VILLAGECAREMAX

PROVIDER MANUAL

VillageCareMAX Managed Long-Term Care (MLTC)

VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)

VillageCareMAX Medicare Health Advantage FLEX Plan (HMO D-SNP)

VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP)

VillageCareMAX Medicare Select Advantage Plan (HMO)

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Section 1: Quick Reference Guides

Provider Quick Reference Guide

VILLAGECAREMAX

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

Quick Reference Guide for Providers

Availity Provider Portal and VillageCareMAX-Altruista Health Provider Authorization Portal

The Availity Provider Portal is a quick, convenient, and secure way to verify member eligibility, review claims status, and more. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting: https://apps.availity.com/. The VillageCareMAX-Altruista Health Provider Authorization Portal integrates with GuidingCare Care Management and allows providers to electronically submit authorizations, check on status of authorizations, update and add additional information to an authorization 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 (Medicaid) 1-855-769-2500 (Medicare) **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: **H2168** MAP 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 -Urgent: any time 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	Medicare Tel: 1-855-296-8800 Medicaid Managed Long Term Care Tel: 1-800-469-6292 Please use the fax numbers below to send auth requests:	7 days/week 8 am - 8 pm	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.
» **DME**	Fax: 978-577-5451		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: 978-367-1872		All requests related to authorizations for Part B Drugs, including New & Continuing Service Requests.
» **Skilled Nursing Facility Admissions**	Fax: 212-402-4468		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 Medicaid. -VCMAX 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.
Dental Services » **LIBERTY Dental Benefits Manager**	Tel: 833-276-0853	Mon - Fri, 8 am - 8 pm	

Revised: 07/2025

Section 1: Quick Reference Guides

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)	1. 24 hours / 7 days 2. Mon – Fri 8 am to 5 pm 3. Mon – Fri, 8am-5pm, Sat – Sun, 10 am to 4 pm 4. Mon- Sun, 9 am to 5 pm 5. Mon - Sat 8 am to 5 pm	
Behavioral Health Services » **Carelon Behavioral Health**	Tel: 800-397-1630	Mon - Fri 8:30 am - 8 pm	Effective 3/1/23, Beacon Health Options became Carelon Behavioral Health
Durable Medical Equipment **1. Integra Partners** **2. Valmar Surgical Supplies**	1. Tel: 888-729-8818 2. Tel: 516-596-3070	1. Mon - Fri, 8 am - 8 pm 2. Mon - Fri, 9 am - 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 » Nursing Home Care » Home Health Care » Adult Day Health Care & Social Day Care » Non-emergency Transportation » Rehabilitation Therapy (PT, OT, ST) » Respiratory Therapy » Nutrition » Social and Environmental Supports » Home Delivered & Congregate Meals » Private Duty Nursing » Community-based Long-Term Services and Supports (LTSS) » Respite services » Tele-Monitoring » Home Infusion	» DME » Hospital admissions » Skilled Nursing Facility admissions » Surgeries » Outpatient Behavioral Health services » Alcohol and Substance Abuse services » *Rehabilitation Therapy (PT, OT, ST, Cardiac & Pulmonary)* » Auth required for all visits » Home Health Care » Organ Transplant » Chiropractic services » Diagnostic Services (MRI/MRA, EMG, PET Scan, Nuclear Medicine, Discogram/Myelogram, CT Scan, EEG) » Mobile Radiology » Acupuncture visits

Claims (Not Applicable for Behavioral Health Claims)

Mail paper claims (CMS-1500 or UB-04) and claims correspondence, including Claims Appeals to:	Electronic Claims Submissions (All Claims DOS):
VillageCareMAX Claims P.O. Box 3238 • Scranton, PA 18505	Use VillageCareMAX 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

Section 1: Quick Reference Guides

LHCSA Quick Reference Guide

VILLAGECAREMAX

VillageCareMAX Managed Long-Term Care (MLTC)

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

Quick Reference Guide for LHCSAs

Provider Portal and VillageCareMAX-Altruista Health Provider Authorization Portal

The VillageCareMAX Provider Portal is a quick, convenient, and secure way to verify member eligibility, review claims status, and more. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting https://apps.availity.com/. The VillageCareMAX-Altruista Health Provider Authorization Portal integrates with GuidingCare Care Management and allows providers to electronically submit authorizations, check on status of authorizations, update and add additional information to an authorization and can be accessed by visiting: https://vcm.guidingcare.com/AuthorizationPortal/.

How to Make a Referral

For your convenience, VillageCareMAX offers the following ways to make a referral:

By email

Email us at vcmaxrefer@villagecare.org
You may attach a spreadsheet with individual referrals listed on each line for batch referrals.

Online via web

Go to www.villagecaremax.org/providers#referrals

By phone

Call us at 1-800-469-6292

How to Check on a Status of a Referral

You may check on a status by calling our

Intake Call Center

212-337-5774

- Speak to an Intake representative
- Track status of referral(s) submitted
- Respond to incoming calls from member services or key partners
- Process referrals, schedule UAS and NYIA assessments
- Educate prospective members about the benefit plan and respond to general enrollment questions

Department	Contact Information	Hours of Operation	Information
Member Enrollment & Eligibility Verifications	EMEDNY toll-free: 1-800-997-1111 (Medicaid) 1-855-769-2500 (Medicare) 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 MAP 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 -Urgent: any time prior to admission but no later than 1 business day after admission -Emergent: within 1 business day of emergent admission
Dental Services » LIBERTY Dental Benefits Manager	Tel: 833-276-0853	Mon - Fri, 8 am - 8 pm	
Optometry/Vision Services » Superior Vision (Versant)	Tel: 866-819-4298	Mon - Fri, 8 am - 8 pm	
Claims/ Provider Services	Tel: 855-769-2500	Mon- Fri, 9 am - 5 pm	
Audiology/Hearing Services » HearUSA (audiology)	Tel: 855-898-1320	Mon - Fri, 8 am - 8 pm	

Section 1: Quick Reference Guides

Authorizations	Tel: 800-469-6292	7 days/week 8 am - 8 pm	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.
» DME	Fax: 978-577-5451		Requests for all new & existing DME/ Medical Necessity, Prescriptions.
» Grievance and Appeals	Fax: 347-226-5180		All requests related to grievance and appeals.
» Skilled Nursing Facility Admissions	Fax: 212-402-4468		All information regarding Skilled Nursing Facility Admissions, including: PRI and Short Term Rehab Requests, Clinicals, Discharge Summaries, Requests for Continuity of Care, etc.
Transportation Services (non-emergency) Sentry Management Solutions	Tel: 844-573-6879	Mon – Sat 7 am - 9 pm Sun 8 am - 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 MAP Services
» DME » Nursing Home Care » Home Health Care » Adult Day Health Care & Social Day Care » Non-emergency Transportation » Rehabilitation Therapy (PT, OT, ST) » Respiratory Therapy » Nutrition » Social and Environmental Supports » Home Delivered & Congregate Meals » Private Duty Nursing » Community-based Long-Term Services and Supports (LTSS) » Respite services » Tele-Monitoring » Home Infusion	» DME » Hospital admissions » Skilled Nursing Facility admissions » Surgeries » Outpatient Behavioral Health services » Alcohol and Substance Abuse services » *Rehabilitation Therapy (PT, OT, ST, Cardiac & Pulmonary)* » Auth required for all visits » Home Health Care » Organ Transplant » Chiropractic services » Diagnostic Services (MRI/MRA, EMG, PET Scan, Nuclear Medicine, Discogram/Myelogram) » Mobile Radiology » Acupuncture visits

Claims

Mail paper claims (CMS-1500 or UB-04) and claims correspondence, including Claims Appeals to:	Electronic Claims Submissions (All Claims DOS):
VillageCareMAX Claims P.O. Box 3238 • Scranton, PA 18505	Use VillageCareMAX 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.
- NPI and Tax ID must be included on all claims.

Revised: 07/2025

www.villagecaremax.org

Section 1: Quick Reference Guides

Provider Authorization Portal Quick Reference Guide

VILLAGECAREMAX
VillageCareMAX Managed Long Term Care (MLTC)
VillageCareMAX Medicare Total Advantage MAP Plan (HMO D-SNP)
VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP)
VillageCareMAX Medicare Health Advantage FLEX Plan (HMO D-SNP)
VillageCareMAX Medicare Health Select Advantage Plan (HMO)

altruista HEALTH

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.

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 user 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 » Once an authorization is closed, a new service request must be submitted; a retro authorization is not applicable.
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 N/A. 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 Information	Option available for authorizations with statuses of Approved, Pending, or Appeal Overturned from the Authorization List or Messages. To add information or request a modification to an existing service, expand authorization, click +Additional Information, and Enter Note or Add Attachments. Click Submit to save.
Request an Authorization Extension	To request an extension on a service, click the Home button to be redirected to the Home page. Please refer to above Request Authorization to submit a New Request.
Messaging Center	From Home page, click envelope icon on left menu to view Messages from reviewers to providers. Unread messages will 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	Claims Appeals or payment disputes must be submitted in writing to: » VillageCareMAX Claims, P.O. Box 3238, Scranton, PA 18505

For authorization questions, please call appropriate number based on the member's Plan:
Medicare: 1-855-296-8800 Medicaid Managed Long Term Care: 1-800-469-6292.
For Assistance or Training of Provider staff on using Portal, please submit your inquiry at
www.villagecaremax.org/providersupport.

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Section 1: Quick Reference Guides

Summary of Changes 2025

VILLAGECAREMAX

How you work with VillageCareMAX
Summary of Changes 2025

Effective for all dates of service, please refer to this document for a quick overview of administrative functions. For more detail, please see the 2025 Provider Manual which is available on our website at www.villagecaremax.org/provider-manual[1].

- Confirm Member Eligibility
- Request Authorization
- Update Your Information/Contract
- Submit Claims
- Submit Claims Inquiry or Dispute/Appeal
- Contact VillageCareMAX

Confirm Member Eligibility

	FOR ALL DATES OF SERVICE
Confirm Member Eligibility	Availity Portal[2] If you are a new user of Availity, create a free account from the above link, or log in with the same information you may use for other Plans.
Member ID	Use the Member ID on the member's card/portal. Please note: • Members renewing their Plan from 2024 will have the same Member ID as 2024. • Members newly enrolling in 2025 will have a new number in the format of the letter M followed by eight numbers.
View Your Panel Members (PCPs)	PCPs on a capitated arrangement will receive their panel list with the monthly payment remittance. PCPs can request a list of their panel membersby submitting an inquiry at www.villagecaremax.org/providersupport[3]. To view information about a specific member, please use the Availity Portal[2].

Request Authorization

	FOR ALL DATES OF SERVICE
Authorization Requests	Use the VillageCareMax Authorization Portal[4] or Call the appropriate number based on the member's Plan • Medicare: 1-855-296-8800 • Medicaid Managed Long Term Care: 1-800-469 6292 or For fax numbers, see the Provider Manual[1]

Section 1: Quick Reference Guides

	FOR ALL DATES OF SERVICE
Member ID	Use the Member ID on the member's card/portal. Please note: • Members renewing their Plan from 2024 will have the same Member ID as 2024. • Members newly enrolling in 2025 will have a new number in the format of the letter M followed by eight numbers.
View Authorizations	Use the VillageCareMax Authorization Portal[4] to search and view pending and processed requests.

Submit Claims

	FOR ALL DATES OF SERVICE
MEDICAL CLAIMS	
Electronic Claims Submission	Starting on January 1st, 2025: • Submit ALL claims, regardless of date of service, using the Availity clearinghouse (no charge to you). ▪ If you received separate authorization numbers for 2024 vs 2025, make sure to attach the correct authorization number to each claim. • Use VillageCareMAX Payer ID: 26545 (no change) • Electronic Claims must be submitted in 837I or 837P format.
Paper Claims Submission	Mail original and corrected claims to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505
Review Claims Status	• Use the Availity Portal[2] to search and view claims. • Download 835 files from the Availity clearinghouse.
Electronic Funds Transfer (EFT) Enrollment or Changes	• Complete the EFT Form available on our website[5]. • Submit to ProviderRelations@villagecare.org.
Electronic Remittance Advice (ERA) Enrollment or Changes	• Starting January 1st, 2025, enroll for ERA through the Availity Portal[2].
DENTAL, VISION, AND BEHAVIORAL HEALTH CLAIMS	
Claims Submission and Appeals	No change - Submit claims to the applicable delegated vendor. See the Provider Manual[1]. • Dental: Liberty Dental • Vision: Superior Vision • Behavioral Health: Carelon

Section 1: Quick Reference Guides

Submit a Claims Inquiry or Dispute/Appeal

	FOR ALL DATES OF SERVICE
Submit Claims Inquiries	Call Provider Services at 1-855-769-2500, and when prompted, select the option for applicable date of service.
Submit Claims Disputes/ Appeals	• Mail original and corrected claims to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505 or; • Fax to: (855) 864-7385 • Ensure you include all required supporting documentation, as described in the Provider Manual[1], to avoid processing delays.

Update Your Information/Contract

	FOR ALL DATES OF SERVICE
Demographic Changes e.g. Tax ID number, NPI number, specialties, provider types (practicing as a PCP, Specialist, Dual), open or closed panels, corporate name, office name, service/correspondence/billing addresses, phone/fax number, email address, provider adds/changes/ terminations under a participating group/IPA/organization, etc.	• Verify your demographic information is still correct on our Provider Online Search tool at providersearch.villagecaremax.org[6] • If you need to update demographic information or submit a provider termination, please use Provider Inquiry webform on our website at www.villagecaremax.org/providersupport[3]. • Please allow thirty (30) business days for provider record updates.
Termination Appeals	To appeal termination of a provider contract or individual providers within a group: • Make the request in writing within thirty (30) days of receipt of notice. • Send to "Provider Relations/Credentialing (URGENT)" at: VillageCareMAX Attn: Provider Relations 120 Broadway, Suite 2840 New York, NY 10271 • NEW: Or email the request to ProviderRelations@villagecare.org

Section 1: Quick Reference Guides

Contact VillageCareMAX

	FOR ALL DATES OF SERVICE
Authorization Requests and Inquiries Care Management Inquiries	• Use the VillageCareMax Authorization Portal[4] or • Call the appropriate number based on the member's Plan ▪ Medicare: 1-855-296-8800 ▪ Medicaid Managed Long Term Care: 1-800-469 6292 or • For fax numbers, see the Provider Manual[1].
Provider Services	• Call Provider Services at 1-855-769-2500, and when prompted, select the option for applicable date of service.
Provider Relations	• Provider Inquiry webform: www.villagecaremax.org/providersupport[3] • Provider Relations Email: ProviderRelations@villagecare.org • Fax: (718) 517-2698
Delegated Vendors for Dental, Vision, Behavioral Health, and Pharmacy, Transportation, Audiology/Hearing, Laboratory, and DME	• No change. See the Provider Manual[1].

[1] VillageCareMAX Provider Manual: https://www.villagecaremax.org/provider-manual
[2] Availity Portal: https://apps.availity.com
[3] VillageCareMax Provider Inquiry Webform: https://www.villagecaremax.org/providersupport
[4] VillageCareMax Authorization Portal: https://vcm.guidingcare.com/AuthorizationPortal
[5] VillageCareMAX Website: https://www.villagecaremax.org/providers
[6] Provider Online Search tool: https://providersearch.villagecaremax.org/

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.

Founded in 1977, VillageCare was initially a health care provider organization that provided 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. Today, VillageCare is a pioneering and innovative continuing care organization that offers community care services and managed care options to people living in New York City, Westchester, Nassau and Putnam (pending DOH approval).

Currently, VillageCareMAX offers five (5) managed care products to individuals living in the Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Staten Island (Richmond), Westchester, and Nassau counties in New York. In January of 2025, we expect to receive approval to serve Putnam County from the New York State Department of Health. Our product offerings:

- **VillageCareMAX Managed Long-Term Care (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 and **VillageCareMAX Medicare Health Advantage FLEX** Plan (collectively, "VillageCareMAX Medicare Health Advantage Plans" or "D-SNP") and the VillageCareMAX Medicare Select Advantage Plan (HMO) (together with the D-SNP Plans, "MA") provide 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 Select Advantage** Plan (HMO) provide Medicare-covered services only. These include all Medicare Part A & B services, and Part D prescription drugs. VillageCareMAX Non-D-SNP Medicare Plan is intended for members who are Medicare eligible and receive financial "Full Extra Help", also referred to as the Low-Income Subsidy Plan (LIS). This plan offers members supplemental benefits like vision, hearing, and dental. This is a $0

premium and deductible plan when the member receives Extra Help. Members pay $0 for primary doctor and preventive visits, and Part D prescription copays are as low as $4.50 for generics and $11.20 for brand medications. Providers will need to collect copays an coinsurance from members for Medicare covered services.

- **VillageCareMAX Medicare Total Advantage** Plan (HMO DSNP) provides all Medicare-covered and Medicaid-covered services (collectively, "VillageCareMAX Medicare Total Advantage Plans" or "MAP"). 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 health care services for chronically ill adults who wish to remain in their own home and communities for as long as possible.

- Members' 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 participating with VillageCareMAX (for MAP and MA Plans, through Carelon Behavioral Health formerly known as Beacon Health Options), 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, Kings (Brooklyn), New York (Manhattan), Putnam, Queens, Richmond (Staten Island) or Westchester counties in New York. (NOTE: VillageCareMAX has received approval to operate in Putnam county effective 1/1/2025.)

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 usually 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 often also have one or more chronic medical and/or psychiatric conditions and/or cognitive impairments.

Section 3: Enrollment Eligibility Criteria

VillageCareMAX Medicare Health Advantage Plans Enrollment Eligibility

To be eligible for enrollment in the VillageCareMAX Medicare Health Advantage Plans, including VillageCareMAX Medicare Health Advantage and VillageCareMAX Medicare Health Advantage FLEX, 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, Kings (Brooklyn), New York (Manhattan), Queens, , Richmond (Staten Island), or Westchester counties.
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, Kings (Brooklyn), New York (Manhattan), Putnam, or Queens counties. Effective January 1, 2024, the VillageCareMAX service area includes residents of Nassau, Richmond (Staten Island), and Westchester counties.
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:

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

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

VillageCareMAX Medicare Select Advantage Enrollment Eligibility

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

1. Be eligible for both Medicare Part A and Medicare Part B

2. Not be eligible for Medicaid

3. Receive financial "Full Extra Help", also referred to as the Low Income Subsidy (LIS)

4. Be a resident of Bronx, Kings (Brooklyn), New York (Manhattan), Putnam Queens, Nassau, Richmond (Staten Island), or Westchester counties.

5. A United States citizen or lawfully present in the United States

6. Not have End-Stage Renal Disease (ESRD) at the time of enrollment

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.

Lead Forms or Brochures can be left behind at facility and if patient/prospect is interested in learning about VillageCareMAX Plans, the Brochure or Lead form can be signed by patient for a VillageCareMAX representative to conduct an outreach.
Signed Brochures or Lead Forms can be scanned and emailed to Medicare Sales Manager to screen for proper eligibility and assign to a Benefit Advisor.

Section 3: Enrollment Eligibility Criteria

If a Social Worker has a potential member interested in learning about our MAP plan, Social Worker can call with patient or legal representative to Member Services Department at 1-800-469-6292 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare.

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 Health Advantage FLEX**
  - **CMS Contract ID: H2168 003**
- **VillageCareMAX Medicare Select Advantage Plan**
  - **CMS Contract ID: H2168 004**
- **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.

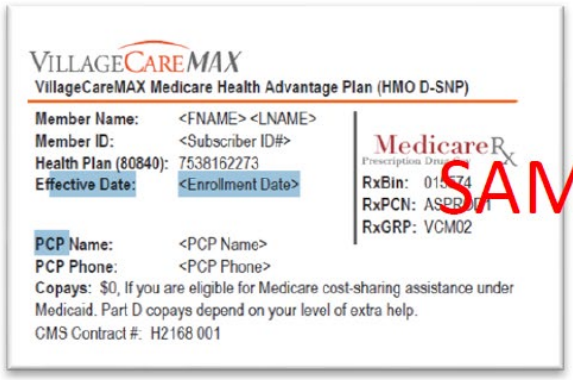
Section 4: Enrollment Eligibility Verification

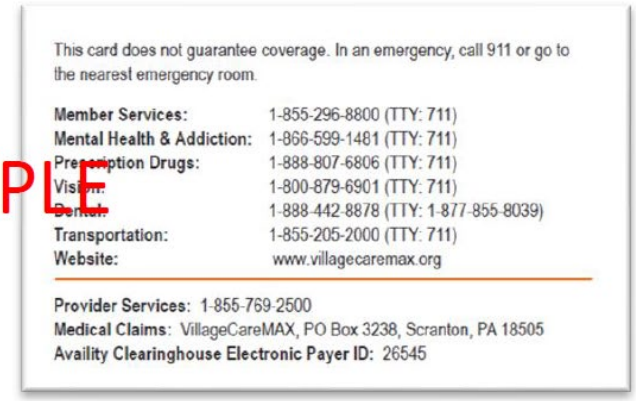
Member ID Cards

VillageCareMAX MLTC Member ID Card

Refer to your QRG for the Claims address for 2024 Dates of Service.

VillageCareMAX Medicare Health Advantage Plan (001) Member ID Card





VillageCareMAX Medicare Total Advantage Plan (002) Member ID Card

Section 4: Enrollment Eligibility Verification

VillageCareMAX Medicare Health Advantage FLEX Plan (003) Member ID Card

VillageCareMAX Medicare Select Advantage Plan (PBP 004) Member ID Card

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Section 5: Covered Benefits

List of Covered Benefits for VillageCareMAX Managed Long Term Care Plan (MLTC), VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP), VillageCareMAX Medicare Health Advantage FLEX Plan (HMO D-SNP), VillageCareMAX Medicare Select Advantage Plan (HMO), and VillageCareMAX 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/.

Unless otherwise indicated, the services under MA apply to Medicare Health Advantage, Medicare Health Advantage FLEX, and Medicare Select Advantage.

See grid below for additional supplemental benefits.

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 (Medicaid Managed Long Term Care) or **1-855-296-8800 (Medicare) or visit our website at http://www.villagecaremax.org for more information.**

Benefits	MLTC	MAP	MA
24/7 Physician Hotline	NC	X	X
Adult Day Health Care	X	X	NC
Ambulatory Surgery Center	NC	X	X
Anesthesia	NC	X	X
Angiograms and Embolization	NC	X	X
Audiology Services (Exam)	X	X	X
Basic Radiology Services	NC	X	X
Blood Transfusion	NC	X	X
Cardiac Rehabilitation Services	NC	X	X
Chemotherapy	NC	X	X
Chiropractic Services	NC	X	X
Consumer Directed Personal Assistance Services (CDPAS)	X	X	NC
CT Scan	NC	X	X
Dentistry[1]	X	X	X
Diabetes Programs and Supplies	X	X	X
Diagnostic Services	NC	X	X
Dialysis	NC	X	X
Discogram/Myelogram	NC	X	X
Durable Medical Equipment (DME)	X	X	X

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

Section 5: Covered Benefits

Benefits	MLTC	MAP	MA
Electromyogram (EMG)	NC	X	X
Emergency Ambulance Services	NC	X	X
Emergency Care	NC	X	X
Hearing Aids / Batteries[2]	X	X	X
Home Delivered and Congregate Meals	X	X	X[3]
Home Health Care	X	X	X
Home Infusion Services	X*	X	X
Hospital Services	NC	X	X
Immunizations	NC	X	X
Infusion	X*	X	X
Inpatient Bariatric Surgery	NC	X	X
Inpatient Hospital Care	NC	X	X
Inpatient Mental Health Care	NC	X	X
Inpatient Organ Transplants	NC	X	X
Inpatient Reconstructive Surgery	NC	X	X
Inpatient Skilled Nursing Facility	X	X	X
Inpatient Substance Abuse and Rehab	NC	X	X
Lab Services	NC	X	X
Medical Social Services	X	X	NC
Medicare Covered Acupuncture	NC	X	X
Mental Health Care	NC	X	X
Mobile Radiology (EKG and X-Rays)	NC	X	X
MRI/MRA	NC	X	X
Nerve block/Epidurals	NC	X	X
Non-Emergency Transportation[4] **/ Ambulance Services**	NC	X*	X
Nuclear Medicine	NC	X	X
Nurse Practitioner	NC	X	X
Nutrition	X	X	X*
Occupational Therapy[5]	X	X	X

[2] Hearing Aid Batteries do not require prior authorization.
[3] Effective 1/1/2022, Home Delivered/Congregate Meals immediately following surgery or inpatient hospitalization will be a supplemental benefit for the Medicare Health Advantage Plan only – not applicable to Medicare Health Advantage FLEX Plan.
[4] Effective 3/1/2024, Non-Emergency Medical Transportation is no longer covered by MLTC and MAP plan. VillageCareMAX will continue to cover Medicare covered transportation services through Sentry. For SADC programs that provide or subcontract transportation as part of their contract with VillageCareMAX to-and-from the program, the transportation will be covered by the plan through SADC. All providers are required to use billing code A0130 effective 4/1/2024.
[5] 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

Section 5: Covered Benefits

Benefits	MLTC	MAP	MA
Orthopedic Footwear	X	X	X
Part B Drugs (when billed by a physician or facility)	NC	X	X
Partial Hospitalization	NC	X	X
Personal Care Services	X	X	NC
Personal Emergency Response Services (PERS)	X	X	NC
Pet Scan	NC	X	X
Physical Therapy[4]	X	X	X
Physician Assistant	NC	X	X
Physician Specialist Services	NC	X	X
Podiatry Services	X	X	X
Primary Care Physician Services	NC	X	X
Private Duty Nursing	X	X	NC
Prosthetics/ Medical Surgical Supplies	X	X	X
Psychiatry	NC	X	X
Pulmonary Rehabilitation Services	NC	X	X
Respiratory Therapy	X	X	X*
Social and Environmental Supports	X	X	NC
Social Care Network[6]	X	X	NC
Social Day Care	X	X	NC
Speech Therapy[4]	X	X	X
Substance Abuse Care	NC	X	X
Telehealth	X	X	X
Tuberculosis screening & clinical management	NC	X	X
Ultrasound	NC	X	X
Urgent Care	NC	X	X
Vision Services – Eye Exam and Eyewear	X	X	X
Worldwide Emergency/Urgent Care	NC	X	X

KEY
X = Covered Benefit
NC = Not Covered
X* = Service may only be partially covered under this Plan. Providers may contact Utilization Management at 1-800-469-6292 (Medicaid MLTC) or 1-855-296-8800 (Medicare) visit our website at http://www.villagecaremax.org for more information.

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: private practitioners' offices, certified hospital out-patient departments, and diagnostic & treatment centers (free-standing clinics). If not POS 12: GP, GN, GO modifier needed.

[5] Effective 3/1/2024, the ADHC transportation benefit is carved out of the Managed Long-Term Care (MLTC) Plan benefit package. ADHCs now need to bill Medicaid FFS to seek reimbursement and not MLTC or MAP plans.

[6] Effective 1/1/2025, Social Care Network added per approval by DOH.

Section 5: Covered Benefits

Transportation Benefit

As a follow-up communication to the VillageCareMAX Provider Bulletin sent in May 2024, effective 3/1/2024, Non-Emergency Medical Transportation is no longer covered by MLTC and MAP plan(s). VillageCareMAX will continue to cover the following Medicare covered transportation services through our transportation vendor, Sentry.

For Social Adult Day Care (SADC) programs that provide or subcontract transportation as part of their contract with VillageCareMAX to-and-from the program, the transportation requires approval by the plan as per their current contract in order to be covered. For SADC programs that DO NOT provide or subcontract transportation as part of their contract with VillageCareMAX to-and-from the program, the transportation will be covered by Fee for Service Medicaid through MAS.

Below grid applies to Plans: VillageCareMAX Medicare Total Advantage ("MTA"), VillageCareMAX Medicare Health Advantage ("MHA"), VillageCareMAX Medicare Health Advantage FLEX ("MHA Flex") VillageCareMAX Medicare Select Advantage ("MSA")

Benefit	Prior Auth Required (Yes/No)	Plan Coverage
Emergency Ambulance Services *(Medicare-covered)* Transport to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health	No	MTA Dual(501) MTA Medicare Only(503) MHA(301) MHA Flex(311) MSA(601)
Non-Emergency Ambulance Services *(Medicare-covered)* Medicare covers limited non-emergency ambulances. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	Yes (via Vendor Eligibility File)	MTA Dual(501) MTA Medicare Only(503) MHA(301) MHA Flex(311) MSA(601)
Non-Emergency Transportation *(Part C Supplemental Benefit)* Plan covers non-emergency transportation services that are not covered by Medicare as a supplemental benefit. Covered benefits include: • Up to 36 one-way trips per year to plan approved locations. • Transportation trips are covered for travel by taxi, van, or ride share services.	Yes (via Vendor Eligibility File)	MHA(301) MHA Flex(311)
Non-Medical Transportation *(Part C Supplemental Benefit)* Plan covers non-emergency transportation services that are not covered by Medicare as a supplemental benefit. Covered benefits include: • Up to 12 one- way trips (6 round trips) per year for non- medical appointments to plan approved locations. • Transportation trips are covered for travel by taxi, van, or ride share services.	Yes (via Vendor Eligibility File)	MTA Dual(501) MTA Medicare Only(503)

Section 5: Covered Benefits

Sentry Non-Emergent Ambulance Request

Please allow VCM 1 business day to process the request once received
Fax request to 212-402-4468 (hospital) / 978-967-8030 (SNF)
Call request to Customer Service:
1-855-296-8800 (Medicare) or
1-800-469-6292 (Medicaid Managed Long Term Care)

Transportation Requests:

- Patient name, plan ID, DOB
- Medical reason for ambulance request
- Date of service
- Pick up address: Name of Hospital & address
- Drop off address: Name of Hospital/SNF & address
- Contact person in the hospital: (nurses' station number)
- Details where the patient is (floor-room):
- Best contact number for patient/aid/family member:

Additional information if known:

- Weight of the patient
- Height of the patient
- Oxygen needed?
- Bariatric stretcher needed?
- Are there steps in the patient's home, if so, how many?
- Is the patient aware of their surroundings?
- Does the patient have access and keys to the drop off location?
- Are they traveling alone?
- Does the patient have a DNR?

Section 5: Covered Benefits

2025 Supplemental Benefits Comparison

VillageCareMAX 2023 Medicare Advantage Supplemental Benefit Summary Changes from prior year are highlighted in yellow below				
CMS Contract-Plan #	**H2168-001**	**H2168-002**	**H2168-003**	**H2168-004**
Plan Name	**VillageCareMAX Medicare Health Advantage Plan**	**VillageCareMAX Medicare Total Advantage Plan**	**VillageCareMAX Medicare Health Advantage FLEX Plan**	**VillageCareMAX Medicare Select Advantage Plan[7]**
Description	**Supplemental Benefits**			
Worldwide Emergency/Urgent Coverage	$0 Copay, $50,000 Limit Per Year	$0 Copay, $50,000 Limit Per Year	$0 Copay, $50,000 Limit Per Year	$50,000 Limit Per Year
Non-Emergency Medical Transportation	$0 Copay, Limit 36 One Way Trips Per Year	Not Covered	$0 Copay, Limit 36 One Way Trips Per Year	Not Covered
Acupuncture	Not Covered	$0 Copay, Up to 5 visits per month, with maximum of 54 visits per year (up to $80 limit per visit)	$0 Copay, Up to 8 visits per month, with maximum of 32 visits per year (up to $80 limit per visit)	Not Covered
Preventive Dental	$0 Copay, no allowance limit	$0 Copay, no allowance limit	$0 Copay, no allowance limit	$0 Copay, no allowance limit
Comprehensive Dental	$0 Copay, no allowance limit	$0 Copay, no allowance limit	$0 Copay, no allowance limit	$0 Copay, no allowance limit
Routine Eye Exams	$0 Copay, Limit 1 Visit Per Year	$0 Copay, Limit 1 Visit Per Year	$0 Copay, Limit 1 Visit Per Year	$0 Copay, Limit 1 Visit Per Year
Glasses/Contacts	$0 Copay, $350 per year for eyewear with a limit. - contacts (unlimited) - eyeglasses (lenses + frames) - 1 per year - lenses (1 pair per year) - frames (1 per year)	$0 Copay, $350 per year for eyewear with a limit. - contacts (unlimited) - eyeglasses (lenses + frames) - 1 per year - lenses (1 pair per year) - frames (1 per year)	$0 Copay, $300 per year for eyewear with a limit. - contacts (unlimited) - eyeglasses (lenses + frames) - 1 per year - lenses (1 pair per year) - frames (1 per year)	$0 Copay, $300 per year for eyewear with a limit. - contacts (unlimited) - eyeglasses (lenses + frames) - 1 per year - lenses (1 pair per year) - frames (1 per year)
Routine Hearing Test	$0 Copay, Limit 1 Visit Per Year	Not Covered	$0 Copay, Limit 1 Visit Per Year	$0 Copay, Limit 1 Visit Per Year
Hearing Aids	$0 Copay, $750 per ear every year with a maximum of up to $1500 limit every year for 2 hearing aids	$0 Copay, $625 per ear every year with a maximum of up to $1250 limit every year for 2 hearing aids	$0 Copay, $750 per ear every year with a maximum of up to $1500 limit every year for 2 hearing aids.	$0 Copay, $375 per ear every year with a maximum of up to $750

[7] Please refer to Chapter 4 of the Evidence of Coverage for Covered Services:
https://d2mcoh0vajf3v0.cloudfront.net/production/public/files/docs/MAPD/2025/EOC/MBR25-23_C%202025%20EOC%20MSA.pdf

				limit every year for 2 hearing aids.
Grocery Items	Included as part of OTC benefit for those that qualify for VBID	Included as part of OTC benefit for those that qualify for SSBCI	Included as part of OTC benefit for those that qualify for VBID	Not Covered
OTC Card ***VBID and SSBCI Benefits – Food & Produce/Grocery, Utilities, Rental Assistance, Gas At-The-Pump***	$**265** monthly limit combined for both OTC items and VBBID benefits for those who qualify. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities, OTC hearing, and OTC COVID tests.	$**300** monthly limit combined for both OTC items and SSBCI benefits for those who qualify. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities, OTC hearing, and OTC COVID tests.	$**195** monthly limit combined for both OTC items and VBID benefits for those who qualify. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities, OTC hearing, and OTC COVID tests.	Not Covered
Fitness Benefit	$0 Copay, Monthly membership to participating fitness locations and in-home fitness programs/kits.	$0 Copay, Monthly membership to participating fitness locations and in-home fitness programs/kits.	$0 Copay, Monthly membership to participating fitness locations and in-home fitness programs/kits.	$0 Copay, Monthly membership to participating fitness locations and in-home fitness programs/kits.
Therapeutic Shoes/Diabetic Footcare (Non-Covered)	$0 Copay, Limit of 1 additional pair of diabetic shoes per year for individuals with diabetes and severe diabetic foot disease.	Not Covered	$0 Copay, Limit of 1 additional pair of diabetic shoes per year for individuals with diabetes and severe diabetic foot disease.	$0 Copay, Limit of 1 additional pair of diabetic shoes per year for individuals with diabetes and severe diabetic foot disease.
Meal Benefit (immediately following surgery or inpatient hospitalization)	2 meals per day for 4 weeks (2 x 28 days = 56 meals total)	Not Covered under Supplemental	Not Covered	Not Covered
Flex Benefit	Not Covered	$575 per year allowance towards additional dental, vision, or hearing benefits (dispensed in equal monthly amounts – approximately $47.92 monthly -- over the course of the year) Unused amount rolls over each month but expires at the end of the year	$1,500 per year allowance towards additional dental, vision, or hearing benefits (distributed monthly in equal amounts -- $125 monthly – over the course of the year) Unused amount rolls over each month but expires at the end of the year	Not Covered
Non-Medical Transportation	VBID Benefit: Up to 12 round trips (24 one-way trips) per year	SSBCI Benefit: Up to 12 round trips (24 one-way trips) per year	VBID Benefit: Up to 12 round trips (24 one-way trips) per year	Not Covered

One In-Home Safety Assessment	One safety evaluation at home per year. Required to obtain safety devices.	Not Covered	One safety evaluation at home per year. Required to obtain safety devices.	Not Covered
Bathroom Safety Devices	Up to $150 per year to spend on the following safety Devices and Modifications (safety evaluation must support the need for the devices): Shower Chair Reach Stick Raised Toilet Seat Handheld Shower Device Transfer Bench	Not Covered	Up to $150 per year to spend on the following for safety Devices and Modifications (safety evaluation must support the need for the devices): Shower Chair Reach Stick Raised Toilet Seat Handheld Shower Device Transfer Bench	Not Covered

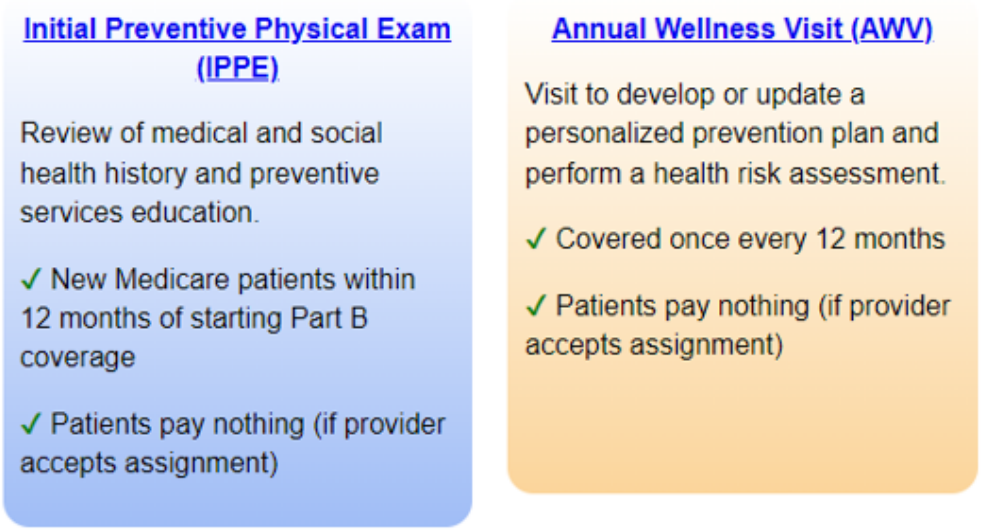
Section 5: Covered Benefits

Annual Wellness Visits

We would like to remind providers of the importance of **Preventive Care Exams and Visits** for our members. These visits are a key component of preventive care, helping identify potential health risks and supporting the overall well-being of your patients.

Key Points to Remember:

- **Annual Wellness Visits (AWVs)** are covered by the member's benefit plan at no cost to them.
- Annual Wellness Visits are different from **Initial Preventative Physical Exams (IPPE)**.



- There are **no prior authorization requirements** for AWVs and IPPE, making it easier for patients to access these vital preventive services.

- **Procedure Codes for AWVs:**
  - **G0402:** Initial preventive physical examination (IPPE) – "Welcome to Medicare" visit
  - **G0438:** Annual wellness visit, initial visit
  - **G0439:** Annual wellness visit, subsequent visit
- Wellness visits can be performed during a primary care appointment or, in some cases, during a specialty visit (e.g., with a cardiologist, pulmonologist, or endocrinologist).
- Encouraging annual check-ups ensures early detection of potential health issues and helps patients maintain their health.

For additional information about Annual Wellness Visits, please visit the following website: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Section 5: Covered Benefits

2025 Special Supplemental Benefits for the Chronically Ill (SSBCI) and Value-Based Insurance Design (VBID)

In 2025, VillageCareMAX is offering SSBCI benefits to members in the MAP plan and VBID benefits to members in the D-SNP and D-SNP Flex plans. The benefit offerings for both SSBCI and VBID are healthy foods/groceries, rental assistance, utilities, and vehicle gas at-the-pump – all of which can be accessed via the OTC card.

Members qualify for VBID due to receiving "Extra Help". Members qualify for SSBCI if they meet the following criteria:

1. has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
2. has a high risk of hospitalization or other adverse health outcomes; and
3. requires intensive care coordination.

Care Management evaluates member through completion of the Health Risk Assessment or similar survey to determine if the member qualifies.

Complex Chronic Conditions include:

Chronic alcohol and other drug dependence
Autoimmune disorders
Cancer
Cardiovascular disorders
Chronic heart failure
Dementia
Diabetes
End-stage liver disease
End-stage renal disease (ESRD)
Gastrointestinal disorders
Severe hematologic disorders,
HIV/AIDS
Chronic lung disorders
Chronic and disabling mental health conditions
Neurologic disorders
Stroke
Osteoporosis
Inflammatory disorders
Eye disorders

Frequently Asked Questions (FAQ) 2025 OTC Card

Q1: Which vendor manages the OTC, SSBCI (Groceries and Utilities), Flex benefits and Rewards Program in 2025?
A1: In 2025, VillageCareMAX works with Solutran to manage members' OTC, SSBCI, VBID,s, Flex benefit and rewards program benefits..

Q2: How much do members receive per month in 2025 for their OTC and VBID/SSBCI benefits?
A2: The monthly funds are different per each plan:

- Medicare Health Advantage: $265 for OTC and VBID combined

- Medicare Health Advantage Flex: $195 for OTC and VBID combined
- Medicare Total Advantage: $300 for OTC and SSBCI combined
- Medicare Select Advantage: Not covered

Q3: The Medicare Total Advantage and Medicare Health Advantage Flex members also receive FLEX benefits. How much is their benefit?
A3: Medicare Total Advantage members receive $575 per year (distributed in 12 equal monthly amounts) and Medicare Health Advantage FLEX members receive $1,500 per year allowance (distributed in 12 equal monthly amounts) towards additional Dental, Vision, or Hearing benefits.

Q4: Do the unused funds for OTC, VBID, SSBCI and Flex benefits expire at the end of each month?
A4: No, the unused funds now carry over from month to month but expire on 12/31/2025.

Q5: What does the OTC card look like?
A5: This is the front and back images of the OTC card:

Q6: What materials will members receive and what languages are available?
A6: Members receive a personalized welcome kit in the mail including:

- Letter
- Program card
- Catalog
- Instructions to download mobile app

These materials are available in English, Spanish, Chinese, Russian, and Haitian-Creole.

Q7: What is covered by the OTC, VBID/SSBCI, and Flex benefits?
A7: Some covered items include:

- **OTC items:** Pain relief, vitamins, allergy and sinus, cold and flu, dental and oral health, diabetes care, first aid, home health care and daily living, OTC hearing aids and OTC COVID-19 test kits.

- **VBID/SSBCI (Groceries)**: Fresh produce, dairy products, meat and seafood. beans and legumes, pantry staples, healthy grains, nutritional shakes and bars.
- **VBID/SSBCI (Utilities)**: Gas, electricity, water, and internet/telecommunications.
- VBID/SSBCI (Other): Rental/mortgage payments to certain property managers or banking institutions; automobile gas at-the-pump
- **Flex benefit (Medicare Total Advantage and Medicare Health Advantage Flex plan only):** Copays and out-of-network bills for dental, vision or hearing services, glasses, lens upgrades, contacts, prescription sunglasses.

Note: This is not a complete list. Please refer to OTC catalog or check online at https://healthybenefitsplus.com/VillageCareMAX for a full list of qualified items and categories.

Q8: What is not covered by the OTC, VBID/SSBCI and Flex benefits?
A8: OTC card cannot be used to buy alcohol, tobacco, or firearms, or used at an ATM to get cash. For more information, read the cardholder agreement online at https://healthybenefitsplus.com/VillageCareMAX

Q9: Who is qualified for VBID and SSBCI benefits; how is qualification determined?
A9: Members enrolled in MHA and MHA Flex plans qualify for VBID benefits due to receiving "Extra Help"
Members enrolled in Medicare Total Advantage must meet clinical criteria to receive SSBCI benefits.

- Medicare Health Advantage/Medicare Health Advantage Flex – Members receiving "Extra Help" (Low Income Subsidy) automatically qualify
- Medicare Total Advantage – All members meet the criteria due to their chronic conditions and will automatically qualify for SSBCI benefits.

Q10: How to activate OTC card?
A10: There are Four ways for members to activate their OTC card:

- **By Designated Activation Line:** 1-855-256-4620
- **By phone:** 1-833-818-9227 (TTY 711)
- **Online**: https://healthybenefitsplus.com/VillageCareMAX
- **Mobile App (Most recommended):** Healthy Benefits+ app (See Q10 for instructions on how to download the app)

Q11: How to purchase OTC items?
A11: There are Four ways for members to purchase the OTC items:

- **In-store:** check online at https://healthybenefitsplus.com/VillageCareMAX to locate a participating retailer.
- **By phone**: 1-833-818-9227 (TTY 711)
- **Online:** https://healthybenefitsplus.com/VillageCareMAX
- **Mobile App (Most recommended):** Healthy Benefits+ app (See Q10 for instruction on how to download the app)

Q12: How to download the Mobile App?
A12: Members can download the Healthy Benefits+ App or simply scan the QR code to download the mobile app.

Section 5: Covered Benefits

Q13: What information is available on the portal (https://healthybenefitsplus.com/VillageCareMAX) and mobile app (Healthy Benefits+ App)?
A13: Members can activate their OTC card, view benefits & balance, browse eligible products & services, find participating retailers, checkout with barcode or card number, request a category and many more.

Q14: Can the mobile app be used as the digital card?
A14: Yes, simply scan the barcode in the mobile app at the checkout.

Q15: Can the members scan product barcodes while shopping in the store to verify benefit eligibility with the Healthy Benefits+ mobile app?
A15: Yes, they can.

Q16: What price applies at checkout?
A16: Online and in-store pricing may not be the same as the prices listed in the catalog. The online and in-store price applies at checkout.

Q17: Do members pay sales tax?
A17: Yes, all orders are subject to the local state sales tax.

Q18: What if the purchase costs more than the remaining funds?
A18: If the purchase total is more than the available funds on the OTC card, members can pay the balance due out of pocket.

Q19: How can members get a replacement card?
A19: Members may ask for a replacement card to be mailed by visiting https://healthybenefitsplus.com/VillageCareMAX or calling 1-833-818-9227 (TTY 711) 8am-8pm, 7 days a week from October to March , 8am-8pm Mon-Fri from April to September.

Q20: What to do if members lose their card and need to make a purchase?
A20: If members lose their card, do not have access to the mobile app or experience issues using the card, they can pay for eligible items on their own and ask VillageCareMAX to pay them back. Members must submit the receipt and a list of items purchased to: VillageCareMAX at 112 Charles Street, New York NY 10014 or fax to: 212-337-5711.

Q21: How to pay for the utilities? (Utilities are part of the SSBCI benefits, criteria will apply.)

A21: Members can pay their utility bill online at https://healthybenefitsplus.com/VillageCareMAX using the Bill Pay option, or by calling their utility service provider. Have the bill available, and the 16-digit card number, 3-digit CVV on the back of the card, and the member's zip code to pay for the bill.

Q22: If members reside in a household where they are not the name listed on the utility account. Can they make the payment with the card?
A22: Yes, they can. There will be no issues to utilize the card for bill payment with another name on the account.

Q23: Which plan's Reward Program is managed by Solutran in 2025?
A23: In 2024, VillageCareMAX works with Solutran to manage the Rewards program for Medicare Total Advantage, Medicare Health Advantage, Medicare Health Advantage FLEX, Medicare Select Advantage, and effective January 1, 2025: Managed Long Term Care.

Q24: How does the Rewards Program work?
A24: The VillageCareMAX Rewards Program allows members to earn rewards ($15 - $25) by completing specific preventive care activities. For each healthy action taken, members will receive a reward added to their OTC card. Rewards funds expire one year from issuance.

Annual Notice of Change (ANOC)

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

Medicare Total Advantage:

https://www.villagecaremax.org/map/2025-plan-materials-and-resources

Medicare Health Advantage:

https://www.villagecaremax.org/dsnp/2025-plan-materials-and-resources

Medicare Health Advantage FLEX:

https://www.villagecaremax.org/mhaf/2025-plan-materials-and-resources

Medicare Select Advantage:

https://www.villagecaremax.org/mapd/2025-plan-materials-and-resources

Behavioral Health Services

As of January 1, 2023, VillageCareMAX is partnering with Carelon Behavioral Health (fka Beacon Health Options) ("Carelon") as our behavioral health benefit manager to provide behavioral health services and ensure VillageCareMAX MAP and MA members can access behavioral health care.

Section 5: Covered Benefits

Carelon offers clinical mental health and substance use disorder management, specialty programs for autism and depression, and offers access to a broad network of behavioral health providers and facilities, encompassing all levels of specialty mental health and addiction services for MAP and D-SNP members.

All Utilization Management, Care Management, Provider Relations, claims processing, and Call Center Operations related to Behavioral Health will be managed by Carelon.

Providers who wish to provide Behavioral Health services to VillageCareMAX members must be participating with VillageCareMAX through Carelon.

Any claims related to covered Behavioral Health services must be submitted to Carelon for payment.

Behavioral health services include, but are not limited to:

- Emergency Behavioral Health Services
    - Presented to emergency department and admitted to Psychiatric unit or Substance Use Disorder (SUD) service
    - Comprehensive Psychiatric Emergency Program (CPEP) services
    - Carelon contracted emergency service provider for assessment and screening purposes
    - Behavioral health emergency service providers in any setting
- Inpatient Admissions for Behavioral Health Services
    - Substance Use Disorder, Withdrawal Management, Detox
    - Inpatient Psychiatric Admission
    - Psychiatric/SUD assessments, evaluations, and consults
- Altered Cognition/Neurological Services treated by Behavioral Health Services:
    - Dementia, Delirium, Amnesia
    - Other neurological disorders i.e. head injury with cognitive changes, delirium due to SUD, behavioral manifestations of symptoms
- Non-Emergent Transportation to and from appointments related to Behavioral Health Services.
- Outpatient Situations for Behavioral Health Services:
    - Psychological or Neuropsychological Testing
    - Primary Treatment for SUD with Behavioral Health provider
    - Harm Reduction Services
    - Services rendered in NYS Office of Mental Health (OMH) or NYS Office of Addiction Services and Supports (OASAS) settings
    - Eating Disorders treatment with approved Behavioral Health service

Also, effective January 1, 2023, New York State Department of Health has carved in additional behavioral health services for **MAP** members:

- CORE (Community Oriented Recovery and Empowerment) Services:
  - Community Psychiatric Supports and Treatment (CPST)
  - Empowerment Services – Peer Supports
  - Family Support Training (FST)
  - Psychosocial Rehabilitation (PSR)
- OASAS Services:
  - Outpatient Opioid Treatment, and the following freestanding inpatient programs:
    - Inpatient Rehab
    - Inpatient Detox
    - Residential Services (Part 820)
- Mental Health Outpatient Services:
  - For those who are eligible, programs include:
    - Office of Mental Health (OMH) Assertive Community Treatment (ACT)
    - OMH Continuing Day Treatment (CDT)
    - OMH Comprehensive Psychiatric Emergency Program (CPEP)
    - OMH Partial Hospitalization
    - OMH Personalized Recovery Oriented Services (PROS)
    - Adult Crisis Intervention (CI)

Social Care Network (SCN)

As of January 1, 2025, VillageCareMAX is contracting with the following Social Care Network (SCN) providers for VillageCareMAX MLTC and MAP members to improve integration across health, behavioral health, and social care.

SCNs will identify Medicaid Members' unmet social needs, navigate Members to Health-Related Social Needs (HRSN) services, and reimburse HRSN service providers.

SCNs can include a range of service providers such as Community-Based Organizations (CBOs) and other partners (e.g., regional non-profits, health care providers).

Organizations in an SCN will use shared data and technology to better integrate social, behavioral, and physical health services and improve Member experience.

Organization Name	Region	Location	Website
Health and Welfare Council of Long Island "HEALI"	Long Island: Nassau, Suffolk	110 Walt Whitman Rd. Suite 101 Huntington Station, NY 11746	www.healiny.org
Hudson Valley Care Coalition	Hudson Valley: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	560 White Plains, Suite 200 Tarrytown NY 10591	https://hudsonvalleycare.org/

Public Health Solutions	NY (Manhattan), Queens, Brooklyn (Kings)	40 Worth St, 4th Fl, New York , NY 10013	https://wholeyou.nyc
Staten Island Performing Provider System LLC	Richmond (Staten Island)	1 Edgewater Plaza Suite 700 Staten Island, NY 10305	https://statenislandpps.org/social-care-network/ for information.
Somos Healthcare Providers, Inc. DBA Somos Community Care	Bronx	2910 Exterior St, 1st Fl, Bronx, NY 10463	www.somosscn.org

Please see the New York State Department of Health website at the following link for more information on SCNs: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/

Public Partnerships LLC (PPL)

PPL was selected as the Statewide Fiscal Intermediary (SFI) vendor, and effective April 1, 2025, will be the only entity authorized to provide fiscal intermediary services for the CDPAP per Social Services Law section 365-f. See the announcement here

Per guidance provided by New York State Department of Health (NYS DOH), Fiscal Intermediaries (FIs) are working with plans to transition members to Public Partnerships LLC (PPL). Please see click the following links to review the memos and policies from NYS DOH:

- CDPAP Registration Flyer - English
- CDPAP Registration Flyer - Spanish
- A message from the Department of Health
- Understanding the Differences Between CDPAP and PCS
- What to Know About: Differences Between CDPAP and PCS

If you have any questions, please contact PPL Customer Support at: 1-833-247-5346 or email: StatewideFI@health.ny.gov. For more information visit: health.ny.gov/CDPAP.

NYS DOH Memo: CDPAP Statewide Fiscal Intermediary Transition Policy for Current Fiscal Intermediaries

NYS DOH MLTC Policy 24.04: CDPAP Statewide Fiscal Intermediary Transition Policy for Medicaid Managed Care Plans

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.
- Staff Structure and Oversight
- Care Coordination Processes
- Interdisciplinary Care Team (ICT).
- Provider Network
- Clinical Practice Guidelines and Protocols.
- MOC Training for VillageCareMAX Staff and Provider Network.
- Health Risk Assessments.
- Face-to-Face Encounters
- Individualized Care Plans (ICP).
- Care Transitions Protocols
- Care Management Stratification.
- Quality Measurement & Performance
- Key Performance Indicators

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.
- Improve beneficiary health outcomes as selected by the plan.
- Ensure appropriate use of clinical practice guidelines that meet the unique needs of members.

MOC Training for the Provider Network:

1. *Initial and annual training for network providers and out-of-network providers seen by enrollees on a routine basis.*

Section 6: Model of Care

VillageCareMAX provides initial MOC training and annual training to network and out-of-network providers that members see on a routine basis using the following methods:

- New Provider Orientation (in person or via teleconference).
- Provider Manual Distribution
- Provider Newsletter and Updates
- VillageCareMAX Website
- Face-to-Face Training

VillageCareMAX's Model of Care training has been developed and is reviewed annually by the Director of Learning and Development, working with the AVP of Quality Management. The AVP of Medicare Compliance will have oversight to ensure that the training reflects current regulatory requirements. ***Please refer to*** Appendix 15 ***for the MOC training slides.***

The model of care training will describe the regulatory requirements as well as the role of the Nurse Care Manager, the Transition of Care Manager, the ICT, health risk assessment tool, and the model's goals and quality metrics. Please refer to Appendix 15 or the VillageCareMAX website at www.villagecare.org under the For Providers section for the MOC training slides, which will cover the following topics:

Provider Model of Care Training

Topics	Description
VillageCareMAX Overview	Program Offerings Population Characteristics
Model of Care Definitions	Model of Care Scope & Purpose Development & Maintenance Goals
Model of Care Training Requirement	Training Requirements for Staff & Providers
Model of Care Components and State Model of Care Requirements	Essential Elements of the Model of Care

Additional Content	Care Manager Responsibilities Transition of Care Nurse Responsibilities Member Services Responsibilities Health Risk Assessment Purpose & Process Individualized Care Plan Purpose & Process Performance & Health Outcomes Measurement
Clinical Practice Guidelines	Conditions, Clinical Practice Guidelines, and Source by Specialty

Although VillageCareMAX has an extensive and comprehensive provider network, occasionally services are provided by non-network providers. VillageCareMAX uses claims data to identify out-of-network providers who provide care on a routine basis which is considered 4 or more physician encounters per year.

2. *How the organization documents evidence of training (maintains records) on the MOC training.*
   The following methods are used to document evidence that the providers have received the MOC training materials:

   - MOC Training that occurs on the website will generate an attestation. Proof of attestations are maintained in a central location.
   - An attestation from a physician group attesting that the paneled providers received the training materials.
   - An email list or attendance list will serve as documentation that MOC training materials were provided, and outreach was conducted to contracted and routine non-contracted providers.

   The Network Management staff will determine the best option for coordinating the delivery of training materials to the providers.

3. *Explain challenges associated with the completion of MOC training for network providers.*
   The most common challenges associated with completing the provider network MOC training are related to providers who are not able to complete the required training in a timely manner. Frequently this is due to scheduling conflicts and the providers' goal of prioritizing care delivery for their patients over other important tasks. Providers are

required to take similar MOC training from every payer that they are contracted with impacting completion compliance.

Non-participating providers' willingness to participate in VillageCareMAX training sessions including completing an attestation is a challenge.

VillageCareMAX chose to develop an online webinar training system to avoid the most common challenges associated with getting network and non-network routine providers to complete MOC training. The availability of web-based training removes several barriers for providers, most importantly being time and location. Because the training can be completed remotely, providers can complete the training at a time that is convenient for their schedule.

To encourage the highest level of participation and compliance possible, VillageCareMAX utilizes the following:

- Network Management promotes training in the Provider Bulletins published throughout the year and sent to all providers in the network.
- Network Management Specialists call practice managers directly and/or make in person visits to the practices, to explain the training process, answer questions, and encourage managers to promote the training within their offices.

VillageCareMAX utilizes these practices across the entire provider network and has found that regular promotion and reminders of the importance of training, along with personal follow up to key providers has helped improve training completion.

4. *Specific actions taken when the required MOC training is deficient or has not been completed.*
   VillageCareMAX regularly reviews training records to ensure that providers have received the MOC training materials. Despite best efforts to encourage timely participation, there are inevitably some providers who do not or cannot complete training.

   Administrative staff in the Network Management Department will produce quarterly reports to determine if network providers have received the training materials. These reports will be presented to the Credentialing Committee and reported at the QMIC.

Nurse Care Manager and Interdisciplinary Care Team

Each VillageCareMAX Member is assigned to a Care Manager and Interdisciplinary Care Team (ICT). The ICT includes the Care Manager, the enrollee, the enrollee's family, informal caregivers as requested and the Primary Care Provider (PCP). In addition, specialists, other providers, and staff are involved in the ICT as needed. The Interdisciplinary Care Team has ongoing responsibility for ensuring that the member's health risks are identified on an ongoing

basis and that the member's healthcare needs and risks are appropriately addressed by the individualized care plan (ICP).

The Nurse Care Manager facilitates the ICT meeting by sharing information across settings and disciplines and ensuring timely and effective communication between the member and/or caregiver and the care team. Primary responsibilities of the care manager include conducting initial and ongoing assessments and preparing a collaborative ICP based on the member and/or caregiver review and input. The Care Manager arranges for interpreters as necessary to facilitate communications with the ICT. The Care Manager monitors the accomplishment of the ICP goals and works with the member and/or caregiver and the ICT to accomplish the goals.

Member Services Representatives

Member Services Representatives are responsible for handling all calls that come through the VillageCareMAX call center from prospective and active members and providers. The team serves as the main point of communication for the interdisciplinary team. MSRs typically receive calls from members regarding benefits, eligibility, service request and grievance and appeals. MSRs speak a range of languages to accommodate the cultural and linguistic diversity of the population.

Health Risk Assessment

VillageCareMAX utilizes a Health Risk Assessment Tool (HRAT) to assess risk for members in accordance with State and Federal Regulations. The Health Risk Assessment Tool is completed telephonically or via telehealth within 90 days of enrollment. All Medicare populations are reassessed within 365 days of the last assessment completed. The data collected in the HRA is used to support the development of the individualized care plan (ICP), which is completed within 30 days after completion of the HRA. The HRA assesses 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.

Individualized Care Plan

Based on the assessments results, each Member is assigned a Care Manager (CM), 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 to achieve such goals.

Performance and Health Outcome Measurement

Section 6: Model of Care

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.

Annual VillageCareMAX Special Needs Plan Model of Care

The **Special Needs Plans (SNP) Model of Care Training Program** is a basic training required by The Centers for Medicare & Medicaid Services (CMS) for all contracted medical Providers and staff. As per CMS, "the Model of Care is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices." VillageCareMAX participating providers are required to complete this training for all SNP Plans on an annual basis. The purpose of the training is to identify how the Provider of care will support the Special Needs Plan Model of Care while understanding CMS requirements for managing those members.

Please refer to Appendix 15 to review the VillageCareMAX Special Needs Plan Model of Care Training and Attestation Form.

Section 7: Participating Provider Responsibilities

Responsibilities of All Participating Providers

Participating Providers are responsible for providing care in accordance with their respective agreement and all applicable VillageCareMAX policies and procedures, including complying and cooperating with the coordination of benefits and, depending on 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) for Medicaid

Managed Long Term Care or 1-855-296-8800 for Medicare 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) for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare 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.

The following conditions apply to all contracts with providers of covered services (including management agreements, as applicable, “Provider Contract”):

- 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 obligations under VillageCareMAX’s Agreement and applicable state and federal laws and regulations.

- 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.

- Providers shall diligently perform delegated activities and comply with reporting responsibilities, as provided.

- Provider Contract may be terminated when the Department or VillageCareMAX determines that a provider has 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.

- VillageCareMAX shall conduct ongoing monitoring of the provider’s compliance with the Provider Contract, which includes but is not limited to. Corrective action, revocation of the Provider Contract or imposing sanctions if the provider’s performance is inadequate.

- Any and all disputes between VillageCareMAX and its providers 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, 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 Commissioner will be given notice of all issues going to arbitration or mediation and copies of all decisions.

- Provider shall participate in VillageCareMAX's quality assurance, service authorization and grievance and appeals processes, and the monitoring and evaluation of VillageCareMAX's plan.

- Provider shall 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.

- Subcontractors, if any, 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.

- 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 or MAP, 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.

- Value Based Payment (VBP) arrangements, as applicable, shall align 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.

- 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 t because 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.

- 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.

- 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.
    - Documentation of Care Management activities is performed primarily in VillageCareMAX online electronic record management system, using specific software designed to facilitate clinical care management and related decision-making. These online records reflect all VillageCareMAX member assessments, communication and actions taken during the prior approval and concurrent care management processes.
- 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
    - 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
    - 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.
- Comply with the terms and conditions of their agreement with VillageCareMAX and all applicable VillageCareMAX policies and procedures.

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:
    - 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:
    - How to identify community-based and facility-based Long Term Care Services and Supports (LTSS)
    - How to assist the Member in obtaining community-based and facility-based LTSS
- Support Carelon in managing care for our MAP and MA members in Primary Care Settings including:
    - Identify behavioral health needs for appropriate behavioral health referrals directly to Carelon;
    - Assist the Member in obtaining behavioral health services through Carelon;
    - Integrate Behavioral Health Screening Tools into care settings
    - Participate in Member's Interdisciplinary Care Team with VillageCareMAX and Carelon
    - Identify co-occurring conditions for appropriate Behavioral Health referrals directly to Carelon
    - Screening for Depression, Anxiety, Substance Use Disorders and tobacco
    - Screening of high risk medical population for Behavioral Health conditions and/or psychosocial stressors that may impact Member's medical condition or adherence to treatment regimens
    - Screening, Brief Intervention, Referral and Treatment (SBRIT) – use of clinical guidelines for Behavioral Health conditions commonly treated in primary care settings.

Section 7: Participating Provider Responsibilities

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).
  - 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 is partnering with Carelon Behavioral Health (fka Beacon Health Options) ("Carelon") to provide our MAP and MA 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.

In order to provide behavioral health services to our Members, providers must be participating with VillageCareMAX; MAP and MA providers must be participating with VillageCareMAX through the Carelon provider network. If providers are already participating with VillageCareMAX through Carelon, providers do not need to re-contract with Carelon, however, providers are encouraged to check their participation status with Carelon.

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.

Section 7: Participating Provider Responsibilities

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) with VillageCareMAX, and for MAP and MA, with Carelon if they wish to do so, and if the Member has approved his/her participation on the ICT. Please see Section 6 for more information about the VillageCareMAX interdisciplinary care team.

Certain behavioral and mental health providers are required to maintain a system of 24-hour on-call 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.

Crisis intervention services: 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 or Carelon (for MAP and MA) and agrees to provide mental health and/or substance abuse services to Members, to accept reimbursement directly from Carelon according to the contracted rates. Participating providers must maintain approved credentialing status with Carelon to remain active network participants.

See Section 9 "Authorization Requirements" for additional information.

To check MAP or MA provider's Carelon participation status, or to join the VillageCareMAX provider network through Carelon, please contact Carelon via Carelon's website at https://www.beaconhealthoptions.com/providers, or via Carelon's National Provider Services line at (800) 397-1630, between 8 a.m. and 8 pm ET, Monday through Friday. To join Carelon's network, providers can visit https://www.beaconhealthoptions.com/providers/join-our-network/

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.
- Should work with Plan to assist current member´s to assemble and submit the necessary documentation to support an application for Medicaid coverage of a permanent RHCF placement to the LDSS 60-90 days from the date of admission to the nursing home to submit an application for coverage of the permanent placement to the LDSS.

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

Note: 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;
  - Dental care, services provided in accordance with State guidelines for dental care;
  - Rehabilitation therapy and speech-language pathology services, including the arrangement of transportation;
  - Pharmaceutical services, with supervision in taking prescribed drugs and in administering medication, as appropriate;
  - Supportive services, including laboratory, X-ray, and other such services.
  - 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 Adult 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:
  - Be developed within 30 days;
  - Be reviewed at least annually;
  - Promotes the highest functional level possible;
  - Builds on existing capabilities or development of new capabilities or compensating;
  - 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.

Social Adult Day Care (SADC) Providers Compliance Roles and Responsibilities:

Entity	Role	Website	Agency Email
NYSOFA	The New York State (NYS) Office for the Aging (NYSOFA) provides general oversight of aging programs in NYS. NYSOFA has an overall goal to improve access to, and availability of, appropriate and cost-effective non- medical support services for older individuals to maximize their ability to age in their community and avoid higher levels of care and publicly financed care. NYSOFA funds 13 SADC programs directly and approximately 80 through the Local Offices for the Aging across NYS. All SADCs are required to conduct an annual self-evaluation, per Title 9 NYCRR §6654.20, which is available on NYSOFA's website.	https://aging.ny.gov/social-adult-day-services-sads	SADSMonitoring@aging.ny.gov
NYC Department for the Aging SADC Ombuds Office	The NYC Department for the Aging's (NYC Aging) Ombuds Office is charged with enforcing Local Law 9 of 2015, which requires all SADCs operating in NYC to register (for a fee) with NYC Aging, to maintain that registration with any updates or changes, and to comply with other relevant law and rules. The Local Law authorizes and requires NYC Aging to exercise certain enforcement oversight over SADCs operating in NYC; the Ombuds Office accepts and investigates complaints within its jurisdiction, refers complaints outside of its jurisdiction, issues corrective action plans, and may issue penalty-bearing violations where appropriate.	NYC Aging Website SADC Registration Portal	sadc-ombuds@aging.nyc.gov
OMIG	The NYS Office of the Medicaid Inspector General (OMIG) in conjunction with DOH, per MLTC Policy 15.01(a) have established a certification requirement for SADC entities that wish to contract with MLTC plans to ensure those entities involved in the delivery of SADC services are in compliance with relevant rules and regulations. MLTC Policy 15.01(a) can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_15.01_a.pdf Per MLTC Policy 15.01(a) all SADCs contracted with a MLTC plan must annually complete a certification with OMIG and attest to the SADC's compliance with Title 9 NYCRR §6654.20.	SADC Certification Form	N/A
SADC HCBS Compliance Team	The SADC Home and Community Based Services (HCBS) Compliance team is subset of the DOH Division of Health Plan Contracting and Ovesight's (DHPCO) Bureau of Managed Long Term Care (BMLTC) Surveillance Team that is focused on ensuring and validating SADC site specific compliance with the HCBS Settings Final Rule and communicating those determinations to their contracted	SADC HCBS Guidance Falls Under MLTC Policy 21.05 on the MLTC Policy Documents Website:	HCBSSADCSiteAssessments@health.ny.gov

	MLTC plans.	https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm	
BMLTC Surveillance Team	The BMLTC Surveillance Team oversees the MLTC plans. MLTC plans that contract with DOH sub-contract with SADCs to provide social day care services. Therefore, the BMLTC Surveillance Team is responsible for ensuring MLTC plans provide appropriate oversight of their contracted SADCs.	NYS DOH Managed Long Term Care Website: https://www.health.ny.gov/health_care/managed_care/mltc/	mltcsurvey@health.ny.gov
MLTC TAC	The MLTC Technical Assistance Center (TAC) handles complaints and concerns regarding MLTC plans and services which may include SADCs.	https://www.health.ny.gov/health_care/managed_care/mltc/mltcomplaint.htm	mltctac@health.ny.gov

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.

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.
- Meals are only covered when billed with POS 12 (Home).
    - Meals are non-covered when billed with Place of Service (POS) 99 (Social Day Care).

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:

- Member's name and VillageCareMAX identification number,
- Date of transport
- Pick-up address and time of pick-up
- Drop-off address and time of drop-off
- Vehicle license plate number, and
- Full name of the driver (printed, not signature)

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. **Urgent services**: 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:
        - Individuals in receipt of services from a mobile crisis team not currently receiving treatment.
        - Individuals in domestic violence shelter not currently receiving treatment.

- Homeless individuals and those present at NYC homeless shelters who are not currently receiving treatment.
- Individuals aging out of foster care who are not currently receiving treatment.
- Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days, who are not currently receiving treatment.
- Individuals referred by rape crisis centers.
- Individuals referred by the court system.

10. **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:** 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. **DME and Medical Supply:** Delivery must occur within seventy-two (72) hours of request if expedited need, unless custom ordered. Otherwise, within five (5) business days of request.

19. **Prosthetics and Orthotics:** Measurement within fourteen (14) days of request.

20. **Social and Environmental Support:** Delivery within fourteen (14) days of request unless custom ordered.
21. **Meals (Home and/or Congregate):** Provided on the date and time requested by VillageCareMAX up to fourteen (14) days of request.
22. **Skilled Nursing Facility**: 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. **Physical, Occupational & Speech Therapy (in home):** 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. **Transportation**: Pick up within thirty (30) minutes of scheduled time.
29. **Personal Care initial visit:** Must occur on the date and time requested by VillageCareMAX up to thirty (30) days of receipt of authorization.
30. **Private Duty Nursing**: Date and time as requested by VillageCareMAX up to fourteen (14) days of request.
31. **Clinical notes**: Submitted within forty-eight (48) hours of any assessment visit.
32. **Progress notes and summaries:** Submitted every two (2) weeks thereafter unless otherwise requested or there is a change in Member health status.

Section 9: Authorization Requirements

Prior Authorization

Members are 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, Members Authorized Representative 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 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare, submit a request through the GuidingCare Authorization portal or send your request via Fax to the department fax listed below based on type of request. 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.

DME:	(978) 577-5451
Inpatient:	(212) 402-4468
SNF:	(212) 402-4468
Outpatient:	(978) 367-1872

A **Prior Authorization** (approval in advance) is a request by the Member, Members Authorized Representative 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 can provide them to our Members. Please refer to Section 10 for Services that require Prior Authorization. You can also contact VillageCareMAX at 1-800-469-6292 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare 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 the plan reviews the Members care they are receiving to determine if the Member still requires the care. We may also review other treatments and services the Members already receive (**retrospective review)**.

Section 9: Authorization Requirements

Medically Necessary means services that are needed 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 Servic**e is a request from a Member, authorized 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 2022, VillageCareMAX launched a new authorization portal at https://www.villagecaremax.org/provider-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.

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 at https://www.villagecaremax.org/provider-portal.

The Authorization Portal is the preferred and quickest method for requests for authorization and clinical submission. Providers should contact their Provider Relations Account Manager if any questions on how to access the Authorization Portal, or contact the

following phone numbers 1-800-4MY-MAXCARE (1-800-469-6292) for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare.

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;

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, the plan will process the request at the opening of the next business hour unless it is urgent and requires immediate review. 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, Health Advantage FLEX and Select Advantage (MA)	Total Advantage (MAP)
Standard Determination	14 Calendar Days	14 Calendar Days	14 Calendar Days
Standard Determination with Extension	Additional 14 Calendar Days	Additional 14 Calendar Days	Additional 14 Calendar Days
Expedited Determination	72 hours	72 hours	72 hours
Expedited Determination with Extension	Additional 14 Calendar Days	Additional 14 Calendar Days	Additional 14 Calendar Days

VillageCareMAX MLTC, Health Advantage & Total Advantage Prior Authorization Timeframes

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 72 hours 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

  - 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.
  - 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 at https://www.villagecaremax.org/provider-portal 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.

Section 9: Authorization Requirements

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 member 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	978-577-5451	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	978-367-1872	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.
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	978-577-5451	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

Skilled Nursing Facilities		
Fax Line Name	**Fax #**	**Description**
Skilled Nursing Facility Admissions	212-402-4468	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

Section 9: Authorization Requirements

Section 10: List of Services that Require Prior Authorization

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), VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP), VillageCareMAX Medicare Health Advantage FLEX Plan (HMO D-SNP), VillageCareMAX Medicare Select Advantage Plan (HMO), and VillageCareMAX Medicare Total Advantage Plan (MAP).
Unless otherwise indicated, the services under MA apply to Medicare Health Advantage, Medicare Health Advantage FLEX, and Medicare Select Advantage.

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. Providers should always contact Utilization Management to verify if prior authorization is required.

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	MA
24/7 Physician Hotline	NC	NA	NA
Acupuncture[8]	NC	X	X
Adult Day Health Care	X	X	NC
Ambulatory Surgery Center	NC	X	X
Assistive Technology (AT)	X	X	NC
Audiology Services (Hearing Exam)	NA	NA	NA
Cardiac Rehabilitation Services	NC	X	X
Chiropractic Services	NC	X	X
Community Transitional Services (CTS)[9]	X	X	NC
Consumer Directed Personal Assistance Services (CDPAS)	X	X	NC
Dentistry	NA	NA	X
Diabetes Programs and Supplies	NA	X	X
Diagnostic Services[10]	NC	X	X
Discogram/Myelogram	NC	X	X
Durable Medical Equipment (DME) / Medical Supplies[11]	X	X	X

[8] Effective August 1, 2025, see below Medicare Benefit Grid for all Rehab, including Acupuncture services, which require prior authorization.
[9] Community First Choice Option (CFCO) services contingent upon approval by NYS DOH.
[10] Effective January 1, 2022, see below Medicare Benefit Grid for Diagnostic Services that require prior authorization.
[11] See Appendix 10 for a list of DME services that do **not** require prior authorization.

Electromyogram (EMG)	NC	X	X
Environmental Modifications (EMods)[7]	X	X	NC
Hearing Aids[12]	X*	X*	X*
Home and Bathroom Safety Devices	NC	NC	X (DSNP only) [13]
Home Delivered and Congregate Meals	X	X	X (DSNP only[14]
Home Health Care	X	X	X
Home Infusion Services	X	X	X
In-Home Safety Assessment	NC	NC	X (DSNP only)[9]
Inpatient Bariatric Surgery	NC	X	X
Inpatient Hospital Care	NC	X	X
Inpatient Mental Health Care	NC	X	X
Inpatient Organ Transplants	NC	X	X
Inpatient Reconstructive Surgery	NC	X	X
Inpatient Skilled Nursing Facility	X	X	X
Inpatient Substance Abuse and Rehab	NC	X	X
Lab Services (Molecular Pathology, Cryptogenic studies and Genomic Sequencing Procedures)	NC	X	X
Lab Services (All other services)	NC	NA	NA
Medical Social Services	NA	X	X (DSNP only)
Mobile Radiology (EKG and X-Rays)	NC	NA	NA
Mobile Radiology (All other services)	NC	X	X
Moving Assistance (MA)[7]	X	X	NC
MRI/MRA	NC	X	X
Non-Emergency Transportation / Ambulance Services	X	X	X
Nuclear Medicine	NC	X	X
Nutrition	X	X	X
Occupational Therapy	X	X	X
Orthopedic Footwear	X	X	X
Part B Drugs (when billed by a physician or facility)	NC	X	X
Partial Hospitalization	NC	X	X

[12] 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.
[13] Effective January 1, 2023, contingent upon approval by VillageCareMAX, a supplemental benefit has been added for Home and Bathroom Safety Devices and In-Home Safety Assessment for the Medicare Health Advantage Plan (not applicable to Medicare Health Advantage FLEX).
[14] Effective January 1, 2022, VillageCareMAX implemented a supplemental meals benefit immediately following surgery or inpatient hospitalization only for the Medicare Health Advantage Plan (not applicable to Medicare Health Advantage FLEX).

Personal Care Services	X	X	NC
Personal Emergency Response Services (PERS)	X	X	NC
Pet Scan	NC	X	X
Physical Therapy	X	X	X
Private Duty Nursing	X	X	NC
Pulmonary Rehabilitation Services	NC	X	X
Respiratory Therapy	X	X	X
Skill Acquisition Maintenance and Enhancement (SAME)[7]	X	X	NC
Social and Environmental Supports	X	X	NC
Social Day Care	X	X	NC
Speech Therapy	X	X	X
Substance Abuse Care	NC	X	X
Telehealth	X	X	X
Vehicle Modifications (VMods)[7]	X	X	NC
Vision Services - Eye Exam and Eyewear	NA	NA	NA
Worldwide Emergency/Urgent Care	NC	NA	NA

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

VillageCareMAX Medicare Health Advantage Plans (D-SNP), VillageCareMAX Medicare Select Advantage Plan (HMO), 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	Yes	Yes	Not Applicable

• 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			
Acupuncture *Supplemental Benefit*: Plan covers acupuncture as a supplemental benefit: Covered for up to **32** treatments (for FLEX) and **54** treatments (for MAP) per year when provided by a certified and licensed provider in the VillageCareMAX network. For FLEX, Limited to up to $80 per visit and 8 visits per month with a maximum of 32 visits per year. For MAP, Limited to up to $80 per visit and 5 visits per month with a maximum of 54 visits per year.	Yes	Yes	Not Applicable
Ambulatory Surgery Center (ASC): The facility services furnished in connection with covered surgical procedures provided in an ASC	Yes	Yes	Not Applicable
Diagnostic Services -CT scans, EKGs and X-rays when a provider orders them as part of treatment for a medical problem -Radiation (radium and isotope) therapy, including technician materials and supplies -Surgical supplies, i.e. dressings -Splints, casts, and other devices used for fractures and dislocations -Medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition -Blood, including storage and administration -Other outpatient diagnostic tests	**No** (some exclusions apply): Basic Diagnostic: EKG, Ultrasound, Aniograms and Embolization, , XRAY, & Electromyogram (EMG) **Yes**: all advanced diagnostics i.e. PET Scan, MRI/MRA, Nuclear Studies, Nerve block/Epidurals, Discogram/Myelogram, CT Scan including CTA, Total Body CT, and Codes: 73706, 75571, 75574, 75635, 76376, 76377) EEG	Yes	1 – For Participating Providers = Basic Diagnostic do not require prior Auth 2 – For Participating Providers = All Advanced diagnostics require prior Auth 3- For Non-Participating Providers = All diagnostics Services require prior Auths
Outpatient Physical Therapy (PT) 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	Yes	Yes	Not Applicable

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
Preventive Services	No	No	Not Applicable
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, Medicare is the primary payor for COVID-19 vaccines, tests, and treatment.	Yes	Yes	Not Applicable
Pulmonary Rehabilitation Services Comprehensive programs are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	Yes	Yes	Not Applicable

See Appendix 16 for VillageCareMAX MA and MAP Specialist Services that do not require Prior Authorization in an Office Setting only.

Section 11: Claims Submission

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. **Please refer to your contract to confirm specific timeframes as they may differ from below.**

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
DSNP Flex	90 days	30 (Eclaims); 45 (Paper)	60 days	60 days
MAP	90 days	30 (Eclaims); 45 (Paper)	60 days	30 days
MSA	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: **26545**. 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.

Section 11: Claims Submission

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

1. 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.

2. With the exception of below Vendor Providers, All paper claims, correspondence, and Claims Disputes and Appeals should be submitted to the following. If you have any questions, please call Provider Services at **1-855-769-2500**.

FOR ALL DATES OF SERVICE	
Medical Claims	
Electronic Claims Submission	**Starting on January 1st, 2025:** **Submit ALL claims, regardless of date of service, using the Availity clearinghouse (no charge to you).** • If you received separate authorization numbers for 2024 vs 2025, make sure to attach the correct authorization number to each claim. • Use VillageCareMAX **Payer ID: 26545** (no change) • Electronic Claims must be submitted in 837I or 837P format.
Paper Claims Submission	Mail **original** and **corrected** claims to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505
Review Claims Status	• Use the Availity Portal to search and view claims • Download 835 files from the Availity clearinghouse
Electronic Funds Transfer (EFT) Enrollment or Changes	• Complete the EFT Form available on our website. • Submit completed EFT Form, updated W9, Voided Check, and Bank Letter to ProviderRelations@villagecare.org • Allow up to 30 business days for completion of EFT setup.
Electronic Remittance Advice (ERA) Enrollment or Changes	Starting January 1st, 2025, enroll for ERA through the Availity Portal

3. 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**

4. In 2025, VillageCareMAX will be implementing a new Claims system called "Facets" to help providers submit claims more efficiently and conveniently.

For Vendor Providers, VillageCareMAX partners with below Vendors to delegate certain administrative responsibilities for certain dental, vision, and behavioral health provider services*

including, but not limited to: claims processing, authorization requests and inquiries, member and provider services, provider participation.

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

All covered Behavioral Health claims for VillageCareMAX Medicare Total Advantage (MAP), VillageCareMAX Medicare Health Advantage (HMO D-SNP), VillageCareMAX Medicare Health Advantage FLEX (HMO D-SNP), and VillageCareMAX Medicare Select Advantage Plan (HMO) should be submitted as follows:

Claims DOS on or after January 1, 2023
Carelon Behavioral Health (fka Beacon Health Options)
Availity is Carelon Behavioral Health multi-payer portal for submitting the following transactions: • Claim Submissions (Direct Data Entry Professional and Facility Claims) applications or EDI using the Availity EDI Gateway • Eligibility & Benefits • Claim Status
Tel: (800) 397-1630; General Info: (800) 888-3944;
Monday – Friday, 8:00am – 8:00pm

Section 11: Claims Submission

https://www.beaconhealthoptions.com/providers
For more information regarding claims submissions and eligibility, benefits and claim status please click here: https://s21151.pcdn.co/wp-content/uploads/2.18.22-Availity-Transition_Updated-Provider-FAQ_FINAL.pdf

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.

Section 11: Claims Submission

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/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 Appendix 3 to have payments deposited directly into your bank account.

Balance Billing, Improper Billing, Cost-Sharing

In no event can a Provider bill VillageCareMAX MLTC, D-SNP, or MAP Members for any balance remaining on a claim.

VillageCareMAX shall adopt measures to protect dually eligible enrollees from improper billing and educate network providers about applicable billing requirements. VillageCareMAX, including VillageCareMAX MLTC, D-SNP, and MAP Plans, providers and suppliers, including pharmacies, must refrain from collecting Medicare cost sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) program, a dually eligible program which exempts individuals from Medicare cost-sharing liability (42 C.F.R. § 422.504(g)(1)(iii); Calendar Year (CY) 2019 and 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter).

Section 11: Claims Submission

Pursuant to updates to section 20.2.4.2 (D-SNPs With or Without Medicare Zero-Dollar Cost Sharing) of Chapter 16-B of the Medicare Managed Care Manual, regarding which plans qualify as Medicare Zero-Dollar Cost Sharing D-SNPs, VillageCareMAX D-DSNP

A Medicare Zero-Dollar Cost Sharing D-SNP is a D-SNP under which all Medicare Part A and B services are provided with no Medicare cost sharing to all enrollees who remain dually enrolled in both Medicare and Medicaid. This term encompasses the following types of plan designs:

1. *Where cost sharing for enrollees is $0 as part of the plan design (i.e., cost sharing for all Part A and B benefits has been reduced to $0 as part of the supplemental benefits provided by the D-SNP); and*
2. *Where there is cost sharing in the plan design, but all individuals who are eligible to enroll in the D-SNP are protected by sections 1848(g)(3)(A) and 1866(a)(1)(A) of the Act from cost sharing, or otherwise qualify for Medicaid coverage of cost sharing (see section 1852(a)(7) of the Act and 42 CFR 422.504(g)(1)(iii) for cost sharing protections afforded non-QMB full-benefit dually eligible individuals).*

CMS uses the designation of a Medicare Zero-Dollar Cost Sharing D-SNP to ensure that information provided to beneficiaries is accurate, clear, and consistent with the requirements on MA organizations at 42 CFR 422.111 and 422.2260-422.2267.

For a Medicare Zero-Dollar Cost Sharing D-SNP, information on Medicare Plan Finder on Medicare.gov describe all Part A and B services under the D-SNP, such as inpatient hospital stays and doctor visits, as available at no cost to the enrollee.

To reinforce billing requirements, simplify compliance, and prevent improper billing, VillageCareMAX affirmatively inform providers if member cost-sharing liability is zero. VillageCareMAX provides information through eligibility-verification systems, online provider portals and phone query mechanisms and indicate members owe $0 directly on the Explanations of Payment statements for providers and on member identification cards. VillageCareMAX is committed to ensuring providers do not discriminate against enrollees based on their payment status, e.g., specifically, providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program (Medicare Managed Care Manual, Chapter 4, Section 10.5.2)

In no event can a Provider bill VillageCareMAX Medicare Select Advantage Plan Members for any balance remaining on a claim for Part C services.

VillageCareMAX Medicare Select Advantage Plan benefit includes limited copays and coinsurance for certain Part D services only.

Claim Service Code Guidelines

Section 11: Claims Submission

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
03 – Podiatry
04 – Psychology
06 – Rehabilitation Therapy
07 – Nursing
41 – Nurse Practitioner/Midwives
75 – Clinical Social Worker
85 – Freestanding Clinic
87 – Hospital OP/ER Room

Modifier 59

Appropriate Usage Guidelines[15]

[15] References:
https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf
https://www.hhs.gov/guidance/document/proper-use-modifiers-59-xepsu

• Documentation indicates two separate procedures performed on the same day by the same physician represented by a different session or patient encounter, different procedure or surgery, different site, or separate injury (or area of injury)

• Use Modifier 59 with the secondary, additional or lesser procedure of combinations listed in National Correct Coding Initiative (NCCI) edits.

• Use Modifier 59 when there is no other appropriate modifier.

• Use Modifier 59 on the second initial injection procedure code when the IV protocol requires two separate IV sites or when the patient has to come back for a separately identifiable service.

Inappropriate Usage Guidelines

• Code combination not appearing in the NCCI edits

• Submission of Evaluation and Management (E/M) Codes

• Submission of weekly radiation therapy management codes (CPT 77427)

• The NCCI tables lists the procedure code pair with a modifier indicator of "0"

• Documentation does not support the separate and distinct status

• Exact same procedure code performed twice on the same day

• Multiple administration of injections of the same drug

• Multiple surgical procedures via same cite/incision or operative session

• If a valid modifier exists to identify the services

Claims Inquiry

Call Provider Services at 1-855-769-2500 and when prompted, select the option for 2025 if inquiring about a claim with dates of service in 2025; select the option for 2024 if inquiring about a claim with dates of service in 2024.

As a reminder, the VillageCareMAX Provider Portal is a quick, convenient and secure way to verify member eligibility, review claim status, enroll for Electronic Remittance Advice (ERA) and much more as indicated below. The portal is available 24 hours a day, 7 days a week and can be accessed by visiting Availity at https://apps.availity.com/

- 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 Section 10 to verify if a covered service requires authorization. You may contact 1-800-469-6292 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare 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

PAY CODE	PAY CODE DESCRIPTION
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 contract between VillageCareMAX and DOH. 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.

In accordance with the contract between VillageCareMAX and NYSDOH, 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.

Self-Disclosure Program

Medicaid entities/Providers are required to report, return, and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self-Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later.

Identification of Overpayment

Section 11: Claims Submission

Per OMIG, an overpayment has been identified when a Medicaid entity/Provider has, or should have, through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was received, and they have quantified the amount of the overpayment. Medicaid entities/Providers should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received. Additionally, if a Medicaid entity/Provider is the subject of a government audit, part of that Medicaid entity's/Provider's due diligence is to review the audit results and look at past and future periods - not covered in the audit scope - to identify any overpayments resulting from similar issues. Medicaid entities/Providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program. Note: Voiding or adjusting claims does not satisfy the Medicaid entity's/Provider's obligation to report and explain the identified overpayment.

Timeframes

While both Federal and State regulations require a Medicaid entity/Provider to report, return, and explain an overpayment within sixty (60) days from identification, the actual timeframes for processing can vary. A Medicaid entity's/Provider's 60-day time frame will be tolled, or paused, when a completed Self-Disclosure is received by OMIG. The time frame to repay will remain tolled during OMIG's review.

For detail information, visit the New York State Office of the Medicaid Inspector General's Website: https://omig.ny.gov/provider-resources/self-disclosure

Disclosure related to damaged, lost or destroyed records

Pursuant 18 NYCRR Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

Submission Process

Timely report overpayments to OMIG via two self-disclosure pathways, full process, or abbreviated process, both at: https://omig.ny.gov/self-disclosure-submission-information-and-instructions

Timely report damaged, lost and/ or destroyed records to OMIG at: https://omig.ny.gov/self-disclosure-submission-information-and-instructions

Notify VillageCareMAX of any overpayment or damaged, lost or destroyed records.

Section 12: Claims Appeals

Claim Appeals

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

Definitions:

Claim Appeals: Provider does not agree with claim determination (denial).

Payment Dispute: Provider does not agree with the amount of payment.

If your claim was processed and you disagree with how it was processed, you may submit a Claim Appeal or Payment Dispute in writing to:

	For all Dates of Service
Submit Claims Disputes or Claims Appeals	• Mail **original** and **corrected** claims to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505 or Fax to: (855) 864-7385

All claim appeals generally must be submitted within forty-five (45) days for MLTC or sixty (60) days for MA and MAP of receipt of a claim determination for all lines of business and must include the following information:

- VillageCareMAX Claim number
- Authorization number
- VillageCareMAX Member ID number and Name
- Provider's ID number, Name, Address, and Telephone 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. Click here for more examples of supporting documentation.

- Non-Participating/Out-of-Network Providers must fill out and submit a Waiver of Liability Form (See www.villagecaremax.org/waiver-liability-form).

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. All corrected claims must be submitted within forty-five (45 days) for MLTC or sixty (60) days for MA and MAP of claim processing/paid date.

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

	For all Dates of Service
Corrected Paper Claims Submission	Mail **original** and **corrected** claims to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505

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. Please refer to your contract for exact timeframes.

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 for MLTC or sixty (60) calendar days for MA and MAP of receipt of a claim determination for all lines of business.

	For all Dates of Service
In-Network (INN) and Out-of-Network (OON) Provider Payment Disputes	All disputes must be in writing and sent to: VillageCareMAX Claims PO Box 3238 Scranton, PA 18505 Signed Waiver of Liability must be accompanied with all appeal requests

Waiver of Liability forms can be accessed at: www.villagecaremax.org/waiver-liability-form

Supporting Documentation

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.
- Waiver of Liability Form (required for Out-of-Network/Non-Participating providers) – Please see www.villagecaremax.org/waiver-liability-form.

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 for MLTC and MA; thirty (30 days) for MAP, 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 sixty (60) calendar time frame for all lines of business, 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 the Availity Portal at: https://apps.availity.com/.

To request or view authorizations, please visit the VillageCareMAX Authorization Portal at: https://vcm.guidingcare.com/AuthorizationPortal

Please note, once an authorization is closed, Provider cannot submit a request for a retro-authorization. A new service request must be submitted.

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 a material 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), including FLEX (HMO D-SNP) and VillageCareMAX Medicare Select Advantage (HMO) 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:
  - Enter the NAMI amount determined by the 834 file, which is the source of truth for reporting NAMI on all Medicaid claims. NAMI amount is always determined by the 834 file.
  - In cases where the member's budget (NAMI amount) has increased or decreased based on the new information CMS receives, the new NAMI will be reflected on the 834 file.
  - 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 834 file.

Section 14: Medicaid Surplus and NAMI

Please note that claims without accurate NAMI may 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 respective 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 a patient towards any Managed Care product type.
- The provider is required to offer patients a list of all the plans they have 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.

In addition, participating providers must not:

- Offer sales/appointment forms to Members
- Accept or solicit 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 available at https://www.cms.gov.

VillageCareMAX:

- Will not conduct sales presentations, distribute and accept enrollment applications or solicit prospective enrollees 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 directly or indirectly engage in door-to-door, telephone, email, texting, or other "Cold-call" marketing activities. 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 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 reviewed and approved by VillageCareMAX, may require approval 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

VillageCareMAX is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI). Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Participating Providers shall ensure the confidentiality of Members' PHI and provide Members with access to their PHI in accordance with applicable federal and state law, regulation and guidelines including but not limited to the confidentiality requirements set forth in the New York State Public Health Law, the New York State Social Services Law, Medicaid/Medicare laws and the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations (HIPAA). 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.

Generally, covered health plans and covered providers are not required to obtain Member consent or authorization for use and disclosure of PHI for treatment, payment and health care operations.

Reporting a Breach

If a provider becomes aware that a breach of VillageCareMAX member's PHI has occurred, the provider should notify VillageCareMAX immediately. In accordance with HIPAA/HITECH requirenments, notify the individuals whose PHI was breached, and report the breach to the federal Department of Health and Human Services (DHHS). Individuals should be notified in writing, and provided with basic information about the breach, including when the breach occurred and when discovered, type of PHI involved, investigation and corrective actions, and contact information for any questions.

To report a breach to VillageCareMAX, please call VillageCareMAX Member Services.

To report a breach to DHHS, please click on the link below:
HTTPS://WWW.HHS.GOV/HIPAA/FOR-PROFESSIONALS/BREACH-NOTIFICATION/BREACH-REPORTING/INDEX.HTML

Section 18: Member Rights and Responsibilities

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, VillageCareMAX Medicare Health Advantage FLEX, VillageCareMAX Total Advantage, and VillageCareMAX Medicare Select Advantage Plan Member Rights

As a Member of VillageCareMAX Medicare Health Advantage, VillageCareMAX Medicare Health Advantage FLEX, **VillageCareMAX Total Advantage**, and VillageCareMAX Medicare

Section 18: Member Rights and Responsibilities

Select 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 MA and VillageCareMAX MAP 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 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare. 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 Medicare Health Advantage FLEX (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. The VillageCareMAX Medicare Select Advantage (HMO) Evidence of Coverage is available in English, Spanish, Chinese and Korean.

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 detailed in Appendix 15, or visit our website at **https://www.villagecaremax.org/providers#clas**, and click on the link for Cultural Sensitivity Awareness Training Online Attestation Form.

Providers may also use the CLAS Training Attestation Form (See Appendix 18) and send to their Provider Relations Account Manager, or submit to the Provider Relations Team via email ProviderRelations@villagecare.org or via fax: (718) 517-2698.

Section 18: Member Rights and Responsibilities

For questions, please contact the Provider Relations Department at (718) 517-2783 or via provider inquiry webform at https://www.villagecaremax.org/providersupport..

For the current CLAS and Attestation Form, please refer to Appendix 15.

Section 19: Grievance and Appeals

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 member's satisfaction
		Standard Grievance: 45 calendar days to resolve a standard grievance. An Acknowledgement letter is sent to the member within 15 business days of the received of the grievance and a Resolution is send to the 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 Member is not satisfied with the Plan's decision about a grievance, the 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 Member can also request an **Expedited appeal** which will need to be resolved within 2 Business days
MHA, MHA FLEX, MSA and MAP	• Expedited • Standard • Grievance Extension • Grievances Appeals	**Expedited Grievance:** Resolved within 24 hours af
		Standard Grievances: Must be resolved within 30 calendar days**.** An acknowledgement letter is sent to the Member within 15 calendar days of the receipt of the grievance.

LINE OF BUSINESS	CATEGORY	TIME FRAMES
		Grievance Extension is the same as the MLTC Program

Grievances

A grievance is any communication by a 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 MLTC 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.

MLTC 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 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 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, including Medicare Health Advantage FLEX and Medicare Select Advantage, & Medicare Total Advantage

Section 19: Grievance and Appeals

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;
- 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.

Section 19: Grievance and Appeals

Appeals of Grievances

A MLTC 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 sixty (60) 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 an Appeal with VillageCareMAX and get VillageCareMAX final adverse determination.

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 sixty (60) days of VillageCareMAX action. If the request is made after sixty (60) 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 seventy-two hours (72) after receiving the appeal 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 four (4) months 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 one hundred-twenty (120) 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.

Section 19: Grievance and Appeals

VillageCareMAX Medicare Health Advantage Plan (D-SNP), including Medicare Health Advantage FLEX and Medicare Select Advantage (HMO), 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.
    - 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.
    - 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**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - 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.
    - 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.
    - 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**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - 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), including Medicare Health Advantage FLEX Plan (D-SNP) and Medicare Select Advantage (HMO), 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 Determinations (Initial Decision)	72-hour time limit	24-hour time limit

1st Level - Part D Redetermination Appeal	7-day time limit	72-hour time limit
2nd Level - IRE (Independent Review Entity) Review	7-day time limit	72-hour time limit
3rd Level (Office of Medicare Hearings and Appeals) For amounts in controversy ≥ $140	Administrative Law Judge Standard Decision 90-day time limit	Administrative Law Judge Expedited Decision 10-day time limit
4th Level (Medicare Appeals Council – MAC)	Standard Decision 90-day time limit	Standard Decision 10-day time limit
5th FINAL Level - Judicial Review (Federal District Court) For amounts in controversy ≥ $1,400	Federal District Court	

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 for MLTC or sixty (60) days for MA and MAP 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.

Section 21: Credentialing

Provider Credentialing

The VillageCareMAX Credentialing 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 documents from the provider via Salesforce Health Cloud V12 Platform and reviewing any license and certification 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 fraud, waste and 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, but not limited to:

- VillageCareMAX will send the provider a link with the credentialing application to completed and signed credentialing application and submit back to VillageCareMAX in Salesforce Health Cloud V12 Credentialing Platform;
- All regulatory business licenses, registrations and operating 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).
- W9
- Any additional supporting documentation required by VillageCareMAX to complete credentialing verification.

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.

Section 21: Credentialing

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

Individual Credentialing, but not limited to:

MDs, DOs, DPMs, DCs, NPs, PTs, DMDs and DDSs credentialed by Liberty Health Plan, and behavioral health care providers credentialed by Carelon Behavioral Health (fka Beacon Health Options), 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)
- NPI
- Re-attestment of CAQH profile of every 120 days

Note: Providers who have been identified as precluded or excluded from participating with Medicare and/or New York State Medicaid Program, or have decided to OPT OUT of Medicare, will be excluded from participating in the VillageCareMAX network. 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 will be considered for for recredentialing, every three years and 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.

Vendor Credentialing

VillageCareMAX has entered a Management Services Agreement with the following Vendors to manage certain categories of benefits. Providers with one of the following Provider Types who are interested in participating with VillageCareMAX should contact the Vendor at the Website or Contact Info listed below:

Provider Type	Vendor	Website	Contact Info
Dental Providers	LIBERTY Dental Plan	https://www.libertydentalplan.com/Providers/Join-Our-Network	(888) 700-0643
Vision Providers	Versant Health	https://davisvision.com/eye-care-professionals/join/apply/ https://superiorvision.com/eye-care-professionals/join/apply/	(866) 819-4298 providerhelp@versanthealth.com
Behavioral Health Providers	Carelon Behavioral Health (fka Beacon Health Options)	https://www.carelonbehavioralhealth.com/providers/join-our-network	(800) 397-1630

Non-Emergent Transportation Providers	Sentry Management Solutions	https://nemt.sentryms.com/register/index	(844) 573-6879
Audiology/Hearing Aid Providers	HearUSA	https://www.hearusa.com/contact-us/	(800) 333-3389
Durable Medical Equipment (DME) Providers	Integra Partners	https://accessintegra.com/join-the-integra-network/	(888) 729-8818 network@accessintegra.com

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, pending 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 delegated credentialing entities processes will be reviewed and approved by the VillageCareMAX Credentialing Committee for formal review and approval.

Section 21: Credentialing

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 presented and reviewed at the Credentialing Committee for consideration and appropriate action.

Section 21: Credentialing

Provider Demographic Updates and Terminations

Participating Providers must inform VillageCareMAX of any changes in demographics including but not limited to: Tax ID number, NPI number, specialties, provider types (practicing as a PCP, Specialist, Dual), open or closed panels, corporate name, office name, service/correspondence/billing addresses, phone/fax number, email address, provider adds/changes/terminations under a participating group/IPA/organization, etc. as soon as the changes are known.

Demographic additions, changes, and/or terminations from the VillageCareMAX network should be submitted to VillageCareMAX thirty (30) days prior to the effective date of the change or termination.

For **demographic changes** or **termination request**s for directly contracted and credentialed providers, please submit your change request via the provider inquiry web form at https://www.villagecaremax.org/providersupport, and please allow thirty (30) days for record updates.

You may also fill out the Provider Information Change Form (See Appendix 8) or the VillageCareMAX Provider Termination Form (see Appendix 17) and submit to your Provider Relations Account Manager or providerrelations@villagecare.org.

For Demographic changes and termination requests for delegated contracted and credentialed providers, please fill out the **VillageCareMAX Provider Delegated Roster** and submit to DelegateRosters@villagecare.org. To request the Delegated Roster template, please reach out to your Provider Relations Account Manager or submit your request via the provider inquiry web form at https://www.villagecaremax.org/providersupport.

Delegation Audit Monitoring

Once a delegated facility request to join the VillageCareMAX network the following steps are required to conduct a Delegated Audit. A virtual audit is conducted by the Credentialing Department, the Credentialing Department outreach to the delegated facility requesting required credentialing documentations. The objective of the Delegated Audit is to evaluate and assess the credentialing and recredentialing processes of the delegated facility and to ensure compliance with applicable VillageCareMAX credentialing and recredentialing standards, policies and procedures, including but not limited to the National Committee for Quality Assurance (NCQA) and Joint Commission on Hospital Accreditation (JCOHA), regulatory timeliness, notification requirements and standards when performing the credentialing and recredentialing delegated services.

Review of delegate's credentialing activities

Section 21: Credentialing

VillageCareMAX sends an Initial Due Diligence Questionnaire and Provider Audit Selection Template—via email to the facility to be completed and submitted back to VillageCareMAX along with other required documents.

- Performed annually to ensure continued compliance.
- Review of delegate's:
- Policies and procedures
- File review using one of the following NCQA audit process methods required.
- Five percent (5%) of network or 50 files, minimum of 10 initial and 10 recred files
- May use 8/30 methodology.

Review Initial Due Diligence Questionnaire

Utilize Provider Audit Selection Template to select the providers that VillageCareMAX would like to conduct an audit review on, which is 5% of the delegated facility provider roster.

- Delegated facility submits their delegated roster records to VillageCareMAX via SFTP Drive (Secure File Transfer Protocol)
- Once the delegated roster is received via SFTP, the Credentialing Department downloads the delegated roster to begin the audit process.
- During the delegated audit process the Credentialing Department utilizes the Audit Select Template to conduct a Quality Review check of all delegated provider files.
- Review the delegated facility P&P compliance.
- Delegated provider files
- Final quality assurance review

Calculate the audit outcome percentile per each provider. This score is based on NCQA required credentialing documents and the goal is to be at 100% compliance. If a facility is below the 100% percentile, they would have failed their delegated audit and additional documents would be requested.

- Passed the CMS Medicare Opt-out website check? Y/N
- Total Score
- Possible Score
- Percentage (possible/total)

If errors are found during the process, an email will be sent to the delegated facility requesting any clarification need or updated documents within a 2 week (10 business days) turnaround time. Once the delegated audit is re-reviewed and completed by the Credentialing Department, a confirmation letter is sent to the delegated facility informing the facility if they have pass/failed the audit.

Section 21: Credentialing

Annual Audit: Monitor other Organization Credentialing Process

Three months prior to the anniversary date of the Annual Delegated Audit an outreach is made by the Credentialing Department via email to the delegated facility requesting documentations for their annual delegated audit. Utilize Provider Audit Selection Template to select the providers that VillageCareMAX would like to conduct an audit review on, which is 5% of the delegated facility provider roster.

- Delegated facility submits their delegated roster records to VillageCareMAX via SFTP Drive
- Once the delegated roster is received via SFTP, the Credentialing Department download the delegated roster to begin the audit process.
- During the delegated audit process the Credentialing Department utilizes the Audit Select Template to conduct a Quality Review check of all delegated provider files.
- Review the delegated facility P&P compliance.
- Delegated provider files
- Final quality assurance review

If errors are found during the process, an email will be sent to the delegated facility requesting any clarification need or updated documents within 2 weeks turnaround time.
Calculate the audit outcome percentile per each provider. This score is based on NCQA required credentialing documents and the goal is to be at 100% compliance. If a facility/ individual provider is below the 100% percentile, they would have failed their delegated audit and additional documents will be requested.

- Passed the CMS Medicare Opt-out website check? Y/N
- Total Score
- Possible Score
- Percentage (possible/total)

Once the delegated audit is rev-viewed and completed by the Credentialing Department a confirmation letter is sent to the delegated facility informing the facility if they have pass/failed the audit. Ongoing monitoring enables companies to verify the identity of their clients while continuously monitoring their activities for any signs of suspicious behavior. This proactive approach helps build an ongoing KYC (know your customer) process rather than a one-and-done procedure. Prevent fraud and other financial crimes.

All delegated credentialing relationships will be defined in a written contractual agreement, which will comply with the standards outlined in the VillageCareMAX Credentialing program. Ongoing monitoring of entities delegated for credentialing shall be performed by the Credentialing department. Oversight of delegated credentialing shall be the responsibility of the VillageCareMAX Credentialing Committee in collaboration with the VillageCareMAX

Compliance Committee. A separate Delegation of Credentialing/Recredentialing policy outlines the process for delegation of those.

CAQH Individual Provider Credentialing Process

Once a provider has gone through the nomination process a credentialing case is automatically generated and the case is entered into the credentialing queue. The Credentialing Department will review the case within 48 hours. Prior to the case being moved forward minimum requirements need to be met. This includes; (1) CAQH has been re-attested within the past 120 days, (2) The provider is not on the preclusion list, (3) The provider is not showing as in-network on the Provider Master File, (4) A contract has been loaded for the provider (5) The provider has a Medicaid ID# (if applicable). If one or more of these requirements are not met the Provider Relation team is informed via a task and the case is closed.

If a provider has met the requirements the case ownership is changed to a Credentialing Specialist in the Credentialing Department and a PSV is ordered via CAQH. The average time it takes for a PSV to be completed and returned is 14 days. The Credentialing Department receives the PSV from CAQH with in that 14 days. The Credentialing Department first validates malpractice case history and sanctions report and then validates that all required documents are received. If any credentialing documents are missing or exported from the PSV, the Provider Relations Department will be notified by the Credentialing Department of any missing documents by sending a task in Salesforce Health Cloud V12 Platform.

The case file is then updated under Internal Review process with the date of the review, a missing documents status, and a note of what creds were missing at the time will be updated in Salesforce Health Cloud Platform. The Provider Relations Department will start the minimum 3 outreach attempts, first by email, second and final attempt by phone calls, within 30 business days. All outreach attempts by the Provider Relations Department will be documented in Salesforce Health Cloud V12 Platform. If missing credentialing documents are not received within 30 days after the Internal Review date the case is discontinued.

Once the Provider Relations Department has received the missing credentialing documents from the provider/group, a Task will be sent via Salesforce Health Cloud V12 Platform, to the Credentialing Department informing them that the credentialing documents s have been received and is attached in the system. The Credentialing Department then reviews the documents to ensure that they meet VillageCareMAX requirements. Once all required credentialing documents are validated, the internal review date is updated in Salesforce Health Cloud V12 Platform.

The Senior Medical Director reviews the case, enters his recommendation, and then moves to the Credentialing Committee phase for committee review. Once the practitioner is approved by the Senior Medical Director during Credentialing Committee, the Credentialing Department will

update the approval date and close out the credentialing approval date in Salesforce Health Cloud V12 Platform.

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

- 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 V**illageCareMAX 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/providers for policy and procedure updates.

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

Section 25: Quality Management

The VillageCareMAX Quality Management and 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 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 as they receive care; and Member satisfaction. The QMPI Program Description, the QMPI Work Plan and the QMPI Program Evaluation are reviewed and approved annually by the Board of Directors. C

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 t about which a question has been raised as to 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.
- VillageCareMAX (QM) staff may identify events through the following:
    - Routine medical record review/quality measurement activity
    - 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 for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare, 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
    - If the case is a grievance about quality, the Grievance Policy timelines are followed.
    - 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.
        - 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.
    - All other incidents/QOC concerns are investigated as quickly as the situation warrants. The Grievances & Appeals 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 Clinical Quality of Care 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 theGrievances & Appeals 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 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 Grievances & Appeals 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 ad hoc 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 requests, and the Grievances &Appeals 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.

Section 25: Quality Management

Reporting

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 Quality Improvement 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
- 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 and disseminates evidence-based guidelines for the provision of acute, chronic, preventive, and behavioral health care services that are relevant to our population. Clinical Practice Guidelines serve as a decision support tool for providers and members. These guidelines aid in establishing practices consistent with national standards of care, and standardization of these practices network-wide, thereby reducing unnecessary variation in care. Guidelines are reviewed annually and updated no less than every two years, or as national guidelines change. Updates to the Clinical Practice Guidelines are reviewed by the VCMAX Clinical Guideline Committee and the Quality Management Improvement Committee immediately preceding any policy revision. Clinical Practice Guidelines are not intended as a substitute for the professional assessment of the practitioner but are to be used as a tool to assist in the management of certain types of preventive and clinical care. Individual patient treatment may vary.

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 Quality Improvement.

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 quality improvement initiatives.
- 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 claim 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, NYSDOH, CMS for Medicare Advantage HMO Dual Eligible Special Needs Plans. Measures for quality reporting are included in Appendix 5.

Section 25: Quality Management

Clinical Criteria

To access the clinical criteria that was used to make a determination, please visit the VillageCareMAX website, click on Resources, and select Clinical Criteria Guidelines or access directly at the following link: https://www.villagecaremax.org/providers/transparency

VillageCareMAX uses evidence-based clinical guidelines from nationally recognized sources during review of organizational determinations for our Medicare products. VillageCareMAX utilizes InterQual guidelines as the evidence-based tool that supports clinical decision-making. To review the guidelines utilized for a specific diagnosis or procedure, please access the following link:

InterQual® Criteria

***Registration is required to view the guidelines. Accounts are free and available to the public.**

Members should consult their member-specific benefit plan document for information regarding covered benefits. As always, a member should discuss any medical concerns with their primary care provider.

Section 26: Fraud Waste and Abuse

Fraud, Waste and Abuse Investigation

VillageCareMAX has a Compliance Program and a Special Investigations Unit and investigates complaints of potential fraud, waste and/or abuse. Substantiated complaints are reported to the appropriate regulatory and law enforcement agencies, as required. Members, Providers, employees or the public can report suspected activity or behavior by writing to:

Chief Compliance Officer
VillageCareMAX
120 Broadway, Suite 2840
New York, NY 10271
(212) 337-5673

Or contact the Compliance Hotline at (844) 348-2664
Or online at www.villagecare.ethicspoint.com.
The hotline is available 24 hours a day/ seven days a week and is confidential and anonymous.

Members, Providers, employees, and the public can report suspected fraudulent or abusive behavior by calling VillageCareMAX at 1-800-4MY-MAXCARE (1-800-469-6292). Following the receipt of an issue which may indicate potential fraud and/or abuse Compliance will conduct an investigation to assess the nature and scope of the issue.

As necessary and appropriate, cases may also be 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 our Fraud, Waste & Abuse policies, 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/.

Medicare First Tier, Downstream and Related (FDR) 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 per Chapter 21 of the Managed Care Manual Section 50.3.2.

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" equal to three times the amount of the government's damages plus a civil penalty) of up to $11,000 per false 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.

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise aiding 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 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 several 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 training within 90 days of hire and annually thereafter. A record of all employees' and contractors' receipt of the policies, Standards of Conduct, and related information must be maintained for a period of ten years and should be provided upon request.
***Note:** Medicare has developed additional training for employees that is also required annually.. 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 more information regarding this requirement on our website at:
http://villagecaremax.org/provider-compliance/

Section 27: False Claims Act

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.ny.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] or on the internet at (https://www.gpo.gov/fdsys/pkg/CFR-2006-title42-vol3/pdf/CFR-2006-title42-vol3-sec422-504.pdf).
- Providers/suppliers should maintain a medical record for each Medicare or Medicaid beneficiary that is their patient during the applicable Record Retention Period as defined

by VillageCareMAX policy and federal, state and local laws and requirements. The Record Retention Period is the period during which a medical record must be maintained by the organization because it is needed for operational, legal, fiscal, historical or other purposes such as compliance with the VillageCareMAX Record Retention Schedule.

- Certain Record Retention Periods noted in the VillageCareMAX Record Retention Schedule are based on federal, state or local laws, or based on guidance provided by regulatory agencies ("Legally Mandated Record Retention Period"). However, the VillageCareMAX policy may impose certain Record Retention Periods that are not Legally Mandated Record Retention Periods but have been adopted by VillageCareMAX and its affiliated organizations pursuant to industry best practices. In addition, individual contracts entered into by VillageCareMAX and its affiliated organizations may impose Record Retention Periods other than the Record Retention Periods set forth in the Record Retention Schedule.
- Medical records must be accurate, complete, timely, 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.
- The Medicare program does not require specific media formats for medical records. However, the medical records must to be in their original format or in a legally reproducible format, 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.
- Providers and subcontractors must further ensure that pertinent contracts, books, documents, papers and records of their operations are available to the Department of Health (DOH), the Office of the Medicaid Inspector General (OMIG), the Department of Health and Human Services (DHHS), the Comptroller of the State of New York, the Comptroller General of the United States and the New York State Office of the Attorney General (OAG) 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 NOAG, DOH, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, CMS, and/or their respective authorized representatives with access to all the provider's subcontractor's premises, physical facilities, equipment, books, records, contracts, computers 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.
- Any questions regarding the requirements of this section should be directed to your VillageCareMAX provider representative or account manager.

Appendix

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

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

Appendix 17: Participating Provider Termination Form

Appendix 1

Appendix 1: VillageCareMAX Lead Form

VILLAGECAREMAX

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 contacted with information about VillageCareMAX's Medicare Advantage Special Needs Plans (SNP) HMO for individuals eligible for both Medicare and Medicaid.

My permission to be contacted is valid from the date of my signature until next available enrollment opportunity only. I understand that a VillageCareMAX Advisor will explain this information to me.

Beneficiary Signature: _____ Date: _____

I heard about VillageCareMAX Medicare Advantage Plan from:

☐ Print or Radio Ad ☐ Direct Mail/ Poster or Flier ☐ Doctor ☐ Friend or Family

☐ Community or Special Event Other (*please specify*) _____

FOR OFFICE USE ONLY – DO NOT WRITE IN THIS SECTION

Agent's Name: _____ Event: _____

VillageCareMAX is an HMO plan with Medicare and New York State Medicaid contracts. Enrollment inVillageCareMAX depends on contract renewal.
VillageCareMAX complies with Federal civil rights laws and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. ATENCION: si habla español, tiene a su español servicios gratuitos de 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務。請致電1-800-469-6292（TTY：711）.

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Appendix 2

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) for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare, 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) for Medicaid Managed Long Term Care or 1-855-296-8800 for Medicare.

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

Appendix 3: Electronic Funds Transfer

VILLAGECAREMAX
LIVE THE LIFE YOU WANT!

EFT/ACH REQUEST FORM

General Information: ☐ NEW Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Requested Effective Date: _____

Provider Name: _____

Provider Contact Name: _____

Provider Address: _____

Contact Phone #: _____

Contact Email: _____

Tax ID Number: _____

All applicable Billing/Pay to NPI: _____

Current Bank Information (if existing provider requesting changes):

ACH Routing Number (ABA#): _____

Bank Account Number: _____

Bank Name: _____

Bank Address: _____

Check one ☐ Savings ☐ Checking

New Bank Information (if you are a new provider to VCM):

ACH Routing Number (ABA#): _____

Bank Account Number: _____

Bank Name: _____

Bank Address: _____

Check one ☐ Savings ☐ Checking

Form Completed By: _____ Date: _____

Additional Instructions

(1) 30 days is needed to process a request.
(2) Please attach a copy of a voided check , current W9 and a Bank Letter.
(3) Email: providerrelations@villagecare.org

Appendix 4

Appendix 4: Service Authorization Request Form

VILLAGECAREMAX

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, Home modifications, Auth changes or corrections.**	**646-362-2004**
SNF Admissions	**978-967-8030**		
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 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 of the member or ability to regain maximum function in serious jeopardy.		
MEMBER INFORMATION		
Last Name	First Name	
Member ID	DOB	
PROVIDER INFORMATION		
Check One: You are the ☐Prescribing/Ordering ☐Referring		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax
Check One: You are the ☐Requesting Provider ☐Servicing Provider		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax
CLINICAL INFORMATION		
Member Symptoms and Duration		
Summary of Clinical Findings		
Order Description		
Medical Justification		
Diagnosis		
SERVICE TYPE REQUIRING AUTHORIZATION		
Place of Service		
Start Date of Service	End Date of Service	
Order Date	Quantity Requested	Time Requested
Ambulatory/Outpatient Services	**Inpatient Care**	**Outpatient Services**
☐Surgery/Procedure ☐Infusion or Oncology Medications	☐Acute Inpatient Admission ☐Short Term/Acute Rehab ☐Skilled Nursing Facility	☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy
Home Health Services	**Ancillary Services**	**Durable Medical Equipment**
☐Home Health Please circle: SN,PT,ST,MSW ☐Hospice ☐Infusion Therapy ☐Respite Care	☐Acupuncture	☐Prosthetic Device ☐Enteral Supplies ☐Incontinence Supplies ☐Medical Supplies ☐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

Appendix 5

VillageCareMAX

Appendix 5: Quality Improvement Program

PURPOSE

The VillageCareMAX Quality Improvement (QI) Program Description provides the framework to improve the health of the members and communities served. The QI Program is designed to conduct meaningful quality improvement activities across the organization aimed at improving member health outcomes, quality of care, services delivered and overall customer satisfaction.

The Quality Improvement (QI) Program is designed to monitor and evaluate the quality, safety, appropriateness and outcomes of care and services delivered to our members objectively and systematically. The QI Program provides a mechanism that continuously pursues opportunities for improvement and problem resolution.

The Quality Program Description delineates accountability for quality within the organization, beginning with the Board of Directors and flowing through to the various committees and departments. The Quality Program Description describes VillageCareMAX's approach to continuously improve the quality of its health care coverage.

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 in the five (5) boroughs of New York City, Nassau and Westchester counties. The plans offered by VillageCareMAX include:

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- **Medicaid Managed Long Term Care (MLTC) Plan**
  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:
    - Eligible for Medicaid; Age 18 or older; reside within the service area outlined above.
    - Assessed as eligible for nursing home level of care (as of the time of enrollment) according to the Uniform Assessment System (UAS) for individuals with Medicaid-only or those with Medicare & Medicaid age 18-20 years old; and
    - Expected to need care management and community based long-term care services for a continuous period of more than 120 days from the date of enrollment.

- **Medicare Advantage Dual Eligible Special Needs Plans:**
  VillageCareMAX offers three 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. This plan covers all Medicare Part A, Part B, and Part D services.
    - **VillageCareMAX Medicare Health Advantage FLEX**, for dual eligible individuals who reside in the service area. This plan covers all Medicare Part A, Part B, Part D and offers members more flexibility to choose supplemental benefits that are beneficial for each member.
    - **VillageCareMAX Medicare Total Advantage**, for dual eligible individuals who are also nursing home eligible (based on the UAS assessment) and require LTSS for a continuous period of 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.

- **Medicare Advantage**
  VillageCareMAX offers one Medicare Select Advantage Plan which is a Medicare Advantage Prescription Drug Plan designed for members who have Medicare and are eligible for Extra Help. To enroll in the plan, individuals must:
    - Have both Medicare Part A and Medicare Part B.

- Live within one of the following service areas; following counties in New York: Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Nassau, and Westchester.
- Must be a United States citizen or lawfully present in the United States.

Members of the plan are covered for:

- Medicare benefits for inpatient and outpatient services covered under Medicare Part A & Part B.
- Extra benefits that are not covered by Medicare include additional coverage for hearing, dental, vision, fitness membership, and more. This document includes a summary of these benefits.
- Drug Coverage: Medicare Part D & Part B prescription drugs.

GOVERNANCE AND ACCOUNTABILITY

The Board:

The Board of Directors has authority and provides direct oversight of the VCMAX Quality Program and its activities. The Board receives reports from the Quality Management Improvement Committee on a regular basis, but no less than quarterly. The Quality Improvement Program is reviewed and approved annually by the Board of Directors. The Board of Directors delegates the operating authorization of the QI Program to the Quality Management Improvement Committee.

President/CEO (Chief Executive Officer):

The President/CEO supports the QI Program through oversight and supervision of the Quality Department and operations. The formal reports to the Board of Directors are coordinated through the President/CEO.

Chief Operating Officer (COO):

The Chief Operating Officer (COO) is responsible for executing the internal operational strategies necessary to achieve the goals and objectives of the Quality Improvement Program and for ensuring the Quality Program is evaluated, updated, and approved annually.

Senior Medical Director:

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The VillageCareMAX Senior Medical Director is responsible for quality-focused areas and providing clinical input into organizational initiatives and provides clinical guidance for quality improvement activities.

Vice President of Innovation, Strategic Initiatives, & Product Development

The Vice President (VP) of Innovation, Strategic Initiatives & Product Development is responsible for overall supervision of the Quality Improvement Program and its implementation. The responsibilities include ensuring that recommendations of the Quality Management Improvement Committee are implemented and overseeing Performance Improvement Projects (PIPs) and the Chronic Care Improvement Program (CCIP) in collaboration with the Assistant Vice President of Quality Management.

Assistant Vice President of Quality Management:

The Assistant Vice President (AVP) of Quality Management shares the responsibility for the day-to-day functions of the Quality Improvement Program. The AVP of Quality Management directs staff in carrying out responsibilities and compiling measurement data related to essential indicators.

The AVP of Quality Management assists the Vice President of Innovation, Strategic Initiatives & Product Development in the identification of meaningful reporting, data collection, analysis of data and preparation of information for presentation to the committees. In addition, the AVP facilitates/directs actions and interventions necessary to enhance performance.

The Quality Management and Improvement Committee (QMIC):

The Quality Management and Improvement Committee (QMIC) is responsible for developing the Quality Improvement Program. The Committee is responsible for planning and coordinating organization-wide improvement initiatives and establishing the quality goals for the year.

The Committee reviews results of quality indicators, studies, and audits, and makes recommendations to improve quality of services and operations based on the information. This may include revisions to policies or procedures, changes in service delivery, or the formulation of

quality improvement project teams to examine issues in more depth. The Chief Operating Officer/designee provides the Board of Directors with the required reports.

- **Committee Membership**: President/CEO, Chief Operating Officer, Executive Vice President of Clinical Services & Network Management, Vice President of Innovation, Strategic Initiatives & Product Development, Assistant Vice President of Quality Management, Quality Management Staff, Sr. Medical Director, , SVP of Business Development & Health Plan Operations, , VP of Care Management, Chief Compliance Officer, AVP Regulatory Affairs, Director of Enrollment, Chief Legal Officer, Chief Financial Officer, , VP of Network Management, Chief Information Officer, Chief Administrative Officer, AVP of Data Analytics, Director of Pharmacy or Pharmacy Specialist, AVP of Utilization Management, and Clinical Director of Behavioral Services.
- **Reports To**: Board of Directors
- **Meeting Frequency**: The QMIC meets quarterly, meeting minutes and attendance records are maintained.
- **Responsibilities**:
  - Evaluate data collected pertaining to quality indicators, performance standards, and member satisfaction.
  - Makes recommendations to the Board of Directors to improve processes and outcomes.

Other Quality Improvement Sub-Committees

Behavioral Health Quality Management Improvement Subcommittee:

The Behavioral Health Quality Management Improvement Subcommittee provides oversight of the Behavioral Health quality management program's development and implementation. The subcommittee reviews and analyzes Behavioral Health data, interpreting the variances, drawing conclusions, and recommending interventions, with measurable outcomes for the VillageCareMAX Health Advantage, Total Advantage, and Select Advantage membership.

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.

Behavioral Health Utilization Management Subcommittee:

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The Behavioral Health Utilization Management (UM) Subcommittee provides oversight of the development and implementation of a process to collect, monitor, analyze evaluate and report utilization data consistent with reporting requirements. The Behavioral Health UM Subcommittee reviews and analyzes UM data, interpreting the variances, drawing conclusions, and recommending interventions, with measurable outcomes for the VillageCareMAX Health Advantage, Total Advantage and Select Advantage membership.

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 Senior Medical Director, Executive Vice President of Clinical Services & Network Management, the Chief Compliance Office, the Assistant Vice President of Quality Management, and other department leaders in VillageCareMAX.

Member Experience Steering Committee:
The Member Experience Steering Committee provides oversight of the development and implementation of a process to collect, monitor, analyze evaluate and report member experience data. The Member Experience Steering Committee will establish and maintain a member-centric culture for the organization. The committee will review and analyze member experience data from CAHPS, HOS, and other member experience survey sources and implement focused interventions with measurable outcomes relative to member experience for all lines of business.

Member Advisory Committee:
The Member Advisory Committee provides information on matters of concern to members and caregivers, including those related to quality of care, access to services, and customer service. The committee implements strategies to improve member experience with the health plan and member retention. Members are invited to participate via phone calls, notices in the member newsletter, and postings on the VillageCareMAX website.

Delegation Oversight Committee:
The Delegation Oversight Committee (DOC) ensures that VCMAX's delegates comply with VCMAX standards, federal and state regulatory requirements. The committee also maintains VCMAX's delegation policies and procedures and ensures that all delegation agreements remain consistent with VCMAX policies.

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SCOPE OF THE QUALITY IMPROVEMENT PROGRAM

The scope of the Quality Improvement Program is comprehensive and addresses the quality of services provided to VCMAX members and incorporates all lines of business, benefit packages, care settings and services in its quality management and improvement activities.

The QI Program is comprised of quality indicators that are objective, measurable and relate to the entire range of services provided by the Plan, and which focus on potential clinical problem areas (high volume service, high-risk diagnoses, or adverse outcomes). The areas of focus include:

- Continuity and Coordination of Care
- Access and Availability of Services
- Pharmacy Management
- Complex Care Needs of Members
- Quality of Clinical Care
- Member Experience & Engagement
- Preventative Health Promotion
- Population Health
- Cultural and Linguistic Care
- Utilization Management
- Credentialing and Re-Credentialing
- Delegation Oversight

Member Experience & Engagement:
The monitoring of Member Satisfaction requires all Medicare Advantage health plans to contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS) and Health Outcome Survey (HOS) vendor to conduct the required surveys and report its performance to CMS annually. Member satisfaction is also monitored throughout the year by reviewing VillageCareMAX developed surveys, complaints, grievances, and appeals information. The plan also reviews results of surveys conducted by the New York State Department of Health (NYSDOH) and/or its contractor to help drive improvement in member satisfaction. A Net Promoter Score is used to monitor results of the internal Member Surveys as an indication of loyalty members have with the Plan.

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VillageCareMAX established workgroups dedicated to improving member experience. The groups focus on customer service, the provider-patient experience and understanding the pharmacy benefits. The workgroups collect member experience data using member surveys, pharmacy data, call calibration assessments, complaints, grievances, and appeals data. The data is analyzed to identify opportunities to improve the member experience with the health plan.

In addition, VillageCareMAX established a disenrollment workgroup. This workgroup is dedicated to retaining members. This group focuses on members who choose to leave the Plan. The workgroup collects member data from disenrollment surveys and disenrollment data provided by CMS. The data is analyzed to identify opportunities to improve the member experience and decrease disenrollment.

VillageCareMAX is focused on engaging the provider in the member experience program. To assist in accomplishing this, VillageCareMAX is collaborating with Press Ganey to give providers access to member engagement focused Microlearning Modules. Providers gain the skills and knowledge needed to improve patient experience in their daily work. The microlearning modules provide specific, easy to implement techniques for use in "real-life" situations. To reinforce best practices, providers are also given digital handouts that highlight the key points from each microlearning module. In addition, Press Ganey supports our provider facing teams through a comprehensive train-the-trainer workshop and certification program. This training prepares the provider facing team to become member experience champions who provide patient experience coaching to the VillageCareMAX providers. Team members who complete the training receive certification to teach the content to others.

Member Incentive Program:
The member incentive program is a program designed to improve member engagement and provide health education information to the member. The interventions support the members to actively seek needed care and reward them for health and wellness behaviors.

Quality of Clinical Care:
The Quality Department collects and reports Healthcare Effectiveness Data and Information Set (HEDIS) data according to National Committee for Quality Assurance (NCQA) and CMS requirements. HEDIS results are analyzed for opportunities to improve all measures. VCMAX monitors the results of these metrics to assess the effectiveness of care and services rendered to Medicare Advantage members.

The Center for Medicare and Medicaid (CMS) uses the Star Rating Program to measure quality of care, member experience and plan administration of contractual standards. CMS calculates the Star Ratings using data from the following sources:

- Healthcare Effectiveness Data and Information (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcome Survey (HOS),

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- Part C & D Reporting Requirements
- Call Center Monitoring
- Independent Review Entity (IRE)
- Prescription Drug Events (PDE)
- Complaints Tracking Module (CTM)
- Medicare Beneficiary Database Suite of Systems (MBDSS)

The CMS Star Ratings data are utilized to identify areas for improvement and develop performance improvement projects.

The New York State Managed Long Term Care performance data evaluates the performance of NY State certified MLTC/MAP Plans and provides a basis for data-driven improvement initiatives. NYSDOH assesses the quality of care provided by the Plan as compared to the statewide average.

The monitoring of metrics for HEDIS and MLTC measures, and implementation of interventions to positively impact performance is conducted throughout the year.

Chronic Care Improvement Programs (CCIPs):
VCMAX's Chronic Care Improvement Program (CCIP) objectives are designed to improve the health status of its eligible members at risk for chronic conditions. The program achieves this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness, prevention of complications and other co-morbidities. CCIPs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship and the development of members' plan of care. The CCIPs are selected based on an analysis of disease prevalence data within the population.

Performance Improvement Projects (PIPs):
PIPs are initiatives, which focus on one, or more clinical and/or non-clinical areas with the aim of improving health outcomes and enrollee satisfaction based on priorities identified by the NYSDOH. VCMAX conducts quality and performance improvement projects with the aim of achieving meaningful and sustainable improvements, which are statistically significant, in aspects of clinical and non-clinical care.

Quality Improvement Projects (QIPs):
VCMAX will conduct Quality Improvement Projects (QIPs) using the Plan-Do-Study- Act Model to address opportunities for improvement.

Quality improvement projects include the following elements:

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- Measurement of performance using objective indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions based on the performance measures.
- Planning and initiation of activities for increasing or sustaining improvement.

Clinical Practice & Preventive Health Guidelines:
VCMAX systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines. These guidelines are endorsed from peer-reviewed sources for diseases and health conditions identified as most relevant to its membership for the provision of preventive, acute or chronic medical and behavioral health services.

Clinical Practice and Preventive Health Guidelines are presented to Quality Management Improvement Committee for review and adoption. The Clinical Practice and Preventive Health Guidelines are disseminated to practitioners via the provider newsletter, targeted mailings and they are posted on the VillageCareMAX website.

Member Safety:
The Quality Department works collaboratively with the Medication Adherence Team comprised of the Medical Management and Pharmacy Department to monitor and identify performance improvement opportunities related to member safety such as medication adherence, prescribing and adverse occurrences. In addition, the Quality team reviews member appeals, grievances, and complaints to identify safety concerns. Falls risk assessments are conducted by Care Managers to identify members at risk of falling. Care Managers review falls risk with the interdisciplinary care team and integrate preventive interventions into the members' plan of care.

Health Equity:
Cultural and Linguistic Program:
VillageCareMAX promotes the delivery of services in a culturally competent manner to all members including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds as well as members with diverse sexual orientation, gender identities and members of diverse faith communities. VCMAX Cultural and Linguistic Program is based on the National CLAS standards of the US Department of Health and Human Services.

Social Determinants of Health:

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Social determinants of health (SDOH) are the non-medical factors that influence health outcomes. They are conditions in which people are born, live, work, play, worship, and age that affect a wide range of health functioning and quality of life outcomes and risks. Social determinants of health have a major impact on people's health, wellbeing, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

VillageCareMAX has four Community Centers located in the Bronx, Brooklyn, Manhattan, and Queens, which serve as a valuable community resource for member education and engagement.

VillageCareMAX conducts an annual community health needs assessment to obtain information about the current health status, needs, and issues in the communities we serve. The community health needs assessment guides the Plan in developing quality improvement activities.

In addition, VillageCareMAX conducts social determinants of health assessments for all members upon enrollment and annually. Members with identified social determinants of health needs are educated regarding Plan benefits which may help with SDOH needs. For needs not covered under Plan benefits, members are referred to community-based organizations for assistance. All members with identified SDOH needs are reassessed within 90 days to ensure their needs are being addressed.

Managing Chronic Illnesses:
VillageCareMAX is dedicated to providing quality care to our members while improving their ability to manage their chronic illnesses at home. The Plan utilizes both internal and external resources to accomplish this goal.

AIRnyc is an independent community-based organization working to reduce barriers to health for NYC's most vulnerable individuals. VCMAX collaborates with AIRnyc to address health literacy in members with Chronic Obstructive Pulmonary Disease (COPD). Health Disparities are major contributors to COPD, such as environmental factors and socioeconomic status. AIRnyc provides telephonic coaching for members with COPD. In addition, AIRncy assesses members for social needs and assists them with navigating medical and social services.

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Emerest Connect Health provides in-home remote patient monitoring for the most vulnerable members. Emerest provides members with remote monitoring hardware and software for the provision of services. Members and their caregivers receive education regarding the use of the technology and how the remote monitoring program works. This platform allows for real time observation of chronic disease symptoms, spots early signs of exacerbation, and assists members in attaining immediate attention, when necessary.

The Quality Team will continue to address diabetes care through the Diabetes Performance Improvement Project. Diabetic members continue to receive enhanced Care Management interventions and education to promote member self-management. The project aims to ensure diabetic members receive care that aligns with the clinical practice guidelines and best practices.

The "VillageCare Living Well" website offers members and caregivers access to information regarding preventive health and managing chronic illnesses.

Provider Performance Improvement:
The Quality Department delivers information to providers to facilitate the delivery of high-quality, cost-effective care. The following reports are provided to physician practices to support timely comprehensive care to members.

- Gaps in Care Reports
- Member Experience Data
- Pharmacy Reports
- Care Management Reports
- Utilization Management Reports.

The success and impact of VCMAX's Quality Improvement Program is dependent on physician engagement with and support of the program.

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.

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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 QI PROGRAM

The Quality Management Improvement Committee reviews the annual evaluation, which details the results of the quality activities. The Quality Improvement Program provides a year-end summary of the progress and result of clinical and service quality improvement initiatives. It also evaluates the overall effectiveness of the quality program and identifies quality measurement and improvement opportunities for the coming year. Discussion of the program evaluation provides an opportunity to identify gaps, strengths, and best practices within the program, focusing on future activities. The Chief Operating Officer/designee will provide the Board of Directors with the annual evaluation of the QI Program.

Appendix 6

Appendix 6: Clinical Practice Guidelines

VILLAGECAREMAX
LIVE THE LIFE YOU WANT!

Clinical Practice Guidelines

Condition/Disease	Guideline Title	Recognized Source	URL
Adult Routine Preventive Care	U.S. Preventive Services Task Force (USPSTF) A and B Recommendations	United States Preventive Services Task Force (USPSTF)	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations
Alcohol Withdrawal Management	Clinical Practice Guideline on Alcohol Withdrawal Management	American Society of Addiction Medicine	https://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal-management-guideline

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Condition/Disease	Guideline Title	Recognized Source	URL
Asthma	2020 Focused Updates to the Asthma Management Guidelines (National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma)	National Heart, Lung and Blood Institute	https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/2020-focused-updates-asthma-management-guidelines
Atrial Fibrillation	2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines	American College of Cardiology (ACC), American Heart Association (AHA)	https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000665
Bipolar Disorder	Practice Guideline for the Treatment of Patients With Bipolar Disorder	American Psychiatric Association	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf
Cholesterol Management	2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol	American Heart Association (AHA), American College of Cardiology (ACC)	https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000625

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Condition/Disease	Guideline Title	Recognized Source	URL
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for Prevention, Diagnosis and Management of COPD (2024 Report)	Global Initiative for Chronic Obstructive Lung Disease (GOLD)	https://goldcopd.org/2024-gold-report/
Coronary Artery Disease	2014 ACC/AHA/AATS/PCNA/SCAI /STS Focused Update of the Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons	https://www.ahajournals.org/doi/full/10.1161/cir.0000000000000095
Coronary Artery Disease	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task for of Clinical Practice Guidelines	American College of Cardiology (ACC, American Heart Association (AHA)	https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000678

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Condition/Disease	Guideline Title	Recognized Source	URL
Covid-19	National Institute of Health (NIH) COVID-19 Treatment Guidelines	National Institutes of Health (NIH) Centers for Disease Control and Prevention (CDC) Food and Drug Administration (FDA)	https://www.covid19treatmentguidelines.nih.gov/about-the-guidelines/whats-new/
Depressive Disorder	Practice Guideline for the Treatment of Patients with Major Depressive Disorder	American Psychiatric Association	https://psychiatryonline.org/guidelines
Diabetes	Standards of Medical Care in Diabetes 2024	American Diabetes Association	https://diabetesjournals.org/care/issue/47/Supplement_1
Fall Prevention	American Family Physician Preventing Falls in Older Persons	American Academy of Family Physicians	https://www.aafp.org/afp/2017/0815/p240.html
Heart Failure	2024 ACC Expert Consensus Decision Pathway for Treatment of Heart Failure With Reduced Ejection Fraction	American College of Cardiology (ACC)	https://www.jacc.org/doi/10.1016/j.jacc.2023.12.024?_ga=2.109351941.1030501.1718032503-1210283476.1718032503
Human Immunodeficiency Virus (HIV)	Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America	Infectious Diseases Society of America	https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/

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Condition/Disease	Guideline Title	Recognized Source	URL
Hypertension	2020 International Society of Hypertension Global Hypertension Practice Guidelines	International Society of Hypertension (ISH), American Heart Association (AHA)	https://www.ahajournals.org/doi/10.1161/HYPERTENSIONAHA.120.15026
Kidney Disease	National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI)™ Commentary Volume 63, ISSUE 5, P713-735, May 01, 2014 PDF [596 KB] KDOQI US Commentary on the 2012 KDIGO Clinical Practice Guideline for the Evaluation and Management of CKD	National Kidney Foundation	https://www.ajkd.org/article/S0272-6386(14)00491-0/fulltext
Long-Acting Injectables in the Treatment of Schizophrenia	Practical Guidance for the Use of Long-Acting Injectable Antipsychotics in the Treatment of Schizophrenia	NIH-National Library of Medicine	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9809355/
Obesity	VA/DoD Clinical Practice Guideline for the Management of Adult Overweight and Obesity	Veterans' Health Administration, Office of Quality & Performance, Evidence Review Subgroup	https://www.healthquality.va.gov/guidelines/CD/obesity/VADoDObesityCPGFinal5087242020.pdf

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Condition/Disease	Guideline Title	Recognized Source	URL
Opioid Use Disorder	The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update	American Society of Addiction Medicine (ASAM)	https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline
Opioid Use in the Management of Chronic Pain	The Use of Opioids in the Management of Chronic Pain	U.S. Department of Veteran's Affairs	https://www.healthquality.va.gov/guidelines/pain/cot/
Osteoporosis	American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis—2020 Update	American Association of Clinical Endocrinologists, American College of Endocrinology	https://www.sciencedirect.com/science/article/pii/S1530891X20428277
Pain Management	University of Michigan Pain Management Clinical Care Guidelines	National Library of Medicine (NLM), National Institutes of Health (NIH),	https://www.ncbi.nlm.nih.gov/books/NBK572296/
Panic Disorder	Practice Guideline for the Treatment of Patients With Panic Disorder Second Edition	American Psychiatric Association	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf

Appendix 6

Condition/Disease	Guideline Title	Recognized Source	URL
Physical Activity	Physical Activity Guidelines for Americans	U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion	https://health.gov/our-work/nutrition-physical-activity/physical-activity-guidelines/current-guidelines
Tobacco Cessation	Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions	United States Preventive Services Task Force (USPSTF)	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions
Urinary Incontinence-Female	Nonsurgical Management of Urinary Incontinence in Women: A Clinical Practice Guideline From the American College of Physicians	American College of Physicians	https://www.acpjournals.org/doi/10.7326/M13-2410
Urinary Incontinence-Male	Male Urinary Incontinence: Prevalence, Risk Factors, and Preventive Interventions	National Center for Biotechnology Information, U.S. National Library of Medicine, National Institutes of Health	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777062/

Appendix 7

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:

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  - Assessment
  - Plan of care
  - Physician orders
  - Evidence of PCA/HHA supervision
  - Duty sheets outlining the work that is performed. (Note: for split shift cases, each PCA/HHA must keep a duty sheet.)
  - 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: 800-469-6292
  - By Fax: 212-337-5711
  - 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.**
  - Notification of no service to the member
  - Notification of vacations
  - 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

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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.

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	Topic	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

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	Topic	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**	**General:** • 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: o changes in skin integrity, such as blisters, skin tears, bruising or development of decubitus ulcers o falls o changes in mental status o changes in Member's intake, such as Member refusing food or liquids o any emergency situations (see below) **In an emergency:**	By PHONE 800-469-6292

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	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 or Died**	• Paraprofessional will notify licensed agency immediately. • Licensed agency will notify Member Services immediately. Agency should provide as much 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.)	By PHONE 800-469-6292

Appendix 7

	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 212-337-5711 By FAX 212-337-5711

Appendix 7

	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

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	Topic	LHCSA Guidelines	Contact
7.	**Member Request for No Service**	The licensed agency will notify Member Services immediately of all requests for no coverage for one or more days. • They should discuss any concerns for the Member's health or safety if there is no personal care coverage. • 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 service, please follow the guidelines in Section 8 below.*	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org
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. • 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.	By PHONE 800-469-6292

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	Topic	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.	By PHONE 800-469-6292
10.	**Unable to Locate Member**	If the HHA is unable to locate the Member on the first day of service: • 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 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.	By PHONE 800-469-6292
11.	**Member Not Answering Door or Phone**	Paraprofessional will notify his/her agency immediately to report that the Member is not answering the door or phone. • The licensed agency should ensure that the following factors were considered and checked: o Was the Member telephoned? o Did the aide knock on Member's door or ring buzzer?	By PHONE 800-469-6292

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	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. • In most cases, this is the responsibility of the family/ caregiver. • If authorized, and then discharge is delayed, the aide informs agency of hospital pick-up delay.	By FAX or EMAIL, in most circumstances 212-337-5711

Appendix 7

	Topic	LHCSA Guidelines	Contact
		• Licensed agency either approves travel time if necessary and or adjusts the aide's schedule as needed. •	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. **Escorting/Accompanying the Member to the Emergency Room**	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org By PHONE

Appendix 7

	Topic	LHCSA Guidelines	Contact
		• 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 resume services. Any changes to service authorizations will be forwarded to the licensed agency at this time.	800-469-6292
14.	**Incidents and Unsafe Situations including:** • **Verbal or physical abuse of the paraprofessional or Member**	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.	By PHONE 800-469-6292

Appendix 7

	Topic	LHCSA Guidelines	Contact

	• **Threats to the aide/Member's safety in the home**
	• **Unsanitary conditions in the home**
	• **Illegal activity in the home**
	• **Alleged altercation between the aide and Member/family**
	• **Allegations of coercion by the aide, Member, or family**
	• **Motor Vehicle Accidents (while being transported by VillageCareMAX transportation services)**
		• Depending on the situation, the licensed agency manager will:
		  ○ Call 911 if necessary, depending on circumstances.
		  ○ Immediately notify Member Services
		  ○ Make a decision on whether the aide should be released.
		• Licensed agency and VillageCareMAX staff will collaborate to ensure that a plan is established by the end of the day to ensure the staff's safety while attempting to resolve the situation. Follow-up in these circumstances will be closely coordinated and handled on a case-by-case basis.	

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.)	By PHONE 800-469-6292

Appendix 7

	Topic	LHCSA Guidelines	Contact
		• 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.	
16.	**Requests for Overtime**	• VillageCareMAX would like to reinforce that adhering to members' plan of care is critical in ensuring our members receive the services and support necessary to address their identified needs. We recognize, on occasion, circumstances may necessitate deviation from their existing plan of care and additional support for members may be warranted. However, requests for additional Personal Care Aide (PCA) service hours by Licensed Home Care Service Agencies (LHCSA) must be consistent with members' authorized and approved plan of care. • It is the responsibility of the LHCSA to manage approved PCA hours to support the members' plan of care. If the member has a scheduled appointment, providers should adjust the aide's hours for the remainder of the day or week to meet the current number of approved hours in the plan of care. • VillageCareMAX will not approve additional PCA hours outside of the authorized plan of care unless there is an unavoidable, urgent, emergent need for the member. If	Requests for Authorization By PHONE 800-469-6292 Notifications By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org

Appendix 7

	Topic	LHCSA Guidelines	Contact
		this occurs, VillageCareMAX will request clinical documentation to verify the request. • In accordance with our provider contract, VillageCareMAX compensates LHCSAs at a flat hourly rate for PCA services and does not pay a separate premium for overtime work outside of the contracted rate. LHCSAs, as the PCAs' employers, are required to manage their employees' overtime hours in accordance with the New York State Department of Labor laws. Only members or a member's authorized representative can request additional hours above the current plan of care. Those requests will be reviewed based on medical necessity according to the plan's standard clinical review process.	
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,	By FAX or EMAIL 212-337-5711 faxgroup@villagecare.org

	Topic	LHCSA Guidelines	Contact
		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.	

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.

Appendix 7

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

Issue	Detailed Plan for Performance Improvement	Person Responsible	Date to be Completed

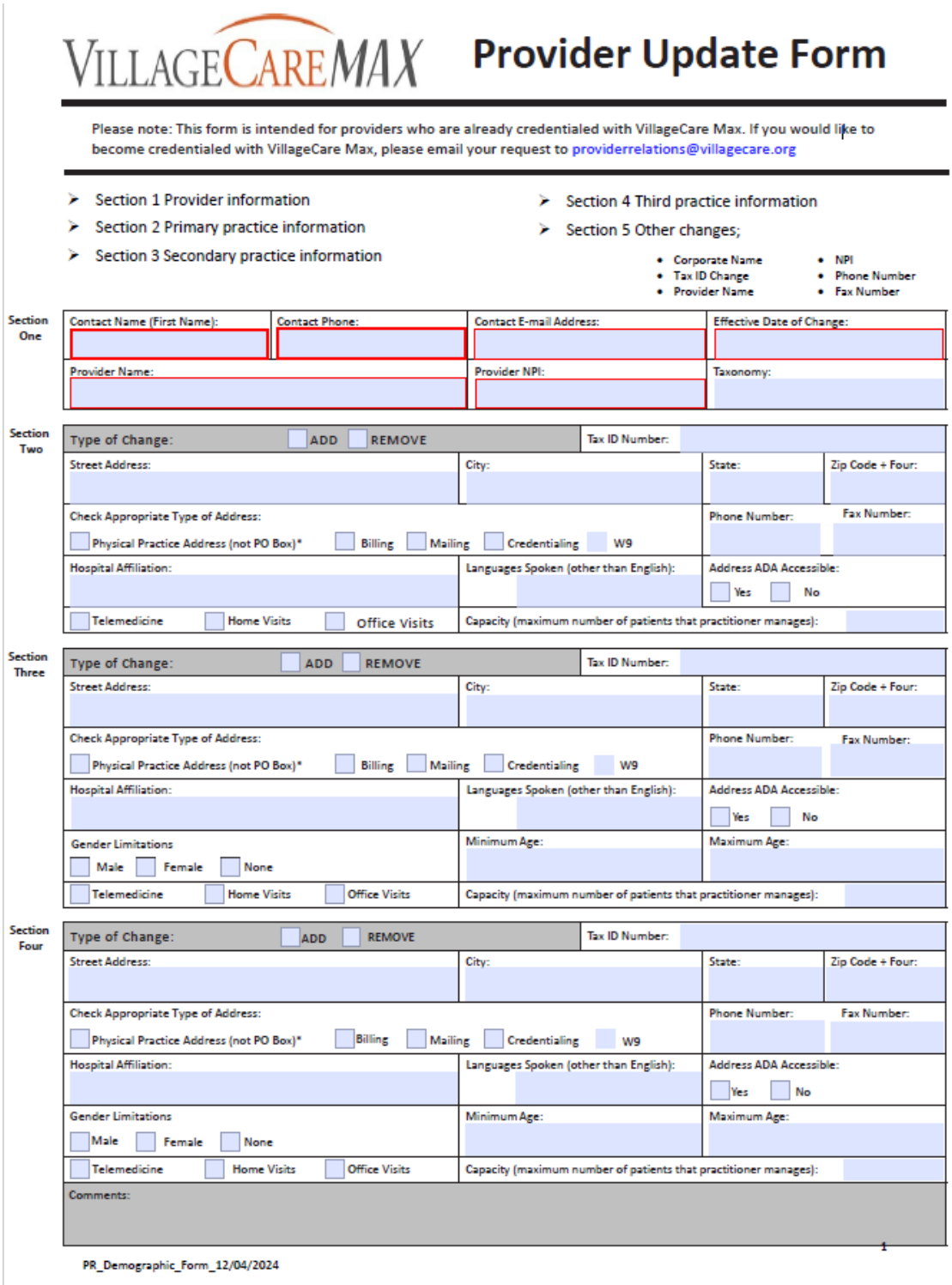
Plan Completed by: _____

Title: _____

Date Submitted: _____

Appendix 8

Appendix 8: Provider Information Change Form



VILLAGECAREMAX

Provider Update Form

Please note: This form is intended for providers who are already credentialed with VillageCare Max. If you would like to become credentialed with VillageCare Max, please email your request to providerrelations@villagecare.org

- Section 1 Provider information
- Section 2 Primary practice information
- Section 3 Secondary practice information
- Section 4 Third practice information
- Section 5 Other changes;
  - Corporate Name
  - Tax ID Change
  - Provider Name
  - NPI
  - Phone Number
  - Fax Number

Section One

Contact Name (First Name):	Contact Phone:	Contact E-mail Address:	Effective Date of Change:
Provider Name:		Provider NPI:	Taxonomy:

Section Two

Type of Change: ☐ ADD ☐ REMOVE			Tax ID Number:
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box)* ☐ Billing ☐ Mailing ☐ Credentialing ☐ W9		Phone Number:	Fax Number:
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
☐ Telemedicine ☐ Home Visits ☐ Office Visits	Capacity (maximum number of patients that practitioner manages):		

Section Three

Type of Change: ☐ ADD ☐ REMOVE			Tax ID Number:
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box)* ☐ Billing ☐ Mailing ☐ Credentialing ☐ W9		Phone Number:	Fax Number:
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
Gender Limitations ☐ Male ☐ Female ☐ None	Minimum Age:	Maximum Age:	
☐ Telemedicine ☐ Home Visits ☐ Office Visits	Capacity (maximum number of patients that practitioner manages):		

Section Four

Type of Change: ☐ ADD ☐ REMOVE			Tax ID Number:
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box)* ☐ Billing ☐ Mailing ☐ Credentialing ☐ W9		Phone Number:	Fax Number:
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
Gender Limitations ☐ Male ☐ Female ☐ None	Minimum Age:	Maximum Age:	
☐ Telemedicine ☐ Home Visits ☐ Office Visits	Capacity (maximum number of patients that practitioner manages):		
Comments:			

1

PR_Demographic_Form_12/04/2024

Form continues on following page

Appendix 8

Section Five

OTHER CHANGES: ☐ CORPORATE ☐ PERSONAL

Changes in this section assume that no other changes are needed. For example, if the information provided below is the Old and New Tax ID Number, we will update only the Tax ID Number and no other changes to existing information will be made.

	OLD	NEW
☐ Corporate Name (W-9 form required)		
☐ Tax ID Number (W-9 form required)		
☐ Provider Name		
☐ Individual NPI Number		
☐ Phone (Practice location)		
☐ Fax (Practice location)		

Section Six

OFFICE HOURS

For Sections Two, Three, and Four, please fill out Office Hours for each **Physical Practice Address (not PO Box)** checked off above.

Please enter Hours in the following format (Example: 9:00am)

	Section Two		Section Three		Section Four	
	From:	To:	From:	To:	From:	To:
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

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 providerrelations@villagecare.org indicating '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.)

Appendix 9

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

Appendix 10: DME Services that do not require Prior Authorization

The DME services below 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:

Medicaid Managed Long Term Care: **1-800-469-6292** or **Medicare: 1-855-296-8800**.

CODE	DESCRIPTION
A4216	STERILE WATER, SALINE AND/OR DEXTROSE, D
A4217	STERILE WATER/SALINE,500 ML
A4221	SUPP FOR MAINTENANCE OF NON-INSULIN INF CATH/WK
A4230	INFUSION SET FOR EXTERNAL INSULIN PUMP,
A4231	INFUSION SET FOR EXTERNAL INSULIN PUMP,
A4233	REPLACEMENT BATTERY, ALKALINE (OTHER THA
A4234	REPLACEMENT BATTERY, ALKALINE, J CELL, F
A4235	REPLACEMENT BATTERY, LITHIUM, FOR USE WI
A4244	ALCOHOL OR PEROXIDE, PER PINT
A4245	ALCOHOL WIPES, PER BOX
A4246	BETADINE OR PHISOHEX SOLUTION, PER PINT
A4250	URINE TEST OR REAGENT STRIPS OR TABLETS
A4252	BLOOD KETONE TEST OR REAGENT STRIP, EACH
A4253	BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR
A4256	NORMAL, LOW AND HIGH CALIBRATOR SOLUTION
A4258	SPRING-POWERED DEVICE FOR LANCET, EACH
A4259	LANCETS, PER BOX OF 100
A4267	CONTRACEPTIVE SUPPLY, CONDOM, MALE, EACH
A4268	CONTRACEPTIVE SUPPLY, CONDOM, FEMALE, EA
A4310	INSERTION TRAY WITHOUT DRAINAGE BAG AND
A4311	INSERTION TRAY WITHOUT DRAINAGE BAG WITH
A4314	INSERTION TRAY WITH DRAINAGE BAG WITH IN
A4320	IRRIGATION TRAY WITH BULB OR PISTON SYRI
A4322	IRRIGATION SYRINGE, BULB OR PISTON, EACH
A4326	MALE EXTERNAL CATHETER WITH INTEGRAL COL
A4331	EXTENSION DRAINAGE TUBING, ANY TYPE, ANY
A4333	URINARY CATHETER ANCHORING DEVICE, ADHES
A4334	URINARY CATHETER ANCHORING DEVICE, LEG S

Appendix 10

A4338	INDWELLING CATHETER; FOLEY TYPE, TWO-WAY
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY
A4346	INDWELLING CATHETER; FOLEY TYPE, THREE W
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT
A4351	INTERMITTENT URINARY CATHETER; STRAIGHT
A4352	INTERMITTENT URINARY CATHETER; COUDE (CU
A4353	INTERMITTENT URINARY CATHETER, WITH INSE
A4354	INSERTION TRAY WITH DRAINAGE BAG BUT WIT
A4356	EXTERNAL URETHRAL CLAMP OR COMPRESSION D
A4357	BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH
A4358	URINARY DRAINAGE BAG, LEG OR ABDOMEN, VI
A4361	OSTOMY FACE PLATE, EACH
A4362	SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT
A4363	OSTOMY CLAMP, ANY TYPE, REPLACEMENT ONLY
A4364	ADHESIVE, LIQUID OR EQUAL, ANY TYPE, PE
A4366	OSTOMY VENT, ANY TYPE, EACH
A4367	OSTOMY BELT, EACH
A4368	OSTOMY FILTER,ANY TYPE, EACH
A4369	OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUS
A4371	OSTOMY SKIN BARRIER,POWDER,PER OZ
A4372	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
A4373	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4375	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTA
A4376	OSTOMY POUCH, DRAINABLE, WITH FACEPLATE
A4377	OSTOMY POUCH, DRAINABLE, FOR USE ON FACE
A4378	OSTOMY POUCH, DRAINABLE, FOR USE ON FACE
A4379	OSTOMY POUCH, URINARY, WITH FACEPLATE AT
A4380	OSTOMY POUCH, URINARY, WITH FACEPLATE AT
A4381	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
A4382	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
A4383	OSTOMY POUCH, URINARY, FOR USE ON FACEPL
A4384	OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EA
A4385	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
A4387	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
A4388	OSTOMY POUCH, DRAINABLE, WITH EXTENDED W
A4389	OSTOMY POUCH, DRAINABLE, WITH BARRIER AT
A4390	OSTOMY POUCH, DRAINABLE, WITH EXTENDED W
A4391	OSTOMY POUCH, URINARY, WITH EXTENDED WEA
A4392	OSTOMY POUCH, URINARY, WITH STANDARD WEA
A4393	OSTOMY POUCH, URINARY, WITH EXTENDED WEA
A4394	OSTOMY DEODORANT, WITH OR WITHOUT LUBRIC

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A4395	OSTOMY DEODORANT FOR USE IN OSTOMY POUCH
A4396	OSTOMY BELT W/PERISTOMAL HERNIA SUPPORT
A4397	IRRIGATION SUPPLY SLEEVE EACH
A4398	OSTOMY IRRIGATION SUPPLY; BAG, EACH
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER,
A4400	OSTOMY IRRIGATION SET EACH
A4402	LUBRICANT, PER OUNCE
A4404	OSTOMY RING, EACH
A4405	OSTOMY SKIN BARRIER, NON-PECTIN BASED, P
A4406	OSTOMY SKIN BARRIER, PECTIN-BASED, PASTE
A4407	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4408	OSTOMY SKIN BARRIER, WTIH FLANGE (SOLID,
A4409	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4410	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4411	OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVA
A4412	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FO
A4413	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, FO
A4414	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4415	OSTOMY SKIN BARRIER, WITH FLANGE (SOLID,
A4416	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
A4417	OSTOMY POUCH, CLOSED, WITH BARRIER ATTAC
A4418	OSTOMY POUCH, CLOSED; WITHOUT BARRIER AT
A4419	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
A4420	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
A4422	OSTOMY ABSORBENT MATERIAL (SHEET/PAD/CRYST
A4423	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER
A4424	OSTOMY POUCH, DRAINABLE, WITH BARRIER AT
A4425	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
A4426	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
A4427	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
A4428	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BA
A4429	OSTOMY POUCH, URINARY, WITH BARRIER ATTACHE
A4430	OSTOMY POUCH, URINARY, WITH EXTENDED WEAR B
A4431	OSTOMY POUCH, URINARY; WITH BARRIER ATTACHED
A4432	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
A4433	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
A4434	OSTOMY POUCH, URINARY; FOR USE ON BARRIER WIT
A4435	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT,
A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCH
A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES
A4455	ADHESIVE REMOVER OR SOLVENT (FOR TAPE, C

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A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH
A4458	ENEMA BAG WITH TUBING, REUSABLE
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH
A4481	TRACHEOSTOMA FILTER, ANY TYPE, ANY SIZE,
A4495	SURGICAL STOCKINGS THIGH LENGTH, EACH
A4500	SURGICAL STOCKINGS BELOW KNEE LENGTH, EA
A4510	SURGICAL STOCKINGS FULL LENGTH, EACH
A4554	DISPOSABLE UNDERPADS, ALL SIZES
A4556	ELECTRODES, (E.G., APNEA MONITOR), PER P
A4557	LEAD WIRES, (E.G., APNEA MONITOR), PER P
A4565	SLINGS
A4570	SPLINT
A4602	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM
A4614	PEAK EXPIRATORY FLOW RATE METER, HAND HE
A4615	CANNULA NASAL
A4616	TUBING,(OXYGEN),PER FOOT
A4618	BREATHING CIRCUITS
A4619	FACE TENT
A4620	VARIABLE CONCENTRATION MASK
A4623	TRACHEOSTOMY, INNER CANNULA
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHE
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTO
A4626	TRACHEOSTOMY CLEANING BRUSH EA
A4628	OROPHARYNGEAL SUCTION CATHETER, EACH
A4629	TRACHEOSTOMY CARE KIT FOR ESTABLISHED TR
A4630	REPLACEMENT BATTERIES, MEDICALLY NECESSA
A4635	UNDERARM PAD,CRUTCH,REPLACEMENT EACH
A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR
A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER,
A4660	SPHYGMOMANOMETER/BLOOD PRESSURE APPARATU
A4670	AUTOMATIC BLOOD PRESSURE MONITOR - SEMI AUTO
A4670	AUTOMATIC BLOOD PRESSURE MONITOR- FULLY AUTO
A4927	GLOVES, NON-STERILE, PER 100
A4930	GLOVES,STERILE PER PAIR
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EA
A4932	RECTAL THERMOMETER, REUSABLE, ANY TYPE,
A5051	OSTOMY POUCH, CLOSED; WITH BARRIER ATTAC
A5052	OSTOMY POUCH, CLOSED; WITHOUT BARRIER AT
A5053	OSTOMY POUCH, CLOSED; FOR USE ON FACEPLA
A5054	OSTOMY POUCH, CLOSED; FOR USE ON BARRIER

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A5055	STOMA CAP EACH
A5056	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR
A5057	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR
A5061	OSTOMY POUCH, DRAINABLE; WITH BARRIER AT
A5062	OSTOMY POUCH, DRAINABLE; WITHOUT BARRIER
A5063	OSTOMY POUCH, DRAINABLE; FOR USE ON BARR
A5071	OSTOMY POUCH, URINARY; WITH BARRIER ATTA
A5072	OSTOMY POUCH, URINARY; WITHOUT BARRIER A
A5073	OSTOMY POUCH, URINARY; FOR USE ON BARRIE
A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STO
A5082	CONTINENT DEVICE; CATHETER FOR CONTINENT
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER
A5093	OSTOMY ACCESSORY CONVEX INSERT
A5105	URINARY SUSPENSORY WITH LEG BAG, WITH OR
A5112	URINARY DRAINAGE BAG, LEG OR ABDOMEN, LA
A5113	LEG STRAP; LATEX, REPLACEMENT ONLY, PER
A5114	LEG STRAP; FOAM OR FABRIC, REPLACEMENT
A5120	SKIN BARRIER, WIPES OR SWABS, EACH
A5121	SKIN BARRIER; SOLID, 6 X 6 OR EQUIVALENT
A5122	SKIN BARRIER; SOLID, 8 X 8 OR EQUIVALENT
A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM
A5131	APPLIANCE CLEANER, INCONTINENCE AND OSTO
A5200	PERCUTANEOUS CATHETER/TUBE ANCHORING DEV
A5500	FOR DIABETICS ONLY, FITTING
A5503	FOR DIABETICS ONLY, MODIFICATION (OF OFF-THE-S
A5504	FOR DIABETICS ONLY, MODIFICATION) OF OFF-THE-S
A5505	FOR DIABETICS ONLY, MODIFICATION OF OFF-THE-SH
A5506	DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WIT
A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED M
A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, D
A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CU
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, S
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE,
A6021	COLLAGEN DRESSING, STERILE, SIZE 16 SQUARE
A6022	COLLAGEN DRESSING, STERILE, SIZE MORE THA
A6023	COLLAGEN DRESSING, STERILE, SIZE MORE THA
A6024	COLLAGEN DRESSING WOUND FILLER, STERILE,
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING

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A6203	COMPOSITE DRESSING, STERILE, PAD SIZE 16
A6204	COMPOSITE DRESSING, STERILE, PAD SIZE MO
A6205	COMPOSITE DRESSING, STERILE, PAD SIZE MO
A6206	CONTACT LAYER, STERILE, 16 SQ. IN. OR LE
A6207	CONTACT LAYER, STERILE, MORE THAN 16 SQ.
A6208	CONTACT LAYER, STERILE, MORE THAN 48 SQ.
A6209	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6210	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6211	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6212	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6213	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6214	FOAM DRESSING, WOUND COVER, STERILE, PAD
A6216	GAUZE NON-IMP NON-STER UP TO 1
A6217	A6216; MORE THAN 16 UP TO 48SQ
A6218	A6216; MORE THAN 48 SQ IN
A6219	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6220	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6221	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6222	GAUZE, IMPREGNATED WITH OTHER THAN WATER
A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER
A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER
A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALI
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
A6233	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT
A6234	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6235	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6236	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6237	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6238	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6239	HYDROCOLLOID DRESSING, WOUND COVER, STER
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PAS
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY
A6242	HYDROGEL DRESSING, WOUND COVER, STERILE,
A6243	HYDROGEL DRESSING, WOUND COVER, STERILE,
A6244	HYDROGEL DRESSING, WOUND COVER, STERILE,
A6245	HYDROGEL DRESSING, WOUND COVER, STERILE,
A6246	HYDROGEL DRESSING, WOUND COVER, STERILE,
A6247	HYDROGEL DRESSING, WOUND COVER, STERILE,

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A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PE
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COV
A6257	TRANSPARENT FILM, STERILE, 16 SQ. IN. OR
A6258	TRANSPARENT FILM, STERILE, MORE THAN 16
A6259	TRANSPARENT FILM, STERILE, MORE THAN 48
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NO
A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6404	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZ
A6407	PACKING STRIPS, NON-IMPREGNATED, STERILE
A6410	EYE PAD, STERILE, EACH
A6411	EYE PAD,NON-STERILE, EACH
A6412	EYE PATCH, OCCLUSIVE, EACH
A6441	PADDING BANDAGE, NON-ELASTIC, NON-WOVEN/
A6442	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6443	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6444	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6445	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6446	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6447	CONFORMING BANDAGE, NON-ELASTIC, KNITTED
A6448	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
A6449	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
A6450	LIGHT COMPRESSION BANDAGE, ELASTIC, KNIT
A6451	MODERATE COMPRESSION BANDAGE, ELASTIC, K
A6452	HIGH COMPRESSION BANDAGE, ELASTIC, KNITT
A6453	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
A6454	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
A6455	SELF-ADHERENT BANDAGE, ELASTIC, NON-KNIT
A6456	ZINC PASTE IMPREGNATED BANDAGE, NON-ELAS
A6457	TUBULAR DRESSING WITH OR WITHOUT ELASTIC
A6530	GRADIENT COMPRESSION STOCKING, BELOW KNE
A6531	GRADIENT COMPRESSION STOCKING, BELOW KNE
A6532	GRADIENT COMPRESSION STOCKING, BELOW KNE
A6533	GRADIENT COMPRESSION STOCKING, THIGH LEN
A6534	GRADIENT COMPRESSION STOCKING, THIGH LEN
A6535	GRADIENT COMPRESSION STOCKING, THIGH LEN

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A6536	GRADIENT COMPRESSION STOCKING, FULL LENG
A6537	GRADIENT COMPRESSION STOCKING, FULL LENG
A6538	GRADIENT COMPRESSION STOCKING, FULL LENG
A6539	GRADIENT COMPRESSION STOCKING, WAIST LEN
A6540	GRADIENT COMPRESSION STOCKING, WAIST LEN
A6541	GRADIENT COMPRESSION STOCKING, WAIST LEN
A6544	GRADIENT COMPRESSION STOCKING, GARTER BE
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION
A7002	TUBING, USED WITH SUCTION PUMP, EACH
A7003	ADMINISTRATION SET, WITH SMALL VOLUME NO
A7004	SMALL VOLUME NONFILTERED PNEUMATIC NEBUL
A7005	ADMINISTRATION SET, WITH SMALL VOLUME NO
A7007	LARGE VOLUME NEBULIZER, DISPOSABLE, UNFI
A7013	FILTER, DISPOSABLE, USED WITH AEROSOL CO
A7014	FILTER, NONDISPOSABLE, USED WITH AEROSOL
A7015	AEROSOL MASK, USED WITH DME NEBULIZER
A7027	COMBINATION ORAL/NASAL MASK, USED WITH C
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FUL
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE,
A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INT
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) U
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESS
A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRES
A7037	TUBING USED WITH POSITIVE AIRWAY PRESSUR
A7038	FILTER, DISPOSABLE, USED WITH POSITIVE A
A7039	FILTER, NON DISPOSABLE, USED WITH POSITI
A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY
A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL U
A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFF
A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED,
A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLES
A7523	TRACH SHOWER PROTECTOR,EACH
A7524	TRACHEOSTOMA STENT/STUD/BUTTON, EACH
A7525	TRACHEOSTOMY MASK,EACH
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED,
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED,
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEA
A9275	HOME GLUCOSE DISPOSABLE MONITOR, INCLUDE

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E0100	CANE, INCLUDES CANES OF ALL MATERIALS, A
E0105	CANE, QUAD OR THREE PRONG, INCLUDES CANE
E0110	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF
E0111	CRUTCH FOREARM, INCLUDES CRUTCHES OF VAR
E0112	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR F
E0113	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIX
E0114	CRUTCHES UNDERARM, OTHER THAN WOOD, ADJU
E0116	CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUS
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FI
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FI
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR
E0144	WALKER ENCLOSED FOUR SIDED FRAMED, RIGID OR FOLDING WHEELED WITH POSTERIOR SEAT
E0153	PLATFORM ATTACHMENT, FOREARM CRUTCH, EAC
E0154	PLATFORM ATTACHMENT,WALKER,EACH
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER,
E0156	SEAT ATTACHMENT, WALKER
E0157	CRUTCH ATTACHMENT, WALKER, EACH
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REP
E0160	SITZ TYPE BATH OR EQUIPMENT, PORTABLE, U
E0163	COMMODE CHAIR, MOBILE OR STATIONARY, WIT
E0165	COMMODE CHAIR, MOBILE OR STATIONARY, WIT
E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR,
E0168	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY D
E0175	FOOT REST, FOR USE WITH COMMODE CHAIR, E
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SH
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEEL
E0241	BATHTUB WALL RAIL EACH
E0243	TOILET RAIL EACH
E0244	RAISED TOILET SEAT
E0245	TUB STOOL OR BENCH
E0246	TRANSFER TUB RAIL ATTACHMENT
E0247	TRANSFER BENCH FOR TUB OR TOILET WITH OR
E0248	TRANSFER BENCH, HEAVY DUTY, FOR TUB OR T
E0271	MATTRESS, INNERSPRING
E0272	MATTRESS, FOAM RUBBER
E0274	TABLE, OVERBED
E0275	BED PAN STANDARD METAL OR PLASTIC
E0276	BED PAN FRACTURE METAL OR PLASTIC
E0305	BED SIDE RAILS, HALF LENGTH
E0310	BED SIDE RAILS, FULL LENGTH

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E0325	URINAL MALE JUG-TYPE ANY MATERIAL
E0326	URINAL FEMALE JUG-TYPE ANY MATERIAL
E0570	NEBULIZER, WITH COMPRESSOR
E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABL
E0603	BREAST PUMP ELECTRIC (AC/DC), ANY TYPE
E0604	BREAST PUMP, HOSPITAL GRADE, ELECTRIC (A
E0605	VAPORIZER,ROOM TYPE
E0607	HOME BLOOD GLUCOSE MONITOR
E0621	SLING OR SEAT,PATIENT LIFT, CANVAS OR NYLON
E0655	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
E0660	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
E0665	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
E0666	NON-SEGMENTAL PNEUMATIC APPLIANCE FOR US
E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, A
E0705	TRANSFER DEVICE, ANY TYPE, EACH
E0710	RESTRAINTS, ANY TYPE (BODY, CHEST, WRIST
E0776	IV POLE
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL
E0890	TRACTION FRAME, ATTACHED TO FOOTBOARD, P
E0900	TRACTION STAND, FREE STANDING, PELVIC TR
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTA
E0944	PELVIC BELT/HARNESS/BOOT
E0950	WHEELCHAIR ACCESSORY, TRAY, EACH
E0951	HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITH
E0952	TOE LOOP/HOLDER, ANY TYPE, EACH
E0953	WHEELCHAIR ACCESSORY,LATERAL THIGH/KNEE SUPP,INC
E0954	WHEELCHAIR ACCESSORY,FOOTBOX,ANY TYPE INC HD,EACH
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONE
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR H
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPO
E0959	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR
E0960	WHEELCHAIR ACCESSORY, SHOULDER HARNESS/S
E0961	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK
E0966	MANUAL WHEELCHAIR ACCESSORY, HEADREST EX
E0967	MAN WC ACCESSORY, RIM/PROJECECTION REPL EACH
E0971	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPIN
E0973	WHEELCHAIR ACCESSORY, ADJUSTABLE HEIGHT,
E0974	MANUAL WHEELCHAIR ACCESSORY, ANTI-ROLLBA
E0978	WHEELCHAIR ACCESSORY, POSITIONING BELT/S
E0990	WHEELCHAIR ACCESSORY, ELEVATING LEG REST
E0992	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT

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E0995	WHEELCHAIR ACCESSORY, CALF REST/PAD,REPL EACH
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCH
E1399*	Miscellaneous DME ***No auth if cost is <= $50**
E2100	BLOOD GLUCOSE MONITOR WITH INTEGRATED VO
E2101	BLOOD GLUCOSE MONITORING WITH INTEGRATED LANCING
E2205	MANUAL WHEELCHAIR ACCESSORY, HANDRIM WIT
E2206	MAN WC ACCESSORY, WHEEL LOCK, COMPLETE REPLA, EACH
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HO
E2209	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT
E2210	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC P
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PN
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC C
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PN
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPUL
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER
E2220	MAN WC ACCESSORY, SOLID PROPULS TIRE,REPLA EACH
E2221	MAN WC ACCESSORY, SOLID CASTER TIRE,REPL EACH
E2222	MAN WC ACCESSORY, SOLID CASTER INTEG WHL,REPL EACH
E2224	MAN WC ACCESSORY, PROPULSION WHL EXCL TIR REPL EACH
E2225	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEE
E2226	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT
E2323	POWER WHEELCHAIR ACCESSORY, SPECIALTY JO
E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEAL
E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SE
E2361	POWER WHEELCHAIR ACCESSORY, 22NF SEALED
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEA
E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEAL
E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED L
E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHAR
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEA
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DR
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNE
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR P
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CA
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNE

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E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE W
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBE
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK,
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WID
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WID
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION,
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WID
E2607	SKIN PROTECTION AND POSITIONING WHEELCHA
E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CU
E2632	SEO, ADDITION TO MOBILE ARM SUPPORT, OFF
E2633	SEO, ADDITION TO MOBILE ARM SUPPORT, SUP
K0001	STANDARD WHEELCHAIR
K0015	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMRES
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST,BASE,REPLACEMENT ONLY,EACH
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION,REPLACEMENT ONLY, EACH
K0019	ARM PAD REPLA, EACH
K0037	HIGH MOUNT FLIP-UP FOOTREST, REPLA EACH
K0038	LEG STRAP,EACH
K0039	LEG STRAP H-STYLE, EACH
K0040	ANGLE ADJUSTABLE FOOTPLATE, EACH
K0041	LARGE SIZED FOOTPLATE, EACH
K0042	STANDARD FOOTPLATE, REPLA, EACH
K0043	FOOTREST, LOWER EXTENSION TUBE,REPLA, EACH
K0044	FOOTREST, UPPER HANGER BRACKET,REPLA, EACH
K0045	FOOTREST, COMPLETE ASSEMBLY,REPLA EACH
K0046	ELEVATING LEGREST, LOWER EXTENSION REPLA,EACH
K0047	ELEVATING LEGREST, UPPER HANGER REPLA,EACH
K0052	SWINGAWAY, DETACHABLE FOOTRESTS,REPLA, EACH
K0053	ELEVATING FOOTRESTS, ARTICULATING (TELES
K0056	SEAT HEIGHT LESS THAN 17" OR EQUAL TO
K0065	SPOKE PROTECTORS,EACH
K0071	FRONT CASTER ASSEMBLY, COMPLETE, WITH PN,REPLA,EACH
K0072	FRONT CASTER ASSEMBLY, COMPLETE, WITH SE,REPLA,EACH

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K0073	CASTER PIN LOCK,EACH
K0077	FRONT CASTER ASSEMBLY, COMPLETE, WITH SO,REPLA,EACH
K0098	DRIVE BELT FOR POWER WHEELCHAIR,REPLA
K0105	IV HANGER, EACH
K0553	SUPPLY ALLOWANCE FOR THERAPEUTIC CGM, ALL ACCESS
K0601	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
K0602	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
K0603	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
K0604	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
K0605	REPLACEMENT BATTERY FOR EXTERNAL INFUSIO
K0739	REPAIR OR NON-ROUTINE SERVICE FOR DURABL
L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM
L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR
L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTI
L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPIT
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLAST
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLAS
L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITA
L0220	THORACIC, RIB BELT, CUSTOM FABRICATED
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT,
L0455	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, E
L0467	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR
L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIEC
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES
L0622	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SAC
L0624	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SAC
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMB
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVID
L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVID
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL
L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH
L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL
L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL
L0970	TLSO, CORSET FRONT
L0972	LSO, CORSET FRONT
L0974	TLSO, FULL CORSET
L0976	LSO, FULL CORSET

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L0978	AXILLARY CRUTCH EXTENSION
L0980	PERITONEAL STRAPS, PAIR
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4
L0984	PROTECTIVE BODY SOCK EACH
L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SAC
L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS
L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS,
L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, C
L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL
L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
L1240	ADDITION TO TLSO, (LOW PROFILE), LUMBAR
L1250	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
L1260	ADDITION TO TLSO, (LOW PROFILE), ANTERIO
L1270	ADDITION TO TLSO, (LOW PROFILE), ABDOMIN
L1280	ADDITION TO TLSO, (LOW PROFILE), RIB GUS
L1290	ADDITION TO TLSO, (LOW PROFILE), LATERAL
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1630	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1650	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1652	HIP ORTHOSIS, BILATERAL THIGH CUFFS WITH
L1660	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP J
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREF
L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREF
L1820	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PAD
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGI
L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), PO
L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S),
L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICAT
L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIF

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L1902	AFO, ANKLE GAUNTLET, PREFABRICATED, INCL
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANK
L1910	ANKLE FOOT ORTHOSIS, POSTERIOR, SINGLE B
L1920	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT WITH
L1930	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MA
L2035	KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC,
L2040	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L2070	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L2080	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L2090	HIP KNEE ANKLE FOOT ORTHOSIS, TORSION CO
L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORT
L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXIO
L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXIO
L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT
L2232	ADDITION TO LOWER EXTREMITY ORTHOSIS, RO
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE
L2260	ADDITION TO LOWER EXTREMITY, REINFORCED
L2265	ADDITION TO LOWER EXTREMITY, LONG TONGUE
L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALG
L2275	ADDITION TO LOWER EXTREMITY, VARUS/VALGU
L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION
L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED
L2335	ADDITION TO LOWER EXTREMITY, ANTERIOR S
L2360	ADDITION TO LOWER EXTREMITY, EXTENDED S
L2370	ADD LOW EXT, PATTEN BOTTOM
L2375	ADDITION TO LOWER EXTREMITY, TORSION CO
L2380	ADDITION TO LOWER EXTREMITY, TORSION CO
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT K
L2387	ADDITION TO LOWER EXTREMITY, POLYCENTRIC
L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNE
L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNE
L2397	ADDITION TO LOWER EXTREMITY ORTHOSIS, SU
L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH
L2415	ADDITION TO KNEE LOCK WITH INTEGRATED RE
L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOC
L2430	ADDITION TO KNEE JOINT, RATCHET LOCK FOR
L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DR

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L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGH
L2570	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONT
L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND
L2660	ADDITION TO LOWER EXTREMITY, THORACIC CO
L2670	ADDITION TO LOWER EXTREMITY, THORACIC CO
L2680	ADDITION TO LOWER EXTREMITY, THORACIC CO
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PL
L2755	ADDITION TO LOWER EXTREMITY ORTHOSIS, HI
L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EX
L2768	ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NO
L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DR
L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KN
L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SO
L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SO
L2840	ADDITION TO LOWER EXTREMITY ORTHOSIS, TI
L2850	ADDITION TO LOWER EXTREMITY ORTHOSIS, FE
L3001	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L3002	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L3003	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L3010	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L3020	FOOT, INSERT, REMOVABLE, MOLDED TO PATIE
L3030	FOOT, INSERT, REMOVABLE, FORMED TO PATIE
L3040	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
L3050	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
L3060	FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED
L3070	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
L3080	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
L3090	FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACH
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT
L3140	FOOT, ABDUCTION ROTATION BAR, INCLUDING
L3150	FOOT, ABDUCTION ROTATATION BAR, WITHOUT
L3160	FOOT, ADJUSTABLE SHOE-STYLED POSITIONING
L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL S
L3201	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O
L3202	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O

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L3203	ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR O
L3204	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
L3206	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
L3207	ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR
L3208	SURGICAL BOOT EACH INFANT
L3209	SURGICAL BOOT EACH CHILD
L3211	SURGICAL BOOT EACH JUNIOR
L3212	BENESCH BOOT PAIR INFANT
L3213	BENESCH BOOT PAIR CHILD
L3214	BENESCH BOOT PAIR JUNIOR
L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD
L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH
L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTO
L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD,
L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH IN
L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP,
L3252	FOOT, SHOE MOLDED TO PATIENT MODEL, PLAS
L3253	FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR
L3254	NON-STANDARD SIZE OR WIDTH
L3255	NON-STANDARD SIZE OR LENGTH
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE F
L3260	SURGICAL BOOT/SHOE, EACH
L3265	PLASTAZOTE SANDAL EACH
L3320	LIFT, ELEVATION, HEEL AND SOLE, CORK, PE
L3485	HEEL, PAD, REMOVABLE FOR SPUR
L3600	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
L3610	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
L3620	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
L3630	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
L3640	TRANSFER OF AN ORTHOSIS FROM ONE SHOE T
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION
L3650	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIG
L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIG
L3670	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (C
L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION R
L3702	ELBOW ORTHOSIS, WITHOUT JOINTS, MAY INCL
L3710	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINT
L3762	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, I
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOIN
L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOIN
L3906	WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY

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L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CON
L3912	HAND FINGER ORTHOSIS, FLEXION GLOVE WITH
L3913	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHO
L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHO
L3919	HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLU
L3921	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MA
L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEA
L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEA
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MO
L3931	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE
L3933	FINGER ORTHOSIS, WITHOUT JOINTS, MAY INC
L3935	FINGER ORTHOSIS, NONTORSION JOINT, MAY I
L3995	ADDITION TO UPPER EXTREMITY ORTHOSIS, SO
L4002	REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDE
L4045	REPLACE NON-MOLDED THIGH LACER, FOR CUST
L4055	REPLACE NON-MOLDED CALF LACER, FOR CUSTO
L4060	REPLACE HIGH ROLL CUFF
L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR
L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH
L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DI
L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIG
L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR D
L4130	REPLACE PRETIBIAL SHELL
L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONE
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REP
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDE
L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDE
L4398	DROP FOOT SPLINT, RECUMENT POSITIONING DEVICE
L7360	SIX VOLT BATTERY, EACH
L7362	BATTERY CHARGER, SIX VOLT, EACH
L8000	BREAST PROSTHESIS, MASTECTOMY BRA
L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH
L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH
L8010	BREAST PROSTHESIS, MASTECTOMY SLEEVE
L8020	BREAST PROSTHESIS, MASTECTOMY FORM
L8030	BREAST PROSTHESIS, SILICONE OR EQUAL, WI
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WI

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L8300	TRUSS, SINGLE WITH STANDARD PAD
L8310	TRUSS, DOUBLE WITH STANDARD PADS
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER P
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH
L8417	PROSTHETIC SHEATH/SOCK, INCLUDING A GEL
L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNE
L8430	PROSTHETIC SOCK, MULTIPLE PLY, ABOVE KNE
L8435	PROSTHETIC SOCK, MULTIPLE PLY, UPPER LI
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH
L8465	PROSTHETIC SHRINKER, UPPER LIMB, EACH
L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BE
L8480	PROSTHETIC SOCK, SINGLE PLY, FITTING, AB
L8485	PROSTHETIC SOCK, SINGLE PLY, FITTING, UP
L8501	TRACHEOSTOMY SPEAKING VALVE
L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY /
L8507	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, PAT
L8510	VOICE AMPLIFIER
L8511	INSERT FOR INDWELLING TRACHEOESOPHAGEAL
L8512	GELATIN CAPSULES OR EQUIVALENT, FOR USE
L8513	CLEANING DEVICE USED WITH TRACHEOESOPHAG
L8514	TRACHEOESOPHAGEAL PUNCTURE DILATOR, REPL
L8515	GELATIN CAPSULE, APPLICATION DEVICE FOR
L8621	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE AND AUDITORY OSSEOINTEGRATED SOUND PROCESSORS,REPLACEMENT, EACH
L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSOR
S8100	HOLDING CHAMBER OR SPACER FOR USE WITH A
S8101	HOLDING CHAMBER OR SPACER FOR USE WITH A
S8185	FLUTTER DEVICE
S8265	HABERMAN FEEDER FOR CLEFT LIP/PALATE
S8270	ENURESIS ALARM, USING AUDITORY BUZZER AN
S8421	GRADIENT PRESSURE AID (SLEEVE AND GLOVE
S8424	GRADIENT PRESSURE AID (SLEEVE), READY MA
S8427	GRADIENT PRESSURE AID (GLOVE), READY MAD
S8428	GRADIENT PRESSURE AID (GAUNTLET), READY
S8460	CAMISOLE,POST-MASTECTOMY
S8999	RESUSCITATION BAG (FOR USE BY PATIENT ON
T4521	ADULT SIZED DISPOSABLE INCONTINENCE PROD

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T4522	ADULT SIZED DISPOSABLE INCONTINENCE PROD
T4523	ADULT SIZED DISPOSABLE INCONTINENCE PROD
T4524	ADULT SIZED DISPOSABLE INCONTINENCE PROD
T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE
T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE
T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PROD
T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERG
T4537	INCONTINENCE PRODUCT, PROTECTIVE UNDERPA
T4539	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUS
T4540	INCONTINENCE PRODUCT, PROTECTIVE UNDERPA
T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/D
T5999	Nasal aspirator
T5999	Plastic strips
T5999	Sterile 6” wood applicator w/cotton tips
T5999	Incentive spirometer
T5999	Basal thermometer
V5266	BATTERY FOR USE IN HEARING DEVICE

Appendix 11

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*

Appendix 11

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 Three or more (Cluster Care)	Per Diem (13 Hours)	T1019	U3	Personal Care Aide Cluster Care
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/Holiday	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
CHHA	HHA - 15 Minutes	Per 15 Minutes	S5125	None	Home Health Aide
CHHA	Nursing Assessment/ Evaluation	Per Visit	T1001	None	Initial Visit

Appendix 11

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
CHHA	Nursing Care in Home (RN)	Per Diem (13 Hours)	T1030	None	Skilled Nursing Subsequent Visit/Revisit
CHHA	Occupational Therapy	Per Visit	S9129	None	Occupational Therapy
CHHA	Physical Therapy	Per Visit	S9131	None	Physical Therapy
CHHA	Speech Therapy	Per Visit	S9128	None	Speech Therapy
CHHA	Nutritional Counseling	Per Visit	S9470	None	Nutrition
CHHA	Medical Social Services	Per Visit	S9127	None	Medical Social Services
CHHA	Respiratory Therapy	Per 15 Minutes	G0237	None	Respiratory Therapy
CHHA	Respiratory Therapy	Per 15 Minutes	G0238	None	Respiratory Therapy
CHHA	Installation	Per Service	S9110	None	Telehealth (for installation)
CHHA	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)

Appendix 11

VCM Service Type	DOH Service Description	DOH Unit of Measurement	DOH Procedure Code	DOH Modifier	VCM Contract Service Description
UAS	UAS Assessment	Per Visit	T2024	None	
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	

***Mutual Member:** A mutual member case is defined as one in which two or more VillageCareMAX members residing in the same household are both in receipt of services from a personal care aide.

Assistance with many Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) are shared and provided by the same aide during overlapping hours for members of a mutual case. VillageCareMAX's authorization will indicate the appropriate mutual case modifier for overlapping hours. Failure to follow the detailed authorization may result in improper claims processing.

Please take note of the mutual case related modifiers above and bill accordingly.

Authorization information for mutual members should be obtained through the VillageCareMAX Authorization portal at www.villagecaremax.org/provider-portal.

Providers are responsible for applying authorizations appropriately. If a Provider bills incorrectly, no authorization adjustments will be made. The claim will be paid at 50% of the reimbursement.

Appendix 12

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

Appendix 12

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.

Appendix 12

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

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.pdf

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

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.

Correspondence	Notification Not Required	Verbal Notification	Fax 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

Appendix 15: VillageCareMAX Special Needs Plan Model of Care & Cultural Sensitivity Training

Please refer to the VillageCareMAX website for the current Special Needs Plan Model of Care and Cultural Sensitivity and Awareness/CLAS Training, Notice, and Attestation:

https://www.villagecaremax.org/providers#clas

VCMAX SPECIAL NEEDS PLAN MODEL OF CARE PROVIDER TRAINING

On an annual basis, please review the Special Needs Plan Model of Care Training at the following link:

VCMAX Special Needs Plan Model of Care Training

Once you have completed the Special Needs Plan Model of Care Training, please complete and submit your Attestation at the following link before December 31 of each year:

VCMAX Special Needs Plan Model of Care Attestation Form

VCMAX CULTURAL SENSITIVITY & AWARENESS PROVIDER TRAINING:

On an annual basis, please review the current Cultural Sensitivity and Awareness Training, Notice, and Attestation:

VCMAX Cultural Sensitivity & Awareness Training

Once you have completed the Cultural Sensitivity Training, please complete and submit your Attestation at the following link before December 31 of each year:

VCMAX Cultural Sensitivity & Awareness Training Attestation Form

Appendix 16

Appendix 16: VillageCareMAX Medicare Health Advantage, Medicare Health Advantage FLEX, Medicare Select 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
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	
46221	Excision Procedures on the Anus	
37220	Revascularization, endovascular, open percuatneous iliac artery.	New 2024

Urology CPT Code	Description	Effective
51741	Uroflowmetry, Complex	
51798	Bladder Scan	
81003	Urine Analysis, Automated	
81002	Urine Analysis, non-Auto	

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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
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)	

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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)	
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose	
J0153	Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds)	
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	
93880	Duplex scan of extracranial arteries; complete bilateral study	
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	
93923	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	

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	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 provocative tests, or measurements with reactive hyperemia)	
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	
93288	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 leadless pacemaker system	
36415	Collection of venous blood by venipuncture	
85610	Prothrombin time test	
93886	Non-Invasive Cerebrovascular Arterial Studies	
93922	Non-Invasive Extremity Arterial Studies (Including Digits)	
93926	Duplex scan of lower extremity arteries or arterial bypass grafts	
93931	Non-Invasive Extremity Arterial Studies (Including Digits).	
93971	Non-Invasive Extremity Venous Studies (Including Digits)	
93241	Holter Monitor	New 2024
75574	CCTA- Cardiac Computed Tomography and Angiography CCTA	New 2024

Audiology	Description	Effective
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	

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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
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report	
92201	Indirect Ophthal	
92202	Indirect Ophthal	
92020	Special Ophthalmological Services and Procedures	
92083	Visual field examination, unilateral or bilateral, with interpretation 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	

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66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid)	
67105	Repair of retinal detachment, 1 or more sessions	
67145	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions	
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions	
67228	Treatment of extensive or progressive retinopathy, 1 or more 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	
0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir	
65420	Excision Procedures on the Cornea.	
65435	Removal or Destruction Procedures on the Cornea.	
65436	Removal or Destruction Procedures on the Cornea.	
65600	Removal or Destruction Procedures on the Cornea.	
65778	Other Procedures on the Cornea.	

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66762	Destruction Procedures on the Iris, Ciliary Body of the Eye.	
67028	Vitreous Procedures on the Posterior Segment of the Eye.	
68040	Incision and Drainage Procedures on the Conjunctiva.	
68801	Dilation of lacrimal punctum, with or without irrigation	
V2623	Prosthetic eye, plastic, cutom	New 2024
V2627	Scleral cover shell used in Lump sum purchase of DME prosthetics, orthotics	New 2024
V2629	Refitting of prosthetic eydse. Cataract survey with an insertion of intraocular lense complex.	New 2024
66984	Cataract surgery extracapsular, with insertion of interocular lens	New 2024

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

Dermatology	Description	Effective
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)	

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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
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	

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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	
10006	Fine Needle Aspiration Biopsy Procedures	
92546	VENG Test	
92588	Audio Exam	
95024	Allergy Testing Procedures	

Pain Management / Ortho	Description	Effective
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	
J0702	Corticosteroid: Betamethasone Acetate Injection 3 MG	

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

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

Neurology	Description	Effective
93886	Non-Invasive Cerebrovascular Arterial Studies.	
93888	Non-Invasive Cerebrovascular Arterial Studies.	
93890	Transcranial Doppler study of the intracranial arteries	
93892	Transcranial Doppler study of the intracranial arteries	
95816	Under Routine Electroencephalography (EEG) Procedures	
95819	Routine Electroencephalography (EEG) Procedures.	
95886	Electromyography Procedures.	
95911	Nerve Conduction Tests.	
95912	Nerve Conduction Tests.	
95908	Under Nerve Conduction Tests	
95885	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED PARASPINAL AREAS	
95700	Electroencephalography (EEG) Continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist	

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95718	Electroencephalography (EEG) Continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	

Podiatry	Description	Effective
11721	Refers to debridement of nails, which is the removal of a toenail bed due to diseased bed	
11730	Surgical Procedures on the Nails	
11750	Excision of nail and nail matrix, partial or complete	
28270	Under repair, revision and or reconstruction procedures on the foot and toes	
28285	Under repair, revision and or reconstruction procedures on the foot and toes	
29550	Under lower extremity application of strapping - any age	
29580	Under lower extremity application of strapping - any age	
64455	Introduction /injection of anesthetic agent (nerve block) diagnostic or therapeutic procedures on the somatic nerves	

Oncology/ Hematology	Description	Effective
Iron-INFU CPT Code		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug)	1/1/2023
96360	Intravenous Infusion, hydration; initial, 31 minutes to 1 hour.	1/1/2023
96361	Intravenous Infusion, hydration; each additional hour (list separately in addition to code for primary procedure)	1/1/2023
Q0081	Infusion therapy, using other than chemotherapeutic drugs, per visit as maintained by CMS falls under Miscellaneous Drugs and Tests .	1/1/2023
A4221	Supplies for maintenance of non-insulin drug infusion catheter, per week (list drugs separately) as maintained by CMS falls under Injection and Infusion Supplies .	1/1/2023
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC coun	1/1/2023
36415	all routine venipunctures, not requiring the skill of a physician, for specimen collection. This includes all venipunctures performed on superficial peripheral veins of the upper and lower extremities	1/1/2023
36593	injection, dwelling or the short infusion of a thrombolytic agent. Note that if thrombolytic injection is performed in combination with	1/1/2023

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	a chemotherapy procedure, CPT code 36593 should not be reported as it is included with the chemotherapy service.	
J7030	Infusion, normal saline solution, 1000 cc or just "Normal saline solution infus" for short, used in Medical care.	
BONE Marrow CPT		
38220	Diagnostic bone marrow aspiration. Before performing the procedure, the whole skin over the bone is cleaned with an antiseptic solution. Then by injecting local anesthesia, the physician insert a needle beneath the skin and rotates until the needle penetrates the cortex	
38221	Bone marrow; biopsy, needle, or trocar. only. Biopsy through the same incision on the same date of service.	
85097	Maintained by American Medical Association, is a medical procedural code under the range - Hematology and Coagulation Procedures.	
NEUPOJIN/ PROCRIT CPT		
99195	Therapeutic phlebotomy, often used in the treatment of polycythemia vera to reduce the hematocrit and red blood cell mass. Therapeutic phlebotomies are used in the treatment of other diseases as well.	
36415	All routine venipunctures, not requiring the skill of a physician, for specimen collection. This includes all venipunctures performed on superficial peripheral veins of the upper and lower extremities.	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count.	
36415	All routine venipunctures, not requiring the skill of a physician, for specimen collection. This includes all venipunctures performed on superficial peripheral veins of the upper and lower extremities.	

Pulmonology CPT code	Description	Effective
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	2025
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	2025
94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	2025
94016	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	2025

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94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	2025
94070	Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)	2025
94150	Vital capacity, total (separate procedure)	2025
94200	Maximum breathing capacity, maximal voluntary ventilation	2025
94375	Respiratory flow volume loop	2025
94450	Breathing response to hypoxia (hypoxia response curve)	2025
94452	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	2025
94453	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	2025
94610	Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube	2025
94617	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)	2025
94618	Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	2025
94619	Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; without electrocardiographic recording(s)	2025
94621	Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings	2025
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	2025
94640	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	2025
94642	Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis	2025
94644	Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour	2025
94645	Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour (List separately in addition to code for primary procedure)	2025
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management	2025
94662	Continuous negative pressure ventilation (CNP), initiation and management	2025
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	2025
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	2025
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent	2025
94669	Mechanical chest wall oscillation to facilitate lung function, per session	2025
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple	2025
94681	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted	2025
94690	Oxygen uptake, expired gas analysis; rest, indirect (separate procedure)	2025
94726	Plethysmography for determination of lung volumes and, when performed, airway resistance	2025

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94727	Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes	2025
94728	Airway resistance by oscillometry	2025
94729	Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)	2025
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	2025
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)	2025
94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)	2025

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

Appendix 17: Participating Provider Termination Form

VILLAGECAREMAX

PROVIDER TERMINATION FORM

The Participating Provider Agreement (PPA) termination will be effective based on the "Without Cause" timeline established in the PPA from date of receipt of this form. Providers shall continue to provide Covered Services to a member until the approved termination date.

	Group	Individual
☐ Terminate **all** under this Tax ID - I understand **all** will be terminated from **all** products and locations under this Tax ID.	☐	☐
☐ Terminate provider (NPI) Only - I understand **all** products and locations will be terminated under the provider Tax ID and NPI(s).	☐	☐
☐ Terminate provider under all Tax ID's - I understand **all** products and locations will be terminated under **all** Tax Id's for this NPI.	☐	☐

Requestor's Contact Information: ***Complete all fields 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
- ☐ Retired
- ☐ Deceased
- ☐ No longer at location
- ☐ Do not wish to participate
- ☐ Moved out of area
- ☐ Other: _____

Authorized Signature: _____ **Date Signed:** _____

Once completed please email the form to Email providerrelations@villagecare.org .

Termination requests take approximately 30 days to process.

Should you have any questions, please contact Provider Relations @ 855-769-2500.

**To rejoin the provider panel, a new PPA must be executed and Credentialing completed if no active Credentialing exists.*

PR_Termination_Form_08/01/2020 Version 1