2024

Elderplan Provider Manual

elderplan homefirst®
a member of MJHS Health System

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SECTION 1
Introduction

A. About this Manual

Thank you for joining the Elderplan network!!

This Provider manual will orient you and your staff on key Policies and Procedures, related to your network participation. It is not intended to alter or modify any benefits to which an Elderplan Member ("Member') is entitled to or to the extent that policies, procedures, expectations are unique to a particular product.

This manual is an extension of your Elderplan provider contract and adds to the understanding of member benefits as outlined in the Member's Handbook and Evidence of Coverage.

We encourage you to keep this provider manual in a convenient and accessible location. Since changes in Medicare and Medicaid policies and Elderplan operations are inevitable over time, changes to policies herein are subject to updates and modifications. Elderplan will provide ongoing updates through Provider mailings, Provider fax or e-mail distribution, and/or Elderplan website and web portal.

The most current version of the provider manual is always available on our website at www.elderplan.org, where you can also access our Provider Web Portal to view your profile, check claims status, review Model of Care training materials, and more. The registration process for the Provider Web Portal only takes a few minutes and is required to establish a secure username and password.

If a member has any questions that are not addressed in this Provider Manual and cannot be answered or resolved through our website, they may call our Customer Service Department at (718) 921-7979 or (800) 353-3765 or you may send an email request to EPProviderservices@mjhs.org.

B. About Elderplan

A company of good, caring people, committed to outstanding service and doing what's right.

Continuing the good work of the Brooklyn Ladies, Elderplan has been a not-for-profit organization for more than 35 years. We reinvest our earnings to bring you improved benefits and services. With local New York offices, we're here in your community, that means looking out for you, caring about you, helping in every way we can. Because that's what good neighbors do.

When it comes down to it, caring is doing. We offer a wide variety of plans to fit the needs of Medicare and Dual-Eligible individuals at every level of health. We work hard to make sure our plans are affordable, easy to understand, and designed to keep our members physically independent - three things we know are vitally important to you.

Our healthy business practices help your practice thrive.

Elderplan knows a great health plan needs more than great health benefits. It also needs a great Provider Services Department that understands the business side of health care.

We remove the hassles physicians normally experience with other health care plans by:

- Performing accurate and timely adjudication of claims
- Assigning a Provider Relations Representative to each participating Provider
- Minimizing referral requirements for routine, medically necessary services provided by participating specialists

At Elderplan, we've also made it easier for patients to follow your prescribed care. Our care managers work with members with advanced chronic conditions and their doctors and nurses. Together, the team assures that a personalized health plan is developed to help the member live the healthiest and most comfortable life possible.

We have developed a Provider Web Portal to better serve health care providers. For participating providers, some of the most common inquiries - including member eligibility and claims details - now can be done online 24 hours a day, 7 days a week. The portal offers other important resources, such as formularies, member eligibility and more!

SECTION 2
Elderplan's Roles and Responsibilities

Elderplan does not discriminate, in terms of participation, reimbursement or indemnification, or those who serve high risk populations or specialize in the treatment of costly conditions, against any health care professional that is acting within the scope of his or her license or certification under state law. Elderplan reserves the right to deny any Provider participation in the Elderplan network if:

- The network of providers in that provider's specialty exceeds the number necessary to service Elderplan's membership volume.
- Quality of care issues have been recorded against the provider in the past.

1. Reimbursement

   Elderplan agrees to reimburse provider per the Elderplan Provider Participation agreement signed by both parties. Elderplan processes claims per the claims processing rules outlined in this provider manual and CMS processing rules and guidelines.

2. Member Eligibility

   Elderplan agrees to provide current member eligibility through its customer service line. Member eligibility accuracy of a dual eligible may be influenced by enrollment status in Medicaid at the time of services rendered.

3. Provider Directories

   Elderplan agrees to provide members and Providers with updated Provider directories as outlined by CMS requirements. Provider directories may be available in paper and/or electronic formats. Our electronic directory can be accessed through the Elderplan website, www.elderplan.org.

A. Customer Service

Elderplan offers members access to their coverage and benefit questions through contact with our Customer Service representatives in our Customer Service Department at (718) 921-7979 or (800) 353-3765.

Elderplan keeps in touch with our members on a regular basis to ensure their experience with the plan is good and their health and wellbeing are maintained or enhanced. All new members that are enrolled in Elderplan Extra Help Plan (009) receive a Welcome Call from a Customer Service Representative within a few weeks

of their enrollment. A representative will review the benefits, programs and services available to the member. New members that are enrolled in other Plans, may receive a new member call from various other departments.

Elderplan also conducts annual member satisfaction surveys. All positive and negative experiences are reviewed and where needed; service improvement action plans are initiated. Elderplan offers members access to their coverage and benefit questions through contact with our Customer Service Representatives in our Customer Service Department at (718) 921-7979 or (800) 353-3765.

Members receive invitations to special events and letters outlining programs and services that may have been developed or enhanced. A quarterly newsletter also updates the member on health information and programs offered through Elderplan.

Members have a process for voicing their grievances and appealing decisions made by Elderplan related to service decisions and payment decisions. The member handbook, given to all members, outlines the process for submitting grievances and appeals.

Members may also file complaints with a Peer Review Organization (PRO) in their area should they have quality of care complaints. Their member handbook also outlines information on how to find a PRO in their area.

1. Member Customer Services

   Elderplan provides member services through our Customer Service Department, Customer Service Representatives assist members with questions about services, benefits, enrollment, and other issues.

   For Members, Customer Service hours are from 8am - 8pm, 7 days a week, by dialing (718) 921-7979 or (800) 353-3765. If a member's inquiry cannot be resolved during the initial call on the same day, then a Customer Service Representative strives to call the member back within 48 hours.

2. Provider Customer Services

   If you have questions regarding benefits, claims, pre-authorizations or any other inquiries, please call Customer Service at (718) 921-7979 or (800) 353-3765, Monday through Friday, 9am – 5pm.

   To avoid busy call volume times, please visit Elderplan's web site www.elderplan.org/for-providers to register for the Provider Web Portal.

B. Provider Relations

1. Dedicated Staff to Assist Our Participating Providers

The Elderplan Provider Relations Department is the primary connection between you and our plan. They are responsible for recruiting and servicing individual physicians, selected physician groups, physical therapists, occupational therapists, speech therapists, chiropractors, and podiatrists.

Elderplan assigns Representatives by region. Each new participating provider will be visited by an Elderplan Provider Relations Representative for an orientation on our plan, products, and procedures. Your Provider Relations Representative will visit your office periodically to ensure the service Elderplan is providing you is efficient and the services you provide to Elderplan members conforms with the contractual agreement and policies and procedures outlined herein.

You should become familiar with your Field Representative as they can aid in making your Elderplan network participation a very positive experience. Your Provider Relations Representative will assist you by:

- Serving as a point of contact with the plan
- Orienting you and your staff on Elderplan's policies and procedures
- Providing ongoing education concerning changes in operational procedures
- Responding in a timely manner to any of your questions or concerns
- Establishing provider connection to the Elderplan's systems
- Assist in administering the credentialing process

2. Elderplan Web Site and Provider Web Portal

Searching for the information you need immediately can now be done with the click of a mouse, 24 hours a day, 7 days a week.

a. Members can access a multitude of information on our web site www.elderplan.org and can find:
   - A participating Provider, Dentist, or Pharmacy
   - Medications in the searchable Formulary
   - Information about benefits
   - Preventive health information
   - Elderplan member program information
   - Member FAQ's

b. Providers can also access a multitude of information on our Provider Portal. Providers and their office staff are encouraged to visit our portal via a link at www.elderplan.org where Providers can register to access information on Members Eligibility, Claims and Authorizations.

In addition to eligibility and claims details, the portal offers important resources such as:

- Portal User Guide
- SNP Model of Care (MOC) training and MOC Attestation
- Summary of Benefits for each Plan
- Compliance Training
- Ability to file an appeal
- Ability to make a claim inquiry
- Ability to upload charts during HEDIS season
- Care Performance Dashboard (PCPs only)
- Other Provider Materials

To learn more about the Provider Web Portal, contact Elderplan Customer Service at (718) 921- 7979 or (800) 353-3765.

To sign up for the Provider Web Portal, simply go to: http://elderplan.org/for-providers and choose the option **"Click Here To Register For The Provider Web Portal Today."**

Please input your information and finalize the request by pressing the "Confirm and Submit" button. You will need to keep your login information on hand to access the valuable data housed in the portal 24 hours a day, 7 days a week.

C. Network Planning and Operations (NPO)

Network Planning and Operations is an Elderplan department responsible for maintaining a network of high-quality Elderplan providers such as nursing homes, hospitals, home care agencies, IPA's, and doctors used by members. The Elderplan network must be sufficient to meet the needs of our members as well as the adequacy criteria of CMS and the New York State Department of Health. Elderplan values our relationships with our providers, and NPO strives to make sure providers have the information they need and that they receive accurate reimbursement according to their provider contracts. NPO is also responsible for the credentialing of our providers and maintaining accurate provider data for the Elderplan directories.

NPO is responsible for provider recruitment when Elderplan explores a service area expansion or a new plan product offering. NPO works closely with Provider Services and Claims.

1. Contracting

The Contracting Department oversees contracting with hospitals, ancillary providers, IPA's and physician groups. Contracting activities include provider recruitment, contract maintenance, negotiations and renegotiations, documentation of quality programs, and collection of provider data.

This department also manages the financial relationship between Elderplan and network providers by facilitating Joint Operating Committee meetings, defining and interpreting contract terms as they relate to claims issues, and amending contracts to comply with CMS and New York State Department of Health reimbursement requirements.

2. Credentialing

The Credentialing Department manages the credentialing and re-credentialing of providers in accordance with requirements (CMS, DOH, etc.).

This area ensures Elderplan's credentialing process meets all State regulations and oversees the proper credentialing/re-credentialing of all providers within the network, including but not limited to verifying site visitation, application processing, performing primary source verification, and gathering and verifying information.

The Credentialing Department is also responsible for maintaining data for the network provider directory.

a. Credentialing Standards

Elderplan follows state and federal regulations. Following receipt and acceptance of a completed provider application and provider contract, Elderplan credentials physicians and allied health providers.

Elderplan's credential verification process includes but is not limited to:

- Primary source verification of the provider's credentials; NYS license, sanctions/exclusion / Medicare Opt-Out lists, Board Certification, and National Practitioner Data Bank.
- Non-board-certified providers require verification of training and require additional documentation.

- Demographic information: SSN, DOB, provider specialty, languages spoken, Medicaid number, Medicare number, NPI
- Office information: tax ID, office address, telephone and fax numbers, handicap accessibility, staff language skills,
- Site visits are performed on all PCP and OBGYN provider offices.

Elderplan re-credentials providers on a three-year cycle from the date of initial credentialing.

3. Provider Data Maintenance (PDM)

The Provider Data Maintenance Team is responsible for loading and maintaining the provider demographic detail for all providers in our network. They oversee provider data management to ensure correct and timely set up and changes of providers according to their contracts and fees.

PDM works with many Elderplan departments to maintain the integrity of all provider data.

D. Claims

1. Claims / Reimbursements

The Claims Department is essential to provider and facility reimbursement. The department receives and processes claims for medical and hospital services rendered to Elderplan members by both participating and non-participating providers. Claims received from provider and facility billing areas are accepted by the department in paper and electronic format. Reimbursement may be on a fee-for-service basis or capitated arrangement.

The accuracy of claims submitted and processed are key to Elderplan's encounter data collection and internal and regulatory reporting requirements.

Payments (Paper checks or Electronic Funds Transfer (EFT), Remittances (Paper EOPs or Electronic Remittance Advice (ERAs – 835)) and EOBs are sent to providers and members on a weekly basis.

The Claims Department is responsible for paying claims as defined in the terms of your contract with Elderplan.

a. Where to submit EDI Claims

Option 1: Change Healthcare (Emdeon) iEDI (Optum)
Elderplan Payer ID – 31625

Option 2: TransShuttle (Axiom)

Go to: https://mjhs.transshuttle.axiom-systems.com

Elderplan accepts electronic claims submitted in the HIPAA compliant format only.

b. Where to submit Paper Claims

Elderplan Claims Department
P.O. Box 73111
Newnan, GA 30271-3111

c. Electronic Fund Transfer (EFT)

Elderplan has partnered with Change Healthcare to offer you the option to select EFT to deposit funds directly into your bank account. To receive your payments electronically please sign up for EFT use the following link, http://www.changehealthcare.com/EFT and select the **"EPayment Request Forms"** link to download the form with instructions.

d. CMS 1500 Claims Submission Requirements (Paper and EDI)

If your organization uses the CMS 1500 form, ICD-10 requires the use of version 02/12 which supersedes version 08/05.

Claim completion requirements apply to providers under fee for service and capitated arrangements. To ensure timely claims adjudication, the following information must be included on the claim form:

- Member's last and first name, the eleven-digit Elderplan ID member number, date of birth
- Provider's name, Elderplan's Provider ID number, CMS 2-digit location code, tax ID number, address
- Date and place of service
- Current procedure code (CPT-4 or HCPCS) with 2-digit CMS place of service code
- Charge amount
- Number of units
- ICD-10-CM diagnosis code(s) coded to the highest specificity
- Complete Box 33 with office location and Elderplan provider ID number
- Complete Box's 17a/b if applicable; 24J; 32A; 32B; 33A; 33B with Elderplan Provider ID number and Provider NPI number

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
1. Type of Insurance	Enter an "X" to indicate "other" type of insurance
1a. Insured's ID #	Enter the member's eleven-digit Elderplan ID number
2. Patient's Name	Enter the patient's last name followed by the first name and middle initial
3. Patient's Birth Date	Enter in 2-digit numbers, month, day and year of patient's date of birth
4. Insured's Name	Leave this field blank if the patient and the insured are the same
5. Patient's Address/ Telephone #	Enter the patient's complete address. Number and street, city, state, zip code, area code and telephone number
6. Patient's Relationship to Insured	Check the appropriate box.
7. Insured's Address	Leave this field blank if the patient and the insured are the same
8. Patient Status	Check the appropriate box.
9. Other Insured's Name	Leave this field blank unless you enter yes in field 11d
9a. Other Insured's Policy or Group Number	Leave this field blank unless there is other Health Benefit Plan (see field 11d)
9b. Other Insured's Date of Birth/ Sex	Leave this field blank unless there is other Health Benefit Plan (see field 11d)
9c. Employer's Name or School	Leave this field blank unless there is other Health Benefit Plan (see field 11d)
9d. Insurance Plan Name or Program Name	Leave this field blank unless there is other Health Benefit Plan (see field 11d)
	If the condition being treated is not related to Patient Employment, Auto Accident and/or other Accident, leave these boxes blank

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
10. Is Patient's Condition Related to: 10a. Employment (current/ previous) 10b. Auto Accident 10c. Other Accident	• Enter an "X" to indicate illness/injury related to Motor Vehicle Accident. Indicate (State) accident occurred, no fault. Leave this box blank if condition is related to an auto accident other than no fault or if no fault benefits are exhausted. • Enter an "X" to indicate illness/injury related to Motor Vehicle Accident. Indicate (State) accident occurred, no fault. Leave this box blank if condition is related to an auto accident other than no fault or if no fault benefits are exhausted. • Enter an "X" to indicate that the condition was related to an accident other than described in 10a or 10b above.
11. Insured's Policy Group or FECA Number	Leave this field blank
11a. Insured's Date of Birth	Leave this field blank
11b. Employer's Name or School Name	Leave this field blank
11c. Insurance Plan Name or Program Name	Insert – Elderplan
11d. Is There Another Health Benefit Plan	Indicate if patient has another medical insurance. If yes, return to and complete items 9a through 9d. If other medical insurance is involved either through payment or denial of a claim, the explanation of benefits from the other insurance carrier must accompany the claim form.
12. Patient's or Authorized Person's Signature/Date	Entering "signature on file" is acceptable provided physician or supplier has patient's or authorized person's signature on file.
13. Insured's or Authorized Person's Signature	Entering "signature on file" is acceptable provided physician or supplier has patient's or authorized person's signature on file.
14. Date of Current Illness	Enter 2-digit numbers for month, day and year
15. If Patient Has Had Same or Similar Illness Give First Date	If patient has had same or similar illness, indicate first date

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
16. Dates Patient Unable to Work in Current Occupation	Leave field blank
17. Name of Referring Physician or another Source	For a physician referral service enter the referring physician's first and last name.
17a. ID Number of Referring Physician 17b. NPI ID Number	Enter the appropriate qualifier and the Elderplan provider number. Enter the NPI ID number of the referring physician.
18. Hospitalization dates related to current services	Enter the dates that apply to current services. If code 21 is entered in field 24b, then completion of fields 18 and 32 are required
19. Reserved for Local Use	Leave this field blank
20. Outside Lab Charges	Leave this field blank
21. Diagnosis or Nature of Illness or Injury	Using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding system, enter the appropriate code coded to the highest specificity (up to 5 digits), which best describes the main condition or symptom of the patient. Relate Items 1, 2, 3 and 4 to Item 24E by line. *Diagnosis codes with subcategories must be entered with the subcategories indicated after the decimal point. A 3-digit diagnosis code (no entry following the decimal point) will only be accepted when the diagnosis code has no subcategories.* **Example:** **786 Symptoms involving respiratory system and other chest symptoms.** **786.51 Precordial Pain** **Enter 786.51 instead of 786** *Please list all appropriate diagnoses.* *Diagnoses that are not coded to the highest specificity will be denied. Should this happen, you may resubmit the claim with the corrected information for consideration of payment provided the correction is submitted within the timely filing timeframe.*

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
22. Medicaid Resubmission/Original Reference Number	Leave this field blank
23. Prior Authorization Number	If the provider is billing for a service, which required prior approval, enter the approval number specified by Elderplan. For an ambulance provider, enter the zip code of address, Point of Pick-up.
24a. Date of Service	Indicate in 2-digit numbers the month, day and year on which a service was rendered. Be sure to enter a date of service for each procedure code listed. Dates should include the "from and to" dates in which the service was performed including same day services.
24b. Place of Service	This code indicates the type of location where each service was rendered. Enter the appropriate CMS 2-digit codes Note: these are the most commonly used codes. Additional codes can be found in the Medicare Claims Processing Manual- Chapter 26, Section 10.5. CMS 1500 11 Office 12 Home 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room-Hospital 24 Ambulatory Surgical Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 41 Ambulance 00-09 Other 62.Comprehensive Outpatient Rehab Facility 65 Independent Kidney Disease Treatment Center

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
	81 Independent Lab 89 Ambulate
24b. Place of Service	*Note: If Code 21, 22, 23, 24 or 00-09 is entered in field 24b for any claim line, the name and address where procedure was performed must be entered in field 32.*
24c. EMG	Complete if appropriate
24d. Procedures, Services, or Supplies	CPT/HCPCS • This code identifies the service, which was rendered to the patient. Enter the appropriate 5-digit number using the current CPT-4 codes corresponding to the service date. • Modifier The 5-digit CPT-4 code identifying a specific procedure may be expanded by two additional characters called a modifier to further define the nature of the procedure. • All anesthesia claims must be submitted with anesthesia CPT-4 codes followed by the "AA" modifier, and not surgical codes. Time must be in hours and minutes and include the start and completed time of anesthesia.
24e. Diagnosis Pointer	For each line enter the appropriate number that corresponds to the code which best describes the main condition or symptom of the patient for which the procedure was performed. At all times coding to the highest specificity is required.
24f. Charges	Enter amount billed for the procedure, even if the service is capitated and is being submitted for encounter reporting purposes.
24g. Days or Units	Procedures performed more than once on the same date of service should be entered with the correct number of times it was performed. When a procedure is only performed once it should be noted as "1" in the space provided.
24h. EPSDT	Leave this field blank

CMS 1500 Version 02/12 BOX NUMBER	REQUIREMENT
24i. ID Qual	Enter the appropriate ID Qualifier
24j. Rendering Provider ID. # Rendering Provider NPI ID. #	Enter the rendering provider NPI number in the box below the Elderplan provider number.
25. Federal Tax ID number	Enter the Employer Federal Tax ID number or the Social Security Number of the payee and check the appropriate box.
26. Patient's Account number	Enter your patient account number. This Will appear on the explanation of payment.
27. Accept Assignment	Enter Y or N
28. Total Charges	Insert Total Billed Amount
29. Amount Paid	If payment from other medical insurance is received, attach the Explanation of Benefits/Payment form to the claim from that insurer.
30. Balance Due	Insert Balance Due
31. Certification (Signature of Physician or Supplier including Degrees or Credentials) Date	The physician must sign the claim form, or a signature stamp may be used. Please note that the certification statement is on the back of the claim form.
32. Service Facility Location Information	If you entered Code 21, 22, 23, 24, 31,32,33 or 00-09 in field 24b, enter the name and address where the service was rendered if different than the billing address (Box number 33)
32a. Provider NPI #	Enter the NPI # of the service facility.
32b. E.P. Provider ID #	Enter the Elderplan provider number of the facility.
33. Billing Provider Info & Ph. #	Enter the providers billing name, address, zip code and phone number.
33a. Provider NPI #	Enter the NPI # of the billing provider or group.
33b. E.P. Provider ID #	Enter the Elderplan provider number assigned to the billing provider or group.

Elderplan requires that **all claims must be submitted within 180 days of the date of service or as contractually agreed upon.**

Providers who need assistance in meeting claims completion criteria should call the Elderplan Customer Service Department for assistance at (718) 921-7979 or (800) 353-3765.

e. UB04 Claims Submission Requirements (Paper and EDI)

Facilities and other institutional providers such as ambulatory surgical centers must submit on UB04s. Submit reporting data on the UB-04 form using the standard CMS data requirements. In addition to the member, provider and procedure information, please ensure the Revenue Codes are accurate. DRG assignments should also be noted where applicable.

All correspondence should be mailed to:

Elderplan
P.O. Box 73111
Newnan, GA 30271-3111

Claims requiring operative or medical reports, EOBs/EOPs or attachments may not be submitted electronically.

EDI claims pass through multiple edits in search of missing information. If there is missing or incorrect information on the first submission, an electronic notification (277 CA) will be generated back to the provider or clearing house with the explanation of the error(s) or missing items. Paper claims will be reviewed for completeness. Paper claims with missing or incorrect information will be returned to the provider with a letter and explanation of the error(s) or missing items. The letter will be accompanied by a copy of the claim.

f. Claims Payment Reconsideration

Claims denied for the following reasons: no record of an authorization, authorization exceeded, untimely filing, reimbursement, invoices and records, etc. may be disputed for payment reconsideration. Request for reconsideration needs to be received by Elderplan within 180 days of the notice of denial.

g. Corrected Claims Resubmission

Replacement claims (also known as corrected claims) are Electronic or Paper re-submissions with the intention of correcting or updating a previously submitted claim.

A replacement is sent when a data element on the original claim either needs to be added or needs to be corrected. **To submit a replacement, certain identifying information must remain unchanged including:**

- provider information
- patient/subscriber information

Replacement claims **must be** submitted within timely filing limits **(180 days from DOS or as contractually agreed upon)**. **Failure to meet the deadline will result in an untimely filing denial as well as a recoupment of the original payment.**

The best process for submitting a replacement of the original claim, **should** be to submit once you are in receipt of an ERA (Electronic Remittance Advice) or paper EOP (Explanation of Payment).

For more detailed instructions, please access the Provider Web Portal**,** or call the Elderplan Customer Service Department at (718) 921-7979 or (800) 353-3765.

h. Claims Status

Providers may call Elderplan Customer Service Department at (718) 921-7979 or (800) 353-3765, or go to the Provider Web Portal to obtain information regarding the status of their claims. Please have the DOS, member name and Elderplan provider ID number available when making a claims status inquiry.

2. Processing Guidelines

a. Coding Guidelines

Elderplan processes claims in accordance with CMS rules and CMS Correct Coding Initiative (CCI) guidelines and rules.

This consistent and objective review initiates corrective coding for CPT4, HCPC and modifier codes on medical, surgical, laboratory, pathology, radiology and anesthesiology services. The system's function is to identify coding inconsistencies such as:

- Bundling
- Mutually exclusive procedures
- Procedures to be excluded from global arrangements
- Fragmentation of claims
- Misuse of modifiers

The EOPs submitted to the provider will outline any reasons for coding denials or payment reductions resulting from code edits. These actions reflect coding practices generally accepted in the industry.

b. Multiple Surgeries

Multiple surgeries are defined as surgeries that occur on the same patient, on the same day, during the same surgical session and/or from one incision or separate incisions. Multiple surgeries are subject to reimbursement reduction in accordance with CMS guidelines, CCI Coding IN for incidental and multiple surgeries.

c. Explanation of Payment Remittance

Payments (Paper checks or EFT) and Remittances (Paper EOPs or ERAs – 835) are generated and sent to the providers on a weekly basis. Provider demographic data, such as provider names, mailing addresses, and Tax ID numbers are stored is our systems and utilized to pay claims and issue 1099 tax forms. It is critical that this information be as up to date as possible. Please ensure your office notifies Elderplan if there are any changes.

d. Capitated Providers-Monthly Member Rosters

Elderplan generates member rosters and capitation payments to all providers under capitation on a monthly basis. Inquiries on your monthly roster or payment should be directed to Customer Service Department at (718) 921-7979 or (800) 353-3765.

e. Recoupment of Overpayments

Elderplan utilizes a systematic rolling recoupment process. Your explanation of payment (EOP) will outline how the recoupment was made. Within a given pay period, if more adjustments are processed to recoup dollars then the claims that are paid, you will see a negative balance on your EOP. The EOP will list all payments with a "claims paid this run" total, but you will not receive a check. The attached check amount will read $0. As such, future claims paid to you will recoup against the negative balance until the balance is satisfied. Once the balance is satisfied, checks will be issued with the appropriate dollars for the check run.

If additional information is needed to track a negative balance, please contact the Customer Service Department at (718) 921-7979 or (800) 353-3765.

f. Coordination of Benefits

Elderplan expects providers to seek payment for services rendered to members from all potential health insurance payors for which the member has coverage. In cases where multiple coverage exists, benefit reimbursement is coordinated between payors.

The following instances require the provider to investigate whether additional payor coverage exists:

- A retired member has supplemental health benefits through a previous employer
- A disabled member has supplemental insurance
- A member is dually eligible and covered for Medicare and Medicaid
- The member's injuries/illness initiates no-fault or worker's comp coverage
- The member is under 65 years of age
- The member is currently employed and has additional insurance

In cases where supplemental insurance exists to the member's Elderplan coverage the following is the order used to determine the primary payor:

- Elderplan members have Elderplan's Medicare plan coverage as primary. In the event of an injury sustained as the result of an auto or work-related accident or illness covered by no-fault insurance or worker's compensation. Elderplan may be secondary.
- Elderplan will not cover benefits for any services, which are covered under the Working Aged Provision of Medicare. The provider of services shall bill the primary insurance carrier and bill Elderplan as the secondary insurance carrier for members covered under the Working Aged Provision.
- Dual-eligible Elderplan members covered by Medicare and Medicaid. Medicare is primary and Medicaid is secondary.
- Elderplan will not cover benefits or coordinate benefits for care in the hospital or any other institution, which is owned, operated or maintained by the Veterans Administration.
- Medicaid is the coverage of last resort when coordinating benefits and will be utilized only if all other options are exhausted and only if the services are covered by Elderplan.

Elderplan will not deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless Elderplan has a "reasonable basis" to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if Elderplan requests information from the member regarding other coverage and does not receive the information within 45 days; Elderplan will adjudicate the claim. The claim will not be denied based on non-receipt of information about other coverage.

g. No Fault/Worker's Compensation Claims

Claims qualifying for payment under the member's no-fault insurance plan must be submitted to the no-fault carrier first. A copy of the statement, EOP or EOB from the no-fault carrier outlining the name of the individual that was paid and the amount that was paid should be submitted with claims to Elderplan.

Claims for work-related injuries or illnesses must be submitted to the worker's comp carrier as primary. Once accepted by that carrier as a work-related claim, all claims should be sent to them as the primary carrier. There is no coordination of benefits on worker's compensation claims with Elderplan. In cases where the worker's comp carrier denies the initial claim as work related, Elderplan will provide coverage only when the denial of coverage from worker's comp accompanies the claim.

E. Grievances and Appeals

1. Grievances

Members have the right to file a complaint with Elderplan. A complaint is also known as a grievance. Grievances are complaints that do not involve coverage determinations such as the denial or reduction in payment or service. Examples of grievances include but are not limited to:

- Complaints about the quality of service
- Complaints about office wait time, physician or office staff behavior, inadequacy of the facility
- Involuntary disenrollment
- Reimbursement questions

Members must follow the following process when submitting a grievance to Elderplan. Every attempt will be made to resolve telephonic grievances at the time of the call. Usually a grievance results from misinformation, a

misunderstanding or a lack of information. If a more formal process is needed to resolve a grievance the member may be requested to submit their grievance to:

Elderplan
Attn: Appeals & Grievances Department
55 Water Street, 46th Floor
New York, NY 10041

Upon receipt of the written grievance, Elderplan will advise the member in writing of receipt of the grievance and notification that a determination will be made within thirty **(30)** days. If Elderplan is unable to respond within thirty **(30)** days and requires an extension, the member will be notified in writing of the need for an extension of up to **(14)** days. In quality of care instances, a determination received from Elderplan will be accompanied by information on how to file a complaint with the Quality Improvement Organization.

2. Appeals

Members and providers also have the right to appeal when an initial determination denies service or payment for service rendered.

A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

Public Health Law 4914 was amended to extend external appeal rights to providers about the concurrent adverse determinations. Payment for an external appeal at PHL 4914 was amended to include a health care provider filing an external appeal of a concurrent adverse determination. A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Elderplan; Elderplan is responsible for the full cost of an appeal that is overturned; and the provider and Elderplan must evenly divide the cost of a concurrent adverse determination that is overturned in-part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of Elderplan. For the provider to claim that the appeal of the final adverse

determination is made on behalf of the member will require completion of the external appeal application and the designation. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

Please follow the grid below when determining the type of appeal being filed, the timeframe in which it must be filed and the time frame in which you can expect a response:

Type of Appeal	Time Frame for Submission	Time Frame for Response	Examples of Appeals
Standard Service Appeal **(clinical denial)**	Within sixty **(60)** days from the date of the adverse determination.	Elderplan must respond within thirty **(30)** days of the written appeal from the provider/ facility/ member. An extension of up to **(14)** calendar days is permitted if requested by the member or provider or if Elderplan decides extra time is needed and the extension is in the best interest of the member.	Adverse Determination: clinical denial of service, procedure or admission, denial of extension of treatment.
Standard Pre-Service Appeal for Part B Drugs	Within sixty **(60)** days from the date of the adverse determination.	Elderplan must respond within seven **(7)** days of the appeal from the provider/facility/member. Timeframe cannot be extended.	Adverse initial determination for Pre-Service, Part B (Step 2 or non-preferred) drugs.

Type of Appeal	Time Frame for Submission	Time Frame for Response	Examples of Appeals
Standard Appeal (non-clinical denial) **1. Incomplete Claim Form** **2. Complete Claim Form**	**1.** If additional information is requested, within one hundred eighty **(180)** days from the date of service. **2.** If no additional information is requested, within one hundred eighty **(180)** days from the date of the EOP.	Elderplan must respond within sixty **(60)** days of the written appeal from the provider/facility/member.	**1.** Request for medical records; mis-coding; incomplete fields, etc. **2.** Lack of authorization; procedure out of scope of service; denial of payment, etc.
Claim, Payment Appeal for Part B Drugs	Within sixty **(60)** days from the date of the adverse determination	Elderplan must respond within sixty **(60)** days of the appeal from the provider/facility/member. Timeframe cannot be extended.	Lack of authorization or new start to a Part B (Step 2 or non-preferred) drug.
Expedited Service Appeal	Immediate if the member's care/health outcomes are jeopardized by the adverse determination.	Elderplan must respond within seventy-two **(72)** hours of the request for an expedited appeal. An extension of up to **14** calendar days is permitted if requested by the member or provider or if Elderplan decides extra time is needed and the extension is in the best interest of the member.	Denials of service, procedure or admission, denial of extension of treatment.
Expedited Pre-Service Appeal for Part B Drugs	Within sixty **(60)** days from the date of the adverse determination.	Elderplan must respond within seventy-two **(72)** hours of the appeal from the provider/facility/member. Timeframe cannot be extended.	Adverse initial determination for Pre-Service, Part B (Step 2 or non-preferred) drugs.

a. Provider External Appeal and/or Alternative Dispute Resolution Process for Medicaid Services

Depending on a provider's contract language, providers may be able to file an External Appeal about concurrent adverse determinations. An Article 28 licensed facility and Elderplan may agree to alternative dispute resolution in lieu of an external appeal. This provision does not impact a member's external appeal rights or right of the member to establish the

provider as their designee. Where agreed to, facilities may be made aware of ADR by letter, in the notice with an initial adverse determination, or some other mechanism. Note, if the member files an external appeal, the external appeal determination takes precedence over the ADR.

A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent.

b. Reconsiderations

A reconsideration can be made by the member, provider or member's designee. It is a request (to appeal) a determination. Members, providers and/ or their designees must submit a reconsideration in writing with supportive documentation within **sixty (60)** days of receipt of the EOP. The request specifically requests the initial determination be overturned. The member, provider or designee filing the reconsideration will receive a letter from Elderplan confirming receipt of the reconsideration letter. Upon receipt the appropriate department will be forwarded the reconsideration:

- Technical denials (i.e. missing CPT code, missing diagnosis code) or payment questions will be forwarded to the Claims Department
- Medically Necessity denials will be forwarded to Medical Management
- DRG validations will be conducted by Medical Management through retrospective review

Elderplan is required to respond to a reconsideration request within **sixty (60)** days for all Medicare products. Send all reconsiderations to:

Elderplan

Attn: Reconsideration Request Department

55 Water Street, 46th Floor

New York, N.Y. 10041

F. Quality Management

The Quality Management Department oversees all activities in the Quality Improvement Program (QIP). The goal of the QI Program is to improve the health outcomes of our membership through ongoing data analysis and quality improvement programs that continuously evaluate the care our members receive and improve the type and levels of care our members can access. The scope of the QI Program encompasses activities that have either direct or indirect influence on the service received by members, the quality of care received by members and the operational processes behind the service and care provided to members. Further, the Quality Management Department oversees the collection, submission and analysis of HEDIS data and the annual medical record review process.

The Quality Improvement Committee (QIC) is the body that oversees all the subcommittee activities. The Plan Quality Improvement Committee reports to the Elderplan Board of Directors (BOD) who is responsible for the quality improvement program, annual work plan and annual QI Program evaluation. The plan's Medical Director is responsible to the BOD and QIC for clinical strategies, clinical quality improvement projects and initiatives.

The QIC structure includes the following subcommittees:

- Appeals and Grievance
- Clinical Practice
- Credentialing
- Customer service
- Pharmacy and Therapeutics
- Utilization Review

The QI Program objectives are the following:

- Facilitate the identification, development and implementation of improvement activities throughout Elderplan
- Improve organizational processes
- Improve organizational communication
- Maximize the use of data collection and analysis for improving member outcomes
- Assess the delivery system available to the membership on an ongoing basis
- Conduct an annual evaluation of the QI Program and develop new programs as needed
- Outline the annual QI Program work plan

1. Elderplan Quality Improvement Committee Structure

Elderplan Inc. has created a structure that facilitates the flow of information among the various subcommittees of the Plan and the Board of Directors. Data is gathered at the departmental level and aggregated and shared with the appropriate subcommittee. Quality improvement initiatives are data-driven. The Quality Improvement Committee oversees and supports communication, discussion, input and decision-making regarding clinical practice and operational performance. The committee structure consists of the following:

2. Committees

a. The Quality Improvement Committee

The Quality Improvement Committee is responsible to identify, prioritize and oversee implementation, monitoring and evaluation of the Quality Improvement Program work plan and Quality Improvement projects. This multi-disciplinary committee accomplishes its responsibilities by review of regularly submitted presentations, reports and minutes of various quality committees and subcommittees.

- **Chairperson:** Executive Director, Medical Affairs
- **Co-Chair**: VP of Quality & Performance Improvement
- **Committee Members**: President & CEO, MJHS Health Plans; Chief Financial Officer; Chief Clinical Officer; Chief Administrative Officer; Chief Marketing Officer; Chief Experience Officer; SVP Health Plan Growth; VP Medical & Case Management; VP Compliance & Privacy; VP Coordinated Care; VP Field Assessment & Education; VP Claims & Call Center; VP Product Management; VP Pharmacy Services; VP Product Management; VP Health Economics; VP Administrative Services; AVP MAPD Products; AVP Contracting & Provider Partnerships; Executive Director, Medical Affairs; Senior Director Appeals and Grievances; Senior Director Member Services; Senior Director Provider Services; Director Medicaid & Integrated Products; Director Project Planning & Auditing; Director Medical Affairs; Director, Delegated Vendor Management; Director, Credentialing and Provider Data Management; Assistant Director Performance Improvement.
- **Meeting Frequency:** Quarterly

b. Plan Subcommittees

The Subcommittees report trends and improvement plans to the Quality Improvement Committee.

i. Appeals and Grievances (A&G) Subcommittee

The Appeals & Grievance (A&G) Subcommittee is responsible for reviewing and analyzing A&G data including but not limited to volumes, categories/reasons for appeal/grievance, overturns/upholds and IRE/IPRO activity. The purpose of the Subcommittee is to identify opportunities for improvement that will ultimately reduce the number of appeals / grievances received and increase customer satisfaction.

- **Chairperson:** Senior Director, Appeals and Grievances
- **Co-Chair**: Manager, Appeals and Grievances
- **Committee Members:** VP, Quality Management & Performance Improvement; Director, Medical Affairs; VP, Compliance & Privacy; VP, Coordinated Care; Director, Member Services; Director, Delegated Vendor Management; Assistant Director, Performance Improvement; Manager, A&G Clinical Review; Par Reconsiderations Supervisor; Manager, Clinical Support; Manager, Claims Operations Support; Pharmacy Services Representative
- **Ad Hoc Members:** Chief Clinical Officer; AVP, Contracting and Provider Partnerships
- **Frequency:** Quarterly

ii. Clinical Practice Subcommittee (CPC)

The Clinical Practice Committee's (CPC) responsibilities include organizational processes related to all aspects of clinical care including but not limited to: peer review/clinical corrective action plans, review of clinical data and development of preventive health programs, disease state management program initiatives, approval of practice guidelines and review approval of clinical policy and procedures.

- **Chairperson:** Executive Director, Medical Affairs
- **Co-Chairperson:** VP, Quality & Performance Improvement
- **Committee Members:** Plan Physicians - three (3) required for quorum; Chief Clinical Officer; VP, Medical & Case Management; Director, Medical Affairs; AVP, Contracting and Provider Partnerships; Director, ISNP & GCC Clinical Services; Assistant Director, Performance Improvement
- **Ad Hoc**: Chief Administrative Officer; VP, Pharmacy; Director, ISNP & GCC Clinical Services
- **Frequency:** 4 times/year

iii. Credentialing /Re-Credentialing Subcommittee (CRED/Re-Cred)

The Credentialing/Re-credentialing Subcommittee is responsible for the provision and oversight of Elderplan Network by ensuring that it consists of qualified practitioners and facilities, which meets or exceed Elderplan standards for participation and quality of care. The Subcommittee ensures that all providers and candidates are evaluated by a committee of their professional peers.

- **Chairperson:** Executive Director, Medical Affairs
- **Co-Chair:** Director, Credentialing and Provider Data Management
- **Committee Members:** Elderplan Participating Physicians (number may vary); VP, Quality Management & Performance Improvement; Credentialing Manager; Credentialing Supervisor, A&G Representative
- **Ad Hoc:** Assistant Director, Special Investigations Unit; Pharmacy representative
- **Frequency:** Monthly

iv. Customer Service Subcommittee (CSC)

The goal of the Customer Service Subcommittee is to maintain and increase customer satisfaction. Our customers are defined as members, providers, and staff. The subcommittee is responsible for the tracking, trending, analysis, monitoring and improving systems and processes that impact customer satisfaction. The Customer Satisfaction Subcommittee will make recommendations for change based on the data analysis and customer feedback, monitor implementation and evaluate results of all initiatives.

- **Chairperson:** Senior Director, Member Services
- **Co-Chair:** Senior Director, Provider Services
- **Committee Members**: VP, Quality Management & Performance Improvement; VP, Product Management; VP, Coordinated Care; AVP, Sales; AVP, MAPD Products; Senior Director, Appeals and Grievances; Director, Provider Relations & Project Planning; Director, Delegated Vendor Management; Assistant Director, Performance Improvement; Manager, Provider Services; Manager, Clinical Support Services; Trainer, Customer Service (as requested); Pharmacy representative; Compliance representative; Claims representative

- **Ad Hoc:** VP, Pharmacy Services; VP, Administrative Services; EP IS representative
- **Frequency**: Quarterly

v. Pharmacy and Therapeutics Subcommittee (P&T)

The Pharmacy & Therapeutics (P&T) Subcommittee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. The Committee is responsible for ensuring the Plan's compliance with the requirements of Part D formulary development and oversight. In addition, the Subcommittee reports drug utilization trends, potential issues and mitigation plans for effective and safety use of the drugs by our members. Elderplan Pharmacy department oversees the PBM's policies and procedures that outline and guide utilization management processes such as Part D coverage determinations, drug utilization review (prospective and retrospective), formulary development and maintenance, etc. Since 2017 Elderplan has used CVS Caremark for formulary development and maintenance, which will be reported to this Subcommittee. The purpose of Elderplan P&T meetings is to report and discuss pharmacy utilization/trends, DUR programs, MTMP, formulary changes, and patient safety measures that are Part D plan Star measures.

- **Chairperson**: VP, Pharmacy Services
- **Co-Chairperson**: Executive Director, Medical Affairs
- **Committee Members:** VP, Medical & Case Management; VP, Quality Management & Performance Improvement; Director, Pharmacy Services; Director, ISNP Clinical Services & QM; Assistant Director, Performance Improvement; Assistant Director, Performance Improvement; Plan Pharmacists and Pharmacy Specialists
- **Ad Hoc:** Network Provider Operations Representative
- **Frequency:** Quarterly

vi. Utilization Review Subcommittee (UR)

The Utilization Review Subcommittee is responsible for the review and analysis of utilization data. This data is used as foundation for the UM programs, requirements, and performance improvement activities. Collection and analysis of claim, encounter and administrative data is

used to establish baseline, evaluate performance, prioritize improvement initiatives, allocate resources and evaluate effectiveness.

- **Chairperson:** VP, Medical & Case Management
- **Committee Members:** Executive Director, Medical Affairs; Chief Clinical Officer; VP, Quality Management & Performance Improvement; AVP, MAPD; VP, Product Management; AVP, Facility-Based Products; Executive Director, Medical Affairs; Assistant Director, Performance Improvement; Informatics Representative; Coordinated Care Representative; Claims Representative
- **Frequency**: 4 times/year

Providers expressing an interest in joining any of the subcommittees with provider representation are encouraged to contact the Provider Services Department at (718) 921-7979 or (800) 353-3765. Your input is invaluable for initiating and establishing health policies and overseeing quality improvement initiatives for Elderplan members.

3. Quality of Care Concerns

If a quality-of-care concern is uncovered during a medical record review or in response to a member quality grievance, Elderplan will share its findings with the provider. The provider will have the opportunity to respond to Elderplan's findings within 30 days of receipt of the notice. If no response is received within 30 days of the notice, Elderplan may request a plan of correction from the provider. Quality of care concerns will be filed with Network Planning and Operations for further review and action.

4. Non-Compliance with Medical Record Requests

Providers who are not compliant with Elderplan's requests for medical records will be notified by phone and/or mail of their non-compliance. The Provider Relations Department will be made aware of non-compliance issues. Non-compliance events will be documented in the provider's file for further review and action.

5. HEDIS

Elderplan, as a Medicare Advantage managed care organization (MCO), reports on HEDIS measures. HEDIS measures performance against a set of standardized measures of preventative and behavioral health services; chronic care

management medication management; utilization; and member health outcomes. Elderplan annually collects data from several sources to report its performance on the HEDIS set of measures including:

- Claims data (Encounter & Pharmacy)
- Medical records

As a participating provider with Elderplan you may receive a request for on-site chart reviews, or a medical records fax request in lieu of an onsite chart review to assist Elderplan in reporting the most accurate values on their HEDIS report. Elderplan will conduct these onsite reviews with staff from provider relations/business development and contracted entities. Your support during the scheduling and visits is appreciated. HEDIS reviews occur annually from February to June. In January of the calendar year, you will receive an introduction letter informing you of the upcoming medical record review as well as the contracted entity who will conduct the reviews on Elderplan's behalf. Elderplan will do its best to keep office disruption to a minimum. You cannot refuse an Elderplan representative from conducting an onsite review.

For your reference Elderplan has listed below the HEDIS measures that are required for Elderplan to monitor: (*indicates onsite medical record review)

a. Effectiveness of Care / Prevention and Screening
   - Breast Cancer Screening
   - Colorectal Cancer Screening*
   - Care for the Older Adults

b. Effectiveness of Care / Respiratory Conditions
   - Appropriate Testing for Pharyngitis
   - Use of Spirometry Testing in the Assessment and Diagnosis of COPD
   - Pharmacotherapy Management of COPD Exacerbation

c. Effectiveness of Care / Cardiovascular
   - Controlling High Blood Pressure*
   - Persistence of Beta Blocker Treatment after A Heart Attack
   - Statin Therapy for Patients with Cardiovascular Disease
   - Cardiac Rehabilitation

d. Effectiveness of Care / Diabetes
   - Comprehensive Diabetes Care*
     - HbA1c Testing
     - HbA1c Poor Control (>9%)
     - HbA1c Control (<8.0%)
     - Eye Exam (Retinal)

- Blood Pressure Controlled <140/90 mm Hg
- Kidney Health Evaluation for Patients with Diabetes
- Statin Therapy for Patients with Diabetes

e. Effectiveness of Care / Musculoskeletal

- Osteoporosis Management in Women Who Had a Fracture
- Osteoporosis Screening in Older Women

f. Effectiveness of Care / Behavioral Health

- Antidepressant Medication Management
- Follow-up after Hospitalization for Mental Illness
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Pharmacotherapy for Opioid Use Disorder

g. Effectiveness of Care / Medication Management

- Transitions of Care*
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

h. Overuse/Appropriateness

- Non-Recommended PSA-Based Screening in Older Men
- Appropriate Treatment for Upper Respiratory Infection
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Use of Imaging Studies for Low Back Pain
- Potentially Harmful Drug-Disease Interactions in Older Adults
- Use of High-Risk Medications in Older Adults
- Use of Opioids at High Dosage
- Use of Opioids from Multiple Providers
- Risk of Continued Opioid Use

i. Access/Availability of Care

- Adults' Access to Preventive/Ambulatory Health Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

j. Use of Services

- Frequency of Selected Procedures
- Identification of Alcohol and Other Drug Services

- Mental Health Utilization
- Antibiotic Utilization
- Standardized Healthcare-Associated Infection Ratio

k. Risk Adjusted Utilization

- Plan All-Cause Readmission
- Hospitalization Following Discharge from a Skilled Nursing Facility
- Acute Hospital Utilization
- Inpatient Hospital Utilization
- Emergency Department Utilization
- Hospitalization for Potentially Preventable Complications

HEDIS measures are added annually and as such the list above may not be all encompassing. For an update of the measures or to request a HEDIS guide which contains descriptions for each of the measures along with appropriate CPT and ICD codes, please contact Elderplan's Quality Department.

6. Provider Incentive Program

Overview

Elderplan is committed to providing high quality care and improving health outcomes for our members. We know that our network of primary care providers ("PCPs") plays an important role in achieving this goal. Through our partnership with Stellar Health, Elderplan rewards PCPs for effectively managing our members' health and improving outcomes. The Program offers monthly incentive payments to Providers that use the Stellar application to view their member's quality data, close gaps, and upload medical records

Reporting and Data Submission

Performance for the program is calculated via claims submission and supplemental data for select set of quality and medication adherence data.

You will have access to quality reports via Steller Health's quality reporting tool. Stellar Health offers a free web-based platform designed to help primary care providers close gaps that address chronic disease management and preventive care. The Stellar platform can also be used to schedule screenings and report test results.

If you are not already enrolled, you can sign up for Stellar Health by contacting provider@stellar.health or by reaching out to your designated Provider Services Representative.

Please refer to Elderplan's HEDIS Provider Guide for details on the measure criteria.

Deadlines and Payments

All claims for the measurement year 2023 must be submitted by 2/28/2024. Claims and supplemental data submitted after the deadline will not be included when calculating incentive performance.

7. CPT Category II Codes

Elderplan encourages providers to use CPT Category II Codes to facilitate medical record reviews. CPT Category II Codes were developed for performance measurement to decrease the need for record abstraction and chart review, thereby minimizing administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. According to the American Medical Association, these codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

Examples of CPT Category II Codes that are helpful with HEDIS measures and medical record review include the following:

Code	Description
1111F	Transitions of Care, the Discharge medications were discussed and reconciled with current medications in outpatient record
1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)
1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)
1125F	Pain assessment and documented in the medical record
1126F	Pain assessment but no pain documented in the medical record

Code	Description
1157F	Advance care plan or similar legal document present in the medical record (COA)
1158F	Advance care planning discussion documented in the medical record (COA)
1159F	Medication list documented in medical record
1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record
1170F	Functional status assessed
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.
3044F	Most recent hemoglobin A1C (HbA1c) level <7.0% (Diabetes Mellitus)
3044F	Most recent hemoglobin A1C (HbA1c) level <7.0% (Diabetes Mellitus)
3044F	Most recent hemoglobin A1C (HbA1c) level <7.0% (Diabetes Mellitus)
3046F	Most recent hemoglobin A1C (HbA1c) level > 9.0% (Diabetes Mellitus)

Code	Description
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (Diabetes Mellitus)
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (Diabetes Mellitus)
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
3074F	Most recent systolic blood pressure < 130 mm Hg (HTN)
3075F	Most recent systolic blood pressure 130 to 139 mm Hg (HTN)
3077F	Most recent systolic blood pressure >= 140 mm Hg (HTN)
3078F	Most recent diastolic blood pressure < 80 mm Hg (HTN)
3079F	Most recent diastolic blood pressure 80 – 90 mm Hg (HTN)
3080F	Most recent diastolic blood pressure >= 90 mm Hg (HTN)

8. Eligibility

A Medicare beneficiary is generally eligible to enroll in Elderplan provided they:

- Qualify for a Medicare Advantage plan– Elderplan's contract with CMS limits enrollments to beneficiaries who obtain Medicare status through age or disability.
- Are entitled to Medicare Part A and enrolled in Medicare Part B – If the prospect has Medicare Part B only, they are not eligible to enroll in Elderplan.
- Permanently reside in the Elderplan service area at least six months of the year as defined in the Member's Evidence of Coverage.

9. Member Enrollment

Eligible individuals may enroll in Elderplan during the Annual Enrollment Period between October 15 and December 7 of each year, for enrollment effective the first day of the following year. Additionally, individuals may disenroll from Medicare Advantage plans and return to Traditional Medicare during the Annual Disenrollment Period, January 1 through February 14th, the

individual can add a stand-alone prescription drug plan to accompany Traditional Medicare. However, there are exceptions that may allow an individual to enroll in Elderplan outside of these election periods. The Elderplan individual election form must be submitted to CMS in order to be processed. Generally, an enrollment received prior to the end of the month will be effective the first of the calendar month following the date the election is made. As indicated above exceptions and other election periods apply; please contact Elderplan's Enrollment Department for exceptions and rules.

Individuals interested in becoming Elderplan Members may call the Elderplan Enrollment Department at (718) 921-7898 or (800) 353-3765; Monday through Friday between 8:00 a.m. and 5:00 p.m. Elderplan encourages providers to refer prospective members to the Enrollment Department.

10. Disenrollment

Generally, there are only certain times during the year when Medicare Advantage plan members may voluntarily end their membership. Every year from October 15 through December 7 during the Annual Election Period, anyone with Medicare may switch from one way of getting Medicare to another for the following year (effective January 1 of the following year). As with enrollments, exceptions and other election periods may apply. Please contact Elderplan's Customer Service department at (718) 921-7979 or (800) 353-3765, between 8:00 am and 8:00 pm seven days a week, for additional information.

Under no circumstances are participating providers, their staff, Elderplan staff, or other agents to encourage or request an Elderplan member to disenroll from Elderplan, join another plan, or change insurance coverage.

If a Primary Care Physician receives a request from a member to disenroll, the Primary Care Physician must tell the member to contact Elderplan Customer Service at (718) 921-7979 or (800) 353-3765, or 711 for TTY users, as soon as possible so that the request can be processed in a timely manner.

Written requests for disenrollment should be immediately sent by fax to Elderplan at (718) 630- 2624, and then mailed to:

Elderplan
Attn: Customer Service Department
55 Water Street, 46th Floor
New York, NY 10041

In special cases, Elderplan may involuntarily disenroll a member. However, involuntary disenrollments require prior approval from the Centers for Medicare and Medicaid Services. Please note no member shall be disenrolled because of the member's health status.

For additional information about disenrollments, contact Elderplan Customer Service at (718) 921-7979 or (800) 353-3765.

11. Release of Information to Members

Members are entitled access to, or copies of, records concerning their health care. All or part of the medical record may be released upon written authorization from the member or other "qualified person" in accordance with applicable state and federal law.

Qualified persons other than the member who may request access or copies on behalf of the member include, but are not limited to:

- Legally authorized representative acting under the authority of a Power of Attorney
- Health Care Proxy Agent for an incapacitated person
- Court-appointed guardian for an incapacitated person
- Other legally appointed representative or guardian

12. Members Requesting Records

A written request, either in the form of a letter or an authorization form signed by the member or qualified person should include:

- Name of the physician, facility or provider from whom the information is requested
- Name and address of the institution, agency, or individual that is to receive the information
- Member's full name, address, date of birth, and Social Security Number or Elderplan identification number
- The extent or nature of the information to be released, including dates of treatment
- The date or event when the authorization will expire
- Signature of member or qualified person

Member requests should be honored within 10 days of the date of receipt of the written authorization.

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member

or others or would have a detrimental effect on the provider's professional relationship with the patient or his or her ability to provide treatment. Personal notes or observations may be excluded from any disclosure based on the provider's reasonable judgment.

If a member requests to review or inspect their records in person, the physician may place reasonable limitations on the time, place, and frequency of any record inspections.

Special authorizations, forms and procedures are required for HIV-related testing (both before and after the test is performed) and for release of any HIV-related information from the medical record. The informed consent form and the authorization for release of confidential HIV-related information must be the New York State Department of Health approved forms or must be forms that have been approved by the New York State Department of Health. All authorizations requesting the release of mental health records must specify that the information requested concerns mental health treatment.

G. Medical Management Program

The Medical Management Program is responsible for assuring appropriate utilization of services by maximizing the quality of care while providing services in the most efficient and cost-effective manner possible, the program incorporates the following functions:

- Prospective, concurrent and retrospective clinical reviews
- Ongoing planning and coordination of services provided to Elderplan members.

Medical Management begins with the prior authorization of services. Services covered under the member's EOC requiring prior authorization are evaluated against the plan's criteria to establish medical necessity.

The program also identifies and evaluates high-risk members who may be eligible to participate in our (specialized programs like a home visiting Nurse Practitioner, health coaching, etc.). These programs are designed to maximize the member's health and wellness and manage health crises more effectively.

1. Emergency Care

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services include inpatient and outpatient services that are furnished by a provider qualified to render services to evaluate or stabilize an emergent medical condition.

Elderplan will cover services furnished by a participating or non-participating provider when an emergency medical condition exists, or a Plan provider instructs the member to seek emergency services within or outside the Plan.

Prior authorization for treatment of emergency medical conditions and out-of-area urgently needed care is not required. In the event of an emergency medical condition, the member is encouraged to go to the closest emergency room or the nearest hospital or call 911 for assistance. Elderplan offers worldwide emergency coverage on some products. Members are requested to contact Elderplan and/or their Primary Care Physician within 24 hours of the emergency, or as soon as reasonably possible as instructed on their membership identification card and in their Evidence of Coverage booklet.

Should the emergency result in a medically necessary hospital admission, Elderplan will cover the cost of the emergency services and the cost of all medically necessary inpatient days until the member may be safely discharged or transferred to a next level of care.

2. Post-Stabilization Care

Post Stabilization Care Services are provided after emergency care is received, and additional services or post stabilization care is medically necessary to ensure that the member remains stabilized from the time that the treating hospital requests authorization from Elderplan or until:

- The member is discharged
- A plan physician arrives and assumes responsibility for the member's care
- The treating physician and Elderplan agree to another arrangement.

3. Potential Transfer of Members

If an emergency medical condition is treated at a non-contracted facility and requires a level of care and/or treatment that the facility cannot provide, the patient may be evaluated for transfer to a contracted facility. The hospital

attending physician must collaborate with the primary care physician and/or receiving hospital attending physician once medical stabilization is achieved. The transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records, and uses qualified personnel and transportation equipment for the transfer. The receiving facility must have an available bed and qualified personnel to accept the transfer and provide appropriate medical treatment. The Elderplan Inpatient Case Manager is available to assist the collaborating physicians during this process.

4. Medical Review Process

a. Criteria

The medical review process utilizes the most current version of InterQual Guidelines for inpatient and outpatient care. Elderplan follows Medicare Coverage guidelines for outpatient therapies such as Physical Therapy, Occupational Therapy, Speech Therapy, Durable Medical Equipment and Mental Health and Substance Abuse care. Additional criteria may be used as deemed appropriate or necessary. All criteria are used in conjunction with the application of professional medical judgment and/or guidance from the Elderplan Physician Advisors.

Criteria used in the medical review process are available to all providers upon written request.

b. Standard (Organization) Determinations (Medicare)

A standard (organization) determination is a plan decision to pay for, provide, authorize, deny, or discontinue a service requested. Providers and members are notified in writing within 14 days of the plan decision. In cases of denials, please review letter content under the **Service Denial/ Adverse Determination** section below.

As of January 1, 2022, a standard, pre-service organization determination for selected Part B (Step 2 or non-preferred) drugs will be completed by Elderplan within 72 hours. Timeframe cannot be extended for Part B drugs.

c. Expedited (Organization) Determination Process (Medicare)

Members or providers may request an expedited initial determination when the provider or member believes an immediate determination is warranted, as delay in treatment would negatively impact the member's health.

Expedited determinations may be requested for a continuation or extension of health care services, additional procedures/ treatments/ services for members undergoing a course of continued treatment. Such requests may apply to inpatient and outpatient services. Expedited request from physicians that have supporting statements/documentation are processed within 72 hours. Elderplan does not accept expedited requests from vendors, but will follow Medicare's expediency rules, to make a determination as quickly as possible. Expedited determinations are preferred in writing via fax, but may be submitted in person, or via telephone. Requests are tracked and determinations must be made within 72 hours of the initial request providing sufficient information is made available. Requests that are approved are communicated verbally upon decision and followed with written confirmation. A request that is denied is communicated verbally and a written notice is generated within regulated timeframes. Members/Member's representatives are given appeal rights in writing should they disagree with the determination. If a member requests an expedited determination and the plan disagrees and opts to treat the determination as a standard request, the member/member's representative will be given a Notice of Right to an Expedited Grievance. To request an expedited initial determination, please contact the Customer Service Department immediately at (718) 921-7979 or (800) 353-3765.

The timeframe for standard or expedited (organization) determinations may be extended by up to 14 calendar days if the member or member's designee requests the extension or if the organization justifies a need for additional information in favor of the member.

As of January 1, 2022, an expedited, pre-service organization determination for selected Part B (Step 2 or non-preferred) drugs will be completed by Elderplan within 24 hours. Timeframe cannot be extended for Part B drugs.

5. Levels of Review

a. Prior-Authorization/ Prospective Review

Prior authorization requests received through Medical Management Intake get a first level review. The professional staff conducting first level reviews includes: licensed registered nurses, physician assistants, or

paraprofessionals such as licensed practical nurses, social workers and health information professionals.

- The first level review is a screening process to validate the approved criteria utilized to establish medical necessity and appropriateness of the level of care.
- A second level review may be necessary to render a determination of medical necessity. Second level reviewers or physician advisor reviewers hold an unrestricted license and are board certified physicians. When appropriate, second level reviewers consult with physician specialists in reviewing the services rendered by a like specialist. Only a clinical peer may render adverse determinations for medical necessity.

Prior Authorization is the prospective review or first level review of medical services before the services are rendered. Certain services as outlined in the benefits section and member's EOC require prior authorization. Elderplan's Medical Management program evaluates a request for prior authorization against established medical criteria to:

- Establish medical necessity,
- Determine appropriateness of level of care,
- Establish coverage under the member's benefits,

In the event the provider is uncertain whether a service requires prior authorization or not they should call Medical Management for confirmation prior to providing the service. Prior authorization does not guarantee payment if the member has dis-enrolled and eligibility was not verified prior to the service.

All requests for prior authorization must be called in to the Customer Service Department (718) 921- 7979 or (800) 353-3765.

Payment to both the facility and attending physician will be denied if:

- Services requiring prior authorization are rendered by participating providers without authorization.
- The requested clinical information is not provided or is insufficient.
- If length of stay or dates of service exceed the authorized length of stay or period and approval for extension is not obtained from Elderplan.
- The member was dis-enrolled on the date of admission or procedure and failed to notify his/her provider.

If prior authorization for a service is needed urgently during non-business hours, the provider should arrange for or provide the necessary services and contact the Medical Management Department for authorization the next business day.

b. Adverse Determinations

Adverse Determinations, which limit or reduce or deny services based on medical necessity are only made by Elderplan physician advisor reviewers. This may also apply to Part B drug, step therapy exception denials. Elderplan will provide verbal and written notification within the requested time frame. The process for appealing the decision will also be included in the letter.

c. Practitioner Denials

Elderplan educates enrollees and practitioners that when there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive from the health plan a detailed written notice regarding the practitioner's decision.

In the event the member should contact Elderplan, the Medical Management Department will contact you to receive details of the service denial. The plan will then issue a Notice of Denial of Medical Coverage to the member/ member's representative, explaining the reason for the denial and notifying the member of appeal rights.

d. Concurrent Review (Medicare)

Concurrent review focuses on the continued care review for medical necessity and appropriateness of level of care.

PCP offices or staff at the admitting facility are required to notify Elderplan within 24 hours of any emergency admission.

Notification may come from the member or representative of that member, from staff at the admitting facility, or from the PCP's office.

Inpatient concurrent review consists of:

- **Admission Review** – Conducted to determine the appropriateness of emergent admissions, based on clinical information during the first 24 hours of admission. When Elderplan notification requirements are

met, emergency admissions that occur when Elderplan is closed will be reviewed on the next business day so medical necessity of the admission can be determined.

- **Continued Stay Review** – Conducted to ensure that inpatient care continues to be appropriate. Continued stay reviews are conducted prior to the expiration of the initially assigned length of stay.

- **Discharge Planning** – Begins prior to admission, except with emergency admissions, where it is initiated upon receipt of the first review of the case. Discharge planning facilitates moving a member efficiently through the health care system.

- **Discharge Review** – Is conducted to ensure the member's stability and discharge readiness to the most appropriate and safe setting. Part of our discharge review includes follow-up telephone calls to assess members' transition from one level of care to the next. Safe transition should include a follow-up visit with the primary care physician within the first seven days of discharge. Elderplan Care Managers will often advocate with the provider office to facilitate that visit.

e. Inpatient Denials

The Important Message notice is delivered to the member by the hospital within two days of admission. The member or member's representative must sign the notice.

The signed copy is re-issued to the member/ member's representative within two days of planned discharge. A member may request a Quality Improvement Organization (QIO) review up until the date of discharge on the notice. If the member/ member's representative requests QIO review, the plan will issue a Detailed Notice to the member with a copy to the QIO, explaining the reason for discharge. The QIO reviews the request and makes a determination within one business day of receipt of the request and the hospital records and notifies the member of its decision. If the QIO upholds the adverse determination made by Elderplan, the member will become liable for hospital costs commencing at noon of the day following receipt of the QIO determination.

f. Outpatient concurrent

Review is conducted prior to the expiration of the authorization period for all outpatient services requiring continued authorization. Examples may include

home health services, physical therapy, and DME rentals. Providers/vendors are responsible for obtaining authorization for continued services prior to expiration of existing authorization.

g. Retrospective Review

Retrospective medical record review may be required for health care services that were provided without formal prior authorization and medical necessity screening. A retrospective review can be triggered by claims/encounter data where services are denied for failure to obtain prior authorization or pre-defined focused reviews such as DRG validation, short stay and/or readmission reviews.

A retrospective review does not guarantee full payment for all services or inpatient days if services were determined to be either not medically necessary, and/or the length of stay/services exceeds established medical criteria and/or the level of care was inappropriate.

h. Physician Review

Elderplan prides itself on providing its members with the very best network of quality care providers to meet all their medical needs. As such, when our Medical Management staff requires assistance in making a medical necessity or level of care determination, Elderplan has an established group of physician advisor reviewers.

When the physician advisor reviewer believes the requested service is unnecessary, the treating physician is notified immediately and afforded the opportunity to discuss the case with the physician reviewer. If additional information is requested but not provided or is insufficient to justify the requested service, the physician reviewer will utilize available information to make a determination. When the treating physician does not agree with an adverse determination, the physician advisor reviewer informs the treating physician that a denial, including appeal rights, will be issued to all appropriate parties.

i. Notice of Determination

A determination is an Elderplan decision to pay for, provide, authorize, deny or discontinue service.

Providers and members are notified of standard and adverse determinations in writing. Adverse determinations are communicated telephonically and in writing. When an adverse determination is issued the provider and member

are advised of their right to appeal the determination. The written notice will include:

- Reason for the denial
- Notification format and language pre-approved by DOH and CMS
- Right to a standard or expedited reconsideration
- Information, that the provider may act as the member's designee
- Explains the appeals process and time frames for service denials, payment denials and or expedited appeals.

j. Medicaid Services

Elderplan has a contract with the NYS Department of Health to provide certain Medicaid services for specific plans.

Elderplan/HomeFirst (MLTCP) is contracted to provide certain Medicaid services, such as Care Management, Nursing Home Care, Home Care services (RN/PT/OT/SP/HHA), Adult Day Care, Personal Care (PCW), Durable Medical Equipment, Incontinence Supplies, Personal Emergency Response System (PERS), Non-emergent Transportation, Consumer Directed Personal Assistance Services, Podiatry, Dentistry, Optometry/Eyeglasses, PT/OT/SP outpatient services, Audiology/Hearing Aids, Respiratory Therapy, Nutrition, Private Duty Nursing, Meals on Wheels, Social Day Care, Social and Environmental Supports. Elderplan's MAP plan provides the same services as stated above, plus medically appropriate Medicare services.

Service Authorization Requests

- **Prior authorization requests** – Review of a request by the member or provider on the member's behalf, for coverage of a new service or to change a service in the plan of case for a new authorization period, before the service is provided to the member.
    - **Expedited time frame** – within seventy-two 72 hours after receipt of the Service Authorization request.
    - **Standard time frame** – within three (3) business days after receipt of necessary information, but no more than fourteen (14) days after receipt of request for Service Authorization.
- **Concurrent Review** – Review of a request by a member or provider on the member's behalf, 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.

- **Expedited** – within one (1) business day after receipt of necessary information but no more than seventy-two (72) hours of receipt of the Service Authorization Request.
- **Standard** – within one (1) business day after receipt of necessary information but no more than fourteen (14) days of receipt of the Service Authorization Request.

In cases of a request for Medicaid covered home health care services following an inpatient admission, one (1) business after receipt of necessary information, then seventy-two (72) hours after receipt of the Service Authorization Request.

Extensions may be requested by the member or provider (on behalf of the member). The plan may also initiate an extension if it can justify the need for additional information and if the extension is in the member's interest. An expedited or standard time frame may be extended for up to 14 calendar days. The member will receive a notification of extension along with grievance rights.

6. 2024 Part B Drug Step Therapy Program

In certain cases, Elderplan may require a member to try a **Step 1 (Preferred)** Drug to treat their medical condition before proceeding to a **Step 2 (Non-Preferred)** Drug. Our Step 1 (Preferred) Drugs promote therapeutic effectiveness and are low in drug cost.

Part B Drug Step Therapy does **not** apply to a member if the member has already been receiving treatment with a Non-Preferred Drug in the past 365 days. If a member is new to treatment, and the provider determines that a Non-Preferred Drug is the best fit for the member, the provider may request a Non-Preferred Part B Drug.

Instructions on how to request a Non-Preferred Part B Drug can be found on our Provider Web Portal at www.elderplan.org/for-providers/ or on our website at www.elderplan.org/for-providers/provider-materials/.
Non-Preferred Part B Drug Requests may be faxed to (929) 275-3223.

The table on the next page includes the drug classes included in Elderplan's Part B Drug Step Therapy Program. *

Drug Class	Step 1 Drugs (Preferred)	Step 2 Drugs (Non-Preferred)
Hematologic, Neutropenia Colony Stimulating Factors – Long Acting	Neulasta Fulphila	Udenyca Nyvepria Ziextenzo Fylnetra Rolvedon Stimufend
Hematologic, Neutropenia Colony Stimulating Factors – Short Acting	Zarxio	Granix Leukine Neupogen Nivestym Releuko
Trastuzumab	Kanjinti Trazimera	Herzuma Ogivri Ontruzant Herceptin Herceptin Hylecta

**This Part B Drug list may be subject to change throughout the year. Non-preferred product(s) are only available if process exception criteria are met. This list indicates the common uses for which the drug is prescribed. Some medicines are prescribed for more than one condition. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Elderplan. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber. Listed therapeutic classes and specific drug preferred designations are subject to change based on new drug launches, product approvals, drug withdrawals and other market changes.*
Updated as of 01/01/2024.

H. Coordinated Care Management

Coordinated Care Management is available to all our members in our Special Needs Products (Elderplan for Medicaid Beneficiaries, Elderplan Plus Long-Term Care and Elderplan Advantage for Nursing Home Residents) and to our HomeFirst members as well. Care Management prides itself on the coordination of medical and social interventions to maximize our member's health, independence and wellness keeping them physically, socially and mentally functional for as long as possible. The integration of the various medical and social interventions is critical to keeping our members active and well in their community until it becomes necessary to assist them in alternate living arrangements.

The interventions of the Elderplan Coordinated Care Model provide support to our members and physicians through a collaborative process, which assesses, plans,

implements, coordinates, monitors, and evaluates options and services to meet the individual member's health care needs. This model focuses on members identified as at risk for adverse health events and may benefit from interventions and services available. Members' needs are identified during the initial enrollment process, risk stratification tools, clinical algorithms, authorization process, concurrent review, or in response to a referral generated by a provider, member or informal caregiver, as well as data from specific targeted reports.

The Model is designed to provide:

- Improved member care.
- Identification of options in health care delivery.
- Identification and coordination of appropriate plan benefits.
- Identification of possible community resources.
- Collaborative care planning through the creation, review and update of a care plan with the member/caregivers, the Primary Care Physician and their providers involved in the member's care.
- Monitoring of quality and appropriateness of care and timeliness of services delivered.
- Improved communication among members, their caregiver(s), health care providers, the community, and Elderplan
- Increased physician and member/caregiver knowledge, skill, and comfort in the care for all members confronting end of life illness.
- Empowerment of members to articulate preferences about desired care as well as the kinds of treatment they do not want.
- Member education regarding health prevention, management, and disease process to members and their families.

Transitional care nurses are also available to assist our members in HomeFirst and Special Needs Products when they experience a change in their normal level of care (for example, an inpatient hospitalization). They are available to assist the member, representatives, and care teams to safely and efficiently transition the member to the next appropriate level of care.

1. Clinical Case Management and Other Programs

If you have a member that is not in one of Elderplan's Special Needs Products or HomeFirst, they can still be eligible for Clinical Case Management, based on their needs. An interdisciplinary team is available to evaluate and coordinate care for those members who have chronic conditions or needs temporary assistance during an acute episode.

2. Chronic Care Improvement Program

All members that meet the requirements for Elderplan's Chronic Care Improvement Program will also have access to an interdisciplinary team to assist the member in the education and self-management of their chronic condition. This program if offered to all Elderplan members meet the program's requirements, regardless of product.

3. Medication Therapy Management (MTM) for Part D Pharmacy Management

All members that meet the requirements for Elderplan's MTM program will have access to a comprehensive review of their current medications, completed by a pharmacist. All information is communicated to the member, member's representative, prescribing physicians, and primary care physicians. If you would like to refer a member for Clinical Case Management or reach Customer Service call (718) 921-7979 or (800) 353-3765.

4. Disease Management (DM) Programs

In addition, the Disease Management Team manages three (3) Disease Management (DM) Programs that assist qualified member's in Elderplan products (Medicaid Beneficiaries, Plus Long-term Care, Extra Help, and Flex) to have access to education and self-management resources of their chronic condition.

a. Congestive Heart Failure (CHF) Disease Management Program

Members that meet the requirements for Elderplan's CHF 90-day program will have access to a disease management specialist and educational resources. Educational resources may include, how to best manage this condition and identify worsening signs and symptoms , improve medication adherence, the impacts on health and quality of life, the importance of a healthy diet to prevent hospitalization and rehospitalization.

b. Diabetes Disease Management Program

Members with diabetes diagnosis are eligible for this 180-day program. Member's will have access to a comprehensive assessment of risks for potential complications related to diabetes mellitus, diet modification, medication (oral and injectable) adherence, blood glucose and hemoglobin monitoring and reduction of hemoglobin by 9%.

c. Sepsis Disease Management Program

Sepsis Disease Management Program focuses on comprehensive assessment of and education on Sepsis risk factors for high risk Elderplan members that meet the program requirements. Risk factors include a previous episode of Sepsis or infection, current potential source of infection and immobility . This is a 30-day program offered to all Elderplan members that meet the program's requirements, regardless of product.

I. Vendor Oversight Program

Vendors in managed care organizations (MCOs) provide a number of ancillary services to a MCO's membership. Ancillary service vendors are often delegated a variety of MCO operations such as customer service, claims processing and payment, utilization management, quality management, network management and reporting on their specialty area. Vendors manage the benefits and networks for services such as radiology, transportation, audiology, vision, dental, prescription drugs & pharmacy, and disease specific and population management activities.

Regardless of what services and delegated operations are being managed by a vendor, oversight is critical to ensure the vendor is managing member care effectively, efficiently and compliantly. In addition, the vendors must be responsive to the plan needs and manage to contract. Monthly reporting from vendors and regular meetings between the plan and vendors help ensure optimal performance from the vendor and proper oversight by the plan.

Elderplan's Delegated Vendor Oversight Committee meets regularly to review monthly vendor metric reports. Performance standards for each metric are communicated to the vendor and must be met. Vendors who are repeatedly unsuccessful in meeting the standards for any metric will be flagged by the Committee for review. Vendors may be required to submit Corrective Action Plans (CAPs). Repeated compliance issues and/or failure to meet performance standards or the expectations of a CAP could result in termination of the vendor's contract with the plan.

Section 3
Provider Roles and Responsibilities

All Elderplan participating professionals, hospitals, facilities, agencies, and ancillary providers agree to:

A. Physician Office Performance Standard

1. Access to Care

Elderplan providers must accommodate the following types of appointments within the indicated time frames:

Type of Appointment	Scheduling Requirement
Urgent but non-emergency	within 24 hours
Non-urgent, but in need of attention	within one week
Routine and preventive care	within 28 days

Providers must maintain a mechanism for **24 Hour/ 7 Day** patient telephone access and office coverage to respond to emergencies for their patients. Pre-recorded referral to a hospital Emergency Department does not constitute appropriate 24 Hours/7 Day coverage. Primary care physicians must have appropriate back-up for absences.

This 24-hour access will include:

- An answering service or machine with an appropriate message explaining:
    - That patients should go to the emergency room if they reasonably believe that their health is in serious jeopardy if they do not seek immediate medical treatment.
    - How to access medical attention outside of an ER for conditions that are not life- or limb-threatening.
- Coverage by another practitioner in the event the practitioner is unavailable.
- A method to communicate issues, calls and advice from covering practitioners to the PCP and the member's file.

Covering practitioners should be contracted and credentialed by Elderplan's companies. Practitioners must provide Elderplan with a list of the covering physicians and notify us of any changes. If the covering practitioner in the coverage group does not participate with the Elderplan plan, the network practice must inform that practitioner of our policies and procedures. Out-of-network

practitioners are prohibited from balance billing and they must clearly identify the name of the practice/practitioner for whom they are covering.

Patients should be instructed by the covering physician to follow up with their PCP. Only one visit will be approved for the covering practitioner's services, unless the office is closed for more than 24 hours. If a practice is closed for an extended period of time, the practice must notify the Provider Relations department and any members that may be affected by the closure.

Providers who fail to meet office performance standards will need to prepare a corrective action plan for submission to the Quality Management Department. Providers deemed not in compliance with office performance standards may have their contract terminated. On the day of an appointment, a member should not wait more than thirty **(30) minutes** past their scheduled appointment time. If an emergency arises for the provider and the wait time is more than fifteen **(15) minutes**, the member must be notified of the delay and given the option to reschedule.

Members should be notified in advance, if the situation permits, of any appointment cancellations or postponements and should be given the opportunity to reschedule cancelled appointments.

2. Telephone Response Time

Provider office telephone response time guidelines to member calls are the following:

Type of Call	Response Time
Emergency condition	Immediate
Urgent condition	Within 4 hours
Semi-urgent condition	Within the provider office hours
Routine condition	Within 2 business days
After Hours calls	When the condition level is not made clear a 30-minute response time is expected

Elderplan defines these levels of conditions accordingly:

- **Emergency:**
  those conditions whose onset are acute and may occur with or without a prior medical history of the condition. Symptoms are of sufficient severity that a prudent layperson could reasonably expect the absence of immediate medical attention could result in serious damage or death.
- **Urgent:**
  usually occur over a period of a few days and may occur with or without a prior medical history of the condition. These illnesses and injuries need to be evaluated and/or treated urgently but will not immediately cause permanent damage or death.
- **Semi-urgent:**
  usually conditions that last greater than a few days' duration that are persistent and may occur with or without a prior medical history of the condition.
- **Routine:**
  conditions that are chronic in duration. Preventive health care services are associated with keeping the member healthy.

B. Confidentiality

Provider and staff must maintain complete confidentiality of all medical records and patient visits/admissions. Medical record release, other than to the plan or noted government agencies, may only occur with the patient's written consent or if required by law.

C. Conflict of Interest

No practitioner in Medical Management may review any case in which he or she is professionally involved.

Elderplan does not reward practitioners or other individual professional consultants performing utilization review for issuing denials of coverage or service.

D. Reporting Elder Abuse

If a provider suspects Elder Abuse, the provider should immediately initiate the proper notifications to any agency or authority that are required by the law in effect at the time. In addition, for Elderplan Special Needs Plans, please advise the Care Management Team of your concern and action by calling (718) 921-7979 or (800) 353-3765.

E. Transition of Care

Provider agrees to provide transition of care to new members and members transitioning from a provider leaving the Elderplan network per the following guidelines:

1. New Member

When a new member is currently undergoing a course of treatment for a life-threatening or debilitating condition, with a non-participating provider upon or prior to enrollment with Elderplan, the member will have the option of continuing care for up to 60 days of their enrollment date to allow for consultations, medical record transfer, and stabilization of their medical condition. After the 60- day period, the transition must be complete, and care must be received from participating providers. The Medical Management Department will assist with and coordinate the transition of care plan.

2. Participating Provider Leaves the Plan

When a provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, Elderplan will authorize the member to continue an ongoing course of treatment for a life-threatening or debilitating condition, for a period of up to 90 days. The request for continuation of care will be authorized if the request is agreed to or made by the member, and the provider agrees to accept Elderplan's reimbursement rates as payment in full. The provider must also agree to adhere to Elderplan's quality assurance requirements, abide by Elderplan's policies and procedures, and supply Elderplan with all necessary medical information and encounter data related to the member's care. The Medical Management Department will assist with and coordinate the transition of care plan.

F. Closing Panels

Providers may not close panels to Elderplan members without explicit notification to Elderplan. The notification must be submitted in writing within **60 days** prior to the date on which they intend to close the panel. Panels may only be closed if it applies to all patients regardless of insurance coverage. Providers may not discriminate by closing their patient panel to Elderplan members only or by Elderplan product line.

G. Specialist Communication with PCP

Specialists must work closely with a member's PCP to foster continuity of care and promptly provide consultation and progress reports to the PCP.

H. Individual Provider Training

1. Model of Care

Elderplan has created Model of Care training materials that outline coordination of care delivered by our network of providers who have clinical expertise to meet the targeted population's specialized needs. Coordination of care is an integral component of the partnership between providers and Elderplan toward improving our members' health and wellness. Elderplan's Model of Care training is made available to all of our providers through Elderplan's website at www.elderplan.org

All our participating Medicare Providers are required to review the Model of care training slides and complete the attestation form to confirm your yearly compliance with CMS-SNP guidelines.

I. Contractual Requirements

The Elderplan provider contract is consistent with the requirements imposed upon the provider under the New York State Managed Long Term Care Partial Capitation Contract ("MLTC Contract") and the Medicaid Advantage Plus Model Contract ("MAP Contract"). Provider must comply with all contractual, administrative, medical management, quality management, appeals & grievances, and reimbursement policies outlined in the Elderplan provider contract, and circulated updates to this Provider Manual. Failure to adhere or comply with all contractual/regulatory requirements may result in termination of your contract.

The provider is expected to coordinate referrals for Elderplan members who require care outside the scope of the provider's practice to appropriate in-network specialists, participating ancillary providers or facilities for medical care or services. A full list of participating providers can be found on the Elderplan's web site at http://www.elderplan.org/find-a-provider/.

Note: An Elderplan PCP who has training in a sub-specialty may be credentialed in that specialty and participate as a specialist in Elderplan's network. Such providers are called "Dual Providers". Out-of-network referrals require prior authorization.

A referral should be made only when, in your professional opinion, you believe it is medically appropriate and necessary. If you have never seen the patient before, you have the right to ask the patient to come in for an examination and diagnosis before issuing a referral. If you do not examine the patient on the day you issue a referral, you may not charge for any evaluation and management service at that time. For complete details log on to www.elderplan.org.

At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat Elderplan members.

J. Non-Discrimination, ADA Compliance and Accessibility:

1. Non-Discrimination

Provider must not differentiate or discriminate in accepting and treating patients based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

a. Age Discrimination

Elderplan and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds. Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Further, Section 504 of the Rehabilitation Act of 1973 requires providers (e.g., facilities, clinics, individual providers) who receive payments, directly or indirectly, from Medicaid or Medicare ensure individuals with disabilities have an equal opportunity to receive services by way of accessible health care services. Under the ADA, Title III, public entities, such as private doctors' offices, hospitals and clinics are required to make reasonable accommodations for individuals with disabilities irrespective of the receipt of federal funds.

2. ADA Compliance & Accessibility

Accessibility of doctors' offices, clinics and other health care providers is essential in providing medical care to people with disabilities. Medical care providers are required to make their services available in an accessible manner. This standard includes physical access, non-discrimination in policies and procedures and communication. Accessibility needs should be noted in the member's chart, so the provider is prepared to accommodate the member on future visits.

a. Physical accessibility

Physical accessibility is not limited to entry to a provider site (including accessibility along public transportation routes and/or availability of

parking with adequate number of accessible parking spaces and path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs), but also means access to services within a site, such as:

- accessible exam tables,
- accessible stretcher or gurney, or a patient lift,
- trained staff available to assist the member with transfers,
- accessible medical equipment.

Provider site physical accessibility is verified during Elderplan credentialing process. When a member is unable to sufficiently access a provider location, alternative treatment locations will be made available.

b. Communications Access

Communications with individuals with disabilities are required to be as effective as communication with others, including members with hearing, vision, or speech impairment. Providers are encouraged to utilize the TTY (teletypewriter lines) at 711. Member materials are made available in alternate formats such as Braille, larger print, or audio. Elderplan Member Service should be contacted at (718) 921-7979 or (800) 353-3765 for additional information.

Elderplan emphasizes the importance of utilizing additional resources when caring for a diverse population, which includes but is not limited to the following:

i. Tele-Interpreters (24-Hour Telephone Language Services that helps bridge communication barriers resulting from languages and cultural differences)

ii. TTY (teletypewriter lines) can be accessed at 711.

iii. Recruiting and training bilingual/multilingual staff interacting with the member population and serving as a support to the provider community as necessary.

iv. Making Member materials available in an alternate format such as Braille, larger print, or audio. Elderplan Member Service should be contacted at (718) 921-7979 or (800) 353-3765 for additional information.

v. Bridging the Providers and the Members to the appropriate community-based organizations optimizing the access to the resources available for the diverse population.

3. Cultural Competency

Elderplan takes pride in serving an incredibly culturally diverse member population. Rooted in the long tradition of caring for New York elderly and disabled of various ethnic and cultural backgrounds, Elderplan strives to meet the individual needs of the population it serves through recognizing the diversity and providing appropriate support to the members with unique linguistic and communication needs as well as to the provider community treating this population.

The required Elderplan Cultural Competency training helps medical, behavioral, community-based and facility-based LTSS providers to appreciate the cultural diversity and make appropriate accommodations when providing services to the culturally diverse population.

Elderplan Provider Cultural Competency training helps the providers to identify the cultural and/ or linguistic barriers in member population and offers a relevant tutorial designed to build on to the providers' cultural sensitivity as well as decrease potential health care disparities experienced by the diverse population. The required training tutorial Cultural competency can be accessed through:

- Elderplan Provider Web Portal
- One-on-one in-service training sessions facilitated by a Provider Relations Representative onsite.

The provider is required to attest to taking the Cultural Competency Course and offering it to the practice/facility staff by filling out an Attestation form available via the Provider portal. Provider may either utilize Cultural Competency tutorial available on Elderplan web portal or attest to taking the equivalent course as training requirements may be met by demonstrating completion of Cultural Competency certificate program or another New York State Cultural Competency training program. Examples of proof of training completion may include copies of course certifications, pre/post-test and knowledge check results and are subject to random audits by Elderplan Provider Relations team.

L. Collection of Co-payments

Specialist offices should collect member co-payments at the time of service. The co-payment, in conjunction with an office visit, represents your reimbursement in full for services rendered. Member co-payment information is outlined on the member's membership card. Failure to collect co-pay from the member does not make

Elderplan responsible for the co-payment. Providers may only bill members for co-pays that were not collected at time of service.

M. Ethical and Evidence-Based Medical Practice

Provider agrees to provide services within the scope of the provider's license and/or specialty. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.

Provider agrees to relate to Elderplan any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

Evidence-based practice (EBP) is an approach to the delivery of health care whereby health professionals and health care services providers use the best evidence available to identify and select proven and effective medical and therapeutic interventions, educational models, and pharmaceutical therapies, and to make clinical decisions for individual Members that has been demonstrated through research, evaluation and successful clinical trials to be most successful in addressing a specific Member's health needs and conditions.

EBP values, enhances, and builds on clinical expertise, knowledge of disease mechanisms, research and evaluation of clinical and therapeutic practices and educational models, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on Member characteristics, situations, and preferences. It recognizes that health care is individualized, person-centered and dynamic as the health industry finds innovative and proven methodologies for effective interventions to diagnose and treat Member conditions that support the achievement of lasting improvements and enhanced Member health outcomes.

Elderplan supports the implementation of EBP and requires Providers to identify and utilize these proven and effective models and interventions in the services they provide to Elderplan Members.

N. Your Most Important Resource

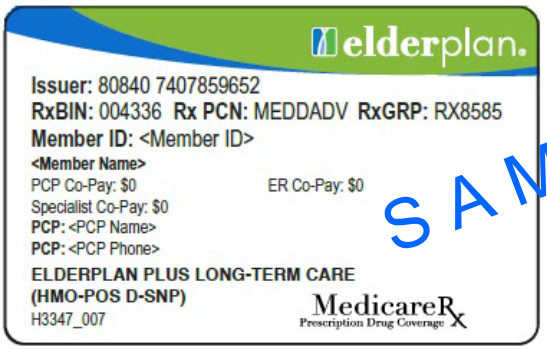
Medicare Advantage Membership Card

You and your staff should familiarize yourself with Elderplan's member ID cards. The member ID card provides you with information on co-pay requirements, care management authorization requirements, drug benefit information, product

identification, and other high-level information to help you collect any advance payments from the member and ensure you pre-authorize services.

Sample ID Card

Card Front



Card Back

Important information:

Member Name: identifies the name of the member covered by the plan
Member Number: number assigned by Elderplan unique to the member named on the card.

O. Elderplan Pre-Authorization

Participating providers must contact Elderplan to receive approval for the procedure and/or admission as outlined in the member's Evidence of Coverage and/ or provider manual and provider updates. All non-participating provider's visits and services must receive prior-authorization. Emergency care does not require prior-authorization. Emergency admissions require notification within 24 hours of admission.

P. Verifying Eligibility

Verifying eligibility and product participation is extremely important in the care and payment process. Eligibility and product participation determines one's coverage status with Elderplan. Failure to establish these elements may result in non-reimbursement for services rendered.

All Primary Care and Specialty Care Physicians must verify a member's eligibility and product participation at the time of service. To verify membership/ eligibility, call

Elderplan Customer Service at (718) 921-7979 or (800) 353-3765 or use the Elderplan web portal. To sign up for the Provider Portal, simply go to: **http://elderplan.org/for-providers/** and choose the option **"Click Here To Register For The Provider Web Portal Today."**

To verify product participation, please refer to the lower left-hand corner of the member ID card or call Elderplan Customer Service at (718) 921-7979 or (800) 353-3765.

It is the provider's responsibility to request the member's membership card at the time of service. Elderplan does not retrieve membership cards from members when they disenroll or lose coverage; therefore, presentation of a membership card is **NOT** a guarantee of eligibility.

Though capitated Primary Care Physicians can consult their membership roster of the present month to ensure the member appears on their list, verification of eligibility through Elderplan Customer Service or web is always recommended. If the member is on the capitation list, the provider has received the monthly capitation payment for that member and can thus provide services during that month.

Q. Social Adult Day Care Certificate

The Department of Health (DOH), in conjunction with the Office of the Medicaid Inspector General (OMIG) and the New York State Office for the Aging (NYSOFA) have established a Certification requirement for Social Adult Day Care (SADC) entities that wish to contract with Managed Long Term Care (MLTC) plans.

This Certification has been implemented to ensure those entities involved in the delivery of SADC services follow relevant rules and regulations.

The goal is to ensure eligible individuals have access to safe SADC service settings.

Completion of the Certification will attest to a SADCs compliance with Title 9 NYCRR section 6654.20, as required under Article VII, section C of the Managed Long-Term Care model contract.

- The Certification must be completed electronically, via OMIG's website: https://www.omig.ny.gov/sadc-certification

  The SADC must print and retain a copy of the confirmation as proof of completion. The SADC must also provide a copy of this confirmation to the MLTC plan. (Upon completion, the confirmation will be automatically sent to the email address provided on the electronic Certification form).

Any SADC seeking to enter into a new contract with Elderplan would need to successfully complete the Certification first, and provide a copy of the confirmation page to Elderplan as proof of completion.

R. Provider Termination and Disciplinary Action

1. Discipline of Providers

The Credentialing Subcommittee has responsibility for recommending suspension or termination of a participating provider for substandard performance or failure to comply with the requirements outlined in the Elderplan Provider Agreement.

If the Credentialing Subcommittee recommends suspension or termination of a participating provider, written notification is sent to the practitioner. The practitioner may then request a hearing in writing. The written request for a hearing must be sent by certified mail, return receipt requested to the Credentialing Subcommittee of its proposed action. The provider may appeal any formal disciplinary action, except for automatic terminations based on license suspensions/revocations and preclusions/exclusions from Medicaid/Medicare programs.

1. Notification of Change

Provider must notify Elderplan **within two business days** if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification in **two business days** is also required when any reportable action is taken by a City, State or Federal agency.

- Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur because of item above, the provider must notify Elderplan immediately.
- Groups or IPA's must contact Network Planning and Operations or Business Development as soon as a new associate joins the group or IPA. Elderplan will provide instructions to begin the credentialing process for the new providers in the group or IPA.
- Any change, addition or deletion of office location, office hours, associated providers, TIN or billing address should be sent in writing **within 60 days** to ensure accuracy of Elderplan directories and databases.

2. Appeal of Disciplinary Action

The provider may appeal any formal disciplinary action, except that providers participating only in Elderplan Managed Long Term Care Plans may not appeal a formal disciplinary action taken based on Immediate Action Events. Requests for appeal must be submitted in writing and sent by certified mail, return receipt requested to the Credentialing Subcommittee within 30 days after the provider receives notice from the Subcommittee of its proposed action.

- Elderplan credentials providers upon acceptance of application and signed participation contract.
- Elderplan re-credentials all participating providers on a three (3) year cycle from date of initial credentialing.
- Provider must notify Elderplan **within two business days** if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification in **two business days** is also required when any reportable action is taken by a City, State or Federal agency.
- Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur because of item above, the provider must notify Elderplan immediately.
- Groups or IPA's must contact Network Planning and operations as soon as a new associate joins the group or IPA. Elderplan will provide you the necessary materials to begin the credentialing process for the new providers in the group or IPA. You may also request application materials through the Elderplan IVR.
- Any change, addition or deletion of office hours, associate or billing address should be sent in writing **within 60 days** to ensure accuracy of Elderplan directories and databases.

S. Billing Requirements

1. Provider may **NOT** balance bill members for authorized and/or covered services.
2. Provider may bill member for co-pays not collected at time of service.
3. Provider agrees that co-pays and Elderplan reimbursement for services constitute payment in full.
4. Provider agrees to follow CMS and Elderplan billing guidelines.

5. A provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member and that Elderplan does not cover the service.

T. Medical Records and On-site Auditing

Elderplan participating physicians' offices must maintain medical records in accordance with good professional medical documentation standards. The provider and office staff must provide Elderplan staff with member medical records upon request. Elderplan staff must also have access to member medical records for on-site chart reviews. The physician's office responsibilities are as follows:

- Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
- Maintaining medical records in a safe and secure manner that ensures member confidentiality and medical record confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
- Making the medical record available when requested by the Plan and regulatory agencies. Providers are required to allow medical information to be accessed by Elderplan, the New York State Department of Health, and the Centers for Medicare and Medicaid Services.
- Keeping medical records for ten years after the death or disenrollment of a member from Elderplan. The record shall be kept in a place and form that is acceptable to the Department of Health and in accordance with New York State Article 44.
- New York Education Law 6530(32) requires that all New York practicing physicians and other healthcare professionals maintain detailed records for each patient. Maintaining proper medical records is a professional responsibility of a New York doctor or another practitioner.
- Elderplan’s requests for information and data relating to current or past membership must be responded to in an expedited manner when such expediency is required. All information shall be provided to Elderplan at no charge. Failure to comply to Elderplan’s requests may lead to contract termination.

U. Medical Record Documentation Criteria

The medical record must be written in ink or computer generated and contain at minimum:

1. Each page of the medical record contains identifying information for the member.
2. All entries must contain author identification and professional title.
3. All entries must be dated.
4. All entries must be in ink or computer generated.
5. Identification of all providers participating in care and information on services furnished are found in the record.
6. An up-to-date problem list, including significant illnesses and medical/psychological conditions, is present in the record.
7. Each note describes presenting complaints, diagnoses, and treatment plan.
8. A medication list containing prescribed medications, including dosages and dates of initial or refill prescriptions are present in the record.
9. Information on allergies and adverse reactions (or notation that patient has no known allergies or adverse reactions) is contained in the record.
10. The record contains documentation of past medical history, physical examinations, necessary treatments, and possible risk factors for the member relevant to a treatment.
11. Information on Advance Directives (or notation of discussion whereby member does not have or wish to have an Advance Directive)
12. The record must be legible to individuals other than the writer.

V. Member's Rights and Responsibilities

Elderplan members have the right to:

- Receive considerate, courteous, and respectful care.
- Refuse to participate in or be a patient for research purposes.
- Change physicians in accordance with the provisions of the member's Evidence of Coverage.
- Be assured that only persons having the qualifications established by Medicare and Elderplan will provide medical services.

- Obtain from the member's physicians, at reasonable times, comprehensive information about the physicians' diagnosis, treatment, and prognosis in terms that the member can reasonably be expected to understand. When it is not medically advisable to provide such information to the member, the information should be made available to an appropriate person on the member's behalf.
- Receive from the member's physician information necessary to enable the member to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of the action.
- Be informed, upon request, as to all medication given the member, the reasons for prescribing the medication, and the expected effects of the medication.
- Be treated in clean facilities, and with clean equipment and materials.
- Request a second opinion.
- Be assured privacy related to the member's medical care program is respected and secured. This shall mean at minimum that a person not directly involved in the member's care may not be present without the member's permission during any portion of the member's case discussion, consultation, examination or treatment.
- Expect all communication, records, and other information pertaining to the member's care or otherwise regarding the member's personal condition will be kept confidential except if disclosure is required by law or permitted by the member.
- Request that unaltered copies of a member's complete medical records be forwarded to the physician or hospital of the member's choice, the cost of duplication and forwarding to be paid by the member.
- Written request, to have made available to the member copies of the member's medical records; Reasonable fees may be charged for such copies. However, information may be withheld from a member if, in the reasonable exercise of a physician's professional judgment, it is believed that release of such information would adversely affect the member's health.

Elderplan members have the responsibility to:

- To know and confirm their benefits before receiving treatment
- To contact an appropriate health care professional when they have a medical need or concern

- To show their ID card before receiving health care services
- To pay any necessary co-payment at the time services are rendered
- Use emergency room services only for injury or illness that in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- To keep scheduled appointments
- To provide information needed for care and treatment
- To follow agreed-upon instructions and guidelines of doctors and health care professionals.
- To participate in understanding their health problems and developing a mutually agreed-upon treatment goals.
- To access our Web site or call Customer Care to verify that the selected provider or health care professional participates in the Elderplan network before receiving services.

1. Second Opinions

Elderplan Members, their Authorized Representatives and their health care providers acting on behalf of the Elderplan Members have a right to request the second opinion for a recommended surgical procedures or medical treatment plan at no cost to the member (relevant co-pays may apply depending on the plan.)

No referral, or prior authorization is required to receive the second opinion from the Elderplan participating providers. Prior authorization must be requested in the event the second opinion is sought from an out-of-network provider.

When issuing the prior authorization, the following factors are being considered:

a. Lack of availability of an in-network provider with the scope of practice and clinical background including training and expertise, related to the particular illness or condition associated with the request for a second opinion and within reasonable time and distance standards.

b. The member questions that of recommended surgical procedures or medical treatment plan is medically necessary or clinically appropriate.

c. The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

d. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.

e. The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or treatment plan.

All requests for prior authorization must be called in to the Medical Management Department via Customer Service (718) 921-7979 or (800) 353-3765. Prior authorization may be requested by either the PCP or by a specialist.

2. Member's Right to File a Grievance

Members have the right to file a complaint or grievance without fear of penalty when they feel they have received inappropriate treatment by the Plan or a Plan provider.

Examples of grievances are: Quality of care, office waiting times, and appointment waiting times. Please consult the Appeal and Grievances section of this manual for further details.

W. Benefits Summary

1. Medicare Advantage and Special Needs Plans

Final regulations on the Medicare+Choice program were promulgated in June 2000, which created the Medicare Advantage program, or Medicare Part C of Title XVIII of the Social Security Act. The primary goal of the Medicare Advantage program is to provide Medicare beneficiaries with a wide range of health plan options to complement the Original Medicare option.

Under the Medicare Advantage plan, Elderplan receives a monthly premium from CMS for each Medicare beneficiary electing to enroll in Elderplan's Medicare Advantage program. Elderplan provides enhanced benefits to its members for the premium received from CMS for each Medicare beneficiary

electing to enroll in Elderplan's Medicare Advantage program. Elderplan provides enhanced benefits to its members for the premium received from CMS.

All Elderplan products offer a POS (Point-of-Service) option that will allow members to receive care outside of the network for specific services defined by the plan. Elderplan plans will have the same costs In and Out of the Network to support access to care.

2. Elderplan's Medicare Advantage Plans

- **Elderplan for Medicaid Beneficiaries (HMO-POS D-SNP)** A plan designed to help make sure Medicare beneficiaries who are eligible for Medicaid or another NY State medical assistance program get all the benefits they're entitled to under both programs plus more.

  The beneficiary for the Elderplan for Medicaid Beneficiaries plans (Dual plan) is one that has Partial or Full Medicaid. Elderplan will cover all Medicare covered benefits and Medicaid will cover the cost-share for those benefits for members who have Full Medicaid.

- **Elderplan Plus Long-Term Care (HMO-POS D-SNP)** A plan designed for individuals receiving both Medicare and Medicaid and require Long Term Care services and supports. The plan provides the care and support needed to stay in the comfortable surroundings of their home.

  The Medicare beneficiary for the Elderplan Plus Long-Term Care plan is a beneficiary with FULL Medicaid, who has chronic health care needs and is eligible to live in a nursing home but would prefer and are able to live safely at home.

- **Elderplan Assist (HMO-POS IE-SNP)** A plan created to meet the needs of people who currently reside in a congregated living facility (i.e. assisted living facility) but require an institutional level of care. A major focus of the Elderplan Assist is to identify members in the Plan's contracted Assisted Living Facilities who may require additional supportive services to remain in the community rather than face the prospect of admission to a nursing home.

  Medicare Beneficiaries may or may not have Medicaid. If they have Medicaid, all cost sharing is based on the beneficiary's level of Medicaid eligibility.

- **Elderplan Flex (HMO-POS)** A plan that was created for Medicare beneficiaries who do not qualify for Low Income Subsidy (LIS) / Extra Help. Elderplan Flex offers a $0 premium, low co-pays, and no referrals to see your doctor. In addition to medical and hospital coverage, you will have the flexibility to choose a Select Extra that is most important to you.
- **Elderplan Extra Help (HMO-POS)** A plan that was created for individuals receiving Medicare who have limited resources and income. Eligible individuals may be able to get Extra Help from the government to help pay for prescription coverage while enrolled in Elderplan Extra Help.

  The ideal Medicare beneficiary for the Elderplan Extra Help (HMO-POS) plan is one that receives Extra Help (LIS).
- **Elderplan Advantage for Nursing Home Residents (HMO-POS I-SNP)** A plan created for people who live in a nursing home that is in Elderplan's network. We offer a skilled Nurse Practitioner (NP) who looks out for beneficiaries or their loved one, delivering an added level of care, comfort and peace of mind.

  The Medicare Beneficiaries may or may not have Medicaid. If they have Medicaid, all cost sharing is based on the beneficiary's level of Medicaid eligibility.
- **Elderplan Select (HMO-POS I-SNP/IE-SNP)** A low-cost hybrid plan with a $0 plan premium created for Medicare eligible members residing in a Nursing Home or Assisted Living Facility who are not eligible for Medicaid or Low-Income Subsidy (LIS) in facility setting.
  The ideal beneficiary for the Elderplan Select plan is a Medicare beneficiary who:
  - Resides in a contracted Nursing Home or Assisted Living Facility.
  - Currently enrolled in Original Medicare or Traditional Community-based MAPD plan.
  - Not eligible for Medicaid or Low-Income Subsidy (LIS) in facility settings.
  - This plan provides an extra layer of care through the services of a specially trained Nurse Practitioner (NP).

3. Managed Long-Term Care Plans

- **HomeFirst Managed Long-Term Care (MLTC) Plan** A plan designed for those who receive Medicaid. While enrolled in HomeFirst, members can

keep their own doctor as well as their Medicare and Part D coverage if they have it. There is no cost to obtain care from this plan.

4. Ancillary Benefits

Elderplan members have access to a broad range of ancillary services. Ancillary services may be provided directly through the Elderplan network or through a vendor network. Vendor networks abide by the same Elderplan policies and procedures as physicians and other medical professionals. Certain ancillary services require prior authorization. Please call Medical Management via Elderplan Customer Service Department at (718) 921- 7979 or (800) 353-3765 to verify if authorization is required.

5. Pharmacy Benefits

Elderplan also provides Prescription Drug coverage and has a Formulary (a list of preferred prescription drugs). The searchable formulary may be viewed by accessing Elderplan's website at www.elderplan.org. Certain drugs need authorization from Elderplan prior to dispensing at the pharmacy. The Prior Authorization Approval List link can also be found on the Elderplan website, www.elderplan.org. If you have any questions regarding prior authorizations, call our pharmacy benefit manager at (800) 361-4542 or Customer Service Department at (718) 921- 7979 or (800) 353-3765, or the TTY number for the hearing impaired, 711, seven days a week between the hours of 8:00 AM and 8:00 PM.

X. Vendor Relationships

1. Transportation

As part of the ongoing New York State Medicaid Redesign initiative, the New York State Department of Health is streamlining transportation coordination through Medical Answering Service (MAS) across government programs for enhanced efficiency and statewide coordination.

As of March 1, 2024, non-emergency medical transportation (NEMT) will be covered under regular Medicaid and managed by the Statewide Transportation Broker – MAS for all Managed Long-Term Care (MLTC) and Medicaid Advantage Plus (MAP) plans. While NEMT remains a benefit covered by the MLTC and MAP programs, it is **no longer** included or provided by Elderplan/HomeFirst through ModivCare.

MAS hours of operation are 24 hours/ 7 days a week/ 365 days a year.

To Make a Reservation: 1-844-666-6270 (Downstate)
1-866-932-7740 (Upstate)

Website: https://www.medanswering.com/

Provider Login Page: https://www.medanswering.com/login.taf

2. Dental

Elderplan is contracted with Healthplex for dental services.

To schedule an appointment: 1-866-759-6493

3. Vision

Elderplan is contracted with Superior for vision services.

To schedule an appointment: 1-844-353-2902

4. Audiology

Elderplan is contracted with HearUSA for hearing/ audiology services.

HearUSA Hotline: 1-877-664-9353

5. High-Tech Radiology

Elderplan is contracted with Care to Care for high-tech radiology services.

Claims Inquiries: 1-800-610-6114

Precertification: 1-866-390-7526

6. Telehealth

Elderplan is contracted with Teladoc for telehealth services.

To schedule an appointment: 1-800-835-2362

7. Fitness & Wellness

Elderplan is contracted with Silver & Fit to provide members with physical and wellness fitness benefits.

Silver & Fit Hotline: 1-877-427-4788

8. Mental Fitness

Elderplan is contracted with BrainHQ for mental fitness services.

Visit: *https://elderplan.brainhq.com* **or call:** 1-888-496-1675

9. Behavioral Health

Elderplan is contracted with Carelon (formerly known as Beacon Health Options) for behavioral health services (MAP only).

For behavioral health related inquiries: 1-833-918-0808

10. Laboratory Services

Elderplan is contracted with the below list of in-network laboratories:

- BioDiagnostic Labs
- Bio-Reference Laboratories
- Centers Laboratory
- MedLabs Diagnostics
- Empire City Laboratories
- Labcorp (Laboratory Corporation of America Holdings)
- Lenco Diagnostic Laboratory
- Quest Diagnostics
- Sunrise Medical Laboratories
- Xeron Clinical Laboratories

For a complete list of laboratories and drawing stations, refer to the provider directory at Elderplan.org > "Find A Provider".

Section 4
Compliance/Fraud Waste and Abuse (FWA) Program and Training Requirements

A. Overview: Elderplan Compliance Program and Training

Elderplan maintains a Compliance Program which delineates its commitment to and comprehensive strategy for compliance with applicable federal and state laws and adherence to high ethical business standards. It also outlines the company's approach to prevent, detect and mitigate fraud, waste, and abuse.

B. Provider and Other Business Partner Compliance Requirements

As part of their contractual obligations, providers and other business partners contracted with Elderplan to provide care and/or services must meet general compliance program and fraud, waste and abuse prevention and control requirements, respectively. This section outlines these requirements.

For the purpose of this section, the following terms and conditions apply:

1. Medicare Providers and other Business Partners

   Individual, ancillary, facility and other direct care providers, vendors or first tier, downstream or related entities (FDRs) that have a contract with Elderplan to provide Medicare-related care or services to Elderplan members in an Elderplan Medicare Advantage-Prescription Drug plan, including a Special Needs Plan or the Medicaid Advantage Plus (MAP) plan, must meet Elderplan compliance program requirements and Medicare compliance and fraud, waste and abuse training requirements described herein.

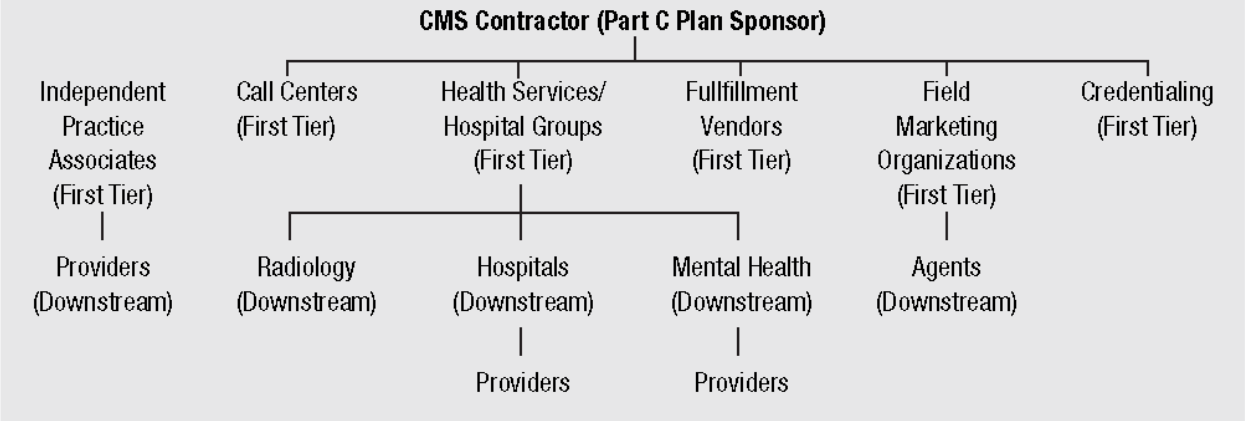
2. Medicaid Providers and other Business Partners

   Individual, ancillary, facility, community-based and facility-based long-term services and supports and other direct care providers or vendors that have a contract to provide Medicaid-related care or services to members in the Elderplan Partial Capitation Managed Long Term Care plan (the HomeFirst plan) or the Medicaid Advantage Plus (MAP) plan, must meet Elderplan compliance program requirements described herein.

3. Medicare First Tier, Downstream and Related Entities (FDRs)

Elderplan contracts with many Medicare Providers and other Business partners to deliver health plan benefits and services. These business partners, whether individuals or entities, are broadly categorized as a first tier (a party that is directly contracted with Elderplan), downstream (a subcontractor or party that is indirectly providing care or services for Elderplan based on a higher-level contract with another entity), or related entity (a party that meets certain legal criteria relating it to Elderplan) (FDRs). Differentiating between these categories is relevant because a first-tier entity has an additional obligation to ensure its downstream entities adhere to Elderplan compliance program requirements including training requirements, as well as all applicable federal and state compliance requirements. See Table 1 for a CMS developed graphic demonstrating a FDR hierarchy for a Medicare Advantage plan.

Table 1:



4. Elderplan Compliance Program Requirements

All Providers and other Business Partners must adhere to Elderplan compliance policies, procedures and standards of conduct which are encompassed in our MJHS/Elderplan Code of Conduct and Policy Pursuant to The Federal Deficit Reduction Act of 2005 or implement their own compliance policies, procedures and standards of conduct, which may be in the form of a code of conduct, that meet federal and state requirements. These compliance policies and procedures are referred to herein as the "Compliance Program Documents"

Medicare Providers and other Business Partners who are first tier entities must ensure that providers and vendors that conduct business on their behalf also complete these compliance program requirements.

5. Compliance Program Document Completion Timeframes

All Elderplan Providers and other Business Partners' governing body members, employees (including temporary staff), volunteers and interns must successfully read and attest to their understanding and adherence with the Compliance Program Documents within 90-days of the contract effective date and then annually thereafter. For entities using their own compliance documents, Elderplan expects that these entities' employees and associates will receive the respective compliance documents upon hire/appointment (within 90-days of hire/appointment) and then annually thereafter.

a. Document Maintenance

Providers and other Business Partners must maintain thorough and accurate records that governing body members and employees have read and attested to the Compliance Program Documents. Medicare Providers and other Business Partners must maintain proof for at least 10 years from the date the Compliance Program Documents were successfully read and attested to. Medicaid Providers and other Business Partners must maintain proof of completion for at least 6 years from the date the Compliance Program Documents were successfully read and attested to.

6. Medicare Compliance and Fraud, Waste and Abuse Training requirements

Elderplan strongly recommends that all Medicare Providers, FDRs and other Business Partners, including their governing body members, employees, volunteers and interns, satisfactorily complete the CMS Medicare Parts C and D General Compliance Training and the Combating Medicare Parts C and D Fraud, Waste, and Abuse training courses. These trainings are available via CMS Medicare Learning Network (MLN) website.

Medicare Providers or other Business Partners who have met the FWA certification requirements through enrollment into the Medicare Parts A or B Program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the Combating Medicare Parts C and D Fraud, Waste, and Abuse requirement.

a. Medicare Compliance Training Timeframes

Elderplan recommends that Medicare Providers and Business Partners, including governing body members, employees and other associates successfully complete the Medicare Parts C and D General Compliance Training and, as applicable, the Combating Medicare Parts C and D Fraud, Waste, and Abuse training **within 90-days of the contract effective date** and then annually thereafter. Training schedules based on training

completion within 90-day of hire/appointment date and then annually thereafter is acceptable for entities who take the Medicare trainings for multiple Medicare Advantage Organizations.

b. Document Maintenance

The records of trainings including topic, content, attendance, and, if applicable, certificates of completion and test scores should be maintained for a period of no less than 10 years from the date the training is completed.

7. New York State Office of the Medicaid Inspector General (OMIG) Compliance Certification Requirements

Many Medicaid Providers and other Business Partners will meet the OMIG criteria obligating them to develop and implement a compliance program in adherence with OMIG guidelines. Elderplan expects applicable Medicaid Providers and other Business Partners to develop such compliance programs and to annually certify their compliance programs in adherence with OMIG compliance requirements.

8. Accessing Elderplan Medicare and Medicaid Compliance Program Requirements

Elderplan makes available its Compliance Program Documents to Medicare and Medicaid Providers and Business Partners, respectively, by way of its Compliance and Fraud, Waste and Abuse (FWA) Program, Training and Reporting for Providers and FDRs webpage at https://www.elderplan.org/for-providers/compliance-fwa-training-and-reporting/.

9. Reporting information about Suspected Non-Compliance or Fraud, Waste and Abuse related to Elderplan Health Plans

If you have information about possible non-compliance or fraud, waste and abuse concerning Elderplan health plans or its members, you may report that information using the contacts below. Reports may be made anonymously.

a. Report to Elderplan's Compliance Officer:

Candice Weatherly
(718) 759-4260
cweather@mjhs.org

b. Call the anonymous Elderplan Compliance and Ethics Hotline 24 hours a day/ 7 days a week:

1-855-395-9169. To ensure confidentiality and anonymity, the hotline is operated by a third-party vendor.

c. Anonymously submit your question or concern electronically to the Elderplan Compliance and Ethics Hotline web portal:

www.mjhs.ethicspoint.com. To ensure confidentiality and anonymity, the hotline is operated by a third-party vendor.

d. Write to us:
Elderplan Regulatory Compliance
55 Water Street, 46th Floor
New York, NY 10041