAX Participating Provider Agreement. VillageCareMAX will comply with the requirements of Section 4406-d of the New York Public Health Law when terminating a health care professional's contract. Under this policy, the term "health care professional" shall be defined in accordance with Section 4406-d of Public Health Law, as a health care professional licensed, registered or certified pursuant to Title Eight of the New York Education Law. Organization providers do not have appeal rights.

In some cases, a health care professional whose contract is being terminated or who is being denied continuing network participation at the time of re-credentialing, may be eligible to appeal the termination. Appeals rights do not apply in cases of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health care professional's ability to practice or in cases of non-renewal of a health care provider's contract. Health care professional who are terminated for non-compliance with recredentialing will not be entitled to appeals rights but may re-apply for initial credentialing.

VillageCareMAX will provide health care professionals with the reason for terminations in writing and will include:

- Notice that the health care professional has the right to request a hearing or review, at the health care professional's discretion, before a panel appointed by the health plan
- Time limit of thirty (30) days from receipt of notice within which the health care professional may request the hearing
- Time limit for a hearing date which is required to be held within not less than 30 days after the date the hearing was requested

Reasons for termination include, but are not limited to:

- Rendering care to members in a harmful, potentially harmful, personally offensive, or unnecessary, or inefficient manner
- Failure to provide access to care to an extent that continuity of care to enrolled patients is inadequate
- Failure to comply with VillageCareMAX's policies and/or procedures, including those for utilization management, quality improvement, or billing
- Loss or restriction of hospital privileges
- Loss, suspension, revocation or limitations on license or DEA registration
- Censure, suspension, or disqualification from participation in Medicare or Medicaid
- Indictment or conviction of a felony
- Failure to comply with the recredentialing process or submitting false, incomplete or misleading information with respect to credentials
- Failure to maintain appropriate malpractice insurance coverage

Section 23: Termination of Participating Providers

• Physical or mental impairment, including chemical dependency, which affects the ability to provide care to patients

In order to appeal the termination of a provider contract, the provider must make the request in writing within thirty (30) days of receipt of notice. Appeals requests should be sent to the attention of: "Provider Relations/Credentialing (URGENT)" at:

VillageCareMAX Attn: Provider Relations 120 Broadway, Suite 2840 New York, NY 10271

Appeals/Hearing Panel

When an Appeal of a termination is received, the Credentialing Manager, in conjunction with the Medical Director, will determine that the Appeal is eligible for a Hearing.

Within fourteen (14) days of receipt of an eligible request for a Hearing, the Credentialing Committee Medical Director Chair will schedule the Hearing at a mutually agreeable time but no later than thirty (30) days from receipt of the request.

The Credentialing Committee Medical Director Chair will appoint an impartial Review Panel of three (3) clinicians, at least one of whom is a clinical peer in the same discipline and same or similar specialty as the provider under review, at least one other clinical peer, and none of whom are members of the Credentialing Committee.

The Hearing may be conducted telephonically or at VillageCareMAX offices during regular business hours.

The health care professional who is appealing may choose to have a representative represent him/her and may provide witnesses to support his/her appeal.

The hearing will include: Chairman's Statement of the Procedure, Presentation of Evidence by Credentialing Committee, Presentation of Evidence by the Health Care Professional, Credentialing Committee Rebuttal (as appropriate), and Summary Statements.

The health care professional will be notified in writing of the Review Panel's decision within thirty (30) days of the Hearing.

VillageCareMAX Duty to Report

VillageCareMAX is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

Section 23: Termination of Participating Providers

- 1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.
- 2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
- 3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member's health

Continuation of Treatment

*Please refer to your contract to confirm specific language.

The Provider agrees that in the event of plan's insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period.

Health Care Provider agrees that in no event, including, but not limited to nonpayment by the plan, insolvency of the plan or breach of the Participating Provider Agreement, shall Health Care Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against VillageCareMAX Members or persons (other than the plan) acting on a VillageCareMAX Member's behalf for Covered Services provided pursuant to the Participating Provider Agreement.

In the event of termination of the Participating Provider Agreement, the Provider agrees to: (i) continue to provide services to Members pursuant to the terms of the Participating Provider Agreement for one hundred eighty (180) days following notice of termination or until such time VillageCareMAX makes other arrangements for Members, whichever first occurs; (ii) continue to permit VillageCareMAX access to all records of Members who have or are receiving services; and (iii) provide VillageCareMAX with copies all records of services rendered to Members on or prior to the effective date of terminations.

Contracted Provider Voluntary Termination Request

For contracted providers who wish to terminate their Participating Provider Agreement with VillageCareMAX, please refer to the Termination section of the Agreement for appropriate notice timeframes, and fill out the VillageCareMAX Provider Termination Form (see Appendix 17) to begin the termination process.

Section 24: Policies and Procedures

Updates and Changes to Policies and Procedures

If VillageCareMAX updates or makes changes to policies and procedures related to Participating Providers, these changes will be posted on the plan's website. Please see http://www.villagecaremax.org for policy and procedure updates.

Participating Providers will be provided with in-service and orientation programs as required.

The VillageCareMAX Quality Management and Performance Improvement (QMPI) Program provides a framework for monitoring and evaluating critical aspects of service delivery, including Eligibility and Enrollment, Disenrollment, Grievances & Appeals, and Care Coordination. Care Coordination includes the functions of Case Management and Utilization Management. Case Management is the coordination of care across time and across different care settings including acute care, and also engaging the individual Members and their informal supports in the development and execution of the care plan, to the extent desired by each individual. Utilization management maximizes quality of care, while providing services in the most efficient and cost effective manner.

Measures will be selected to track and trend the access, timeliness and quality of delivery of these services to Members; Member outcomes at they receive care; and Member satisfaction. The QMPI Program Description along with the QMPI Work Plan and a QMPI Program Evaluation are reviewed and approved annually by the Board of Directors.

In addition to ongoing QMPI activities and monitoring, VillageCareMAX identifies and investigates adverse events and potential quality of care issues including: Unusual Events, CMS Never Events and State reporting requirements. Appropriate actions are taken to resolve these issues and where possible to prevent and reduce future occurrences.

Incidents and Quality of Care (QOC) Concerns

1. Incidents can be:

- Sentinel events which are the unexpected occurrence that already has or has the potential to cause the Member mental or physical harm, loss of limb, death, or threatens life.
- The National Quality Forum's List of Serious Reportable Adverse Events (CMS adopted "Never Events")
- Incidents which providers are required to report via NYSPORT
- Serious incidents which providers are required to report to the New York State Office of Mental Health
- Critical Incidents which are any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a Member.

Reportable Critical Incidents are defined as:

- Abuse
- Neglect or patient abandonment
- Exploitation
- Rights Violations
- Falls that require medical intervention
- Serious Injury
- Missing Person

- Death
- Medical Emergency
- Restraints
- Medical Errors
- Law Enforcement Contact
- Suicide Attempt
- 2. A QOC Concern can be any clinical or medical event other than an incident about which a question has been raised as to the whether the appropriate medical protocol was followed or a generally accepted standard of care maintained. These include:
 - Occurrences as listed on the NYSPORT reporting requirements for providers:
 - Other New York State Office of Mental Health reporting requirements,
 - Additionally, the Plan may identify other potential quality of care concerns for investigation, tracking and trending.

Identification of an Incident or Quality of Care Concern

A number of parties can identify an incident or QOC concern. Examples include:

- A Member, family member or caregiver may file verbally or in writing a grievance about an incident or QOC concern.
- A UR Nurse may learn of an incident during the service authorization process.
- A Care Manager may identify a concern during the care management or care planning process.
- As encouraged, a provider may proactively report an incident relative to their practice, or an incident or QOC concern regarding another practitioner to a Member's Care Manager.
- Quality Management (QM) staff may identify events through
- o Routine medical record review/quality measurement activity
 - O Claim based reports designed to identify retrospectively potential incidents and quality of care concerns

Referrals

- 1. Incidents and Quality of Care Concerns can be reported at any point in time in proximity to the event.
- 2. Members and Providers may report them verbally or in writing. If a verbal report is being made, the provider should call 1-800-469-6292, and the member services staff who answers the call can provide assistance. Written notification can be sent by fax to: 212-337-5711.
- 3. At minimum, the referral should include:
 - The name(s) of the Member(s) affected, their date of birth, Membership number and address.

- A description of the incident or concern including the time of the event, location, and extent of injury or damage.
- The steps the facility/provider has taken to date to address the incident if any
- The next steps the facility intends to take to address the incident including timeframes for completion if any.
- 4. Timelines for Investigation
- a. If the case is a grievance about quality, the Grievance Policy timelines are followed.
- b. Incidents and serious QOC concerns that pose an ongoing or immediate risk to the Member, other Members, or the public are immediately reviewed with the Medical Director or a physician consultant if the Medical Director is not available.
 - i. The Medical Director will direct the plan to take the level of action needed to address the severity of the issue. This may include reporting it to the Department of Health or other government or regulatory bodies, immediately transferring a Member to another facility or provider, or suspending admissions to the facility, provider or practice until the investigation can be completed.
- c. All other incidents/QOC concerns are investigated as quickly as the situation warrants. The QM Department strives to complete the investigations within 30 days (or as indicated by contractor's regulatory requirements) of receiving all needed information.

Investigating an Incident or Quality of Care Concern

- 1. A QA Nurse conducts an initial investigation, which usually involves requesting and reviewing the Member's medical record.
- 2. Depending on the nature of the issue, he/she may also gather other information for analysis including claims, utilization, case management, inquiry and complaint, and provider performance profile data.
- 3. The purpose of the initial investigation is to review the care which was rendered and to ascertain whether the generally accepted standard of care was met. Case medical documentation is usually reviewed against regulatory and accreditation standards and/or industry accepted clinical practice guidelines.

Peer Review

1. Cases which do not meet the standard of care are referred to the Medical Director for determination of next steps.

- 2. Medical record review by a professional from the appropriate subspecialty may be recommended by the Medical Director and facilitated by the QM Department.
- 3. The Medical Director may request that a vendor/facility investigate the incident or quality of care concern.
 - a. A letter summarizing the investigation is signed by the Medical Director and sent to the vendor/facility's Quality Assurance Liaison.
 - b. Medical opinions or conclusions about the quality of care rendered are not asserted in the letter.
 - c. The letter requests that the vendor/facility's Quality Assurance Liaison responds with a description of the incident or concern, the steps taken by the vendor/facility to investigate the incident or issue, and the corrective actions taken.
 - d. The Plan may ask the vendor/facility to report the findings of their investigation.
 - e. The QM Department tracks receipt of response to these requests.
- 4. When an incident or quality of care concern involves an individual practitioner:
 - a. Summaries of the investigation are forwarded to the Provider Relations (PR) Department for inclusion in the provider's file. At minimum, this documentation is reviewed during re-credentialing decisions.
 - b. The Medical Director may request Peer Review of the issue.
 - i. Depending on the severity of the issue this may require an adhoc meeting of the Committee.
 - ii. After review, the Quality Committee may elect to implement disciplinary actions for providers and/or reporting to professional disciplinary agencies.
 - iii. Alternatively, the Committee may request that the provider submit a corrective action plan.
 - iv. The PR Department facilitates the corrective action plan request and the QM Department tracks receipt of responses to these requests.

Oversight

- 1. A brief summary of incidents/concerns, the outcome of the investigations, and follow-up on facility requests for investigations and provider corrective action requests, is reported to the Quality Committee for discussion, clinical program follow-up and next steps to reduce future occurrences in the health care system if appropriate.
- 2. When related to a Member complaint, a summary of a particular incident/concern and the outcome of the investigation may be reported to the Quality Committee for discussion and programmatic follow-up relative to customer service and Member satisfaction.

Reporting

Section 25: Quality Management

The number and type of incidents and QOC concerns reported, and the outcome of the investigations, are aggregated and analyzed at minimum annually and presented to Quality Committee to aide in the identification of potential trends and to determine whether opportunities exist for system wide practice improvement.

Additional Quality Management Activities

VillageCareMAX quality management activities also include broader review and management of the Participating Provider network and key internal operations and processes. This includes periodic measurement and review of:

- Access and Availability
- Medical Records Documentation
- Utilization Review Processes and Appeals
- Service Utilization Rates
- Hospitalization and re-hospitalization rates
- Claims submission and audits
- Complaints (Grievances) and quality of care concerns
- Functional status and other clinical outcomes
- Satisfaction Surveys (rating of provider communication, provider customer service and perceived quality of care)

If deficiencies are identified, corrective measures or a performance improvement plan may be requested. VillageCareMAX will provide resources to assist (i.e., patient or provider education materials) where possible.

In addition, the QA Program will include:

- Seeking the input of Providers and medical professionals representing the composition of the Plan's Provider Network in developing functions and activities;
- Utilizing the Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS), and other measurement results in designing QI activities;
- Implementing a Medical Record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care.
- Measuring Participating Providers and Members, at least annually, regarding their satisfaction with the Plan.
- Measuring clinical reviewer consistency by applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;
- Including Members and their families in Quality Management activities, as evidenced by participation in Member Advisory Committee and Member Feedback Sessions; and

Section 25: Quality Management

• Collaborating with and as further directed by NYSDOH, develop a customized Medical Record review process to monitor the assessment for and provision of Community-based and Facility-based LTSS.

Clinical Practice Guidelines

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

VillageCareMAX adopts guidelines upon the recommendation and approval of the Internal Quality Review Committee. They are communicated to providers, including performance indicators chosen by the clinical Members of the Council, through the Provider Manual, annual mailings, newsletters and the VillageCareMAX web site. Performance against chosen indicators is measured annually – preventive guidelines are measured utilizing HEDIS/QARR measurement tools and clinical guidelines are measured using focused studies methodologies.

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

VillageCareMAX will also in the aggregate, without reference to individual Physicians or Member identifying information, report the following information to CMS and the New York State Department of Health on a quarterly basis or as requested by CMS and the New York State Department of Health:

• QI findings, conclusions, recommendations, actions taken, results or other documentation relative to QI

CMS and the New York State Department of Health, and in the case of Providers of Behavioral Health Services, OMH or OASAS as appropriate, shall be notified of any Participating Provider or First Tier, Downstream or Related Entity to the Medicare Advantage HMO Dual Eligible Special Needs Plan who ceases to be a Participating Provider or First Tier, Downstream, or Related Entity to the Plan for a quality of care issue.

VillageCareMAX has mechanisms in place to:

- Collect data for the measures specified in Appendix 5;
- Utilize results of the measures specified in Appendix 5 in designing QI initiatives.

Section 25: Quality Management

- On an ongoing basis, member surveys are conducted to determine member satisfaction and the member experience.
- Meet Quality Improvement Project Requirements including implementing the Quality Improvement Project Requirements, in a Culturally Competent manner.
- Develop a chronic care improvement program (CCIP) and establish criteria for participation in the CCIP. The CCIP will be relevant to and target the Plan's population.

Provider Reporting and Quality Measures

VillageCareMAX is required to report encounter data to New York State, CMS and other regulatory agencies, which lists the types and number of healthcare services Members receive. Accurate claims data is essential for encounter data submission, utilization reporting and for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.

The claims information you submit to us usually provides the encounter and claims data submitted monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, and that all claims include complete information about the member's diagnosis and services. MEDS is the standard by which the performance of VillageCareMAX, its providers and other managed care organizations is measured. To meet the state mandate, VillageCareMAX requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section above for the specific requirements when submitting claims or encounter data to CMS.

Including all of the applicable member diagnoses in the claims submission is essential for the plan to continuously work on improving members' services and experience and other quality improvement activities but also for accurately reporting members/ participating risk level. In addition to encounter data submission, VillageCareMAX expects its providers to comply with Core Quality Measures established by NCQA, NY SDOH, CMS for Medicare Advantage HMO Dual Eligible Special Needs Plans. Measures for reporting includes measures included in Appendix 5.

Section 26: Fraud Waste and Abuse

Fraud, Waste and Abuse Investigation

VillageCareMAX proactively investigates and resolves all complaints and other reports or findings that raise suspicion of fraud and/or abuse. Such cases and findings are reported to external regulatory and law enforcement agencies as required by law and contract. Members, Providers, employees or the public can report suspected fraudulent or abusive behavior by calling VillageCareMAX at 1-800-4MY-MAXCARE (1-800-469-6292) or writing to:

Compliance Officer VillageCareMAX 120 Broadway, Suite 2840 New York, NY 10271

Following the receipt of an issue which may indicate potential fraud and/or abuse VillageCareMAX will conduct a preliminary investigation to assess the nature and scope of the issue. Based upon the findings of the preliminary investigation, a plan for further investigation and/or resolution of the matter is established.

As necessary and appropriate, cases are reported to regulatory agencies, enforcement agencies and/or professional disciplinary agencies including the New York State Department of Health, the New York City Department of Health and Mental Hygiene, the New York State Office of the Medicaid Inspector General, the New York State Insurance Fraud Bureau, MEDIC, and the New York State Medicaid Fraud Control Unit.

For more information on Fraud, Waste & Abuse, please visit our website at www.villagecaremax.org/fraud-waste-abuse/. A Fraud, Waste and Abuse training module is available on the VillageCareMAX website at https://www.villagecaremax.org/provider-compliance/.

First Tier, Downstream and related entities who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste and abuse.

Section 27: False Claims Act

Scope of the False Claims Act

The False Claims Act (the "FCA") is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term "knowingly" means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include "treble damages" (damages equal to three times the amount of the false claims) and civil penalties of up to \$11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

Potential FCA Violations

Knowingly submitting claims to VillageCareMAX, for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Knowingly billing for services that were not furnished and/or supplies not provided, including billing VillageCareMAX for appointments that the Member failed to keep;
- Submitting a claim for authorized not actual hours of personal care provided;
- Submitting a claim for Durable Medical Equipment or Supplies when delivery was refused by the Member;
- Submitting a claim for two (2) man transportation, as authorized, but providing only one (1) man; or
- Submitting a claim for a service not provided.

The FCA's Qui Tam Provisions

The FCA contains a qui tam, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

Section 27: False Claims Act

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. VillageCareMAX False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws which also apply to the submission of false claims and the making of false statements:

- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.
- Article 176 of the Penal Law makes it a misdemeanor to commit a "fraudulent insurance act," which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds one thousand dollars (\$1,000) the crime is punishable as a felony.
- Article 177 of the Penal Law makes it a misdemeanor to engage in "health care fraud," which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds three thousand dollars (\$3,000) the crime is punishable as a felony.

Annual Compliance Training Requirement

CMS requires that all employees who provide services on behalf of VillageCareMAX's Medicare or Medicaid plans, complete the Compliance and Fraud Waste & Abuse within 90 days of hire and annually thereafter. A record of all employees and contractors receipt of the policies, Standards of Conduct, and information must be maintained for a period of ten years and can be provided upon request.

*Note: Medicare has developed training to meet the annual training requirements. This training can be found on the Medicare Learning Network Provider (MLN) Compliance page as follows: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

You can find additional information regarding this requirement on our website at:

http://villagecaremax.org/provider-compliance/

Home Care Worker Wage Parity Law

This law establishes a minimum wage requirement for home care aides who perform Medicaid reimbursed work (including partial payment for dual-eligible Medicaid and Medicare plans) for certified home health agencies (CHHAs), long-term home health care programs (LTHHCPs), licensed home care service agencies (LHCSAs), limited licensed home care service agencies (LLHCSAs) and other organizations that employ home care aides in New York City or in Nassau, Suffolk or Westchester County. This law is in effect in New York City for services provided on or after March 1, 2012, and in Nassau, Suffolk and Westchester counties for services provided on or after March 1, 2013.

If your organization is a contracted entity providing home care services for VillageCareMAX Medicaid or Managed Long Term Care (MLTC) members, you are required to provide VillageCareMAX with quarterly written certification of your organization's compliance with the minimum wage requirements of the Home Care Worker Wage Parity — Public Health Law of §3614-c. This certification must also be sent to the New York State Department of Health (NYSDOH) annually.

You can find additional information regarding this requirement at the following location:

https://www.health.nv.gov/health care/medicaid/redesign/mrt 61.htm

Submitting Your Certifications to VillageCareMAX

Quarterly certifications are due to VillageCareMAX on March 1, June 1, September 1 and December 1 of each year. Annual certifications are due to the NYSDOH by March 1 of each year.

Please email the certification to VillageCareMAX's Provider Relations department at providerrelations@villagecare.org

Additional Wage Parity Information

For additional information about the Home Care Worker Wage Parity provision and its implementation, please send an email to homecare@health.state.ny.us with "Home Care Worker Parity" in the subject line.

Maintenance of Records Requirement

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (https://www.gpo.gov/fdsys/pkg/CFR-2006-title42-vol3/pdf/CFR-2006-title42-vol3-sec422-504.pdf) on the Internet.

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly. Documentation of Care Management activities is performed primarily in our online computer systems, using specific software designed to facilitate clinical management and decision making. These online records reflect all review findings and actions taken during prior approval and concurrent management processes.

All providers must maintain records of compliance for at least 10 years. These records must be made available to the CMS/NYSDOH/OMIG upon request. If you have any questions about complying with this request, please contact your VillageCareMAX provider representative. Providers and subcontractors will ensure that pertinent contracts, books, documents, papers and records of their operations are available to the Department, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State

Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.

The provider or subcontractor shall provide the New York State Office of the Attorney General, the Department, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider's subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Contractor performance under the Agreement for the purposes of audit, inspection, evaluation and copying. The provider shall give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules, or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider.

Appendices

Appendix 1: VillageCareMAX Lead Form

Appendix 2: Sample Authorization Letter

Appendix 3: Electronic Funds Transfer Form for Providers

Appendix 4: Service Authorization Request Form

Appendix 5: Quality Improvement Program

Appendix 6: Clinical Practice Guidelines

Appendix 7: LHCSA Operational Guidelines

Appendix 8: Provider Information Change Form

Appendix 9: Important Information: CMS -10611 Form - Medicare Outpatient Observation Notice (MOON)

Appendix 10: DME Services that do not require Prior Authorization

Appendix 11: NYS DOH universal billing codes for home care and adult day health care services

Appendix 12: 2019 Medicare Part D Opioid Policies

Appendix 13: Update: NYS Medicaid Program Dental Policy and Procedure Code Manual

Appendix 14: Member Correspondence Grid

Appendix 15: VillageCareMAX Special Needs Plan Model of Care Training

<u>Appendix 16: VillageCareMAX Medicare Health Advantage and Medicare Total Advantage Specialist Services that do not require Prior Authorization</u>

Appendix 17: Participating Provider Termination Form

Appendix 18: VillageCareMAX Culturally and Linguistically Appropriate Services ("CLAS") Training Attestation

Appendix 1: VillageCareMAX Lead Form



SEE WHAT'S POSSIBLE WHEN HEALTH CARE **GETS PERSONAL.**

Lead Form

Beneficiary Name:		
Telephone:		
Address:		
City:	_ State:	Zip:
By signing below, I give permission to be contact Medicare Advantage Special Needs Plans (SNP) and Medicaid.		
My permission to be contacted is valid from the date of opportunity only. I understand that a VillageCareMAX A		
Beneficiary Signature:		Date:
I heard about VillageCareMAX Medicare Advanta	age Plan from:	
☐ Print or Radio Ad ☐ Direct Mail/ Poster of	or Flier 🗖 Doctor	☐ Friend or Family
☐ Community or Special Event Other (plea	ase specify)	
FOR OFFICE USE ONLY – DO	NOT WRITE IN 1	THIS SECTION
Agent's Name:	Event: _	
VillageCareMAX is an HMO plan with Medicare and New Yordepends on contract renewal. VillageCareMAX complies with Federal civil rights laws and of race, color, national origin, age, disability, or sex. ATENCIOI asistencia lingüística. Llame al 1-800-469-6292 (TTY:711). 注意: 如果您使用繁體中文,您可以免費獲得語言援助服	does not exclude pe N: si habla español, t	ople or treat them differently because tiene a su español servicios gratuitos de

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Appendix 2: Sample Authorization Letter

Medicaid #: VCM Member #: DOB: Member Phone #:

BROOKLYN. NY 11235

Dear

This letter is to confirm authorization of your request for services to the provider listed below:

Provider:

Authorization Number: Preliminary Diagnosis:

Place of Service: Type of Service: Procedure Code:

Quantity:

Authorization Valid From: Additional Information:

If you have any questions regarding this authorization, please call VillageCareMAX at 1-800-4MY-MAXCARE (1-800-469-6292), 7 days a week, 8:00 am to 8:00 pm, and reference the authorization number indicated above. If you have a hearing or speech impairment, please call us at TTY/TDD 1-800-662-1220.

Please be advised that any additional services beyond those authorized above are subject to review and re-authorization by VillageCareMAX. Authorizations may be obtained by contacting your VillageCareMAX Care Manager at 1-800-4MY-MAXCARE (1-800-469-6292).

This authorization is only valid for health plan Members who are Members of VillageCareMAX on the day services are rendered. This letter is not a guarantee of payment. Payment for this service is subject to all terms, conditions, limitations, copayments/coinsurance and exclusions as outlined in your Member Handbook and in our Provider Contracts.

Sincerely, VillageCareMAX

Appendix 3: Electronic Funds Transfer and Electronic Remittance Advice Forms

EFT and ERA form links below; Instructions on following page:

VillageCareMAX Payer ID: 26545

Links to EFT/ERA Forms for:

- Professional Providers: https://www.changehealthcare.com/content/dam/changehealthcare/support/enrollment-forms/medical-hospital/ERA/26545ERAP.pdf
- Institutional Providers: https://www.changehealthcare.com/content/dam/changehealthcare/support/enrollment-forms/medical-hospital/ERA/26545ERAI.pdf

Electronic Funds Transfer (EFT) Enrollment Request

- Complete the Change Health Care enrollment forms
- On the form, check the EFT box ☑
- Once completed, Fax the form to **(631) 963-4935**
- You may also email the completed form to <u>EFT@ILSHEALTH.com</u>

EFT Inquiry/Status Update:

Please contact (855) 769-2500 or email EFT@ILSHEALTH.com

EFT Confirmation Process:

A confirmation is sent to the requestor via the email address on the form within 30 days
of receipt of the form, once EFT setup is complete.

Electronic Remittance Advice (ERA/835) Enrollment Request

- Complete the Change Health Care Enrollment forms
- On the form, check the ERA box ☑
- Fax the completed form to (615) 885-3713
- Or email the completed form to BatchEnrollment@ChangeHealthCare.com

ERA Inquiry/Status Update:

• Please contact (866) 924-4634 or email BatchEnrollment@ChangeHealthCare.com

ERA Confirmation Process:

• Change Health Care will send a confirmation email to the requestor within 7 business days, once ERA/835 setup is complete.

For all questions related to EFT or ERA, please contact the phone numbers listed above.

Electronic Funds Transfer (EFT) Form Instructions

The **Change EFT form** is straight forward. Only the **REQUIRED** fields are itemized below.

Payer Information

• This section is prepopulated on the form with the required VillageCareMAX details.

Vendor Information

- **Submitter ID** is the ID of the billing software being used to submit claims to Change.
- **Submitter Name** is the name of the billing software being used to submit claims to Change.

Provider Information (Required Fields)

- Tax ID
- NPI
- Name
- Address
- City
- State
- Zip
- Contact Name
- Contact Phone
- Contact Email

Confirmation Addresses

• Primary Email Address

ERA Receiver

• **Distribution Detail** is provided by the billing software being used to submit claims to Change.

Appendix 4: Service Authorization Request Form

VILLAGE CARE MAX

PRIOR AUTHORIZATION REQUEST FORM

Please use the fax numbers listed below for the submission of requests for prior authorizations.

Inpatient Admissions	212-402-4468	LTSS: SDC, Adult Day Care, Home delivered meals,	646-362-2004
SNF Admissions	978-967-8030	Home modifications, Auth changes or corrections.	
Personal Care Services	646-618-8997	Outpatient Services	978-367-1872
DME	718-517-2709	Part B	917-243-9997

	This standard form should be utilized to submit prior authorization request to VCMAX along with the			
The state of the s	necessary clinical documentation to support the request. Incomplete submissions will be returned			
unprocessed. If you have any questions, please call 800-469-6292. □Expedited Request: Please check if you believe a delay of service could seriously jeopardize the life or health				
			ously jeopardize the life or health	
of the member or ability to regain maximum	m function i	n serious jeopardy.		
MEMBER INFORMATION		First Manage		
Last Name	Last Name First Name			
Member ID		DOB		
PROVIDER INFORMATION				
Check One: You are the ☐Prescribing/Orde	ering 🗆	Referring		
Name	TAX ID		NPI#	
Provider Address				
Phone	Fax		Email	
Contact Person	Phone		Fax	
Check One: You are the ☐Requesting Prov	/ider	Servicing Provider		
Name	TAX ID		NPI#	
Provider Address				
Phone	Fax		Email	
Contact Person	Phone		Fax	
CLINICAL INFORMATION	30000 10000 110 110 110 110 110 110 110			
Member Symptoms and Duration				
Summary of Clinical Findings				
Order Description				
Medical Justification				
Diagnosis				
SERVICE TYPE REQUIRING AUTHORIZATION				
Place of Service				
Start Date of Service	Er	nd Date of Service		
Order Date	Quantity	Requested	Time Requested	
Ambulatory/Outpatient Services	b	patient Care	Outpatient Services	
□Surgery/Procedure	☐Acute Ir	patient Admission	□Physical Therapy	
☐Infusion or Oncology Medications	□Short Te	erm/Acute Rehab	☐Occupational Therapy	
	□Skilled N	Nursing Facility	□Speech Therapy	
Home Health Services	An	cillary Services	Durable Medical Equipment	
☐Home Health Please circle:	□Acupun	cture	□Prosthetic Device	
SN,PT,ST,MSW			☐Enteral Supplies	
□Hospice			□Incontinence Supplies	
□Infusion Therapy □M		☐Medical Supplies		
☐Respite Care			□Purchase □Rental	

Please attach clinical documentation to support the request. I.e. clinical notes, lab results, x-rays etc. Durable Medical Equipment requires a physician signed prescription and letter of medical necessity. V2:5/2/2022

VillageCareMAX

Appendix 5: Quality Improvement Program

PURPOSE

The VillageCareMAX Quality Improvement (QI) Program includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery to members. The program consists of designated structures, processes, and measures, used to assess, assure, and improve access to services and quality of care for all members. Its purpose is to continuously improve the quality, safety, and cost-effectiveness of care and service provided to members.

The QI program provides a framework for monitoring and evaluating critical aspects of care management, service delivery, and customer service. Measures for evaluating the effectiveness of care management, appropriateness of services, customer service and satisfaction, and operational efficiency will be implemented to assist VillageCareMAX in ensuring ongoing quality and continuous performance improvement.

This document describes the QI program. Quality Improvement is the responsibility of all VillageCareMAX staff, and it is an essential component of all the plan's activities. The Quality Improvement program is reviewed annually, and revised as appropriate. In addition, an annual quality improvement workplan, outlining specific projects and workstreams for the coming year is developed and approved by the VillageCareMAX Board of Directors, and monitored throughout the year.

The QI program and all material changes will be submitted to the New York State Department of Health for review and approval.

TARGET POPULATION:

VillageCareMAX is a not for profit health plan offering several plan options to residents of New York City. The plans offered by VillageCareMAX include:

• Medicaid Managed Long Term Care (MLTC) plan. The MLTC is a partially-capitated product for individuals with Medicaid, who

are nursing home eligible, and those with Medicare and Medicaid who wish to remain living in their homes and community and require long-term services and supports (LTSS). The MLTC offers members a benefit package that consists primarily of long term care services traditionally paid for by Medicaid Fee-For- Service. To enroll in the plan, individuals must be eligible for Medicaid and/or Medicare and Medicaid and be:

- o Age 18 or older;
- o A resident of Bronx, Brooklyn, Queens, Manhattan;
- o If Medicaid-only eligible for nursing home level of care (as of the time of enrollment) according to the Uniform Assessment System (UAS); and
- o Expected to need care management and long-term care services for more than 120 days from the date of enrollment.
- Medicare Advantage Dual Eligible Special Needs Plans. VillageCareMAX offers two Medicare Advantage Prescription Drug plans for dual eligible individuals. The plans are:
 - -- VillageCareMAX Medicare Health Advantage, for dual eligible individuals who reside in the service area of Bronx, Brooklyn, Queens, and Manhattan. This plan covers all Medicare Part A, Part B, and Part D services.
 - -- VillageCareMAX Medicare Total Advantage, for dual eligible individuals who are also nursing home eligible (based on the UAS assessment) and require LTSS for more than 120 days from the date of enrollment. This plan covers all Medicare Part A, Part B, and Part D services, as well as a range of Medicaid covered services including home and community-based long term care services and supports.

GOVERNANCE AND ACCOUNTABILITY

The Board:

VillageCareMAX's Board of Directors (Board), maintains ultimate accountability for oversight of the QI Program. The Board will review and approve the QI Program at least annually. The Board will receive reports on QI activities directly from VillageCareMAX's Medical Director on a regular basis, but no less than quarterly.

Medical Director:

The VillageCareMAX Medical Director will be responsible for overall supervision of the QI program and its implementation, and for ensuring that the QI program is evaluated, updated, and approved annually.

Assistant Vice President of Quality and Performance Improvement:

The Assistant Vice President will manage the QI Program and its implementation on a day-to-day basis, including ensuring that recommendations of the Quality Assurance Committee (described below) are implemented.

The Assistant Vice President will supervise the staff that conducts quality audits and studies, and will oversee Quality Improvement Projects (QIPs). In addition, the Assistant Vice President will be responsible for:

- Communicating the decisions of the QA Committee to the appropriate personnel in the VillageCareMAX organization;
- Overseeing the implementation of the performance improvement activities approved by the QA Committee;
- Collection and analysis of data necessary to determine the effectiveness of the performance improvement activity;
- Providing the QA Committee with information and analyses to assess the effectiveness of the implemented performance improvement activity;
- Reviewing performance and quality indicators, and the results of studies and audits, with the Medical Director;
- Ensuring that all quality subcommittees meet on a regular basis and accomplish their assigned tasks; and
- Overseeing the Quality Improvement Committee described later in this document.

The Quality Management and Improvement Committee (QMIC):

The Board will appoint a Quality Management and Improvement Committee (Committee) that is responsible for developing the QI Program. The Committee will be made up of the Medical Director, key plan management staff, Compliance Officer, staff from the Quality Assurance (QA) department and key operations areas, and provider representatives. The Committee is led by the Medical Director, in coordination with the Assistant Vice President for Quality and Performance Improvement. Meetings will be held quarterly, and minutes of these meeting will be documented and shared with the Board. Attendance sheets for each Committee meeting will also be maintained.

The Committee will develop and oversee the implementation of the QI program. It will approve the quality goals for the year, and will determine which studies and audits will be conducted. The Committee will review quality and performance indicators, oversee clinical policy and procedure

development, review the results of quality studies and audits, and make recommendations to improve quality of services and operations based on the information it reviews. This may include revisions to policy or procedures, changes in service delivery, or the formulation of workgroups to look at issues in more depth.

The results of studies and audits, and quality/performance indicators, will be presented to the Committee by the Assistant Vice President or his/her designee, including leaders of operations departments of the health plan. Other VillageCareMAX staff, including Case Management and Provider Relations, will make reports to the Committee on quality related issues identified as the result of day-to-day operations. Workgroups will be assigned to study quality related issues and will also make reports to the Committee, as will representatives of member focus groups which will be formulated to address improved services to members.

In addition to the above, the Committee will review the reports from quality subcommittees (outlined below), and will report a summary of all meetings to the Board of Directors.

Other Quality Improvement Sub-Committees <u>Internal Quality Review Committee (IQRC):</u>

Led by the Assistant Vice President, the Internal Quality Review Committee is a working committee responsible for collecting, analyzing, and integrating data reported to the QMIC. The membership will include but is not limited to Quality Assurance department staff and other VillageCareMAX staff, as needed. The IQRC Committee meets a minimum of eight times per year and ad hoc as needed. Meeting minutes are taken and maintained.

The IQRC Committee:

- Identifies areas of needed quality improvement through analysis of quality indicators, results of quality studies and audits;
- Develops, analyzes, trends, and monitors quality indicators;
- Analyzes the results of Member Satisfaction Surveys and clinical quality improvement programs/ studies/ audits, disenrollment trends, and quality indicators;
- Monitors and evaluates service utilization and appropriateness of care.
- Targets interventions, monitors process improvements, and establishes tracking mechanisms;
- Evaluates the effectiveness of communication to providers and Members;
- Evaluates complaints and appeal data;
- Provides in-depth analysis together with plans of action to affect improvement; and

• Reports findings of all activities to the QMIC.

Utilization Management Committee:

The Utilization Management Committee is chaired by the Medical Director and includes leadership staff from clinical and business operations, pharmacist, claims staff, data analysts, finance staff, and others as needed. The Utilization Management Committee reviews claims and other data related to service utilization in order to understand patterns of service use, and ensure that appropriate care is provided to the enrolled members. The Committee develops strategies to address over-utilization, under-utilization, high cost members and providers, and other opportunities to better manage care.

Credentialing Committee:

The Credentialing Committee reviews the qualifications of all providers (individuals and companies) that have applied to be included in the VillageCareMAX provider network. In addition to new providers, the committee reviews credentials of all current providers every three years, and it reviews providers that have identified issues or sanctions for potential removal from the provider network. The Committee is led by the Credentialing Manager, and includes the Medical Director, Director of Provider Relations, and other department leaders in VillageCareMAX.

Model of Care Committee:

The Model of Care Committee meets quarterly to review outcomes and care management processes for the VillageCareMAX Medicare Advantage plan. As a special needs plan, VillageCareMAX is required to submit its model of care to CMS for approval, and this committee monitors the implementation and results of the approved model of care. The Committee is chaired by the Assistant Vice President for Quality and Performance Improvement, and includes the Medical Director, Assistant Vice President of Clinical Operations, and other department leaders in VillageCareMAX.

Member Experience Workgroup:

The Member Experience Workgroup is charged with analyzing and improving the ability of members to have high quality interactions with VillageCareMAX. This Committee is chaired by the Vice President for Member Experience and Support Services, and includes Board member and a range of staff from all departments and all levels of the organization, including staff who interact directly with

members on a daily basis in their jobs at VillageCareMAX. The Committee monitors member level data, conducts surveys, and implements strategies to improve members' experiences with the health plan and member retention.

Member Advisory Committees:

VillageCareMAX will implement one or more Member Advisory Committees, to ensure that enrolled members have input into the policies and practices of VillageCareMAX. The Committees are led by the Manager of Member Services and are comprised of VillageCareMAX members and key VillageCareMAX staff, including the Assistant Vice President of QA and other QA staff. The Member Advisory Committee(s) will provide information on matters of concern to members, including those related to quality of care, access to services, and customer service. The Assistant Vice President will report to the QMIC Committee on activities and feedback from the Member Advisory Committee, and reports from this Committee will also be presented to the Board of Directors. Issues identified will be incorporated into the quality improvement activities of the Plan.

Policy Committee:

The purpose of the VillageCareMAX Policy Committee (VPC) is to guide good practices in policy governance and ensure collaboration and consistency in VillageCareMAX policy development. The VPC will be the collaborative body with the authority to review, and recommend new and significant changes to existing VillageCareMAX policy to the Policy and Procedures Committee and Compliance Officer for final adoption. The Committee is chaired by the Project Coordinator, and includes the AVP of Government Affairs/Compliance Officer and other department leaders in VillageCareMAX.

COMPONENTS OF THE QUALITY ASSURANCE PROGRAM

Quality Improvement Activities

To ensure ongoing quality improvement of services, care, and operations, VillageCareMAX will have ongoing quality improvement activities in place. Below is a description of the planned quality improvement activities:

Health Outcomes and Quality Measures

QA staff will collect and monitor quality indicators that are objective and measurable and that are related to the entire range of services provided by the plan. QA staff will analyze evidence based health outcome measures and will analyze functional status outcome measures at a member specific level, using information derived from claims and data maintained in the Case Management System.

QA staff will review all grievances and evaluate the impact on the member. QA staff will work with Care Management staff to develop and implement the appropriate intervention for the member, and they will monitor the implementation and outcome, modifying interventions as necessary based on patterns and trends that are observed. QA staff will similarly focus on identifying patterns, trends, and opportunities for improvement based on data collected on reported falls, hospitalizations, and other quality of care issues. Interventions are designed to continuously improve health outcomes.

On a monthly basis, QA staff will compile a Health Outcomes and Quality Measures dashboard which is presented to the IQRC for review. The dashboard will include a range of measures that are reported externally, measures that are monitored in the conduct of quality improvement projects, member services metrics, and the results of clinical audits which focus on implementation of the care plan, care coordination, and quality and appropriateness of care. The QMIC and IQRC (as well as other quality subcommittees) will analyze the reported data, discuss individual interventions, and work with VillageCareMAX staff and providers to implement immediate systemic measures to ensure that member health outcomes and quality of care is maximized.

Access to Care and Services

The adequacy of the provider network will be evaluated on an ongoing basis to ensure that members have access to the care they need. To evaluate adequacy of the provider network, QA staff will conduct a quarterly analysis of complaints filed by members and/or their representatives to identify deficiencies in the provider network. In addition, QA staff will assess compliance with access standards including the length of time to respond to requests for service placement from the plan and the timeliness of receipt of covered services.

The aforementioned information will be reviewed by the QMIC and Credentialing Committee. If the analysis indicates issues with accessing specific providers or services, QA staff will work with the Director of Provider Relations to develop and implement a corrective action plan. This may include adding providers to the network, or working with individual providers to improve their performance. Performance data reported to Provider Relations will be considered during the re-credentialing process.

Member Satisfaction

The QA department will conduct an annual member satisfaction survey. The purpose of the survey will be to measure satisfaction with the health plan and to identify opportunities for improvement. The topics covered by the survey will include satisfaction with Plan Services, Utilization Management, Customer Service, Care Managers, and Provider Relations.

Quality Improvement Projects

VillageCareMAX is committed to improving the quality of the services delivered to both internal and external customers. To this end, the organization will develop and implement projects designed to increase the plan's ability to improve clinical outcomes, and have productive and satisfying interactions with members and providers. Each year the plan will select one or more clinical area as its focus for improvement project(s). The QMIC Committee will identify these activities through analysis of complaints and appeals, Member satisfaction surveys, provider satisfaction surveys and key business indicators. As required by State and Federal regulation, Quality Improvement Projects may be approved in advance and may include period reporting to regulatory authorities.

Complaints

All complaints, including quality of care complaints, will be recorded in the Care Management System, monitored, tracked and analyzed. A summary by complaint type will be reported to the QMIC Committee. Where issues are identified, the QMIC Committee and other quality sub-committees will develop strategies to improve performance in the area(s) with a high complaint rate. This may include the formulation of workgroups to look at specific issues, modifications to the provider network, and changes to business practices.

Ensuring Appropriateness of Care

VilllageCareMAX will perform various quality improvement activities to evaluate the quality and appropriateness of care. The QA department will conduct audits of the clinical information maintained in the HMA System to ensure that Care Managers implement the plan of care and document, provide and/ or arrange for the appropriate interventions to address identified health risks. The results of these audits will be shared with Care Management staff. Where deficiencies are noted, QA staff will develop strategies to improve performance. This may include re-educating/training staff.

Patient Safety

Patient safety activities will be conducted by the QA Department and will be reported at the QA Committee meeting. Some of these activities will include identifying, addressing, then tracking and trending of clinical and service complaints to determine rates of patient safety complaints.

Delegation Oversight of Vendors

VillageCareMAX will conduct annual reviews of delegated vendors to evaluate and monitor care provided to members by delegated vendors. Reviews will include, as applicable, customer service, utilization, quality of care, timeliness and appropriateness of notices to members, and compliance with access standards. Delegation oversight of vendors will be conducted by the Delegated Oversight Manager.

REPORTING TO THE STATE

VillageCareMAX will submit periodic reports to the New York State Department of Health in a data format and according to a time schedule required by the Department of Health.

Reports may include but are not limited to information on: availability; accessibility and acceptability of services; enrollment; member demographics; disenrollment; member health and functional status including the Uniform Assessment System (UAS) data set; service utilization; encounter data; member satisfaction; marketing; grievance and appeals; and other data determined by the Department of Health.

IMPLEMENTATION AND ANNUAL REVIEW OF THE QIPROGRAM

The QI Program will be evaluated on an annual basis. Using data maintained in the Care Management System, as well as from other sources, QA staff will prepare the monthly Health Outcomes and Quality Measures dashboard. This data will be reviewed and analyzed by the QMIC and IQRC, which identifies trends, issues, and areas for improvement. Based on the information presented, the QMIC and IQRC Committees will develop strategies to improve performance. These strategies will be implemented by Case Management and operations staff as required, with QA staff providing oversight.

On an annual basis, the QA Committee will review quality performance for the year, will recommend changes to the QI Program based on performance indicators and other studies, and will set QI priorities for the year. The Assistant Vice President for Quality and Performance

Improvement, working with the plan's Medical Director, will revise the QI Program accordingly. The annual plan will be submitted to the Board for approval.

On an annual basis, the Medical Director will provide the Board with a formal evaluation of the QI Program and associated activities. The report will provide the Board with detailed information on studies and internal quality improvement activities.

Appendix 6: Clinical Practice Guidelines

Clinical Practice Guidelines



Clinical Practice Guidelines

Conditions	Clinical Practice Guidelines	Source
		Respiratory
Asthma	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma: August 28, 2007	Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/guidelines/01 front.pdf
Chronic Obstructive Pulmonary	*COPD Essentials for Health Professionals	National Heart, Lung and Blood Institute/National Institutes of Health

Conditions	Clinical Practice Guidelines	Source
Disease	NIH Publication No.	http://www.healthywomen.org/condition/chronic-obstructive-pulmonary-disease-
(COPD)	07-5845	<u>copd</u>
	Reprinted October	
	2011	
	2011	
Treating	Treating Tobacco Use	Treating Tobacco Use and Dependence: 2008 Update
Tobacco	and Dependence	http://www.ahrq.gov/professionals/clinicians-providers/guidelines-
Use &	2008 Update	recommendations/tobacco/clinicians/update/treating tobacco use08.pdf
Dependence		
'		
		Cardiovascular
Chronic Stable	American College of	American Medical Association
Coronary	Cardiology Foundation	http://www.circ.ahajournals.org/content/125/19/2382.full.pdf
Artery	(ACCF)	nttp://www.circ.anajournais.org/content/125/19/2362.tuii.pui
	American Heart	
Disease	Association (AHA)	
	Physician Consortium	
	for Performance	
	Improvement®	
	(PCPI™) ACCF, AHA,	
	PCPI Approved	
	January 2011	

Conditions	Clinical Practice Guidelines	Source
Congestive Heart Failure (CHF)	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adult	American College of Cardiology http://circ.ahajournals.org/content/119/14/e391.full.pdf
Coronary Heart Disease (CHD)	AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update: Endorsed by the National Heart, Lung, and Blood Institute	American Heart Association http://circ.ahajournals.org/content/113/19/2363.full.pdf+html
Hyperlipidemia	Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection,	National Heart, Lung and Blood Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/resources/heart/atp3full.pdf

Conditions	Clinical Practice Guidelines	Source		
Hypertension	Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) – 2004 National High Blood Pressure Education Program – The Seventh Report of the Joint National Committee on Prevention Detection, Evaluation, and Treatment of High Blood Pressure – 2004	National Heart, Lung and Blood Institute/National Institutes of Health http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf		
	Endocrine			
Diabetes	Standards of Medical Care in Diabetes - 2011	American Diabetes Association http://care.diabetesjournals.org/content/34/Supplement_1/S11.long Mental Health		
	Mental Health			

Conditions	Clinical Practice Guidelines	Source
Depression	Treatment of Patients with Major Depressive Disorder, Third - Edition May 2010	American Psychiatric Association http://psychiatryonline.org/data/Books/prac/PG_Depression3rdEd.pdf
Psychiatric Disorders	American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders	American Psychiatric Association Practice Guidelines http://www.psychiatry.org/practice/clinical-practice-guidelines
		Preventive and Screening Guidelines
Preventive	Guide to Clinical	http://www.ahrq.gov/professionals/clinicians-providers/guidelines-
Screening	Preventive Services,	recommendations/guide/cpsguide.pdf
Guidelines	2014, Recommendations of the U.S. Preventive Services Task Force	
Eye	Recommended Eye	American Optometric Association
Examinations	Examination Frequency for Adult Patients and	http://www.aoa.org/documents/CPG-1.pdf

Conditions	Clinical Practice Guidelines	Source
	Comprehensive Adult Eye and Vision Examination: Revised April 2005 (2nd edition)	
		Sexually Transmitted Diseases
STD	Guidelines for Treatment of Sexually Transmitted Diseases: December 2010 *New York City STD Treatment Guidelines Table for Adults and Adolescents; updated 2011	Centers For Disease Control and Prevention http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf New York City Department of Health & Mental Hygiene http://www.nyc.gov/html/doh/downloads/pdf/std/treat-gl-table.pdf
HIV	Primary Care Approach To The HIV- Infected Patient;	New York State Department of Health AIDS Institute

Conditions	Clinical Practice Guidelines	Source	
	updated April 2011 *New York City STD Treatment Guidelines Table for Adults & Adolescents, updated 2011	http://www.hivguidelines.org/wp-content/uploads/2014/01/primary-care-approach-to-the-hiv-infected-patient.pdf New York City Department of Health & Mental Hygiene http://www.nyc.gov/html/doh/downloads/pdf/std/treat-gl-table.pdf	
		Low Back Pain	
Low Back Pain	Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society; October 2007	American College of Physicians http://www.aafp.org/afp/2008/0601/p1607.html	
	Osteoporosis		

Conditions	Clinical Practice Guidelines	Source
Osteoporosis	Osteoporosis, diagnosis and treatment of: July 2013, 8th Edition	Institute for Clinical System Improvement Diagnosis and Treatment of Osteoporosis
		Urinary Incontinence
Urinary Incontinence	Diagnosis and Treatment of Overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline. 2014 by the American Urological Association	American Urological Association – Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline Agency for Health Care Policy and Research - Urinary Incontinence in Adults: Clinical Practice Guideline Update
		Obesity & Weight Management
Obesity	2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American	American Heart Association http://jaccjacc.cardiosource.com/acc_documents/2013_FULL_Guideline_Obesity.pdf

Conditions	Clinical Practice Guidelines	Source
	College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society	

Appendix 7: LHCSA Operational Guidelines



VillageCareMAX

LHCSA OPERATIONAL GUIDELINES

Introduction:

At VillageCareMAX, we want to work collaboratively with our LHCSA partners to be sure our Members get the best care at all times. As the MLTC plan responsible for coordinating each Member's care, we realize this requires consistent ongoing communication. We sometimes deal with challenging situations; by working together, we can meet our Member's needs and keep them satisfied with the program, safe in the community. The goal of this booklet is to outline a framework for how we will work together to ensure that our Members receive the highest quality care. In general:

- All services based on the LHCSA's plan of care. The types of services provided is based on a comprehensive assessment, which includes an evaluation of personal care tasks that the Member needs assistance with. It is important to keep the plan of care updated so it matches the Member's health care needs.
- The LHCSA will receive an authorization from VillageCareMAX, outlining the days of coverage and number of hours to be covered.
- Each LHCSA is expected to maintain all required documentation, consistent with its regulations and best practices. This includes for each Member, but is not limited to:

- Assessment
- o Plan of care
- o Physician orders
- Evidence of PCA/HHA supervision
- O Duty sheets outlining the work that is performed. (Note: for split shift cases, each PCA/HHA must keep a duty sheet.)
- o Human resources records, consistent with DOH regulation.
- All communication with the Case Manager, Care Coordinator, Member, family Members, aides, and anyone else involved in providing care for the VillageCareMAX Members must be carefully documented -- who did you speak to, at what time and date, what was communicated, what are the follow-up tasks, etc. Each person creating the documentation must sign, initial, date the entry.
- If you have questions at any time, please feel free to call us. Our staff are in the office from 8:30 to 6:00 p.m. Monday through Friday, and staff are on call at all times when the office is closed. Please contact us:

By Phone: 800-469-6292By Fax: 212-337-5711

o By EMAIL: faxgroup@villagecare.org

- Effective March 1, 2019, authorizations will no longer be required for the following:
 - Schedule changes of one of two days. Adjustment requests (i.e. change in days (Mon to Tues/Wed to Thurs) and change in Aide are no longer required.
 - o Notification of no service to the member
 - Notification of vacations
 - o If the member is hospitalized, the current LTSS authorization will **NOT** be end-dated
 - VillageCareMAX will no longer send cancellation of services for disenrolled members. We encourage providers to verify eligibility via ePaces to ensure continuity of care or disenrollment status

Provider Requirements:

- As a reminder, providers are required to notify VillageCareMAX with no expectation to receive a corrected authorization when:
- Member is hospitalized
- There is identification of a clinical issue of serious concern
- Change in member status
- Member is out of service area
- Refusal of service
- Inability to access members home
- Inability to provide service for any reason

Providers are also required to:

- Communicate verbally and in writing regarding the nature and extent of services provided to the member and the member's progress and status.
- Submit incident reports to VillageCareMAX within 10 working days of request
- Communicate to VillageCareMAX any complaint made by or on behalf of the member

For any questions related to authorization inquiries and claims issues, please contact Provider Services at (855) 769-2500.

	Торіс	LHCSA Guidelines	Contact
1.	Member Information Changes	Licensed agency should contact Member Services for each of the following related changes. We will update our records. • Permanent change in the Member's address • Change in the Member's telephone number	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org
2.	Schedule Changes	 Temporary changes in time of day of service or temporary changes in scheduled service days: Licensed agency should notify the Member of the change at least one day in advance, by 3:00 p.m. Licensed agency to notify Member Services of all temporary changes one day in advance. Licensed agency should update their system as appropriate. Permanent changes in time of day of service or permanent changes in scheduled service days: If a Member requests a permanent change in service (either a change in time of day or a change in scheduled days), the licensed agency must notify the Member at least one day in advance of when the change will be implemented. Licensed agency to notify Member Services of all temporary changes one day in advance. Licensed agency should update their system as appropriate. 	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By PHONE 800-469-6292

	Торіс	LHCSA Guidelines	Contact
		 If the Member requests an increase of decrease in services: Licensed agency should inform the Member that requests need to be approved by VillageCareMAX. Licensed agency should contact Member Services to inform us of the request, but VillageCareMAX must also receive the request from the Member. The Care Manager will be contacted and will follow up. 	
3.	Changes in Clinical Condition and Plan of Care	 The paraprofessional should report any changes in the Member's clinical condition or issues/problems in following the Plan of Care directly to his/her agency that will, in turn, report to VillageCareMAX Member Services immediately. Examples of situations that should be reported include but are not limited to: changes in skin integrity, such as blisters, skin tears, bruising or development of decubitus ulcers falls changes in mental status changes in Member's intake, such as Member refusing food or liquids any emergency situations (see below) In an emergency: 	By PHONE 800-469-6292

	Topic	LHCSA Guidelines	Contact
		 In emergent situations observed by a home health aide or other paraprofessional in the home, in which no professional staff, family Member/significant other is available, the home health aide should immediately call the Supervisor at their employing agency who will either direct the person in the home to call 911 or will call 911 for them, based upon an evaluation of the situation. The HHA or paraprofessional in the home will be instructed to remain with the Member, provide appropriate care during that time which he/she is trained and competent to provide, protect the Member from harm and report back to the agency. When a Member is hospitalized before or during the paraprofessional's shift, the paraprofessional or the licensed agency coordinator must notify Member Services of this change in clinical status as soon as they are aware of the admission. In addition, the licensed agency coordinator must also report the hospitalization to discharge the service. (See Section 4 below for more information.) 	By PHONE 800-469-6292
4.	Member Hospitalized, Relocated Out Of Service Area	 Paraprofessional will notify licensed agency immediately. Licensed agency will notify Member Services immediately. Agency should provide as much 	By PHONE
	or Died	information as is available (e.g., the name of the hospital, time of transport to the hospital, if the Member was accompanied by someone, if the Member was admitted or in the Emergency Room, etc.)	800-469-6292

Topic	LHCSA Guidelines	Contact
	VillageCareMAX will provide instructions about suspending services and will update the authorization, as appropriate.	
5. Change of Aide	If the licensed agency must change the aide assigned to the Member, on a permanent or temporary basis: • The licensed agency must notify the Member in advance (if possible) whenever there is a new aide assigned to the Member. Notification should be made at least one day in advance, by 3:00 p.m. and must include the name of the aide who will be coming to the home. • The licensed agency must notify Member Services in advance (if possible) whenever there is a new aide assigned to the Member. Notification should be made at least one day in advance, by 3:00 p.m. If the Member requests a change in aide: • The licensed agency coordinator should honor a request for a permanent aide change only if the request comes from VillageCareMAX. If a Member requests for the permanent aide to be changed, the coordinator should refer the Member to Member Services or his/her Care Manager. If appropriate, the licensed agency can assist the Member in making this request. • If the request is to be granted, VillageCareMAX will provide approval to the Licensed Agency. The Member must be contacted at least one day in advance and	By FAX 800-469-6292 By FAX 800-469-6292

	Topic	LHCSA Guidelines	Contact
		provided with the name of the new aide and when he/she will start work in the home.	
6.	No Shows and Coverage Problems	As soon as the licensed agency becomes aware that an aide has not reported to a Member's home at the scheduled time: • The licensed agency must immediately contact the Member to discuss whether or not a replacement aide is needed. • If a replacement aide is needed, the licensed agency should send a replacement aide and notify the Member of the aide's name and approximate arrival time. • Licensed agency should notify the Member Services immediately of the decision and what time the aide should arrive at the Member's home if the Member is requesting a replacement aide. If VillageCareMAX care manager or Member Services is notified by the Member that an aide has not reported to a Member's home at the scheduled time, Member Services will follow up with the licensed agency immediately. The licensed agency should reach out to the Member (as outlined above) and report back to VillageCareMAX regarding the status of the aide coverage.	By PHONE 800-469-6292

	Topic	LHCSA Guidelines	Contact
7.	Member Request for No	The licensed agency will notify Member Services immediately	
	Service	of all requests for no coverage for one or more days.	By FAX or EMAIL
		• They should discuss any concerns for the Member's health or safety if there is no personal care coverage.	212-337-5711
		 If the licensed agency is concerned that honoring the request for no coverage may be inappropriate or dangerous to the Member, Member Services will discuss the concerns with the Member's care manager. VillageCareMAX will then review the situation and contact the licensed agency with instructions about the Member's services. If the licensed agency does not receive a response from VillageCareMAX by 3 p.m. the same day, we ask that you contact Member Services again for an update. NOTE: If the Member is requesting a permanent stop in 	faxgroup@villagecare.org
		service, please follow the guidelines in Section 8 below.	
8.	Member Refusing Service	A Member refusing service can be a serious concern, particularly if the Member is new/unknown to us or is potentially not stable. • Timely and appropriate follow-up on these situations is very critical. The Licensed Agency coordinate should contact Member Services and provide as much information as possible, regarding the reason the Member is refusing aide service.	By PHONE 800-469-6292
		VillageCareMAX will contact the Member to discuss his/her services, review the situation, and contact the licensed agency with instructions about the Member's services.	

	Торіс	LHCSA Guidelines	Contact
		If the licensed agency does not receive a response from VillageCareMAX by 3 p.m. the same day, we ask that you contact Member Services again for an update.	
9.	Service On Hold	Cases are never placed on hold.	
		• Please identify the reason for suspending services in the Member's home and follow the appropriate guidelines, as outlined in this booklet.	
10.	Unable to Locate Member	If the HHA is unable to locate the Member on the first day of	
		service:	By PHONE
		 The licensed agency should contact Member Services to verify the address. Member Services and/or the Member's Care Manager will attempt to determine the correct address and/or Member's location (e.g. Still in the hospital, staying 	800-469-6292
		 elsewhere temporarily, etc.) VillageCareMAX staff and the licensed agency will collaborate on whether service can be provided that day at another location and/or at a different time. 	
11.	Member Not Answering	Paraprofessional will notify his/her agency immediately to	
	Door or Phone	report that the Member is not answering the door or phone.	By PHONE
		 The licensed agency should ensure that the following factors were considered and checked: Was the Member telephoned? Did the aide knock on Member's door or ring buzzer? 	800-469-6292

	Topic	LHCSA Guidelines	Contact
		 Is the Member hard of hearing? Is it unusual for the Member not to be home; do they have a history of not being home when the aide arrives? Did the aide check with the building's super or neighbor? How long has the aide been trying to gain entry? When was the Member last visited by aide? After making all reasonable efforts to reach the Member and the aide is still not getting a response, the licensed agency should release the aide and immediately notify Member Services of the situation. VillageCareMAX staff will attempt to locate the Member. If possible, the licensed agency should also try calling the Member's home throughout the course of the day to see if someone is home who knows the Member's whereabouts. Any new information should be relayed to Member Services as soon as it is received. Member Services will update licensed agency with next day instructions by 3pm. Unless it is confirmed that the Member is not going to be home, the licensed agency should send the aide again the next day. 	
12.	Hospital Pick-up Delay	Hospital pick-ups are arranged and authorized on a case-by-case	
		basis.	By FAX or EMAIL, in
		• In most cases, this is the responsibility of the family/ caregiver.	most circumstances
		If authorized, and then discharge is delayed, the aide informs agency of hospital pick-up delay.	212-337-5711

	Topic	LHCSA Guidelines	Contact
		 Licensed agency either approves overtime or travel time if necessary and or adjusts the aide's schedule as needed. Up to four hours of overtime can be approved by the licensed agency; any additional overtime must be approved by VillageCareMAX. NOTE: LHCSA must inform VillageCareMAX about each overtime occurrence, so that the service authorization can be updated. The claims for overtime services cannot be paid without an up-to-date authorization. 	faxgroup@villagecare.org By PHONE, if more than four hours of overtime is requested 800-469-6292
13.	Escorting Member	 Escorting/Accompanying the Member (General): The Licensed agency coordinator will determine whether or not escorting is permissible on a case-by-case basis, based on the authorization received from VillageCareMAX. If not already authorized and escorting is requested by the Member, the licensed agency must contact Member Services to discuss and obtain authorization. If escorting is indicated on the authorization for services, the licensed agency may authorize the paraprofessional to accompany the Member, up to four hours per appointment. Member Services must be notified when this occurs, so that an updated authorization can be issued. Any overtime in excess of four hours must be approved in advance by VillageCareMAX; the licensed agency must call Member Services to request authorization. 	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By PHONE

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Topic	LHCSA Guidelines	Contact
	VillageCareMAX monitors overtime. We will encourage Members to make appointments at times when the aide will be present, so overtime can be kept at a minimum.	800-469-6292
	Escorting/Accompanying the Member to the Emergency	
	Room	
	 VillageCareMAX does not routinely authorize service for the aide to accompany a Member who is being transported by ambulance to the emergency room. If requested, the licensed agency must contact Member Services immediately to discuss and obtain authorization. The aide must stay with the Member until EMS has arrived and transported the Member from the home. The aide should provide all available information to the EMS workers, including the Member's health status and the Member's emergency contact(s). The aide must immediately report a change in the Member's clinical status directly to the licensed agency. The licensed agency must contact: (1) the Member's family/caregiver, and (2) Member Services. If the Member is admitted, VillageCareMAX will contact the licensed agency to suspend services for the time that the Member is hospitalized. Upon discharge, VillageCareMAX will contact the licensed agency at least one day in advance, in order to 	

	Topic	LHCSA Guidelines	Contact
14.	Incidents and Unsafe Situations including: • Verbal or physical abuse of the paraprofessional or Member • Threats to the aide/Member's safety in the home	resume services. Any changes to service authorizations will be forwarded to the licensed agency at this time. Paraprofessional should report occurrence of any incident or unsafe situation to his/her licensed agency immediately. • Licensed Agency will ensure that a manager is informed and involved immediately. VillageCareMAX Member Services should be notified as soon as the agency becomes aware of the incident. • Depending on the situation, the licensed agency manager will: • Call 911 if necessary, depending on	By PHONE 800-469-6292
	 by the aide, Member, or family Motor Vehicle Accidents (while being transported by 		

	Topic	LHCSA Guidelines	Contact
	VillageCareMAX transportation services)		
15.	Allegations of Theft	 The Member or family/caregiver may report allegations of theft to the licensed agency or directly to VillageCareMAX. If the report is made to the licensed agency, the agency must ensure that a manager is informed and involved immediately. VillageCareMAX Member Services should be notified as soon as the agency becomes aware. (If the report is made to VillageCareMAX, our staff will notify the licensed agency as soon as we become aware.) The Member or family /caregiver should be encouraged to follow up with the police. Whenever allegations of theft are made, the agency must investigate and provide VillageCareMAX with a report of the outcome of its review. Follow-up in these circumstances will be closely coordinated and handled on a case-by-case basis. If a request is made for a change in aide, this request will be approved. 	By PHONE 800-469-6292
16.	Requests for Overtime and Travel Time	 Requests for overtime are approved if necessary to accompany the Member to an appointment, or if the Member has an issue that requires overtime by the aide in order to maintain the Member's health or safety. The licensed agency should follow the guidelines outlined in Section 13 above. 	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711

	Topic	LHCSA Guidelines	Contact
			faxgroup@villagecare.org
17.	HHA Access to Member's Phone (Call-In System)	 Every aide must have access to the Member's telephone on a daily basis, in order to report his/her time of arrival and departure at the Member's home. If the Member or the Member's family refuses to allow an aide access to the phone, the aide must immediately contact their respective licensed agency. The licensed agency coordinator will instruct aide to stay with Member and provide coverage as usual. The licensed agency coordinator will contact Member Services, and VillageCareMAX staff will follow-up with Member or family/ caregiver about allowing the aide access to the phone and inform the CM that a resolution will be needed before the end of the aide's shift. Until the issue is resolved, the coordinator should register the aide's presence through the Call-In System, or by following the licensed agency's alternative policies and procedures for verifying staff attendance. Manual/paper duty sheets should be used to document the services. If the Member ultimately refuses to allow the aide to use the phone, services will not be suspended. The licensed agency should follow the licensed agency's alternative policies and procedures for verifying staff attendance. Manual/paper duty sheets should be used to document the services. 	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org

Performance Improvement Process:

If VillageCareMAX is notified of a serious performance issue or of a pattern of performance issues, our Quality Management and/or Provider Relations staff will contact the licensed agency or contracted vendor and request that the matter be investigated and that a verbal or written response be submitted to VillageCareMAX immediately. The response should be reviewed and approved by the Contract Manager and/or Administrator at the licensed agency before being submitted to VillageCareMAX.

Performance related issues include gaps or interruptions in any of the following areas:

- Service delivery
- Communication protocol
- Administrative follow up
- Customer satisfaction.

VillageCareMAX will also review the LHCSA's performance indicators and reports of complaints/grievances to insure that agencies are achieving expected performance thresholds for each indicator. VillageCareMAX will monitor performance in the identified area(s) of concern on an ongoing basis. If the pattern continues, or an issue occurs that requires immediate intervention, VCMAX may request that the licensed agency submit a written performance improvement plan of correction. The Licensed agency must ensure that the plan of correction is comprehensive and approved by its Contract Manager and/or Administrator before it is submitted.

VillageCareMAX will continue to monitor performance after the plan of correction has been submitted to insure that the action plan is implemented and achieving improvement objectives. Failure to achieve the targeted improvement may result in a reduction in the volume of cases served by the LHCSA, or additional actions up to the termination of the LHCSA's contract.

Performance improvement plans should be submitted to the VillageCareMAX Quality Management (or designee), depending upon the type of issue and within the time frames requested. Below, please see a sample format for the Plan of Correction document. Please use this format when submitting your plan to VillageCareMAX.

PLEASE NOTE: VillageCareMAX Compliance staff also conduct targeted provider audits, which may also result in requests for a plan of correction, to address findings of fraud, abuse and/or non-compliance with regulatory requirements.

AGENCY'S NAME SUBJECT OR AREA OF DEFICIENCY PLANS FOR IMPROVEMENT

Issue	Detailed Plan for Performan Improvement	ice	Person Responsible	Date to be Completed
Plan Completed by:				
Title:				
Date Submitted:				

Appendix 8: Provider Information Change Form

	VILLAGE <mark>C</mark> A	1AX	Provider Update Form				
	Please note: This form is intended for providers who are become credentialed with VillageCare Max, please email			e already credentialed with VillageCare Max. If you would like to iil your request to providerrelations@villagecare.org			
	 Section 1 Provider informs Section 2 Primary practice Section 3 Secondary pract 	informatio			• Tax I		NPI Phone Number Fax Number
Section One	Contact Name (First Name):	Contact Phone	2:	Contact E-mail Add	ress:	Effective Date of Cha	ange:
	Provider Name:			Provider NPI:		Taxonomy:	
Section	Type of Change:	ADD	REMOVE		Tax ID Number:		
Two	Street Address:			City:		State:	Zip Code + Four:
	Check Appropriate Type of Address: Physical Practice Address (not PO B	ov)	Billing Mail	ing Credentialing		Phone Number:	<u> </u>
	Hospital Affiliation:	,0A) <u>L</u>	Uning Wan	Languages Spoken (other than English):		Address ADA Accessible:	
	Telemedicine Home Visits Office Visits			Capacity (maximum number of patients that practitioner manages):			
Section	Type of Change:	ADD	REMOVE		Tax ID Number:		
Three	Street Address:			City:		State:	Zip Code + Four:
	Check Appropriate Type of Address: Physical Practice Address (not PO B	3ox)	Billing Mail	ing Credentialing	f	Phone Number:	
	Hospital Affiliation:	<u> </u>		Languages Spoken (other than English):		Address ADA Accessible: Yes No	
	Gender Limitations Male Female None			Minimum Age:		Maximum Age:	
	Telemedicine Home Vis	its 🔲	Office Visits	Capacity (maximum r	umber of patients that	practitioner manages):	
Section	Type of Change:	ADD	REMOVE		Tax ID Number:		
Four	Street Address:		_	City:		State:	Zip Code + Four:
	Check Appropriate Type of Address: Physical Practice Address (not PO E	Box) Billi	Mail	ing Credentialing	ŝ	Phone Number:	
	Hospital Affiliation:			Languages Spoken (other than English):		Address ADA Accessi	ble:
	Gender Limitations Male Female None			Minimum Age:		Maximum Age:	
	Telemedicine Home V	isits (Office Visits	Capacity (maximum number of patients that practitioner manages):			
	Comments:						

PR_Demographic_Form_08/01/2020

Form continues on following page

manuscri, we min apacite emy are race is man	mber and no other changes to existing information will be n	nade.
	OLD	NEW
Corporate Name (W-9 form required)		
Tax ID Number (W-9 form required)		
Provider Name	-	
Individual NPI Number		
Phone		

SUBMISSION INSTRUCTIONS:

Complete the form, download or save a copy, and send it (including W-9 and other pertinent documentation as needed) as an email attachment to provider Update' in the subject line. (NOTE: If your Internet browser does not allow typing in the fillable form, you must download the form and use free Adobe Acrobat Reader software to complete it.)

PR_Demographic_Form_08/01/2020

Appendix 9: Important Information: CMS -10611 Form - Medicare Outpatient Observation Notice (MOON)

As of March 8, 2017, hospitals and critical access hospitals (CAHs) are required to provide a Medicare Outpatient Observation Notice to all Medicare beneficiaries who are receiving outpatient observation services and are not an inpatient of a hospital or a CAH. The notice must include the reasons why the individual is an outpatient receiving services and the implication of receiving services.

All hospital and CAHs are required to provider written and oral notification to individuals who receive observation services as outpatients for more than 24 hours.

The notice must be delivered no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted

Appendix 10: DME Services that do not require Prior Authorization

The below DME services do **not** require prior authorization.

DME services not listed below may require prior authorization; however, all services continue to require a physician order.

Please note, this list is subject to change. To confirm or request DME services for your patient, please contact **800-469-6292**.

#	CODE	DESCRIPTION
1	A4216	STERILE WATER, SALINE AND/OR DEXTROSE, D
2	A4217	STERILE WATER/SALINE,500 ML
3	A4221	SUPP FOR MAINTENANCE OF NON-INSULIN INF CATH/WK
4	A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP,
5	A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP,
6	A4233	REPLACEMENT BATTERY, ALKALINE (OTHER THA
7	A4234	REPLACEMENT BATTERY, ALKALINE, J CELL, F
8	A4235	REPLACEMENT BATTERY, LITHIUM, FOR USE WI
9	A4244	ALCOHOL OR PEROXIDE, PER PINT
10	A4245	ALCOHOL WIPES, PER BOX
11	A4246	BETADINE OR PHISOHEX SOLUTION, PER PINT
12	A4250	URINE TEST OR REAGENT STRIPS OR TABLETS
13	A4252	BLOOD KETONE TEST OR REAGENT STRIP, EACH
14	A4253	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR
15	A4256	NORMAL, LOW AND HIGH CALIBRATOR SOLUTION
16	A4258	SPRING-POWERED DEVICE FOR LANCET, EACH
17	A4259	LANCETS, PER BOX OF 100
18	A4265	PARAFFIN, PER POUND
19	A4267	CONTRACEPTIVE SUPPLY, CONDOM, MALE, EACH
20	A4268	CONTRACEPTIVE SUPPLY, CONDOM, FEMALE, EA
21	A4310	INSERTION TRAY WITHOUT DRAINAGE BAG AND
22	A4311	INSERTION TRAY WITHOUT DRAINAGE BAG WITH
23	A4314	INSERTION TRAY WITH DRAINAGE BAG WITH IN
24	A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRI
25	A4322	IRRIGATION SYRINGE, BULB OR PISTON, EACH
26	A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COL
27	A4331	EXTENSION DRAINAGE TUBING, ANY TYPE, ANY
28	A4333	URINARY CATHETER ANCHORING DEVICE, ADHES

29	A4334	URINARY CATHETER ANCHORING DEVICE, LEG S
30	A4338	INDWELLING CATHETER; FOLEY TYPE, TWO-WAY
31	A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY
32	A4346	INDWELLING CATHETER; FOLEY TYPE, THREE W
33	A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT
34	A4351	INTERMITTENT URINARY CATHETER; STRAIGHT
35	A4352	INTERMITTENT URINARY CATHETER; COUDE (CU
36	A4353	INTERMITTENT URINARY CATHETER, WITH INSE
37	A4354	INSERTION TRAY WITH DRAINAGE BAG BUT WIT
38	A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION D
39	A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH
40	A4358	URINARY DRAINAGE BAG, LEG OR ABDOMEN, VI
41	A4361	OSTOMY FACE PLATE, EACH
42	A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT
43	A4363	OSTOMY CLAMP, ANY TYPE, REPLACEMENT ONLY
44	A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PE
45	A4366	OSTOMY VENT, ANY TYPE, EACH
46	A4367	OSTOMY BELT, EACH
47	A4368	OSTOMY FILTER,ANY TYPE, EACH
48	A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUS
49	A4371	OSTOMY SKIN BARRIER,POWDER,PER OZ
50	A4372	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
51	A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
52	A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTA
53	A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE
54	A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACE
55	A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACE
56	A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE AT
57	A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE AT
58	A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
59	A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
60	A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
61	A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EA
62	A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
63	A4387	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
64	A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED W
65	A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER AT
66	A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED W
67	A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEA
68	A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEA
69	A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEA

70	A4394	OSTOMY DEODORANT, WITH OR WITHOUT LUBRIC
71	A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH
72	A4396	OSTOMY BELT W/PERISTOMAL HERNIA SUPPORT
73	A4397	IRRIGATION SUPPLY SLEEVE EACH
74	A4398	OSTOMY IRRIGATION SUPPLY; BAG, EACH
75	A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER,
76	A4400	OSTOMY IRRIGATION SET EACH
77	A4402	LUBRICANT, PER OUNCE
78	A4404	OSTOMY RING, EACH
79	A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED, P
80	A4406	OSTOMY SKIN BARRIER, PECTIN-BASED, PASTE
81	A4407	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
82	A4408	OSTOMY SKIN BARRIER, WTIH FLANGE (SOLID,
83	A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
84	A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
85	A4411	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
86	A4412	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FO
87	A4413	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FO
88	A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
89	A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
90	A4416	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
91	A4417	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
92	A4418	OSTOMY POUCH, CLOSED; WITHOUT BARRIER AT
93	A4419	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
94	A4420	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
95	A4422	OSTOMY ABSORBENT MATERIAL (SHEET/PAD/CRYST
96	A4423	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
97	A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER AT
98	A4425	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
99	A4426	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
100	A4427	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
101	A4428	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BA
102	A4429	OSTOMY POUCH, URINARY, WITH BARRIER ATTACHE
103	A4430	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR B
104	A4431	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED
105	A4432	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
106	A4433	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
107	A4434	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
108	A4435	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT,
109	A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCH
110	A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES

111	A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, C
112	A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH
113	A4458	ENEMA BAG WITH TUBING, REUSABLE
114	A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH
115	A4481	TRACHEOSTOMA FILTER, ANY TYPE, ANY SIZE,
116	A4495	SURGICAL STOCKINGS THIGH LENGTH, EACH
117	A4500	SURGICAL STOCKINGS BELOW KNEE LENGTH, EA
118	A4510	SURGICAL STOCKINGS FULL LENGTH, EACH
119	A4554	DISPOSABLE UNDERPADS, ALL SIZES
120	A4556	ELECTRODES, (E.G., APNEA MONITOR), PER P
121	A4557	LEAD WIRES, (E.G., APNEA MONITOR), PER P
122	A4565	SLINGS
123	A4570	SPLINT
124	A4602	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
125	A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM
126	A4614	PEAK EXPIRATORY FLOW RATE METER, HAND HE
127	A4615	CANNULA NASAL
128	A4616	TUBING,(OXYGEN),PER FOOT
129	A4618	BREATHING CIRCUITS
130	A4619	FACE TENT
131	A4620	VARIABLE CONCENTRATION MASK
132	A4623	TRACHEOSTOMY, INNER CANNULA
133	A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHE
134	A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTO
135	A4626	TRACHEOSTOMY CLEANING BRUSH EA
136	A4628	OROPHARYNGEAL SUCTION CATHETER, EACH
137	A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TR
138	A4630	REPLACEMENT BATTERIES, MEDICALLY NECESSA
139	A4635	UNDERARM PAD,CRUTCH,REPLACEMENT EACH
140	A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR
141	A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER,
142	A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATU
143	A4670	AUTOMATIC BLOOD PRESSURE MONITOR - SEMI AUTO
144	A4670	AUTOMATIC BLOOD PRESSURE MONITOR- FULLY AUTO
145	A4927	GLOVES, NON-STERILE, PER 100
146	A4930	GLOVES,STERILE PER PAIR
147	A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EA
148	A4932	RECTAL THERMOMETER, REUSABLE, ANY TYPE,
149	A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTAC
150	A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER AT
151	A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLA

152	A5054	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
153	A5055	STOMA CAP EACH
154	A5056	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR
155	A5057	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR
156	A5061	OSTOMY POUCH, DRAINABLE; WITH BARRIER AT
157	A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER
158	A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
159	A5071	OSTOMY POUCH, URINARY; WITH BARRIER ATTA
160	A5072	OSTOMY POUCH, URINARY; WITHOUT BARRIER A
161	A5073	OSTOMY POUCH, URINARY; FOR USE ON BARRIE
162	A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STO
163	A5082	CONTINENT DEVICE; CATHETER FOR CONTINENT
164	A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER
165	A5093	OSTOMY ACCESSORY CONVEX INSERT
166	A5105	URINARY SUSPENSORY WITH LEG BAG, WITH OR
167	A5112	URINARY DRAINAGE BAG, LEG OR ABDOMEN, LA
168	A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER
169	A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT
170	A5120	SKIN BARRIER, WIPES OR SWABS, EACH
171	A5121	SKIN BARRIER; SOLID, 6 X 6 OR EQUIVALENT
172	A5122	SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT
173	A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM
174	A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTO
175	A5200	PERCUTANEOUS CATHETER/TUBE ANCHORING DEV
176	A5500	FOR DIABETICS ONLY, FITTING
177	A5503	FOR DIABETICS ONLY, MODIFICATION (OF OFF-THE-S
178	A5504	FOR DIABETICS ONLY, MODIFICATION) OF OFF-THE-S
179	A5505	FOR DIABETICS ONLY, MODIFICATION OF OFF-THE-SH
180	A5506	DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WIT
181	A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED M
182	A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, D
183	A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CU
184	A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, S
185	A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE,
186	A6021	COLLAGEN DRESSING, STERILE, SIZE 16 SQUARE
187	A6022	COLLAGEN DRESSING, STERILE, SIZE MORE THA
188	A6023	COLLAGEN DRESSING, STERILE, SIZE MORE THA
189	A6024	COLLAGEN DRESSING WOUND FILLER, STERILE,
190	A6196	ALGINATE OR OTHER FIBER GELLING DRESSING
191	A6197	ALGINATE OR OTHER FIBER GELLING DRESSING
192	A6198	ALGINATE OR OTHER FIBER GELLING DRESSING

193	A6199	ALGINATE OR OTHER FIBER GELLING DRESSING
194	A6203	COMPOSITE DRESSING, STERILE, PAD SIZE 16
195	A6204	COMPOSITE DRESSING, STERILE, PAD SIZE MO
196	A6205	COMPOSITE DRESSING, STERILE, PAD SIZE MO
197	A6206	CONTACT LAYER, STERILE, 16 SQ. IN. OR LE
198	A6207	CONTACT LAYER, STERILE, MORE THAN 16 SQ.
199	A6208	CONTACT LAYER, STERILE, MORE THAN 48 SQ.
200	A6209	FOAM DRESSING, WOUND COVER, STERILE, PAD
201	A6210	FOAM DRESSING, WOUND COVER, STERILE, PAD
202	A6211	FOAM DRESSING, WOUND COVER, STERILE, PAD
203	A6212	FOAM DRESSING, WOUND COVER, STERILE, PAD
204	A6213	FOAM DRESSING, WOUND COVER, STERILE, PAD
205	A6214	FOAM DRESSING, WOUND COVER, STERILE, PAD
206	A6216	GAUZE NON-IMP NON-STER UP TO 1
207	A6217	A6216; MORE THAN 16 UP TO 48SQ
208	A6218	A6216; MORE THAN 48 SQ IN
209	A6219	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
210	A6220	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
211	A6221	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
212	A6222	GAUZE, IMPREGNATED WITH OTHER THAN WATER
213	A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER
214	A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER
215	A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
216	A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
217	A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
218	A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
219	A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
220	A6233	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
221	A6234	HYDROCOLLOID DRESSING, WOUND COVER, STER
222	A6235	HYDROCOLLOID DRESSING, WOUND COVER, STER
223	A6236	HYDROCOLLOID DRESSING, WOUND COVER, STER
224	A6237	HYDROCOLLOID DRESSING, WOUND COVER, STER
225	A6238	HYDROCOLLOID DRESSING, WOUND COVER, STER
226	A6239	HYDROCOLLOID DRESSING, WOUND COVER, STER
227	A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PAS
228	A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY
229	A6242	HYDROGEL DRESSING, WOUND COVER, STERILE,
230	A6243	HYDROGEL DRESSING, WOUND COVER, STERILE,
231	A6244	HYDROGEL DRESSING, WOUND COVER, STERILE,
232	A6245	HYDROGEL DRESSING, WOUND COVER, STERILE,
233	A6246	HYDROGEL DRESSING, WOUND COVER, STERILE,

234	A6247	HYDROGEL DRESSING, WOUND COVER, STERILE,
235	A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PE
236	A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
237	A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
238	A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
239	A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
240	A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
241	A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
242	A6257	TRANSPARENT FILM, STERILE, 16 SQ. IN. OR
243	A6258	TRANSPARENT FILM, STERILE, MORE THAN 16
244	A6259	TRANSPARENT FILM, STERILE, MORE THAN 48
245	A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NO
246	A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
247	A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
248	A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
249	A6407	PACKING STRIPS, NON-IMPREGNATED, STERILE
250	A6410	EYE PAD, STERILE, EACH
251	A6411	EYE PAD,NON-STERILE, EACH
252	A6412	EYE PATCH, OCCLUSIVE, EACH
253	A6441	PADDING BANDAGE, NON-ELASTIC, NON-WOVEN/
254	A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
255	A6443	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
256	A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
257	A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
258	A6446	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
259	A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
260	A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
261	A6449	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
262	A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
263	A6451	MODERATE COMPRESSION BANDAGE, ELASTIC, K
264	A6452	HIGH COMPRESSION BANDAGE, ELASTIC, KNITT
265	A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
266	A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
267	A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
268	A6456	ZINC PASTE IMPREGNATED BANDAGE, NON-ELAS
269	A6457	TUBULAR DRESSING WITH OR WITHOUT ELASTIC
270	A6530	GRADIENT COMPRESSION STOCKING, BELOW KNE
271	A6531	GRADIENT COMPRESSION STOCKING, BELOW KNE
272	A6532	GRADIENT COMPRESSION STOCKING, BELOW KNE
273	A6533	GRADIENT COMPRESSION STOCKING, THIGH LEN
274	A6534	GRADIENT COMPRESSION STOCKING, THIGH LEN

275	A6535	GRADIENT COMPRESSION STOCKING, THIGH LEN
276	A6536	GRADIENT COMPRESSION STOCKING, FULL LENG
277	A6537	GRADIENT COMPRESSION STOCKING, FULL LENG
278	A6538	GRADIENT COMPRESSION STOCKING, FULL LENG
279	A6539	GRADIENT COMPRESSION STOCKING, WAIST LEN
280	A6540	GRADIENT COMPRESSION STOCKING, WAIST LEN
281	A6541	GRADIENT COMPRESSION STOCKING, WAIST LEN
282	A6544	GRADIENT COMPRESSION STOCKING, GARTER BE
283	A7000	CANISTER, DISPOSABLE, USED WITH SUCTION
284	A7002	TUBING, USED WITH SUCTION PUMP, EACH
285	A7003	ADMINISTRATION SET, WITH SMALL VOLUME NO
286	A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBUL
287	A7005	ADMINISTRATION SET, WITH SMALL VOLUME NO
288	A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFI
289	A7013	FILTER, DISPOSABLE, USED WITH AEROSOL CO
290	A7014	FILTER, NONDISPOSABLE, USED WITH AEROSOL
291	A7015	AEROSOL MASK, USED WITH DME NEBULIZER
292	A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SY
293	A7027	COMBINATION ORAL/NASAL MASK, USED WITH C
294	A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL
295	A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL
296	A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY
297	A7031	FACE MASK INTERFACE, REPLACEMENT FOR FUL
298	A7032	CUSHION FOR USE ON NASAL MASK INTERFACE,
299	A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INT
300	A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) U
301	A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESS
302	A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRES
303	A7037	TUBING USED WITH POSITIVE AIRWAY PRESSUR
304	A7038	FILTER, DISPOSABLE, USED WITH POSITIVE A
305	A7039	FILTER, NON DISPOSABLE, USED WITH POSITI
306	A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY
307	A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL U
308	A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFF
309	A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED,
310	A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLES
311	A7523	TRACH SHOWER PROTECTOR, EACH
312	A7524	TRACHEOSTOMA STENT/STUD/BUTTON, EACH
313	A7525	TRACHEOSTOMY MASK,EACH
314	A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED,
315	A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED,

316	A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEA
317	A9275	HOME GLUCOSE DISPOSABLE MONITOR, INCLUDE
318	A9276	SENSOR,INVASIVE,DISPOSABLE USED W/INTERSTITIAL CGM
319	E0100	CANE, INCLUDES CANES OF ALL MATERIALS, A
320	E0105	CANE, QUAD OR THREE PRONG, INCLUDES CANE
321	E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF
322	E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VAR
323	E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR F
324	E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIX
325	E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJU
326	E0116	CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUS
327	E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FI
328	E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR
329	E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FI
330	E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR
331	E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGI
332	E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FO
333	E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EAC
334	E0154	PLATFORM ATTACHMENT, WALKER, EACH
335	E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER,
336	E0156	SEAT ATTACHMENT, WALKER
337	E0157	CRUTCH ATTACHMENT, WALKER, EACH
338	E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REP
339	E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, U
340	E0163	COMMODE CHAIR, MOBILE OR STATIONARY, WIT
341	E0165	COMMODE CHAIR, MOBILE OR STATIONARY, WIT
342	E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR,
343	E0168	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY D
344	E0175	FOOT REST, FOR USE WITH COMMODE CHAIR, E
345	E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SH
346	E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOT
347	E0210	ELECTRIC HEAT PAD, STANDARD
348	E0215	ELECTRIC HEAT PAD MOIST
349	E0235	PARAFFIN BATH UNIT, PORTABLE (SEE MEDICA
350	E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEEL
351	E0241	BATHTUB WALL RAIL EACH
352	E0243	TOILET RAIL EACH
353	E0244	RAISED TOILET SEAT
354	E0245	TUB STOOL OR BENCH
355	E0246	TRANSFER TUB RAIL ATTACHMENT
356	E0247	TRANSFER BENCH FOR TUB OR TOILET WITH OR

357	E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR T
358	E0271	MATTRESS, INNERSPRING
359	E0272	MATTRESS, FOAM RUBBER
360	E0274	TABLE, OVERBED
361	E0275	BED PAN STANDARD METAL OR PLASTIC
362	E0276	BED PAN FRACTURE METAL OR PLASTIC
363	E0305	BED SIDE RAILS, HALF LENGTH
364	E0310	BED SIDE RAILS, FULL LENGTH
365	E0325	URINAL MALE JUG-TYPE ANY MATERIAL
366	E0326	URINAL FEMALE JUG-TYPE ANY MATERIAL
367	E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLE
368	E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITI
369	E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE A
370	E0570	NEBULIZER, WITH COMPRESSOR
371	E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABL
372	E0602	BREAST PUMP, MANUAL, ANY TYPE
373	E0603	BREAST PUMP ELECTRIC (AC/DC), ANY TYPE
374	E0604	BREAST PUMP, HOSPITAL GRADE, ELECTRIC (A
375	E0605	VAPORIZER,ROOM TYPE
376	E0607	HOME BLOOD GLUCOSE MONITOR
377	E0619	APNEA MONITOR W/RECORDING FEATURE
378	E0621	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON
379	E0627	SEAT LIFT MECH,ELECTRIC, ANY TYPE
380	E0629	SEAT LIFT MECHANISM, NON-ELECTRIC, ANY TYPE
381	E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
382	E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
383	E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
384	E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
385	E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, A
386	E0705	TRANSFER DEVICE, ANY TYPE, EACH
387	E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST
388	E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULAT
389	E0776	IV POLE
390	E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL
391	E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, P
392	E0900	TRACTION STAND, FREE STANDING, PELVIC TR
393	E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTA
394	E0944	PELVIC BELT/HARNESS/BOOT
395	E0950	WHEELCHAIR ACCESSORY, TRAY, EACH
396	E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITH
397	E0952	TOE LOOP/HOLDER, ANY TYPE, EACH

398	E0953	WHEELCHAIR ACCESSORY,LATERAL THIGH/KNEE SUPP,INC
399	E0954	WHEELCHAIR ACCESSORY,FOOTBOX,ANY TYPE INC HD,EACH
400	E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONE
401	E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR H
402	E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPO
403	E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR
404	E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/S
405	E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK
406	E0966	MANUAL WHEELCHAIR ACCESSORY, HEADREST EX
407	E0967	MAN WC ACCESSORY, RIM/PROJECECTION REPL EACH
408	E0971	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPIN
409	E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT,
410	E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBA
411	E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/S
412	E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST
413	E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT
414	E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD,REPL EACH
415	E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCH
416	E1399	Miscellaneous DME (No PA only if cost is <= \$50)
417	E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VO
418	E2205	MANUAL WHEELCHAIR ACCESSORY, HANDRIM WIT
419	E2206	MAN WC ACCESSORY, WHEEL LOCK, COMPLETE REPLA, EACH
420	E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HO
421	E2209	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT
422	E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE
423	E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC P
424	E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PN
425	E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR
426	E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC C
427	E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PN
428	E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPUL
429	E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER
430	E2220	MAN WC ACCESSORY, SOLID PROPULS TIRE,REPLA EACH
431	E2221	MAN WC ACCESSORY, SOLID CASTER TIRE,REPL EACH
432	E2222	MAN WC ACCESSORY, SOLID CASTER INTEG WHL,REPL EACH
433	E2224	MAN WC ACCESSORY, PROPULSION WHL EXCL TIR REPL EACH
434	E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEE
435	E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK
436	E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT
437	E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JO
438	E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR

439	E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON
440	E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEAL
441	E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SE
442	E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED
443	E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON
444	E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEA
445	E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEAL
446	E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED L
447	E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHAR
448	E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEA
449	E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DR
450	E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNE
451	E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR P
452	E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CA
453	E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNE
454	E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED
455	E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED
456	E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE W
457	E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER
458	E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
459	E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
460	E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
461	E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL
462	E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL
463	E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK,
464	E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WID
465	E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WID
466	E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
467	E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
468	E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WID
469	E2607	SKIN PROTECTION AND POSITIONING WHEELCHA
470	E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CU
471	E2632	SEO, ADDITION TO MOBILE ARM SUPPORT, OFF
472	E2633	SEO, ADDITION TO MOBILE ARM SUPPORT, SUP
473	K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMRES
474	K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, REPLACEMENT ONLY, EACH
475	K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION,REPLACEMENT ONLY, EACH
476	K0019	ARM PAD REPLA, EACH
477	K0037	HIGH MOUNT FLIP-UP FOOTREST, REPLA EACH
478	K0038	LEG STRAP,EACH

479	K0039	LEG STRAP H-STYLE, EACH
480	K0040	ANGLE ADJUSTABLE FOOTPLATE, EACH
481	K0041	LARGE SIZED FOOTPLATE, EACH
482	K0042	STANDARD FOOTPLATE, REPLA, EACH
483	K0043	FOOTREST, LOWER EXTENSION TUBE, REPLA, EACH
484	K0044	FOOTREST, UPPER HANGER BRACKET,REPLA, EACH
485	K0045	FOOTREST, COMPLETE ASSEMBLY, REPLA EACH
486	K0046	ELEVATING LEGREST, LOWER EXTENSION REPLA,EACH
487	K0047	ELEVATING LEGREST, UPPER HANGER REPLA,EACH
488	K0052	SWINGAWAY, DETACHABLE FOOTRESTS, REPLA, EACH
489	K0053	ELEVATING FOOTRESTS, ARTICULATING (TELES
490	K0056	SEAT HEIGHT LESS THAN 17" OR EQUAL TO
491	K0065	SPOKE PROTECTORS,EACH
492	K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PN,REPLA,EACH
493	K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SE,REPLA,EACH
494	K0073	CASTER PIN LOCK,EACH
495	K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SO,REPLA,EACH
496	K0098	DRIVE BELT FOR POWER WHEELCHAIR, REPLA
497	K0105	IV HANGER, EACH
498	K0553	SUPPLY ALLOWANCE FOR THERAPEUTIC CGM, ALL ACCESS
499	K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
500	K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
501	K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
502	K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
503	K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
504	K0730	CONTROLLED DOSE INHALATION DRUG DELIVERY
505	K0739	REPAIR OR NON-ROUTINE SERVICE FOR DURABL
506	L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM
507	L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR
508	L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTI
509	L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED
510	L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPIT
511	L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLAST
512	L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLAS
513	L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITA
514	L0220	THORACIC, RIB BELT, CUSTOM FABRICATED
515	L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT,
516	L0455	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, E
517	L0467	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR
518	L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIEC
519	L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES

520	L0622	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES
521	L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SAC
522	L0624	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SAC
523	L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMB
524	L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
525	L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVID
526	L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVID
527	L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL
528	L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL
529	L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
530	L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL
531	L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL
532	L0970	TLSO, CORSET FRONT
533	L0972	LSO, CORSET FRONT
534	L0974	TLSO, FULL CORSET
535	L0976	LSO, FULL CORSET
536	L0978	AXILLARY CRUTCH EXTENSION
537	L0980	PERITONEAL STRAPS, PAIR
538	L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4
539	L0984	PROTECTIVE BODY SOCK EACH
540	L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SAC
541	L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
542	L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
543	L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
544	L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
545	L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
546	L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
547	L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
548	L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS
549	L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
550	L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
551	L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
552	L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
553	L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, C
554	L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL
555	L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
556	L1240	ADDITION TO TLSO, (LOW PROFILE), LUMBAR
557	L1250	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
558	L1260	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
559	L1270	ADDITION TO TLSO, (LOW PROFILE), ABDOMIN
560	L1280	ADDITION TO TLSO, (LOW PROFILE), RIB GUS

561	L1290	ADDITION TO TLSO, (LOW PROFILE), LATERAL
562	L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
563	L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
564	L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
565	L1630	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
566	L1650	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
567	L1652	HIP ORTHOSIS, BILATERAL THIGH CUFFS WITH
568	L1660	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
569	L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREF
570	L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREF
571	L1820	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PAD
572	L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGI
573	L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), PO
574	L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S),
575	L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICAT
576	L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIF
577	L1902	AFO, ANKLE GAUNTLET, PREFABRICATED, INCL
578	L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANK
579	L1910	ANKLE FOOT ORTHOSIS, POSTERIOR, SINGLE B
580	L1920	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT WITH
581	L1930	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MA
582	L2035	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC,
583	L2040	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
584	L2070	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
585	L2080	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
586	L2090	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
587	L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORT
588	L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORT
589	L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORT
590	L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORT
591	L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORT
592	L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXIO
593	L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXIO
594	L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT
595	L2232	ADDITION TO LOWER EXTREMITY ORTHOSIS, RO
596	L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE
597	L2260	ADDITION TO LOWER EXTREMITY, REINFORCED
598	L2265	ADDITION TO LOWER EXTREMITY, LONG TONGUE
599	L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALG
600	L2275	ADDITION TO LOWER EXTREMITY, VARUS/VALGU
601	L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION

602	L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED
603	L2335	ADDITION TO LOWER EXTREMITY, ANTERIOR S
604	L2360	ADDITION TO LOWER EXTREMITY, EXTENDED S
605	L2370	ADD LOW EXT, PATTEN BOTTOM
606	L2375	ADDITION TO LOWER EXTREMITY, TORSION CO
607	L2380	ADDITION TO LOWER EXTREMITY, TORSION CO
608	L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT K
609	L2387	ADDITION TO LOWER EXTREMITY, POLYCENTRIC
610	L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNE
611	L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNE
612	L2397	ADDITION TO LOWER EXTREMITY ORTHOSIS, SU
613	L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH
614	L2415	ADDITION TO KNEE LOCK WITH INTEGRATED RE
615	L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOC
616	L2430	ADDITION TO KNEE JOINT, RATCHET LOCK FOR
617	L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DR
618	L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGH
619	L2570	ADDITION TO LOWER EXTREMITY, PELVIC CONT
620	L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONT
621	L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONT
622	L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONT
623	L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND
624	L2660	ADDITION TO LOWER EXTREMITY, THORACIC CO
625	L2670	ADDITION TO LOWER EXTREMITY, THORACIC CO
626	L2680	ADDITION TO LOWER EXTREMITY, THORACIC CO
627	L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PL
628	L2755	ADDITION TO LOWER EXTREMITY ORTHOSIS, HI
629	L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EX
630	L2768	ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER
631	L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NO
632	L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DR
633	L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
634	L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
635	L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
636	L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SO
637	L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SO
638	L2840	ADDITION TO LOWER EXTREMITY ORTHOSIS, TI
639	L2850	ADDITION TO LOWER EXTREMITY ORTHOSIS, FE
640	L3001	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
641	L3002	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
642	L3003	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE

643	L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
644	L3020	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
645	L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIE
646	L3040	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
647	L3050	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
648	L3060	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
649	L3070	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
650	L3080	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
651	L3090	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
652	L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT
653	L3140	FOOT, ABDUCTION ROTATION BAR, INCLUDING
654	L3150	FOOT, ABDUCTION ROTATATION BAR, WITHOUT
655	L3160	FOOT, ADJUSTABLE SHOE-STYLED POSITIONING
656	L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL S
657	L3201	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O
658	L3202	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O
659	L3203	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O
660	L3204	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
661	L3206	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
662	L3207	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
663	L3208	SURGICAL BOOT EACH INFANT
664	L3209	SURGICAL BOOT EACH CHILD
665	L3211	SURGICAL BOOT EACH JUNIOR
666	L3212	BENESCH BOOT PAIR INFANT
667	L3213	BENESCH BOOT PAIR CHILD
668	L3214	BENESCH BOOT PAIR JUNIOR
669	L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD
670	L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH
671	L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTO
672	L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD,
673	L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH IN
674	L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP,
675	L3224	ORTHOPEDIC FOOTWEAR, WOMAN'S SHOE, OXFOR
676	L3225	ORTHOPEDIC FOOTWEAR, MAN'S SHOE, OXFORD,
677	L3252	FOOT, SHOE MOLDED TO PATIENT MODEL, PLAS
678	L3253	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR
679	L3254	NON-STANDARD SIZE OR WIDTH
680	L3255	NON-STANDARD SIZE OR LENGTH
681	L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE F
682	L3260	SURGICAL BOOT/SHOE, EACH
683	L3265	PLASTAZOTE SANDAL EACH

684	L3300	LIFT, ELEVATION, HEEL, TAPERED TO METATA
685	L3310	LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE
686	L3320	LIFT, ELEVATION, HEEL AND SOLE, CORK, PE
687	L3332	LIFT, ELEVATION, INSIDE SHOE, TAPERED, U
688	L3334	LIFT, ELEVATION, HEEL, PER INCH
689	L3340	HEEL WEDGE, SACH
690	L3350	HEEL WEDGE
691	L3360	SOLE WEDGE, OUTSIDE SOLE
692	L3370	SOLE WEDGE, BETWEEN SOLE
693	L3380	CLUBFOOT WEDGE
694	L3390	OUTFLARE WEDGE
695	L3400	METATARSAL BAR WEDGE, ROCKER
696	L3410	METATARSAL BAR WEDGE, BTWN SOL
697	L3420	FULL SOLE AND HEEL WEDGE, BETWEEN SOLE
698	L3430	HEEL COUNTER PLASTIC REINFORCED
699	L3440	HEEL, COUNTER, LEATHER REINFORCED
700	L3450	HEEL, SACH CUSHION TYPE
701	L3455	HEEL, NEW LEATHER, STANDARD
702	L3460	HEEL, NEW RUBBER, STANDARD
703	L3465	HEEL, THOMAS WITH WEDGE
704	L3470	HEEL, THOMAS EXTENDED TO BALL
705	L3480	HEEL, PAD & DEPRESSION FOR SPUR
706	L3485	HEEL, PAD, REMOVABLE FOR SPUR
707	L3540	ORTHOPEDIC SHOE ADDITION, SOLE, FULL
708	L3570	ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENS
709	L3580	ORTHOPEDIC SHOE ADDITION, CONVERT INSTEP
710	L3600	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
711	L3610	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
712	L3620	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
713	L3630	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
714	L3640	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
715	L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION
716	L3650	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIG
717	L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIG
718	L3670	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (C
719	L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION R
720	L3702	ELBOW ORTHOSIS, WITHOUT JOINTS, MAY INCL
721	L3710	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINT
722	L3762	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, I
723	L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOIN
724	L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOIN

725	L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY
726	L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CON
727	L3912	HAND FINGER ORTHOSIS, FLEXION GLOVE WITH
728	L3913	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
729	L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHO
730	L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHO
731	L3919	HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLU
732	L3921	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
733	L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
734	L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
735	L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEA
736	L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEA
737	L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
738	L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
739	L3931	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE
740	L3933	FINGER ORTHOSIS, WITHOUT JOINTS, MAY INC
741	L3935	FINGER ORTHOSIS, NONTORSION JOINT, MAY I
742	L3995	ADDITION TO UPPER EXTREMITY ORTHOSIS, SO
743	L4002	REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDE
744	L4045	REPLACE NON-MOLDED THIGH LACER, FOR CUST
745	L4055	REPLACE NON-MOLDED CALF LACER, FOR CUSTO
746	L4060	REPLACE HIGH ROLL CUFF
747	L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR
748	L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH
749	L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DI
750	L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIG
751	L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR D
752	L4130	REPLACE PRETIBIAL SHELL
753	L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONE
754	L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REP
755	L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDE
756	L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDE
757	L4398	DROP FOOT SPLINT, RECUMENT POSITIONING DEVICE
758	L7360	SIX VOLT BATTERY, EACH
759	L7362	BATTERY CHARGER, SIX VOLT, EACH
760	L8000	BREAST PROSTHESIS, MASTECTOMY BRA
761	L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH
762	L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH
763	L8010	BREAST PROSTHESIS, MASTECTOMY SLEEVE
764	L8020	BREAST PROSTHESIS, MASTECTOMY FORM
765	L8030	BREAST PROSTHESIS, SILICONE OR EQUAL, WI

766	L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WI
767	L8300	TRUSS, SINGLE WITH STANDARD PAD
768	L8310	TRUSS, DOUBLE WITH STANDARD PADS
769	L8320	TRUSS, ADDITION TO STANDARD PAD, WATER P
770	L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL
771	L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH
772	L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH
773	L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH
774	L8417	PROSTHETIC SHEATH/SOCK, INCLUDING A GEL
775	L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNE
776	L8430	PROSTHETIC SOCK, MULTIPLE PLY, ABOVE KNE
777	L8435	PROSTHETIC SOCK, MULTIPLE PLY, UPPER LI
778	L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH
779	L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH
780	L8465	PROSTHETIC SHRINKER, UPPER LIMB, EACH
781	L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BE
782	L8480	PROSTHETIC SOCK, SINGLE PLY, FITTING, AB
783	L8485	PROSTHETIC SOCK, SINGLE PLY, FITTING, UP
784	L8501	TRACHEOSTOMY SPEAKING VALVE
785	L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY /
786	L8507	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, PAT
787	L8510	VOICE AMPLIFIER
788	L8511	INSERT FOR INDWELLING TRACHEOESOPHAGEAL
789	L8512	GELATIN CAPSULES OR EQUIVALENT, FOR USE
790	L8513	CLEANING DEVICE USED WITH TRACHEOESOPHAG
791	L8514	TRACHEOESOPHAGEAL PUNCTURE DILATOR, REPL
792	L8515	GELATIN CAPSULE, APPLICATION DEVICE FOR
700	1 0004	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE AND
	L8621	AUDITORY OSSEOINTEGRATED SOUND PROCESSORS, REPLACEMENT, EACH
794	L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSOR
795	S8100	HOLDING CHAMBER OR SPACER FOR USE WITH A
796	S8101	HOLDING CHAMBER OR SPACER FOR USE WITH A
797	S8185	FLUTTER DEVICE
798	S8265	HABERMAN FEEDER FOR CLEFT LIP/PALATE
799	S8270	ENURESIS ALARM, USING AUDITORY BUZZER AN
800	S8421	GRADIENT PRESSURE AID (SLEEVE AND GLOVE
801	S8424	GRADIENT PRESSURE AID (SLEEVE), READY MA
802	S8427	GRADIENT PRESSURE AID (GLOVE), READY MAD
803	S8428	GRADIENT PRESSURE AID (GAUNTLET), READY
804	S8460	CAMISOLE, POST-MASTECTOMY
805	S8999	RESUSCITATION BAG (FOR USE BY PATIENT ON

806	T4521	ADULT SIZED DISPOSABLE INCONTINENCE PROD
807	T4522	ADULT SIZED DISPOSABLE INCONTINENCE PROD
808	T4523	ADULT SIZED DISPOSABLE INCONTINENCE PROD
809	T4524	ADULT SIZED DISPOSABLE INCONTINENCE PROD
810	T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE
811	T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE
812	T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PROD
813	T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERG
814	T4537	INCONTINENCE PRODUCT, PROTECTIVE UNDERPA
815	T4539	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUS
816	T4540	INCONTINENCE PRODUCT, PROTECTIVE UNDERPA
817	T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/D
818	T5999	Nasal aspirator
819	T5999	Plastic strips
820	T5999	Sterile 6" wood applicator w/cotton tips
821	T5999	Incentive spirometer
822	T5999	Basal thermometer
823	V5266	BATTERY FOR USE IN HEARING DEVICE

Appendix 11: NYS DOH universal billing codes for home care and adult day health care services

Beginning April 1, 2018, the New York State Public Health law requires plans and providers to use consistent standards for the coding of payments for home and community based long term care services claims. Claims under contracts or agreements between any long term care providers and managed long term care plans or managed care plans are required to be processed using the universal standards of coding for payments.

Adult Day Health Care and Long Term Care Services

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description	
ADHC	Adult Day Health Care - Basic Level	Per Diem	S5102	U1	Adult Day Health Care Services	
CDPAS	CDPA Basic 15 Minutes	Per 15 Minutes	T1019	U6	Personal Assistant	
CDPAS	CDPA Two Consumer	Per 15 Minutes	T1019	U7	Personal Assistant mutual	
CDPAS	CDPA Live In	Per Diem (13 Hours)	T1020	U6	Personal Assistant live-in	
CDPAS	CDPA Live In Two Consumer	Per DIEM (13 Hours)	T1020	U7	Personal Assistant mutual live-in	
LHCSA	HHA - 15 Minutes	Per 15 Minutes	S5125	None	Home Health Aide	
LHCSA	HHA Two Client	Per 15 Minutes	S5125	U2	Home Health Aide Mutual	
LHCSA	HHA - Live In	Per Diem (13 Hours)	S5126	None	HHA Live-In	
LHCSA	HHA Live In Two Client	Per Diem (13 Hours)	S5126	U2	HHA Mutual Live-In	

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description	
LHCSA	PCS Level II - 15 Minutes	Per 15 Minutes	T1019	U1	Personal Care Aide	
LHCSA	PCS Level II Basic Two Client	Per 15 Minutes	T1019	U2	Personal Care Aide Mutual	
LHCSA	PCS Level II Weekend/ Holiday	Per 15 Minutes	T1019	TV	Personal Care Aide Weekend/Holiday	
LHCSA	PCS Level II Live In	Per Diem (13 Hours)	T1020	None	PCA live-in	
LHCSA	PCS Level II Live In Two Client	Per Diem (13 Hours)	T1020	U2	PCA Mutual Live-In	
LHCSA	PCS Level II Live in Weekend/Holi day	Per DIEM (13 Hours)	T1020	TV	PCA live-in Weekend/Holiday	
LHCSA	Nursing Care in Home (RN)	Per Diem (13 Hours)	T1030	None	Skilled Nursing /RN services	
LHCSA	LPN	Per Hour	S9124	None	LPN Private Duty Nursing	
СННА	HHA - 15 Minutes	Per 15 Minutes	S5125	None	Home Health Aide	
СННА	Nursing Assessment/ Evaluation	Per Visit	T1001	None	Initial Visit	
СННА	Nursing Care in Home (RN)	Per Diem (13 Hours)	T1030	None	Skilled Nursing Subsequent Visit/Revisit	

VCM Service	DOH Service	DOH Unit of	DOH	DOH	VCM Contract Service
Type	Description	Measurement	Procedure Code	Modifier	Description
CHILLA	0 1	D 17		NI	0 1.77
СННА	Occupational Therapy	Per Visit	S9129	None	Occupational Therapy
СННА	Physical Therapy	Per Visit	S9131	None	Physical Therapy
СННА	Speech Therapy	Per Visit	S9128	None	Speech Therapy
СННА	Nutritional Counseling	Per Visit	S9470	None	Nutrition
СННА	Medical Social Services	Per Visit	S9127	None	Medical Social Services
СННА	Respiratory Therapy	Per 15 Minutes	G0237	None	Respiratory Therapy
СННА	Respiratory Therapy	Per 15 Minutes	G0238	None	Respiratory Therapy
СННА	Installation	Per Service	S9110	None	Telehealth (for installation)
СННА	Monitoring	Monthly	S9110	U1	Telehealth (a day)
PERS Medication	Installation	One Time	T1505	None	Delivery, Removal Nurse Training & User Orientation
PERS Medication	Monitoring	Monthly	S5185	None	Medication Dispensing Monitoring Service & Reporting or System Rental (with Event Reporting)
UAS	UAS Assessment	Per Visit	T2024	None	

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
UAS	UAS Reassessment	Per Visit	T2024	None	
Sign Language	Sign Language/Oral interpreter	Per 15 Minutes	T1013	None	
Soc & Env Supports	Social and Environmental Supports- Home Modification	Per Service	S5165	None	
Soc & Env Supports	Social and Environmental Supports - Assessment	Per Service	T1028	None	

Appendix 12: 2019 Medicare Part D Opioid Policies



2019 Medicare Part D Opioid Policies: Information for Prescribers

The Centers for Medicare and Medicaid Services (CMS) <u>finalized new opioid policies</u> for Medicare drug plans starting on January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The new policies include improved **safety alerts** when opioid prescriptions are dispensed at the pharmacy and **drug management programs** for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions. These policies should not impact patients' access to medication-assisted treatment (MAT), such as buprenorphine.

Opioid Safety Alerts

Part D plans are expected to implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. CMS encourages prescribers to respond to pharmacists' outreach in a timely manner and give the appropriate training to on-call prescribers when necessary to resolve opioid safety edits expeditiously and avoid disruption of therapy.

Opioid Safety Alert	Prescriber's Role
Seven-day supply limit for opioid naïve patients	Patient may receive up to a 7 days supply or request a
("hard edit")	coverage determination for full days supply as written.
Medicare Part D patients who have not filled an	The physician or other prescriber has the right to
opioid prescription recently (such as within the past 60 days) will be limited to a supply of 7 days or less.	request a coverage determination on patient's behalf, including the right to request an expedited or standard
	coverage determination in advance of prescribing an
Limiting the amount dispensed with the first opioid prescription may reduce the risk of a future	opioid.
dependency or overuse of these drugs.	Prescriber only needs to attest to plan that the days
	supply is the intended and medically necessary amount.
Important Note: This alert should not impact patients who	Subsequent prescriptions written by prescribers are not
already take opioids.	subject to the 7 days supply limit, as the patient will no longer be considered opioid naïve.
	longer be considered opioid naive.

Opioid care coordination alert at 90 morphine milligram equivalent (MME)

This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative MME per day across all of their opioid prescription(s) reaches or exceeds 90 MME.

Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.

The prescriber will be contacted to resolve the alerts and to be informed of other opioid prescribers or increasing level (MME) of opioids. Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater.

The prescriber who writes the prescription will trigger the alert and will be contacted even if that prescription itself is below the 90 MME threshold.

Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions.

Important Note:

This is not a prescribing limit. Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber. On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.

Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy ("soft edits")

The alerts will trigger when opioids and benzodiazepines are taken concurrently or if on multiple duplicate long-acting opioids.

The pharmacist will conduct additional safety reviews to determine if the patient's opioid use is safe and clinically appropriate. The prescriber may be contacted.

Optional Safety Alert at 200 MME or more ("hard edit")

Some plans may implement a hard safety alert when a patient's cumulative opioid daily dosage reaches 200 MME or more.

Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.

Important Note:

This is not a prescribing limit. Decisions to taper or discontinue prescription opioids are individualized between the patient and prescriber. This alert stops the pharmacy from processing the prescription until an override is entered or authorized by the plan.

On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid. In the absence of other approved utilization management requirements, once the prescriber(s) attests that the identified cumulative MME level is the intended and medically necessary amount, the medication will be dispensed to the patient.

Drug Management Programs (DMPs)

Medicare Part D plans may have a DMP that limits access to opioids and benzodiazepines for patients who are considered to be at-risk by the plan for prescription drug abuse.

The goal of a DMP is better care coordination for safer use. Coverage limitations under a DMP can include requiring the patient to obtain these medications from a specified prescriber and/or pharmacy, or implementing an individualized POS edit that limits the amount of these medications that will be covered for the patient. The coverage limitation tools may be put in place for 12 months and extended for an additional 12 months (total of 24 months).

Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies. After the plan conducts case management with prescribers, and before implementing a coverage limitation tool, the plan will notify the patient in writing. Plans are required to make reasonable efforts to send the prescriber a copy of the letter. After this 30 day time period, if the plan determines based on its review that the patient is at-risk and implements a limitation, it must send the patient a second written notice confirming the specific limitation and its duration.

If the plan decides to limit coverage under a DMP, the patient and their prescriber have the right to appeal the plan's decision. The patient or prescriber should contact the plan for additional information on how to appeal.

Appendix 13: Update: NYS Medicaid Program Dental Policy and Procedure Code Manual

The Department of Health has updated section VIII of the Dental Policy and Procedure Code Manual. This update is effective **November 12, 2018** and provides procedure codes and general guidelines for dental implants.

Prior approval for implant services will apply to dental practitioners and Article 28 dental clinics.

The updates will be published in the Dental Policy and Procedure Code Manual found online at https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental Policy and Procedure Manual.p df

For more information regarding Dental updates, please refer to LIBERTY Dental Plan's website For Providers: https://www.libertydentalplan.com/Providers/Providers-1.aspx

Appendix 14: Member Correspondence Grid

Our goal at VillageCareMAX is to streamline and facilitate the exchange of information between our organizations and make everyone's day to day operation a bit easier. Effective January 1, 2020, we have established guidelines for select activities where communication is no longer required, required only via phone, or required via fax.

	Notification	Verbal	Fax
Correspondence	Not Required	Notification	Notification
All Scripts: All Scripts Referral and Discharge Information			x
CDPAP Documentation (M11Q, Form, CDPAP Agreement)			x
Complaint: Member/Family Complaint		x	
Complaint: Provider Complaint			x
HCP: Health Care Proxy			x
AOR: Appointment of Representative			x
Hospital Discharge Summary			x
LHCSA 1 hour travel time	x		
LHCSA Replacement Aide	x		
LHCSA Holding Services – Hospitalization		x	
LHCSA Holding Services – Other		x	
LHCSA Holding Services – Vacation		x	
LHCSA Incident Report			x
LHCSA No services for less than 3 consecutive days	x		
LHCSA No services for more than 3 consecutive days			x
LHCSA Nursing Revisit Note, Medication Profile, and Progress Notes			x
LHCSA One day schedule change	x		
LHCSA Overtime			x
LHCSA Permanent schedule change			x
LHCSA Request for increase PCA hours			x
LHCSA Resume services		x	
LHCSA RN Initial Assessment / Reassessment, Medication Profile			x
MCA: Mutual Care Agreement			x
MD Letter			x
SNF/Rehab: PT, OT, and/or ST Progress Notes			x
PERS Incident Report			x
POA: Power of Attorney			x
Prescriptions / Request for Services			x
PRI: Patient Review Instrument			x
Quality Attestation Review			x
RX/DME Request: Other Equipment (Cane, Walker, Wheelchair, etc)			X
RX/DME Requests: Incontinence Supplies			X
RX: Prescriptions for DME Incontinence Supplies			X
RX: Prescriptions for DME Supplies			X
SNF/Rehab Discharge Summary			X
Vendor: Quality/Adverse Event			X

Appendix 15: VillageCareMAX Special Needs Plan Model of Care Training







What is the VillageCareMAX SNP Model of Care Training?



This training ensures providers have knowledge of VCMAX population and the VCMAX Model of Care

Model of Care training is required for employed and contracted personnel who work with VCMAX members

Center for Medicare and Medicaid Services (CMS) requires that Model of Care Training be completed annually by Providers and VillageCare Staff



Training Objectives

At the end of this training you will be able to recall specifics about VillageCareMAX (VCMAX) Special Needs Plan (SNP) Model of Care as it pertains to:

- SNP Background
- VCMAX SNP Model of Care
- How Does MOC Work?
- Care Coordination
- Quality Measurement and Performance Improvement
- Role and Responsibilities of Providers
- Member Experience and Satisfaction





Special Needs Plan (SNP) Background

Congress created Special Needs Plans (SNP) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan which focuses on certain vulnerable groups of Medicare beneficiaries.

SNPs are Medicare Advantage plans with special benefit packages for populations with distinct health care needs.

The goal is to provide extra benefits and team-based care to improve outcomes and decrease costs for special need population through improved coordination.



Foundation of the Model of Care

VillageCareMAX has implemented an evidence-based model of care (MOC) for its health plans. Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve and sustain Member health outcomes across the care continuum in accordance with the requirements set forth by the CMS and DOH.

VILLAGE CARE MAX SNP Model of Care

The VCMAX SNP Model of Care strives to meet the specialized needs of its members and to optimize their health outcomes by using evidence-based practices with an appropriate network of providers and specialists.

VCMAX Special Needs Plans are:





Model of Care Elements

Description of the SNP Population

Characteristics related to the membership that VillageCareMAX and its providers serve.

Care Coordination

How the Special Needs Plan will coordinate health care needs and preferences of the member and share information with the Interdisciplinary Care Team



Special Needs Plan Provider Network

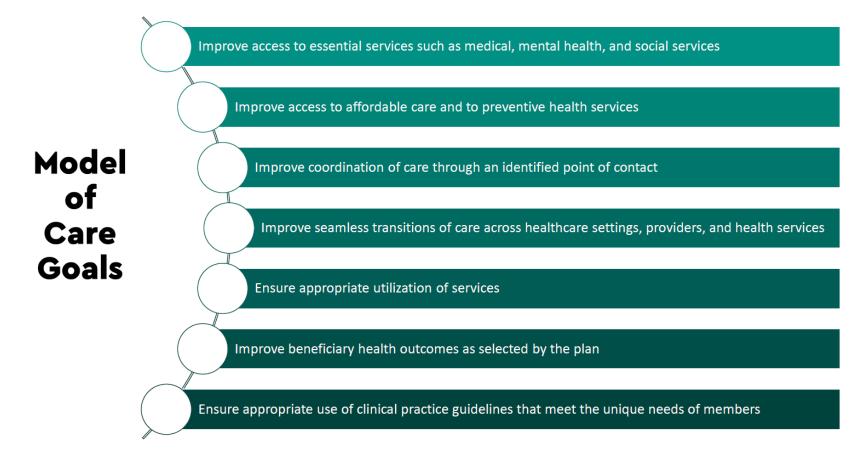
The specialized provider network available to our members. It also describes how the network meets the needs of the target population.

Model Of Care Quality Measurement & Performance Improvement

VillageCareMAX determines goals for our Model of Care related to the improvement of the quality of care our members receive..

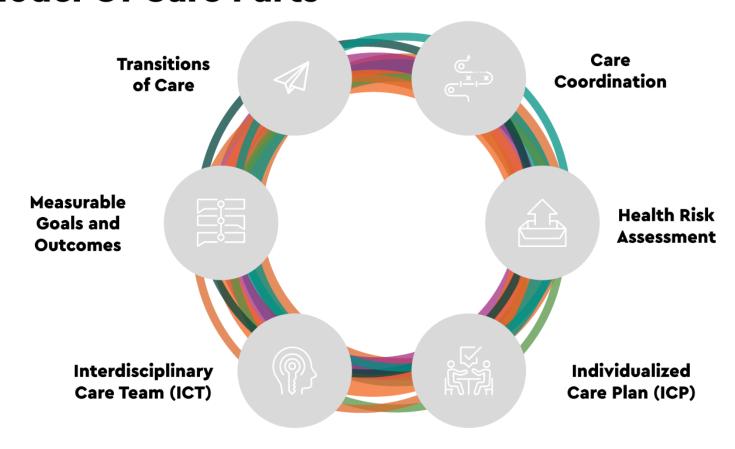








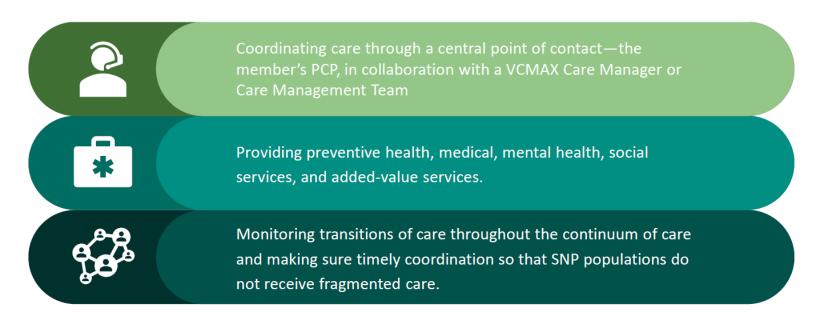
Model Of Care Parts





How Does MOC Work?

VCMAX's Model of Care promotes quality care management and optimal health outcomes for members through facilitation of access to needed resources and care coordination, including:





How We Support the Model of Care

All SNP members receive case management and are notified of their dedicated Care Manager by a welcome phone call Members are stratified according to their risk profile and/or Health Risk
Assessment (HRA) to focus resources on most vulnerable



Care Manager contacts members based on risk, change in status or transition of care needs Contingency planning is in place to avoid disruption of services for events such as natural disasters





How Members Support the Model of Care

Members is informed of and consents to Care Management

Members participates in development of their Care Plan

Member agrees to the goals and interventions of their Care Plan

Member is informed of Interdisciplinary Care Team (ICT) members and meetings

Member either participates in the ICT meeting or provides input through the Care Manager and informed of outcomes

Ongoing member satisfaction with the SNP is measured







Care Coordination

VCMAX conducts Care Coordination to meet the targeted needs of our members by utilizing the following strategies:

- Conducting a Health Risk Assessment (HRA) of the individual's physical, psychosocial, and functional needs, using assessment tools approved by CMS and other appropriate regulatory agencies.
- Developing an Individualized Care Plan (ICP) developed by an Interdisciplinary Care Team (ICT) and, in consultation with the member, identifying goals and objectives as well as specific services and benefits to be provided.
- Coordinating an ICT that manages the member's care and meets regularly to manage the medical, cognitive, psychosocial, and functional needs of the member.



Health Risk Assessment (HRA)

A Health Risk Assessment (HRA) is a screening tool that helps individuals identify and understand their health risks and monitor health status over time. The assessment includes a questionnaire, an assessment of health status, and personalized feedback about actions that can be taken to reduce risks, maintain health, and prevent disease. VillageCareMAX utilizes two different types of HRAs: our Medicare Health Advantage plan uses the HRA and our Medicare Total Advantage plan uses the New York State UAS. Each tool assesses by a series of questions the medical, functional, cognitive, psycho-social and mental health needs of each member.

VCMAX conducts Care Coordination to meet the targeted needs of our members by utilizing the following strategies:

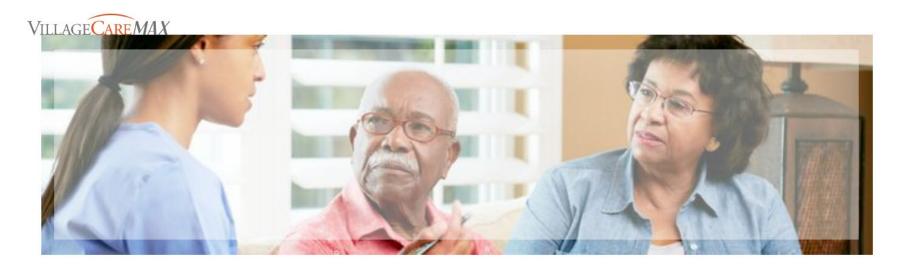
- Establishing an Individualized Care Plan (ICP) developed by the Interdisciplinary Care Team (ICT) and, in consultation with the member, identifying goals and objectives as well as specific services and benefits to be provided based on the HRA.
- Assessing members at enrollment and then reassessing using the appropriate Assessment Tool (HRA) at a minimum interval of every six (6) months, or after changes in condition, using the Uniform Assessment System for New York (UAS-NY) for Medicare Total Advantage members and annually using the HRA for Medicare Health Advantage members.



Interdisciplinary Care Team (ICT)

Each VillageCareMAX Member is assigned to a Care Manager and Interdisciplinary Care Team that will include health care professionals (Member's primary care provider, nurses, social workers, psychologists or therapists, other specialists as appropriate) and a Member Services Representative.

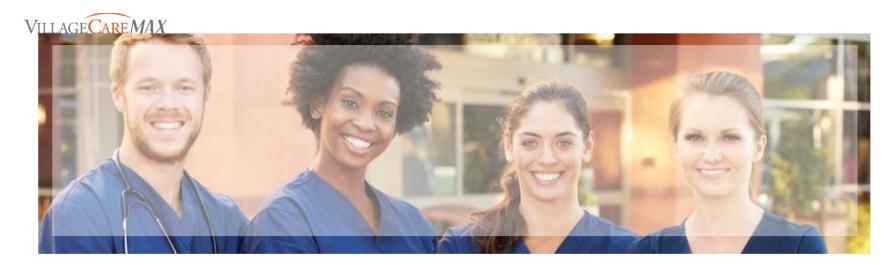
The Interdisciplinary Care Team has ongoing responsibility for ensuring that the Member's health risks are identified on ongoing basis and that the Member's healthcare needs and risks are appropriately addressed by the plan of care.



Individualized Care Plan

Based on the results of the assessments, the member is assigned Care Manager (CM), who is either a registered nurse or a certified social worker.

Care Managers working with the Member, his/her caregivers and the ICT, develop a Person-Centered Service Plan. A Person-Centered Service Plan is a written description in the care management record of Member-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a Member in order to achieve such goals.



Care Manager

As the primary coordinator of care, the Care Manager's responsibilities include:

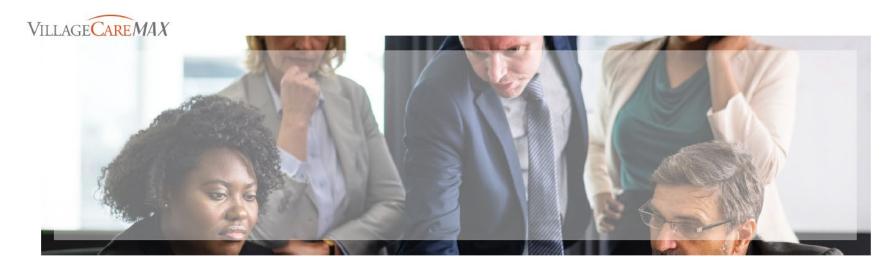
- Ensuring the ongoing identification of health risks by conducting in-home and telephonic assessments.
- Developing a plan of care for the Member and facilitating authorization of covered benefits.
- Implementing the Member's plan of care and coordinating services across the continuum of services.
- Monitoring the delivery of services for quality and effectiveness.
- Integrating feedback, observations, and recommendations of other professionals involved in managing the care of the Member, including Participating Providers, PCPs, Specialists and Providers of non-covered services.
- Collaborating with discharge planners and transition of care staff to coordinate discharge planning from hospital or nursing home stays and facilitate transitions of care.



Member Services

Member Services Representatives serve as liaisons between the Member and their Care Manager, and assist in facilitating communication across the Interdisciplinary Care Team.

Member Services Representatives provide information about VillageCareMAX policies, available services, and Participating Providers, make and confirm service arrangements, and answer questions and resolve problems presented by Members.



Measurable Goals and Outcomes

VillageCareMAX continuously reviews the progress that has been made toward meeting the goals of its Model of Care, and issues related to the MOC structure, provider network, and communications mechanisms.

The Plan will review the results of its performance measures to assure that we continue to promote, improve and sustain Member health outcomes.

An annual member satisfaction survey serves as the method to reflect against the overall goals of the program and recalibrate at the leadership level to ensure that the Model of Care is meeting its overall goals concurrently with an examination of whether the goals continue to be appropriate.



Transition of Care

The Transition of Care Program is designed to bridge the gap for members who may receive care in multiple settings and deliver more comprehensive, coordinated and cost-effective care.

For planned and unplanned transitions from the member's usual care setting to the hospital and transitions from the hospital to the next setting, VCMAX identifies and informs members practitioners

Case Management care transitions protocol is administered in alignment with VCMAX SNP Model of Care (SNP MOC).

Special effort is made to coordinate care when SNP members move from one setting to another, such as when they are discharged from a hospital, to reduce risk of poor-quality care, risks to member's safety and to maximize health outcomes

Utilizing a multidisciplinary team approach to support SNP member's medical, behavioral health, pharmacy, social and financial needs, case managers work with the member, provider, and community delivery systems to coordinate care and services.



Clinical Practice Guidelines

Clinical practice guidelines are systematically developed standards that help practitioners and Members make decisions about appropriate healthcare for specific clinical circumstances.

The use of clinical practice guidelines gives VillageCareMAX the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment.

VillageCareMAX has adopted preventive care and practice guidelines that are based on nationally accepted guidelines.

Providers are informed of the Clinical Practice Guidelines through the Provider Manual, annual mailings, newsletters, and the VillageCareMAX web site.

Please see Section 25 and Appendix 6 for a copy of the Clinical Practice Guidelines within the Provider Manual. VillageCareMAX adopts guidelines upon the recommendation and approval of the Internal Quality Review Committee.



PROVIDER MANUAL

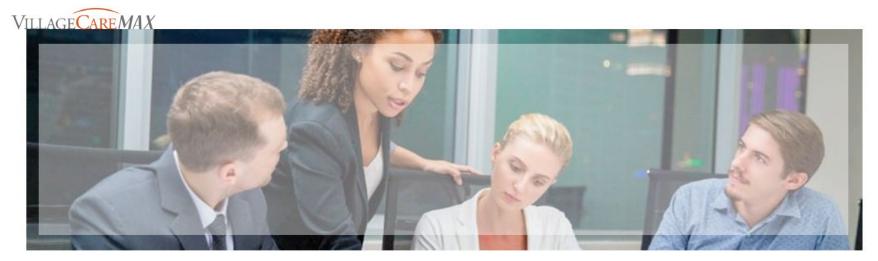


VillageCareMAX Managed Long Term Care (MLTC)

VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)

VillageCareMAX Medicare Total Advantage MAP Plan (HMO D-SNP)





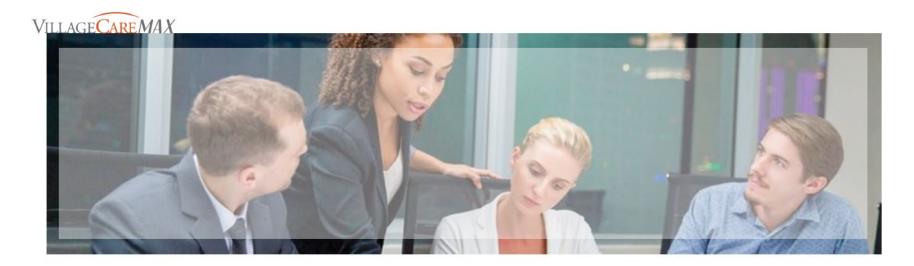
Quality Management and Performance Improvement (QMPI) Program

VillageCareMAX maintains a Quality Management and Performance Improvement (QMPI) Program.

The QMPI Program includes governance/accountability, quality improvement model and activities, member safety activities, and quality measures.

The Quality Department develops goals, measures and benchmarks for assessing performance and identifying opportunities for improvement.

Quality results are used by internal committees and program leaders, to identify and expand best practices, revise and initiate new programs and processes.



Quality Measurement

- Timely Access to care
- Improvement in member health status through specific metrics such as HEDIS, PCP Visits, Admission & Emergency Room utilization
- Completion of a comprehensive Health Risk Assessment
- Implementation of an Individualized Care Plan (ICP) for SNP beneficiaries







Primary Care Physicians



Long Term Care and **Support Providers**

Personal care services Adult day programs Delivered meals programs Consumer directed personal assistant services Personal emergency response systems

Specialists

Can act as PCPs: Geriatricians Nephrologists Pain management specialists Endocrinologists Rheumatologists Cardiologists Oncologists **HIV** specialists

Ancillary Services

Home infusion Durable Medical Equip. (DME) Prosthetics Orthotics Diabetic supplies Diabetic shoes Transportation

Other Practitioners

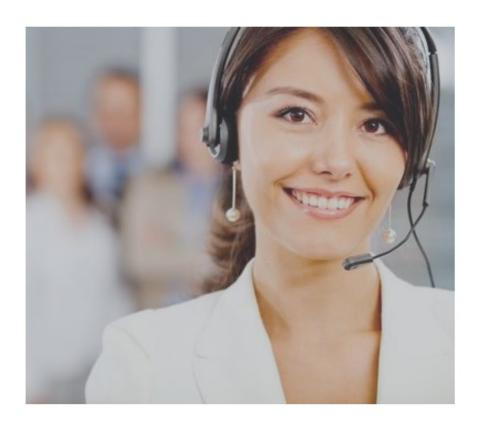
Nurse Practitioners Physical Therapists Occupational Therapists Speech Therapists >200 behavioral and mental health professionals Specialty clinics (e.g. dialysis, lithotripsy, endoscopy)

Facilities

Hospitals Urgent care centers Ambulatory surgery centers SNFs (nursing homes) Hospice Rehabilitation facility

Who Are Our Providers?





How We Support Our Providers

- Ensuring the appropriate types of providers are in the network.
- Support adequate access and availability.
- Credentialing and re-credentialing of providers.
- Provider communications and training in order to support provider involvement in the MOC.
- Community-based Programs/Organizations are also an important part of the VillageCareMAX provider network and are engaged in the continuum of care.





What does this mean for providers?

VCMAX Model of Care strives to enhance the medical and social health outcomes of our members while managing their comorbidities and reducing hospitalization rates.

To support the integrated delivery system all providers are engaged with involvement in the ICT in order to:

- Collaborate with the case management team
- Update Care Plan
- Ensure cost-effective, appropriate care for the right member at the right time



Provider Collaboration



Communicating with VCMAX Case Managers, members and caregivers



Participating in the Interdisciplinary Care Team and collaborating to develop the Interdisciplinary Care Plan (ICP)



Maintaining accurate member's health records and submitting documentation in a timely manner



Updating records as member's status changes or member transitions from one care setting to another



Encouraging and empowering members to continue treatments established in the **ICP**



Provider Responsibilities

Network providers collaborate with members of the Interdisciplinary Care Team (ICT):

Invitation

Once a member enrolls, their Care Manager contacts the member's Primary Care Provider (PCP) to invite their participation in care planning meetings.

Coordination

Providers are responsible for coordinating or delivering care to members.

Collaboration

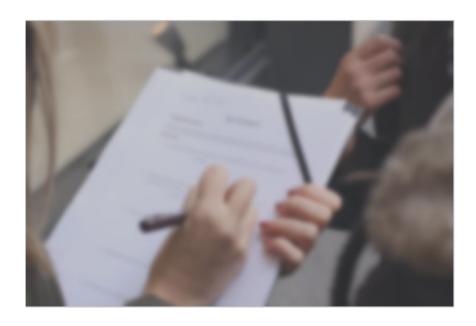
Upon request, the Care Manager may mail a copy to the of the Individualized Care Plan to the PCP.

All updates to the ICP are recorded and appended as documents in the health plan Electronic Health Record.





Routine Member Survey



On an ongoing basis, member surveys are conducted to determine member satisfaction and the member experience.

- An example of a survey to measure member satisfaction is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. VillageCareMAX contracts with a CMS approved vendor to administer the CAHPS.
- CMS selects a sample of eligible members to be surveyed. The survey is sent via mail and administered over the phone as appropriate.
- The survey is sent out to members in their native language, as appropriate, and special accommodations are made for disabled population



We value your continued partnership in delivering high-quality cost-effective healthcare to our members.

Your participation is greatly appreciated, and we look forward to working with you.

Last Updated 10/2020

Resources:

VCMAX Provider Manual https://www.villagecaremax.org/provider-manual

Contact VCMAX Provider Relations 1-718-517-2783 Monday to Friday, 9am-5pm

Appendix 16: VillageCareMAX Medicare Health Advantage and Medicare Total Advantage Specialist Services that do not require Prior Authorization

The following Medicare Services do NOT require Prior Authorization in the Office Setting only:

Gastroenterology CPT code	Description	Effective Date
43235	EGD	
43239	EGD & BX	
43251	EGD & Snare	
G0104	Screening Fex Sig	
45330	Fle Sigmoid	
45331	Sig & Bx	
G0105	Screening Colonosupy High Risk	
G0121	Screening Colonosupy Average Risk	
45378	Colonoscopy	
45380	Incomplete Colonoscopy	
45381	Colon & Bx	
45382	Colon & injection	
45384	Colon & Hemostasis	
45385	Colon & Hot Biopsy	
46600	Anoscopy	
46934	Destruction of Hemorhoid, internal	
45398	Colonoscopy , flexible, proximal to splenic flexure	1/1/2022
46221	Excision Procedures on the Anus	1/1/2022

Hadam CDT Cada	D	Effective
Urology CPT Code	Description	Date
51741	Uroflowmetry, Complex	
51798	Bladder Scan	
81003	Urine Analysis, Automated	
81002	Urine Analysis, non-Auto	
52000	Cysto, Plain	
52214	Cysto w/ fulg small tumor	
52224	Cysto w/ fulguration- minor lesions	
52234	Cysto w/ fulguration (0.5-2.0cm)	
52281	Cysto with dilation	

76775	Ultrasound, Renal	
76872	TRUS, Prostate	
55700	Prostate biopsy, needle/punch	
76942	Sonogram Guidance for biopsy	
51728	Voiding Pressure Studies	
51797	Intra-Abdominal Pressure	
51784	Sphincter- VCUG	
51600	Injection- VCUG	
74455	VCUG for Incontinence	
51741	Uroflowmetry, Complex	
51726	Cystometrogram, Complex	
51700	Bladder Irrigation	
51701	Non- indewlling catheter insertion	
55700	Incision Procedures on the Prostate	
51702	Indwelling cath. Insertion, simple	

Cardiology	Description	Effective Date
Cardiology	Description	Date
93000	routine electrocardiogram (ECG)	
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	

	External electrocardiographic recording up to 48 hours by	
	continuous rhythm recording and storage; includes recording,	
	scanning analysis with report, review and interpretation by a	
93224	physician or other qualified health care professional	
	Cardiovascular stress test using maximal or submaximal treadmill or	
	bicycle exercise, continuous electrocardiographic monitoring, and/or	
93015	pharmacological stress; with supervision, interpretation and report	
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose	
	Injection, adenosine, 1 mg (not to be used to report any adenosine	
J0153	phosphate compounds)	
	Duplex scan of extremity veins including responses to compression	
93970	and other maneuvers; complete bilateral study	
93880	Duplex scan of extracranial arteries; complete bilateral study	
	Duplex scan of lower extremity arteries or arterial bypass grafts;	
93925	complete bilateral study	
	Complete bilateral noninvasive physiologic studies of upper or lower	
	extremity arteries, 3 or more levels (eg, for lower extremity:	
	ankle/brachial indices at distal posterior tibial and anterior	
	tibial/dorsalis pedis arteries plus segmental blood pressure	
	measurements with bidirectional Doppler waveform recording and	
	analysis, at 3 or more levels, or ankle/brachial indices at distal	
	posterior tibial and anterior tibial/dorsalis pedis arteries plus	
	segmental volume plethysmography at 3 or more levels, or	
	ankle/brachial indices at distal posterior tibial and anterior	
	tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen	
	tension measurements at 3 or more levels), or single level study with	
	provocative functional maneuvers (eg, measurements with postural	
93923	provocative tests, or measurements with reactive hyperemia)	
	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass	
93978	grafts; complete study	
	Interrogation device evaluation (in person) with analysis, review and	
	report by a physician or other qualified health care professional,	
	includes connection, recording and disconnection per patient	
	encounter; single, dual, or multiple lead pacemaker system, or	
93288	leadless pacemaker system	
36415	Collection of venous blood by venipuncture	
85610	Prothrombin time test	
93886	Non-Invasive Cerebrovascular Arterial Studies	1/1/2022
93922	Non-Invasive Extremity Arterial Studies (Including Digits)	1/1/2022
93926	Duplex scan of lower extremity arteries or arterial bypass grafts	1/1/2022
93931	Non-Invasive Extremity Arterial Studies (Including Digits).	1/1/2022
93971	Non-Invasive Extremity Venous Studies (Including Digits)	1/1/2022
JJJ/ 1	Non invasive Extremity vehicus studies (including bigits)	1/1/2022

Audiology	Description	Effective Date
92557	Comprehensive audiometry threshold evaluation and speech recognition	
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	
92550	Tympanometry and reflex threshold measurements	
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	
92567	Audiologic Function Tests	
92568	Audiologic Function Tests	
92587	Distortion product evoked otoacoustic emissions	
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system	
92540	Vestibular Function Tests, With Recording (eg, ENG)	
92537	Vestibular Function Tests, With Recording (eg, ENG)	
92547	Vestibular Function Tests, With Recording (eg, ENG)	
V5256	Hearing aid, digital monaural, ite	
V5257	Hearing aid, digital monaural, bte	

Ophthalmology	Description	Effective Date
02225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal	
92225	detachment, melanoma), with interpretation and report	
92201	Indirect Ophthal	
92202	Indirect Ophthal	
92020	Special Ophthalmological Services and Procedures	
	Visual field examination, unilateral or bilateral, with interpretation	
92083	and report	
92250	Ophthalmoscopy Procedures	
92132	Special Ophthalmological Services and Procedures	
92133	Special Ophthalmological Services and Procedures	
92134	Special Ophthalmological Services and Procedures	
92285	Other Specialized Ophthalmological Services and Procedures	
76514	Ophthalmic ultrasound, diagnostic	
76519	Ophthalmic biometry by ultrasound echography, A-scan	
92235	Fluorescein Angiography	

92285	External photo	
92273	Electroretinography (ERG), with interpretation and report	
95060	Schirmer Test	
95930	Evoked Potentials and Reflex Testing Procedures	
92060	Sensorimotor Exam	
65855	Incision Procedures on the Anterior Chamber of the Eye	
92100	Serial tonometry	
92317	Contact lens Fitting	
92015	Refraction	
0507T	Lipi Scan	
87070	Becterial Culture	
92286	Endothelial Cell Photography	
83861	Microfluid Analy Tears	
92025	Corneal Topography	
66761	Destruction Procedures on the Iris, Ciliary Body of the Eye	
00.0=	Discussion of secondary membranous cataract (opacified posterior	
66821	lens capsule and/or anterior hyaloid)	
67105	Repair of retinal detachment, 1 or more sessions	
	Prophylaxis of retinal detachment (eg, retinal break, lattice	
67145	degeneration) without drainage, 1 or more sessions	
	Destruction of localized lesion of retina (eg, macular edema,	
67210	tumors), 1 or more sessions	
	Treatment of extensive or progressive retinopathy, 1 or more	
67228	sessions	
67820	Correction of trichiasis	
68761	Closure of the lacrimal punctum	
68840	Probing and/or Related Procedures on the Lacrimal System	
68810	Probing of nasolacrimal duct, with or without irrigation	
67800	Excision of chalazion	
65210	Removal of foreign body, external eye	
65222	Removal of foreign body, external eye	
66984	Intraocular Lens Procedures	
66985	Secondary IOL	
66982	Intraocular Lens Procedures	
65855	Incision Procedures on the Anterior Chamber of the Eye	
65820	Incision Procedures on the Anterior Chamber of the Eye	
66170	Trabeclectomy ab ext	
66850	Removal of lens material	
67010	vitrectomy, partial ant	
67036	vitrectomy, TPPV	
65430	Scraping comea diagnostic	
65205	F.B reml ext eye superf	

67515	subtenons inj	
67916	Ectropion repair	
67923	Entropion repair	
99070	Supply and material	
68135	Conjuctiva lesion destruction	
68899	Punctual Marsupialization	
	Insertion of anterior segment aqueous drainage device, without	
0191T	extraocular reservoir	
65420	Excision Procedures on the Cornea.	1/1/2022
65435	Removal or Destruction Procedures on the Cornea.	1/1/2022
65436	Removal or Destruction Procedures on the Cornea.	1/1/2022
65600	Removal or Destruction Procedures on the Cornea.	1/1/2022
65778	Other Procedures on the Cornea.	1/1/2022
66762	Destruction Procedures on the Iris, Ciliary Body of the Eye.	1/1/2022
67028	Vitreous Procedures on the Posterior Segment of the Eye.	1/1/2022
68040	Incision and Drainage Procedures on the Conjunctiva.	1/1/2022

		Effective
OBGYN /GYN	Description	Date
76856	Office Sonograms	
76830	Office Sonograms	
58100	Excision Procedures on the Corpus Uteri-Office Procedure	
	Colposcopy of the cervix including upper/adjacent vagina- Office	
57454	Procedures	
19081	Breast Biopsy	1/1/2022
19083	Breast Biopsy	1/1/2022
19085	Breast Biopsy	1/1/2022
19281	Breast Biopsy	1/1/2022
19283	Breast Biopsy	1/1/2022

Dermatology	Description	Effective Date
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions	
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions	

17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)	
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)	
67850	Excision and Destruction Procedures on the Eyelids	
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia)	
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia)	
11900	Injection, intralesional	
11901	Injection, intralesional	
11102	Biopsy Procedures on the Skin	
11103	Biopsy Procedures on the Skin	
11104	Biopsy Procedures on the Skin	
11105	Biopsy Procedures on the Skin	
11106	Biopsy Procedures on the Skin	
67810	Incision Procedures on the Eyelids	
11755	Surgical Procedures on the Nails	
96920	Laser treatment for inflammatory skin disease (psoriasis)	
96921	Laser treatment for inflammatory skin disease (psoriasis)	
96922	Laser treatment for inflammatory skin disease (psoriasis)	
96900	Special Dermatological Procedures	

Ear, Nose and Throat	Description	Effective Date
10060	Abscess(Simple)	
10061	Abscess(Complex)	
11100	Biopsy/Exe lesion	
11443	Biopsy/Exe lesion	
11446	Biopsy/Exe lesion	
30100	biopsy intranasal	
69200	Remove Foreign body	
69210	Remove impacted cerumen	
69799	E- tube inflation	
38505	FNA lymph node	
31505	Laryngoscopy, indirect	

31575	Laryngoscopy, direct	
42700	peritonsillar abscess	
42804	biopsy nasopharynx	
42809	removal forign body throat	
60100	FNA thyroid	
69005	Ear hematoma	
69210	wax removal	
69220	mastoid debridement	
69433	myringotomy + tube	
92504	microscopic procedures	
69420	myringotomy only	
30901	Control hemorrhage-Simp	
30903	Control hemorrhage-Comp	
31231	Nasal endoscopy	
92511	Nasopharyngoscopy	
30130	Turbinectomies	
95004	Allergy Testing Procedures	
10005	Fine Needle Aspiration Biopsy Procedures	1/1/2022
10006	Fine Needle Aspiration Biopsy Procedures	1/1/2022
92546	VENG Test	1/1/2022
92588	Audio Exam	1/1/2022
95024	Allergy Testing Procedures	1/1/2022

Pain Management / Ortho	Description	Effective Date
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral	
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral	
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral	
20553	Trigger point Injection	1/1/2022
J0702	Corticosteroid: Betamethasone Acetate Injection 3 MG	1/1/2022

Endocrinology	Description	Effective Date
76536	Diagnostic Ultrasound Procedures of the Head and Neck	
79005	Therapeutic Nuclear Medicine Procedures	

Rheumatology	Description	Effective Date
	General Introduction or Removal Procedures on the Musculoskeletal	
20610	System	
96372	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions	
J1030	Injection, methylprednisolone acetate, 40 mg as maintained	
J7321	Supartz / Hyalgan per dose	1/1/2022
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection	1/1/2022
J7324	Orthovisc per Dose	1/1/2022
J7325	Synvisc One	1/1/2022
J7327	Monovisc per dose	1/1/2022

		Effective
Neurology	Description	Date
93886	Non-Invasive Cerebrovascular Arterial Studies.	1/1/2022
93888	Non-Invasive Cerebrovascular Arterial Studies.	1/1/2022
93890	Transcranial Doppler study of the intracranial arteries	1/1/2022
93892	Transcranial Doppler study of the intracranial arteries	1/1/2022
95816	Under Routine Electroencephalography (EEG) Procedures	1/1/2022
95819	Routine Electroencephalography (EEG) Procedures.	1/1/2022
95886	Electromyography Procedures.	1/1/2022
95911	Nerve Conduction Tests.	1/1/2022
95912	Nerve Conduction Tests.	1/1/2022

		Effective
Podiatry	Description	Date
	Refers to debridement of nails, which is the removal of a toenail bed	
11721	due to diseased bed	1/1/2022
11730	Surgical Procedures on the Nails	1/1/2022
11750	Excision of nail and nail matrix, partial or complete	1/1/2022

	Under repair, revision and or reconstruction procedures on the foot	
28270	and toes	1/1/2022
	Under repair, revision and or reconstruction procedures on the foot	
28285	and toes	1/1/2022
29550	Under lower extremity application of strapping - any age	1/1/2022
29580	Under lower extremity application of strapping - any age	1/1/2022
	Introduction /injection of anesthetic agent (nerve block) diagnostic	
64455	or therapeutic procedures on the somatic nerves	1/1/2022

Effective April 2022, Per NYS DOH, for members that are duals, having both Medicaid and Medicare coverage, Medicare is the primary payor for COVID-19 vaccines, tests, and treatment.

The Department has created a COVID-19 Fact Sheet for member services staff to provide to members inquiring about COVID-19 vaccines, tests, and treatment. Links to the document are below. The Department is working on translating the COVID-19 Fact Sheet into other languages, and will post them once they are complete.

https://health.ny.gov/health_care/medicaid/redesign/mrt2/policy/index.htm

https://www.health.ny.gov/health_care/medicaid/members/member_factsheets.htm

https://www.health.ny.gov/health_care/medicaid/fact_sheets/docs/covid/english.pdf

Appendix 17: Participating Provider Termination Form



The Participating Provider Agreement (PPA) termin receipt of this form. Providers shall continue to pro-					A from date o
Terminate all under this Tax ID I understand all will be terminated from	om all j	products and locations under this	Tax ID.	Group	Individual
Terminate provider (NPI) Only - I understand all products and location	ns will	be terminated under the provider	Tax ID and	NPI(s).	
Terminate provider under all Tax ID's - I understand all products and location	ons wil	l be terminated under all Tax Id	's for this NF	PI.	
Requestor's Contact Information:		*Coi	mplete all fie	elds below.*	
Effective Date:					
Requested By:					
Requestor's Phone Number:					
Requestor's Email Address:					
Fax Number:					
Office and Provider Information:					
Provider(s) Name:					
Provider(s) NPI:					
Provider(s) Tax ID:					
Office/Group Name:					
Reason For Termination					
□ Office Closed □	Retire	ed		Deceased	
□ No longer at location □	Do no	ot wish to participate		Moved out of area	
Other:					_
Authorized Signature:			Date Sig	ned:	
Term		completed please email the form providerrelations@villagecare.on requests take approximately 30	org.	ess.	
Should you have any o	mestio	ons, please contact Provider l	Relations (9 855-769-2500	
	•17	ust be executed and Credentialing compl			
PR_Termination_Form_08/01/2020 Version	1				

Appendix 18: VillageCareMAX Culturally and Linguistically Appropriate Services ("CLAS") Training Attestation



$\begin{array}{c} {\bf VCMAX} \ {\bf CULTURALLY} \ {\bf AND} \ {\bf LINGUISTICALLY} \ {\bf APPROPRIATE} \ {\bf SERVICES} \ {\bf TRAINING} \\ {\bf ATTESTATION} \end{array}$

From:

TOIII.	First Name	L	ast Name		Practice Name	
	Address					
	City	St	tate		ZIP	
SERVICE ompleted If yo 753- If yo 541- For c Davi	S training for form to below u are a hospita 2621 or via er u are a hospita 0947 or via er community bas dG@villageca	VillageCareMAX, please /: 1 located in the Manhattar mail: sergiof@villagecare. 1 located in the Brooklyn mail: orlandos@villagecare sed providers, please contare.org	and Queensorg and Bronx a e.org act: David G	D LINGUISTICALLY API is form no later than 12/1/26 s area, please contact: Sergi rea, please contact: Orlando odoy at cell# 917-921-5702 t each provider below (note)	O21 and send o Ferguson at cell# (646) o Santos directly at cell# (34 c or via email:	
IRST N	AME	LAST NAME	DEGREE	ORGANIZATION TIN	INDIVIDUAL NPI	
ppropriaty the Official	te Services trai ice for Minorit ove statement	ining, which is a requirem ty Health (OMH) at the U	ent of Villag .S. Departm	ed the 2021 Culturally and I geCareMax employees and i ent of Health and Human So knowledge. Additionally, th	providers are developed ervices (HHS). I declare	
equired	Attestation					
formatio	n completed by			T (1)		
gnature:		First Name (Plea	se print)	Last Name (Please p	print) Date	
		med provider (e.g. self o	ffice manage	er, nurse, other):		

https://www.villagecaremax.org/providers#clas

Please refer to VillageCareMAX website for CLAS Training, Notice, and Attestation: