



Provider Manual



www.amerihealthcaritasnext.com



www.firstchoicenext.com

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This Provider Manual is subject to change. Changes based on state or federal requirements may be made at any time. This document applies to AmeriHealth Caritas Next and First Choice Next individual and family health insurance products both on and off the Health Insurance Marketplace®.

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Welcome

Welcome to the AmeriHealth Caritas Next® and the First ChoiceSM Next HMO Benefit Program offered both on and off of the Health Insurance Marketplace®. AmeriHealth Caritas Next and First Choice Next offer affordable health plans for eligible individuals or families who do not have coverage through their employer and do not qualify for Medicare or Medicaid.

Participating on the Exchange aligns with our vision to empower those in need across their full life journey by providing a health insurance option for those who otherwise would have no access to health insurance coverage. It allows you, the provider, to continue to work with our members under a commercial reimbursement arrangement.

Thank you for your participation in the AmeriHealth Caritas Next or the First Choice Next provider network. We look forward to working with you!

General Information

The Provider Manual is part of your Provider Agreement with AmeriHealth Caritas Next or First Choice Next (referred to as AmeriHealth Caritas Next, First Choice Next, or “the Plan” throughout this manual). This manual supplements the terms of your contract and is updated regularly to provide you with pertinent policies, procedures, and administrative functions relevant to the daily administration of your practice when providing medically necessary covered services to our members, your patients.

This Provider Manual was created to assist you and your office staff with providing services to our members, your patients. As a provider, you agree to use this Provider Manual as a reference pertaining to the provision of medical services for members of the Plan. This Provider Manual is unified for all Exchange jurisdictions. Please note that throughout this document you will find references to sources of information on our website that will further assist you with more detailed requirements related to your specific state.

This Provider Manual may be changed or updated periodically. The Plan will provide you with notice of updates; providers are also responsible to check the Plan’s website, www.amerihealthcaritasnext.com, regularly for updates.

The Provider Manual is one of several communication vehicles that enable us to offer timely, pertinent information to you. We will provide you with regular updates through the following resources:

- The AmeriHealth Caritas Next websites: www.amerihealthcaritasnext.com
- The [NaviNet](#) web portal: An online, no-cost-to-providers gateway that allows real-time transactions between the Plan and its providers
- Provider Notices sent via fax and/or permission-based email

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Account Executives

Provider Network Management Account Executives play a critical role in educating our network providers and their office staff on policies, procedures, and specific billing processes. Account Executives also serve as a liaison for the provider's office and may promote or suggest workflow solutions.

In an effort to build and sustain a strong working relationship with participating providers, Account Executives will:

- Communicate with primary care physician (PCP) offices and specialists on a regular basis to help resolve issues, review medical and claims payment policies, discuss new policy implementation, review utilization reports, recommend sources for more efficient utilization, and explain new products and programs.
- Investigate and assist in providing resolution to provider disputes.
- Assist with policy and procedural issues that your office experiences and recommend potential resolutions.
- Conduct initial orientation with your staff about the Plan.
- Explain procedures for requesting claims adjustments or initiating a provider dispute.

Please note: Account Executives cannot revise claims submissions.

We encourage you to utilize the self-service tools available through the NaviNet web portal, including verification of member eligibility, claim status, and claim inquiry submission.

Account Executives serve multiple provider offices in the network. All inquiries regarding your office are important to us. Your Account Executive will address your questions as promptly as possible. If you need to identify who your Account Executive is, please call Provider Services.

The Provider Services department contact information can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Provider Services

Our Provider Services department serves as a valuable resource to you, in addition to your Account Executive. The role of Provider Services is to:

- Educate providers and facilitate effective communication between providers and the Plan by responding to telephone inquiries in a timely and accurate way.
- Educate providers about self-service utilization.
- Assist providers with claim inquiries.

The Provider Services department contact information can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

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Provider communications

To access the most current and updated information regarding the Plan, our policies, procedures, and processes, refer to the provider section of our website at www.amerihealthcaritasnext.com, NaviNet Plan Central, and this Provider Manual. These resources are designed to work in conjunction with each other to provide your office with timely informational updates.

The Plan will not use a provider's name or image without the provider's written consent.

Provider website

Our provider-dedicated web pages can be found at www.amerihealthcaritasnext.com, featuring up-to-date news and information of interest to providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office. Additionally, you can easily access resources including forms, NaviNet, and provider publications.

NaviNet Plan Central page and provider portal

NaviNet is an easy-to-use, no-cost-to-providers, secure portal that links providers to the Plan members. Our secure provider portal, www.navinet.net, offers web-based solutions that allow providers and the Plan to share critical administrative, financial, and clinical data in one place. This HIPAA-compliant tool provides access to other important tools and resources:

- Member cost-sharing amounts (i.e., copayments, coinsurance, and deductibles)
- Member eligibility and benefits information, including member in pending status
- View the member's ID card
- Member panel roster reports for PCPs in your practice
- Care gap reports to identify needed services
- Member clinical summaries
- Social determinants of health information
- Admission and discharge reports
- Medical and pharmacy claims submission and data
- Claims investigation
- Electronic submission of prior authorization request
- The latest provider news and announcements
- The most current version of our publications and provider manuals
- Links to NaviNet resources
- Plan Contact information

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Register for NaviNet

NaviNet provides a quick and streamlined registration process using our digital documentation system for automated identity and business verification. When registering for NaviNet, please have the following information ready to be entered into the online registration form:

- Office name
- Address
- Phone number
- Tax identification number (TIN)
- Last four digits of your social security number

You will also be asked to attach one of the following documents for verification:

- Certificate of Good Standing
- Sole Proprietor SS-4
- IRS 147C Letter
- Any other IRS or state-issued document that clearly displays your office name and tax identification number (TIN)

The person registering the account will be the designated Security Officer who is the primary contact and manages the account and access.

Self-service requirements

All participating providers, facilities, and billing agencies that support provider organizations are encouraged to have NaviNet access and complete the tasks listed below using NaviNet.

Eligibility and claims status

All participating providers and facilities are required to use NaviNet to verify member eligibility and obtain Plan claims status information. The claim detail provided through NaviNet includes specific information, such as check date, check number, service codes, paid amount, and member responsibility.

Authorizations

All participating providers and facilities should use NaviNet to initiate the following authorization types: medical/surgical procedures, chemotherapy/infusion therapy, durable medical equipment (DME), emergency hospital admission notification, home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, behavioral health inpatient admission, and substance use disorder inpatient rehabilitation.

Requests for medical/surgical procedures can be made up to six months in advance on NaviNet. In some cases, requests for medically necessary care are authorized immediately; however, some authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). NaviNet submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended

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status, please call the Utilization Management department for assistance.

Please Note: If the authorization is in a pended status, it is not yet approved. Providers should not submit any claims or claim inquiry requests that relate to the pended authorization until it has an approved status of “certified”. If claims are submitted prior to the authorization being approved, they may be rejected.

The Utilization Management department contact information can be found at > Pick Your State > For Providers > Prior Authorizations.

Claims investigation inquiry

Providers may question a claim payment or request a claim adjustment by submitting the request via NaviNet using the Claim investigation inquiry transaction. Requests can be submitted for dates of service up to 365 days prior to the current date of service.

NaviNet Security Officer

The NaviNet Security Officer is your office’s primary contact with NaviNet regarding security issues with the portal. NaviNet-enabled offices must designate at least one NaviNet Security Officer. The Security Officer also interacts with NaviNet users in your office and with NaviNet Customer Support to ensure that users are getting the most out of NaviNet. HIPAA mandates that each provider office designate a Security Officer to be aware of the electronic storage and transmission of patient information within and from your office. This person can also take the role of the NaviNet Security Officer.

Roles and responsibilities of the Security Officer

A NaviNet Security Officer is responsible for making sure that NaviNet is used in a HIPAA-compliant way. They are also responsible for configuring providers, users, and permissions so the office can use NaviNet effectively as well as efficiently.

For more detailed information on common Security Officer tasks, as well as best practices, please visit the Security Officers page on NaviNet.

NaviNet resources

Detailed guides, frequently asked questions, and training resources are available to all users for many transactions on NaviNet from the [NaviNet Support Center](#) page. If you are a current NaviNet user and need technical assistance, contact NaviNet at **1-888-482-8057**. If you are not yet NaviNet enabled, go to [NaviNet](#) to sign up.

If you need assistance, call NaviNet Customer Services **1-888-482-8057**. Customer Care hours are Monday through Friday, 8 a.m. to 11 p.m. ET, and Saturdays 8 a.m. to 3 p.m. ET.

Privacy and Confidentiality

Plan obligations

Protecting the privacy of our members’ information is very important to us. That is why the Plan has taken steps to ensure that our members’ PHI, whether in oral, written, or electronic form, is kept confidential. The

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Plan complies with all federal and state privacy and security laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which governs protection of protected health information (PHI), and 42 CFR Part 2 (Part 2), which governs the confidentiality of substance use disorder (SUD) records. All Plan confidentiality, privacy, and security policies and guidelines ensure member information within our organization and with our business associates is used, disclosed, accessed, and shared in accordance with applicable privacy and security laws and regulations.

Provider obligations

As a network provider, you are expected to be familiar with your responsibilities as a covered entity under HIPAA and Part 2 and maintain the confidentiality and privacy of member PHI in electronic, written, and oral forms. Plan providers are also expected to assist with privacy and security investigations, including providing attestations of destruction in a timely manner, in order to ensure that contractual requirements are met.

Allowed activities under the HIPAA privacy regulations

HIPAA allows covered entities, including providers and health plans, to use or disclose PHI for the purposes of treatment, payment, and/or health care operations (TPO) without a member's consent or authorization if both entities have or had a relationship with the member. This includes access to a member's medical records when necessary and appropriate. A covered entity may also use and disclose PHI for its own treatment, payment, and health care operations activities.

"Treatment" includes the provision, coordination, and management of health care, including consultation between providers and referral of a member from one provider to another.

"Payment" includes activities of a health plan to furnish or obtain reimbursement for health care services provided to a member and the activities of a provider to obtain reimbursement for service provided to a member. These activities may include but are not limited to:

- Determination of member eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of providers for payment or reimbursement to fulfill the Plan's coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to members

"Health care operations" include the following activities:

- Quality assessment and improvement activities such as care management and care coordination
- Quality of care reviews in response to member or state/federal queries
- Response to member complaints/grievances
- Site visits as part of credentialing and recredentialing
- Administrative and financial operations such as conducting National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) reviews
- Member services activities

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- Legal/compliance activities such as audit programs, including fraud and abuse detection to assess conformance with compliance programs
- Business planning and development

While there are other purposes under HIPAA for which the Plan and/or a provider might need to use or disclose a member's PHI, TPO covers a broad range of information sharing.

For more detailed information about our members' privacy rights and how we may use and disclose PHI, review our Privacy Notices, which are available on our website at www.amerihealthcaritasnext.com.

Rendering services to members

Be sure to verify member eligibility and cost-sharing amounts (i.e., copayments, coinsurance, and deductibles) each time a member is seen.

For more information regarding cost-sharing amounts, please refer to the member's Schedule of Benefits. The copayment amounts vary according to the member's type of coverage and benefits plan. This can be found at www.amerihealthcaritasnext.com > Pick Your State > View Our Plans > View Our "Metal" Plans > Schedule of Benefits.

How to verify member eligibility

Member ID cards include key information (e.g., name, ID number, prefix, and coverage type), and details may vary by plan. Eligibility verification is not a guarantee of payment. Always review the member's ID card and confirm eligibility in NaviNet under the Eligibility and Benefits Inquiry section. If the member cannot produce an ID card and/or is not on the primary care physician (PCP) roster, request a copy printed from the member portal on our secure member website. A temporary ID card may be accepted as proof of coverage until the permanent card is received; it is valid for up to ten calendar days from the print date. Member ID cards can be viewed on NaviNet under the Eligibility and Benefits Inquiry section.

Participating providers should use the NaviNet web portal for member eligibility inquiries. If coverage is effective before the ID card arrives, verify eligibility in NaviNet using the Eligibility and Benefits Inquiry transaction and select the "Patient Name/Patient Date of Birth" search type.

If there are questions about eligibility, panel assignment, or premium delinquency status, confirm the member's status in NaviNet under the Eligibility and Benefits Inquiry.

The Plan would not pay for any claims, regardless of emergency status, if the member was not eligible at the time of service.

Billing the member

Copayments, coinsurance, and any unpaid portion of the deductible may be collected at the time of service. In-network providers may not bill members for any amounts other than such copayments, coinsurance, or deductibles.

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Copayments

Members are responsible for making all applicable copayments. In addition, please note the following:

Copayment verification:

- Radiology, physical therapy, and occupational therapy services may be subject to copayment amounts that differ from the specialist copayment amount identified on the member's ID card. Copayments for these services should be verified using the Eligibility and Benefits Inquiry on NaviNet.

Collecting copayments:

- Copayments may not be waived and should be collected at the time services are rendered. If a member is unable to pay the copayment at the time services are rendered and has been provided with prior notice of this requirement, providers may bill the member for the copayment.
- A provider must notify a member if the office provides services where the member may be billed by more than one provider. For example, the office must inform the member when they will be charged a copayment for a physician service and a copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two copayments may be required.
- PCPs may not charge a member for a copayment unless the member is seen by a provider. No copayment is to be charged or collected by the PCP if a member is only picking up a copy of a referral or prescription from the office.
- If the member's specified copayment is greater than the allowable amount for the service, only the allowable amount should be collected from the member. However, if the allowable amount for the service is greater than the copayment, the specified copayment should be collected in full from the member. In the event that a copayment is collected and the practice subsequently determines that the allowable amount is less than the copayment, the difference between the copayment and the allowable amount must be refunded to the member within a reasonable period of time at no charge/cost to the member.
- Members who are at high risk for colon cancer or between the ages of 45 and 75 can receive a colon cancer preventive screening colonoscopy with no member cost-sharing (\$0). Providers will be required to put CPT modifier 33 in their claims submission for the service to be covered as preventive care at no cost to the member.
- **Plan Health Care Reform requirements.** The following copayment rules are required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform):
 - There is no member cost-sharing (i.e., \$0 copayment) for preventive services identified under the Affordable Care Act and provided to members by a network provider. A complete list of preventive services with \$0 member cost-sharing can be found on the CMS website:
www.healthcare.gov/coverage/preventive-care-benefits/.

Please note: The \$0 copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the member is experiencing a problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring

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adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for application of a copayment.

Please Note: Health Care Reform regulations require an “embedded” in-network out-of-pocket maximum for each individual to limit the amount of out-of-pocket expenses that any one person will incur. This means that each member enrolled in an individual plan, or any person in a family plan, will only pay the in-network out-of-pocket maximum set for an individual and not be required to pay out of pocket to meet the family in-network out-of-pocket maximum for the Plan. For a family plan, after one person meets the individual in-network out-of-pocket maximum for their plan, the other family members continue to pay out of pocket until the remaining family in-network out-of-pocket maximum amount is met.

The Plan routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the members benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

Covered Health Services

For a list of covered services, please refer to the member’s Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Member cost-share responsibility for covered services

Please refer to the member’s Schedule of Benefits for details about:

- The amount the member must pay for these covered health services (including any deductible, copayment, and/or coinsurance).
- Any limits that apply to these covered health services (including visit, day, and dollar limits on services).
- Any limit to the amount the member is required to pay in a calendar year (out-of-pocket maximum amount).

The Schedule of Benefits and other policy documents are available on request by contacting our Member Services department. The member’s Schedule of Benefits can be found at www.amerihealthcaritasnext.com > Pick Your State > View Our Plans > View Our “Metal” Plans > Schedule of Benefits.

The member’s cost-share responsibility for the covered health services they receive are determined based on where the services are provided. For example, if the member receives allergy testing and treatment in an office-visit setting, the specialist cost-share responsibility will apply. However, if they receive allergy testing provided by an outpatient laboratory center, the laboratory outpatient professional services cost-share responsibility will apply.

Claims and Billing Summary

Claims and billing guidelines outline how providers should submit claims, verify member eligibility and cost-sharing, and use available self-service tools (such as NaviNet) to check claim status, request claim

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investigations/adjustments, and help resolve payment questions. Providers should also follow Plan requirements related to filing deadlines, corrected claims, remittance/payment options, and member billing rules (including copayments, coinsurance, deductibles, and any applicable balance-billing restrictions).

The Claims and Billing Manual can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Claims and Billing > Claims and Billing Manual.

Important definitions

Medically necessary or medical necessity

The covered health services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not for experimental, investigational, or for cosmetic purposes, except as allowed under state law.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
- Within generally accepted standards of medical care in the community
- Not only for the convenience of the insured, the insured's family, or the provider

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Experimental/investigational

Services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by the Plan:

- It is a drug or device that cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective in clinical diagnosis, evaluation, management, or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Please note: Reliable evidence includes but is not limited to reports and articles published in authoritative peer-reviewed medical and scientific literature and assessments and coverage recommendations published by AmeriHealth Caritas Next or First Choice Next for clinical effectiveness.

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Exclusions and Limitations

Covered health services must be administered by a network provider unless the member receives prior authorization for out-of-network services with limited exceptions. For a benefit to be paid, the covered health services must be medically necessary for diagnosis or treatment of an illness or injury or be covered under the member's Evidence of Coverage.

A list of services that are excluded or have limitations can be found on the members Evidence of Coverage located at www.amerhealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

If you are unsure whether a product or service is excluded or has limitations, please contact our Utilization Management department. The Utilization Management department contact information can be found at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Change of Network Status

Updating your provider information

When submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. You are contractually required to notify us in writing with at least 30 days advance notice when changing key provider demographic information.

Providers are required to review current provider directory data as it is listed in the directory and submit updates or corrections through the Provider Data Intake Form (PDIF) posted on NaviNet. The request for validation will occur every 90 days. You will be sent a reminder prior to the due date to remind you to attest to the accuracy of your provider data. Providers will be given 30 days to attest to the accuracy of information or submit any changes. Failure to respond in the specified time frame may result in the removal from our provider directory until you validate your data.

Instructions are as follows:

- Log on to NaviNet.
- Select the appropriate health plan (AmeriHealth Caritas Next or First Choice Next).
- Click the Provider Data Information Form (PDIF) link (in the upper left-hand corner of the Plan Central Page).
- On the Provider Selection screen, click the **Please Select a Provider** menu, select a provider, and hit **Submit**.
- You will be taken to the Provider Self Service screen; in the bottom right portion of the page, click the box titled **Proceed to Provider Updates**.
- Click the box titled **PDIF Update**.
- Click the **Location Selection**.

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- Click the box for the provider(s) for whom you want to attest and/or make changes and click the **Next** box in the bottom right portion of the page.
- Review and make changes to the practitioner summaries, if applicable.
- Provide required documentation, if applicable.
- Attest and click the **Next** box in the bottom right portion of the page.

Provider directory data changes will be reflected within the online provider directory within 14 business days. If the change is not reflected in 14 business days, please contact your Provider Network Management Account Executive.

For additional guidance on the PDIF feature, please call the Provider Services department. Their contact information can be found in the Provider Reference Guide located at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

The recredentialing process is another way we keep your provider information current. Return your recredentialing application packet promptly or update your CAQH application at least quarterly.

If you have accepted any payments during the year, the Plan must report that income on the annual 1099 Form. All providers are reminded that practice demographics should be kept current to receive accurate 1099 Forms. Payments will be processed more efficiently if provider information is current.

Updates resulting in a change on your W-9 form (e.g., changes to a provider's name, tax ID number, billing vendor or "pay to" address, or ownership) require the following signatures:

- Group practices: A signature from a legally authorized representative (e.g., physician or other person who signed the agreement or one who is legally authorized to bind the group practice) of the practice is required.
- Solo practitioners: A signature from the individual practitioner is required.

An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

Closing a PCP practice to additional patients

A participating PCP must notify their Account Executive at least 60 days in advance of any intent to close the practice to additional Plan patients. There are three status levels for offices:

- Open: Practice is accepting new patients.
- Current: Practice is accepting existing patients currently in the practice. Offices with practices designated as "current" will be listed in the Provider Directory as such.
- Frozen/Closed: Practice is not accepting additions to the panel.

Please note: The PCP must notify the Account Executive in writing 60 days in advance of closure.

Changing PCPs

A member can change their PCP by calling Member Services or by accessing the member portal on our website. When members request a PCP change, they will need to provide a reason for the change. The change will take effect within 24 hours.

Please note: Providers cannot make a change to a member's PCP on the member's behalf.

Termination from the Plan network

Providers who choose to resign from the network should first contact their Account Executive to discuss the reason for the termination. In addition to the telephone call, the provider must give the network at least 90 days advance written notice in order to terminate network participation.

Written notice should be submitted to the attention of Provider Correspondence. The address can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

In accordance with your contractual obligation to comply with our policies and procedures and professional licensing standards, a specialist or specialty group must notify affected members if a specialist leaves the group or otherwise becomes unavailable to Plan members or if the group terminates its agreement with the Plan.

To help ensure continuity and coordination of care, we notify members affected by the resignation or termination of a PCP or PCP practice site at least 30 days prior to the effective date of termination and assist them in selecting a different provider or practice site. The Plan's notification of PCP resignation or termination does not relieve the PCP from their professional obligation to also notify their patients of the resignation or termination.

For any questions, please call the Provider Services department. Their contact information can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Patient transition from a pediatrician to an adult PCP

Pediatricians should systematically alert adolescents who are approaching the maximum age for patients treated in their practice to allow them to transition smoothly to a new PCP who has experience in treating adults.

If members require further assistance on how to switch from a pediatrician to a new PCP, ask them to call Member Services at the telephone number on their ID card.

New and existing member continuity of care

The Plan will provide ongoing medical or behavioral health services and coordination to assist members who have an ongoing special condition or are engaged in an active course of treatment when a member is new to the Plan or a provider is terminated from the Plan network.

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- New enrollees may continue a course of treatment with nonparticipating physician/provider for the lesser of a transitional period of up to 90 days or until the treating provider releases the patient from care from the effective date of enrollment in a managed care plan, provided the requirements for an ongoing course of treatment are met.
- Existing enrollees who recently enrolled in the Plan health benefit plan may continue a course of treatment with a nonparticipating physician/provider for the lesser of a transitional period of up to 90 days or until the treating provider releases the patient from care, provided the requirements for an ongoing course of treatment are met.
- Upon member request, members have a right to continue to receive health care services from their nonparticipating physician/provider for the lesser of up to 90 days or until the treating provider releases the patient from care. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
- In the case of pregnancy, pregnancy from the start of the second trimester.
- In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

Terminated providers continuity of care

The Plan provides continuing coverage of covered services for members with a terminated provider when the provider is terminated without cause in the time frames as outlined from the Plan network in the following circumstances:

- The provider chooses to end participation in the Plan network.
- The provider's contract expires or is not renewed.

After termination of a provider's contract without cause, or in the event of payer insolvency, the provider shall continue to provide covered services to members at the current contracted rate when inpatient care of members is ongoing, until the patient is ready for discharge.

This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.

In situations where the provider termination is related to quality of care or fraud, the Plan care management staff assists the member with identifying and transitioning to a new provider.

The Plan will notify members timely of their right to elect continuation of coverage of treatment upon enrollment into the Plan or upon notification of a provider terminating from the network.

The Plan shall include a clear description of a member's rights under this section in its Evidence of Coverage and summary plan description.

Members will be responsible for copayment and deductibles as per their benefit plan.

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Terminated or out-of-network providers continuity of care

The Plan conditions this coverage of continued treatment by an out-of-network or terminated provider on the following terms and conditions:

- The provider agrees to accept the prevailing rate based on contracts the Plan has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the Plan and the insured for all covered services.
- The provider agrees to provide to the Plan Utilization Management (UM) team the necessary medical information related to the care provided. The Plan UM program shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the member.
- The provider agrees otherwise to adhere to the Plan's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization; providing services pursuant to a treatment plan, if any, approved by the Plan; and member-hold-harmless provisions.
- The member or the member's representative notifies the Plan within 45 days of the date of enrollment or notification of terminating provider that they elect to continue receiving treatment by the provider.
- The provider agrees to discontinue providing services at the end of the transition period pursuant to this section and to assist the member in an orderly transition to a network provider.
- The services provided are covered in the member's benefit plan.

The member will not be prohibited from continuing to receive services from the provider at the member's expense.

Members with ongoing special conditions continuity of care

The Plan members who are engaged in an ongoing course of treatment and/or who have an ongoing special condition with a provider who is terminated from the Plan network will have their services covered with that provider up to 90 days, as determined by the treating health care provider, after the date of provider termination with several exceptions, e.g. pregnancy, end of life, etc.

For details on exceptions, please refer to the members Evidence of Coverage located at www.amerihhealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

If the provider is terminated due to quality of care or program integrity (fraud), services will not be continued beyond the provider termination date. If the provider is terminated and the member needs assistance selecting another provider, they are encouraged to call our Rapid Response and Outreach Team.

The contact information for the Rapid Response and Outreach Team can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

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At the end of the transition period, or sooner at the request of the member, the Plan and the nonparticipating provider will assist the member with identifying and transitioning to a participating provider for additional services.

Terminating a member from a practice

If a situation arises when a PCP or other treating provider initiates termination of its provider-patient relationship and needs to release a Plan member from their practice, there are some important things to remember. The PCP or treating provider must notify both the member and the Plan in writing within 30 calendar days if terminating a member from their practice.

To notify the Plan, the provider must contact their Provider Network Management Account Executive or Provider Services. Written notice should be submitted to the attention of Provider Correspondence.

The address can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

The provider must also continue treating the member for current medical conditions for 30 days after ending the provider-patient relationship to allow time for the member to select a different treating provider. During this time, we will assist the member in selecting a different PCP or other treating provider. If the member asks the provider or office staff for assistance in selecting a new PCP or other treating provider, they should be referred to Member Services.

The Member Services department contact information can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

In the event the member is threatening or violent towards the provider or office staff, the member's access to the office may be terminated immediately and the member will be notified in writing.

Nondiscrimination

Physicians cannot discriminate against any member based upon race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; immigration status; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

Medical record requests

When a provider initiates termination of the provider-patient relationship with the member, the provider cannot charge members for requests for copies of medical records. The provider must facilitate the sharing of such records among health care providers directly involved with the member's care.

Member Grievances and Appeals

The Plan may decide to deny or limit a request the provider makes for the member for benefits or services offered by our plan. We provide processes for filing a grievance or appeals. The member has the right to file a grievance, file an appeal, and right to an external review with respect to certain adverse determinations or appeals not decided in their favor.

The member, the member's authorized representative, or provider on a member's behalf, can file a grievance with us at any time. If a provider files a grievance on behalf of the member and we do not have record of the member's consent; the grievance team will need to secure the member's consent for the grievance.

For information regarding Member Grievances and Appeals, please refer to the member's Evidence of Coverage. The Evidence of Coverage can be located at www.amerihhealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Provider Disputes

Providers may file a dispute about the Plan's policies or procedures, or any aspects of the Plan's administrative functions, including proposed actions, claims and billing related issues, and service authorizations. To be deemed timely, claims disputes must be received within 60 calendar days of the subject claim remittance advice or denial. A determination on a claim dispute will be made within 30 calendar days of receipt of such claim dispute by AmeriHealth Caritas Next or First Choice Next. **Providers must exhaust the Plan's claim dispute process as a prerequisite to arbitration or litigation.**

A dispute is a written request from a health care provider to change a decision made by the Plan. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services.

Examples include, but are not limited to:

- Issues with policy, procedures, or administrative functions
- Credentialing concerns, such as timeliness, allegation of discriminatory practice, or policy
- Claim-related issues, including inaccurate payment, claim denials, and post-service authorization denials
- Service issues with the Plan, including failure by the Plan to return a provider's calls, frequency of site visits, and lack of provider network orientation and education

Providers are encouraged to contact their Account Executive or call Provider Services for claim inquiry resolution prior to filing a dispute. A claim inquiry is not a dispute.

The Provider Services department contact information can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

To notify the Plan of a dispute, providers may open a NaviNet dispute with a listing of claims (if applicable) and supporting documentation or mail the required Dispute Form. The form can be found at

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www.amerihealthcaritasnext.com > Pick Your State > For Providers > Forms and Documents > Provider Claim Dispute Form.

The Dispute Form should be submitted to the attention of Provider Disputes. The address can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Please note: A telephone inquiry regarding payment or denial of a claim does not constitute a dispute.

If any dispute regarding a claim remains unresolved following the exhaustion of the applicable provider dispute process, you must notify the Plan of your intention to commence litigation or arbitration, as appropriate, at least sixty (60) days in advance of filing litigation or arbitration. Such notice is a condition precedent for any litigation or arbitration. **Failure to exhaust the applicable dispute process shall be a total and complete defense to claims brought in litigation or arbitration.** To the extent that applicable law requires provider claim disputes to proceed exclusively through any applicable State fair hearing or other administrative process, you must use that process and may not pursue litigation or arbitration as a substitute for that process.

Fraud, Waste, and Abuse

As a provider participating in the Plan network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of the Plan.

Definitions of fraud, waste, and abuse (FWA)

Fraud — an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste — the over-utilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions but rather misuse of resources.

Abuse — provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Plan or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the ACA Exchange program.

Federal False Claims Act

The Federal False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors for payment or approval. Additionally, the FCA prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When the Plan submits claims data to the government for payment, we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors and delegated entities, and we monitor their work to ensure compliance.

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The FCA, through amendments made under the Fraud Enforcement and Recovery Act of 2009, also prohibits knowingly concealing or knowingly and improperly avoiding the return of identified overpayments.

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

Penalties for violating the FCA include civil monetary penalties (CMPs) ranging from \$11,181 to \$22,363 (as adjusted by the Department of Justice under the Federal Civil Penalties Inflation Adjustment Act of 1990) per false claim, and/or exclusion from federally funded programs. In addition, violators are subject to three times the amount of damages sustained by the federal government because of the illegal act(s) unless the violator has voluntarily disclosed the FCA violation under certain conditions.

Program Integrity

The Plan has a dedicated Program Integrity department charged with preventing, detecting, investigating, and reporting fraud, waste, and abuse (FWA) for all of its health insurance products.

The programs of the Program Integrity department are aimed at the accuracy of claims payments and the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of the Plan, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third-party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

Prospective (pre-claims payment)

Claims editing — A review and adjustment of payments based on an identified deviation from the established industry guidelines standards such as Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state regulatory agencies, or Plan medical/claim payment policy.

Medical record/itemized bill review — A medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.

Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested time frame.

A review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

Retrospective (post-claims payment)

Data mining — Using paid claims data, the Plan identifies trends and patterns to identify invalid claim payments or claim overpayments that warrant recovery.

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Medical records review — Medical records may be requested to validate the accuracy of coding for procedures, diagnosis, or diagnosis-related groups (DRGs) billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, readmission review, and pharmacy utilization review.

Please note: If medical records are not received within the requested time frame, the Plan will recover funds from the provider. Your failure to cooperate by providing medical records creates a presumption that the claim as submitted is not supported by the records.

Credit balance review — Service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.

Overpayment collections — Credit balances that have not been resolved in a timely manner may be referred to an external collections vendor to pursue recovery.

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

Compliance with federal and state laws, regulations, and other guidance is a priority of the Plan. If you or any entity with which you contract to provide health care services on behalf of the Plan members becomes concerned about or identifies potential compliance, privacy, fraud, waste, or abuse issues, please contact the Plan online or through our anonymous hotline.

Anonymous hotline and online reporting

Phone hotlines are available 24 hours a day, seven days a week at:

Fraud, Waste, and Abuse Hotline: **1-866-833-9718**

For compliance, privacy, or ethics concerns: **1-800-575-0417**

By email:

Fraud: fraudtip@amerihealthcaritas.com

AmeriHealth Caritas Next Compliance: ACNXCompliance@amerihealthcaritas.com

Corporate Compliance: corpcomp@amerihealthcaritas.com

Corporate Privacy: privacy@amerihealthcaritas.com

By mail:

Mail a written statement to the AmeriHealth Caritas Next OR First Choice Next address found on the Fraud, Waste, and Abuse Plan webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Fraud, Waste, and Abuse > Anonymously report suspected fraud, waste, and abuse.

Below are examples of information that will assist the Plan with an investigation:

- Information (e.g. name of individual making the allegation, address, number).
- Name and identification number of the suspected individual.

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- Approximate dollars involved (if known).
- Place of service
- Description of the suspected fraudulent or abusive activities
- Time frame/date of the suspected activity(ies)

The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with applicable federal and state regulations and contractual requirements. Cross-functional teams include the Special Investigations Unit (SIU) and the Claims Cost Containment Unit.

What to expect as a result of Special Investigations Unit (SIU) activities

The SIU reviews all reports of suspected FWA; as a result, you may be asked to provide certain information for the SIU to conduct a thorough investigation. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with FWA. As a result of these claims accuracy efforts, you may receive letters from the Plan or on behalf of the Plan regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may be contacted by the SIU Intake Unit to verify a report you filed.
- You may be contacted by investigators regarding an issue they are investigating.
- As a provider, you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that the terms of your Provider Agreement require you to provide the records for review.

After the SIU completes its investigation, a number of things may occur. We may make a determination that the dispute was unfounded; or we may make a referral to (1) the applicable State Department of Insurance (DOI) using the specified Fraud, Waste, and Abuse Submission Form, (2) the applicable State Department of Justice or Attorney General's Office, or (3) the federal Office of Inspector General, U.S. Department of Health and Human Services, for further investigation. You may receive an overpayment letter that outlines our findings if we determine that monies are owed to the Plan as a result of an overpayment. You could also receive an informational letter that outlines proper procedures that are to be followed for future reference. We may also place you on prepayment review.

Prepayment review

The Special Investigations Unit (SIU) utilizes the prepayment pending of claims as a corrective action tool. The process automatically pends the provider's claims so that we may conduct a medical record review prior to payment; the review is conducted to determine whether the documentation supports the claim's billed services. Upon completion of the prepayment review, the Plan will process the claim according to the outcome of the clinical record review. The SIU will monitor billing accuracy while the provider is on prepayment review. When a provider's billing accuracy falls into compliance for at least one quarter, the SIU

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will consider removing the provider from prepayment review. Noncompliance with the prepayment review process may result in further actions, up to and including termination from the Plan network.

Claims Cost Containment

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted for potential recovery. Some examples include:

- Incorrect billing from providers causing overpayment
- Overpayment due to updates to provider fee schedules in the claims processing system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/procedure codes, third-party liability, rescissions in coverage, or retrospective determinations of member ineligibility

Refunds for claims overpayments or errors

The Plan and state/federal regulators encourage providers to conduct regular self-audits to ensure accurate payment. Improper payment or overpayment of claims from the Plan must be returned to the Plan. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements within 60 days to return the funds to the Plan. The Plan's Claims Cost Containment Unit is responsible for the manual review of provider-initiated repayment of overpayments. providers who self-identify claim overpayments may submit their inquiries by mail. Written notice should be submitted to the attention of Provider Refunds.

The address for Provider Refunds can be found in the Provider Reference Guide located at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Production of records and examination under oath

When requested by the Plan or designated representatives of federal, state, or local law enforcement and/or regulatory agencies, providers must produce copies of all medical/financial records requested within the requested time frame and must permit access to the original medical/financial records for comparison purposes if requested. Some requests may call for an examination under oath.

If a provider fails or refuses to produce copies and/or permit access to the original medical records as requested, in addition to other remedies, the Plan reserves the right to place the provider on prepayment review.

Providers should also follow Plan requirements related to filing deadlines, corrected claims, remittance/payment options, and member billing rules (including copayments, coinsurance, deductibles, and any applicable balance-billing restrictions).

The Claims and Billing Manual can be found at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Claims and Billing > Claims and Billing Manual.

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Utilization Management

Utilization Management Department contact information

The Utilization Management department contact information can be found at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Prior authorization and notification policy and procedure

- The prior authorization and notification policy and procedure apply to all services and providers except pharmacy providers. Pharmacy providers are subject to the Plan's pharmacy prior authorization processes regardless of network participation status. For information on the pharmacy prior authorization process, see the Pharmacy section of this manual.
- Prior authorizations with the Plan are required for certain services for participating providers. Please refer to the Prior Authorization Lookup Tool for services requiring prior authorization and criteria. For out-of-network providers, prior authorization is required for all services except emergency services. Upon request, providers may call our Utilization Management department for prior authorization criteria and education.
- A toll-free fax line is available to receive inbound communication 24 hours a day, seven days a week. Our staff will be able to answer questions and assist you with your prior authorization request, including requests for inpatient hospitalizations.
- For members new to the Plan, we will allow a member to use an out-of-network provider for medically necessary services for a period of 90 days, with some exceptions, e.g., pregnancy, end of life, etc. The member or provider needs to notify us of existing services so they can receive prior authorization. If the member is pregnant and in her second or third trimester, pregnancy-related services will be covered through postpartum care.
- Determination of lack of medical necessity is considered an adverse action and may be appealed by the member (or by the provider on behalf of the member) under certain circumstances.
- The Plan will provide comprehensive, ongoing provider training and outreach to contracted providers. Training will include prior authorization and billing processes to help providers treating our members to avoid delays in payment or member service delivery.
- The Plan offers training materials on its website and these materials are accessible for both in-network and out-of-network providers.

Prior authorization guidelines

Prior authorization is required to evaluate the medical necessity of proposed services for coverage under applicable benefits programs. When referring members to a hospital, the PCP only needs to refer to the admitting/performing physician, who is then responsible for obtaining prior authorization for the hospital admission.

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Responsibilities

Responsibilities of the admitting/performing physician for hospital admissions:

- Make hospital admission arrangements.
- Acquire the following required information:
 - Member name and date of birth
 - Member ID number
 - Admission date
 - Place of admission
 - Diagnosis
 - Planned procedure
 - Medical information to support the prior authorization review request
- Notify the member's PCP of the diagnosis, planned procedure, and hospital arrangements.
- Contact the hospital with the prior authorization code.

Prior authorization requests

Provider Authorization Lookup Tool

To assist providers with prior authorization requests, the Plan hosts a Prior Authorization Lookup Tool located on the Prior Authorization webpage with the most up-to-date services that require prior authorization. The provider may enter a CPT/HCPCS code and will be advised if the service requires prior authorization. Providers may call Utilization Management with any questions.

Physical health, behavioral health, and pharmacy prior authorization forms can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

NantHealth | NaviNet Medical Authorizations

The Plan has worked with NantHealth | NaviNet to bring you Medical Authorizations, a robust, intuitive, and streamlined online authorizations workflow.

In addition to submitting and inquiring about existing authorizations, you will also be able to:

- Verify if no authorization is required.
- Receive auto approvals, in some circumstances.
- Submit amended authorization.
- Attach supplemental documentation.
- Sign up for in-app status change notifications directly from the health plan.
- Access a multi-payer authorization log.

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- Submit inpatient concurrent reviews online if you have Health Information Exchange (HIE) capabilities. (Fax is no longer required.)
- Review inpatient admission notifications and provide supporting clinical documentation.

Video tutorials and step-by-step instructions will be available via the NaviNet Plan Central page and the NantHealth Help Center. The Plan will offer training on the NaviNet Medical Authorizations system. Contact your Provider Network Management Account Executive for available training dates and times.

The Utilization Management department contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Physical and Behavioral Health Prior Authorizations and Notifications

Referrals

Referrals are not required for members to access in-network specialists for medically necessary covered services. This plan does not include out-of-network benefits; members should be directed to participating (in-network) providers. Out-of-network services may be authorized only when a prior authorization request is submitted and approved in advance, except for emergency services, which do not require prior authorization. Such out-of-network service requests for prior authorization must include the specific reason why in-network care would not be appropriate for the member.

Physical and behavioral health services requiring prior authorizations

For a list of physical and behavioral health services that require prior authorization, please refer to the members Evidence of Coverage. The Evidence of Coverage can be located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Providers are encouraged to use the Prior Authorization Lookup Tool on the Plan website to find out if a service requires prior authorization. This tool can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations > Prior Authorization Lookup Tool.

Certain services or supplies may need to be reviewed before the member receives them to make sure that they are medically necessary and being provided by a network provider. If the member is receiving services from a network provider, the provider will be responsible for obtaining any necessary prior authorization before the member receives services. If the prior authorization is denied and the provider still provides the member with these services, the provider cannot bill the member for these denied services unless the member agreed to receive services at a self-pay rate. If the member is obtaining services outside of our service area or from an out-of-network provider, they will need to make sure that any necessary prior authorization has been received before receiving services. If the member does not, the service may not be covered under this plan.

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Prior authorizations can be retracted after emergency services are provided if the member or their provider materially misrepresented the member's condition. Coverage will also depend on any limitations or exclusions for this plan, payment of premium, eligibility at the time of service, and any deductible or cost-sharing amounts. If the provider or member does not obtain prior authorization before an elective admission to a hospital or certain other facilities, the member may be responsible for all charges related to services that fail to meet prior authorization requirements.

This list of physical or behavioral health services needing prior authorization is subject to change. For the most up-to-date information, visit the Prior Authorization webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Advanced diagnostic imaging services provided by Evolent

The Plan has contracted with Evolent to perform prior authorization for outpatient nonemergent diagnostic imaging services and certain high-technology radiology services for our Plan members. The following diagnostic imaging services, when performed as an outpatient service, require prior authorization by the Plan radiology benefits vendor, Evolent:

- CT/CTA
- MRI/MRA
- PET scan
- MUGA scan
- CCTA
- Myocardial perfusion imaging

To request prior authorization, contact the Plan's radiology benefits vendor Evolent via their provider web-portal at www.radmd.com or by calling Monday through Friday, 8 a.m. to 8 p.m. ET. The ordering physician is responsible for obtaining a prior authorization number for the requested radiology service. Patient symptoms, past clinical history, and prior treatment information will be requested by Evolent and the ordering physician should have this information available at the time of the call. Weekend, holiday, and after-hours prior authorization requests can be submitted online.

Evolent's hours are Monday through Friday, 8 a.m. to 8 p.m. ET, excluding holidays. Evolent's contact information can be found on the Prior Authorizations webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

The Evolent website, www.radmd.com, is available 24 hours a day to providers. Weekends, holidays, and after-hours requests for prior authorization of outpatient elective imaging studies may be called in to Evolent and a message may be left by voicemail. Evolent will contact the requesting provider's office within one business day of retrieval of the voicemail request to obtain necessary demographic and clinical information to process the request.

Physical health services that require notification

Providers are asked to notify the Plan within one business day of when the following services are delivered:

- All newborn deliveries, including those that occur in birthing centers
- Maternity obstetrical services (after first visit) and outpatient care (includes observation for out-of-network providers)
- Continuation of covered services rendered by an out-of-network provider for a new member transitioning to the Plan the first 90 calendar days of enrollment. The Plan will conduct a medical necessity review of services that received prior authorizations from an insurer other than the Plan.
- Inpatient admissions following emergency room medical care, emergency short procedure unit services, or an observation stay
- Organ transplant evaluations

To notify the Plan, refer to the Utilization Management department contact information can be found at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Payment adjustments

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

Clinical criteria, guidelines, and other resources

The Plan uses the following medical necessity criteria as guidelines for determinations related to medical necessity, except where specified under state regulation or contract:

1. State statutes and regulations
2. Federal statutes and regulations
3. Change HealthCare InterQual® Level of Care Criterion
 - InterQual® Level of Care Acute Adult Criteria
 - InterQual® Level of Care Acute Pediatric Criteria
 - InterQual® Level of Care Outpatient Rehabilitation and Chiropractic Criteria
 - InterQual® Home Care Criteria
 - InterQual® Care Planning Procedures Adult Criteria
 - InterQual® Care Planning Procedures Pediatric Criteria
 - InterQual® DME Criteria

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- InterQual® Level of Care Rehabilitation Criteria
 - InterQual® Level of Care Subacute and Skilled Nursing Facility Criteria
 - InterQual® Level of Care Criteria Behavioral Health Psychiatry Adult and Geriatric
 - InterQual® Level of Care Criteria Behavioral Health Psychiatry Child and Adolescent
4. American Society of Addiction Medicine (ASAM) Criteria. Treatment Criteria for Addictive, Substance-related and Co-occurring Conditions, 3rd Edition, 2013 (adult and adolescence). ASAM criteria is used to evaluate level of care (LOC) for Substance Use services.
 5. Corporate Clinical Policies
 6. Evolent Radiology Guidelines

Member considerations

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

Local delivery system

- Availability of subacute care facilities or home care in the Plan service area for post-discharge support
- The Plan benefits for subacute care facilities or home care where needed
- Ability of local hospitals to provide all recommended services within the estimated length of stay
- Availability of the medically necessary behavioral health level of care

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter, or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration, or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Medical Director.

Medical necessity decisions made by the Plan's Medical Director or designee are based on the definition of medical necessity, in conjunction with the member's benefits, medical expertise, application of the Plan medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified health care professionals, or the requesting practitioner/provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

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

Upon request by a member or provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee.

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UM criteria is available on our website at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Plan clinical policies can be found at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Clinical Resources > Clinical Policies.

The Plan will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member.

The Utilization Management staff and physicians involved in medical necessity decisions are assessed semi-annually for consistent application of review criteria.

Hospitalization and Outpatient Services

Ambulatory care

Prior authorization is required for certain outpatient procedures. Prior authorization for these procedures must be obtained at least five business days prior to the scheduled date of the procedure.

Determining whether procedures are cosmetic

The Plan requires prior authorization for procedures that are generally cosmetic. To check whether a procedure is considered cosmetic, use the Prior Authorization Lookup Tool. Some procedures may be covered if medical criteria are met; providers must submit a prior authorization request for coverage consideration.

The Prior Authorization Lookup Tool can be found at www.amerhealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Skilled nursing facilities

Skilled nursing facility (SNF) services are covered for members who need skilled or subacute care. SNF services are subject to prior authorization and may be subject to certain benefits limits.

All SNF admissions are either arranged by care management staff or prior authorized through the prior authorization process. SNF admissions are reviewed weekly or more often, if necessary, to facilitate appropriate use of benefits and to promote optimal benefits coverage.

Inpatient hospital

Inpatient hospital benefits are available to members and are subject to prior authorization. In the case of an urgent or emergent admission for a member, the hospital must notify the Plan within 48 hours, or on the next business day if the 48-hour period ends after 5 p.m. ET.

The attending physician is required to obtain prior authorization for all nonurgent or nonemergent admissions.

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Provider preventable conditions

The Plan will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) with regard to the reimbursement of provider preventable conditions (PPCs). The ACA defines PPCs in two distinct categories: health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs), or never events. Inpatient acute care hospitals, ambulatory surgery centers (ASCs), physicians, and other practitioners are held accountable for never events. Inpatient acute care hospitals are also held accountable for HCACs and OPPCs

Health care-acquired conditions

The category of health care-acquired conditions (HCACs) will apply to Plan inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but are subsequently acquired in that setting:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers (decubitus ulcers)
- Vascular catheter-associated infection
- Mediastinitis after coronary artery bypass graft (CABG)
- Hospital-acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)
- Manifestations of poor glycemic control
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures, except for pediatric and obstetric populations

Other provider-preventable conditions

- Postoperative death in a normal healthy patient
- Death/disability associated with use of contaminated drugs, devices, or biologics
- Death/disability associated with use of device, other than as intended
- Death/disability associated with medication error
- Maternal death/disability with low-risk delivery
- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Death/disability due to wrong oxygen or gas

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Never events:

- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on the wrong patient

The Plan monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies, and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affect the quality of care and service, operations, assets, or the reputation of the Plan.

The Plan's goals are to:

- Have a positive impact on improving patient care, treatment, and services, and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.
- Reduce medical errors through the appropriate use of best clinical practices.
- Use evidence-based medicine and health information technology under the plan or coverage.
- Implement wellness and health promotion activities.
- Implement activities to improve patient safety.

Patient safety standards

In accordance with 45 CFR § 156.1110, when the Plan(s) contract with a hospital with greater than 50 beds, the Plan will verify that the hospital, as defined in section 1861(e) of the Act:

“(i)

(A) Utilizes a patient safety evaluation system as defined in [42 CFR § 3.20](#); and

(B) Implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or

(ii) Implements an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.”

Potential quality of care concerns

Potential quality of care (QOC) concerns are fully investigated by the Plan. Such concerns will be thoroughly investigated by clinical reviewers in accordance with Plan policy. Providers are required to comply with the

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Plan QOC review process by submitting records timely in accordance with our policy and procedures. Failure to provide records on time may result in sanctions.

Summaries and situational reviews are presented to the Credentialing Committee on a monthly basis. Serious QOC concerns may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's network, sanctions, or corrective action. Referral to the QAPIC is at the discretion of the Plan Medical Director or Quality Management (QM) Director.

If the QAPIC investigation involves an action reportable to a national or state entity or database, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and state regulatory agencies.

The QM department reserves the right to take any of the following actions, based on its discretion:

- Require the provider to submit medical records.
- Require the practitioner/provider to submit a written description and explanation of the QOC event or issue, as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conduct a medical record review audit.
- Require that the practitioner/provider conform to a corrective action plan (CAP), which may include continued monitoring by the Plan to help ensure that adverse events do not continue or recur. The CAP will be documented in writing and may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.

This requirement will be documented in writing.

In addition, the QAPIC may recommend implementing formal sanctions, including termination from the Plan network if the offense is deemed an immediate threat to the well-being of Plan members.

The Plan reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the actions listed above.

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

Provider sanctioning policy

It is the goal of the Plan to ensure members receive quality health care services. In the event that medical or behavioral health services rendered to a member by a network provider represent a serious deviation from, or repeated noncompliance with, the Plan's quality standards, recognized treatment patterns of the organized medical community and/or standards established by the state, the network provider may be subject to the Plan's formal sanctioning process.

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Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

Formal sanctioning process

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

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with the Plan on the proposed action.
- Reminder that the practitioner/provider has 30 calendar days following receipt of notification within which to file an appeal through the provider sanctions appeals process.
- Notification that the practitioner/provider may waive their right to a hearing with the Plan and that the right will be considered waived if no written request for a hearing is submitted.

Notice of hearing

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

- The place, date, and time of the hearing, which will not be less than 30 days after the date of the notice
- That the provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the Plan Market Chief Medical Officer and/or upon advice of the AmeriHealth Caritas Legal Affairs department
- A list of witnesses (if any) expected to testify at the hearing on behalf of the Plan

Conduct of the hearing and notice

The hearing will be held before a panel of individuals appointed by the Plan (the Hearing Panel), as follows:

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions.
- The Hearing Panel will be composed of physician members of the Plan's quality-related committees; the Plan's Chief Medical Officer and/or designee; and other physicians and administrative persons affiliated with the Plan as deemed appropriate by the Plan Chief Medical Officer, such as legal counsel.
- The Plan's Chief Medical Officer or their designee serves as the Hearing Officer.
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

Provider hearing rights

The provider has the right to:

- Be represented by an attorney or other person of the provider's choice.

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

Appeal of the Plan decision

The provider may request an appeal after the final decision of the Plan. The practitioner/provider must submit a written appeal by certified mail or via another means providing evidence of receipt, within 30 days of the receipt of the Plan's decision; otherwise, the right to appeal is forfeited. Written appeal will be reviewed, and a decision rendered by the Plan's QAPIC within 45 days of receipt of the notice of the appeal.

Summary actions permitted

The following summary actions can be taken, without the need to conduct a hearing, by the Market President of the Plan or by the Plan's Chief Medical Officer:

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

Laboratory Services

If you are a participating provider, you may bill only for covered services that you or your staff perform. Participating provider offices may not submit claims for services they ordered but did not personally render. Billing of laboratory services performed by a contracted or noncontracted laboratory is not reimbursable to the nonrendering provider.

The Plan requires you to direct members to a participating outpatient laboratory provider for laboratory services and/or lab specimen testing, with the following exceptions:

- In an emergency
- As otherwise required by law

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We use many outpatient labs for Plan member diagnostics, including Quest Diagnostics and DrugScan. You can contact us for more information on other in-network lab providers or you can find them in our searchable online provider directory.

The searchable online provider directory can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug > searchable online provider directory.

Contact information for Provider Services can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Requesting laboratory services

When requesting laboratory services, fill out the laboratory requisition form completely, including the member's insurance information (member ID number, address, type of coverage, etc.), the tests you are ordering, the member's diagnosis, and the location where the reports are to be sent. This helps ensure that the claim from the laboratory will be processed properly and helps reduce member billing issues.

To find local drawing stations for participating laboratories, use the searchable online provider directory located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug.

Once on the Provider Search screen, change the location in the upper right portion of the screen to a city and state or ZIP code based on where the member would like to receive services, select the "Places by Type" search box, then enter the word "Lab" or "Laboratories" and select the link for "Laboratory Services." Search results for the locations in your area will be displayed.

Keep in mind the following:

- PCPs may obtain a specimen in the office or send a member to a drawing station.
- All members sent to a drawing station must be sent with the appropriate laboratory requisition form. The requesting office should complete the appropriate laboratory requisition form. These requisition forms permit multiple providers to receive results; the initiator must provide full names and addresses of the providers who should receive a duplicate copy.

Please note: If the member does not present the requisition form when their blood is drawn, the member will be billed by the drawing station.

Contractual obligation to use participating laboratory providers

Participating providers are required to refer members only to other participating providers for covered services. If a participating provider directs members to a nonparticipating laboratory for laboratory services and/or lab specimen testing and does not obtain prior authorization from the Plan, the ordering provider is required to hold the member harmless.

The ordering provider will be responsible for any and all costs to the member and must reimburse the member for any such costs paid by the member. In addition, further noncompliance may result in immediate termination of your Plan Provider Agreement.

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If a provider 1) refers a member to a nonparticipating laboratory for nonemergent services without obtaining prior authorization from the Plan to do so; 2) sends a member's lab specimen to a nonparticipating laboratory without prior authorization; or 3) provides or orders noncovered services for a member, the provider must inform the member in advance, in writing, of the following:

- The list of the services to be provided
- That the Plan will not pay for or be liable for the listed services
- That the member will be financially responsible for such services

However, the member is not required to agree to receive services from a nonparticipating laboratory (or any) provider.

Providers should also be aware of the coverage status of the tests they order and should notify the member in advance if a service is considered experimental/investigational or is otherwise not covered by the Plan.

Most Cost-Effective Setting Program

The Plan wants to see that our members receive infusion therapy drugs in the most appropriate and cost-effective setting consistent with their medical needs and conditions. The Plan reviews the most appropriate setting for our members to receive certain infusion therapy drugs as part of the prior authorization review process.

The settings that the Plan considers to be cost-effective are:

- An in-network provider office
- The member's home
- An in-network infusion center

Population Health

Overview

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

The Population Health program includes assessment, treatment, education, and other care planning, as well as service coordination. The Population Health program also incorporates health and wellness self-management education. All members in the Population Health program are screened for social determinants of health. The program is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management. The Population Health process also includes reassessing and adjusting the person-centered care plan and its goals as needed. The Population Health program uses evidence-based practice guidelines.

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The Plan's Population Health team includes nurses, licensed mental health and substance use disorder professionals, Care Connectors, clinical pharmacists, Plan medical directors, PCPs, specialists, members and caregivers, parents or guardians, and community agencies. This team works to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes. Our Population Health program applies to all Plan members.

Population Health Program components

Below are the core components to the Plan Population Health Program:

- Bright Start® (maternity management)
- Rapid Response Outreach Team (RROT)
- Complex Care Management (CCM) including disease management for adults and children
- Care Coordination
- Health and wellness activities

Bright Start® (maternity management)

Bright Start® is a multifaceted program designed to improve the health and experience of our Plan's pregnant members by early identification and stratification, care management based off prenatal care guidelines from the American College of Obstetricians and Gynecologists, and community partnerships. This program emphasizes the importance of prenatal and postpartum care while supporting the entire family and their educational and social determinants of health (SDOH) needs. Our nurse care managers serve as a member's single point of contact, assisting with education and support on complex health care needs, care coordination, and connection to obstetrical providers.

Our Bright Start® program provides prenatal education through multimodalities to promote maintenance of a healthy lifestyle during pregnancy and postpartum, including mailings, phone calls, and interactive pregnancy-related texting through a program called Keys to Your Care.

Encourage your patients to self-enroll

Enrollment of maternity members in our Bright Start® perinatal program is imperative for early outreach and improving health outcomes for moms and their infants. We ask that you inform Plan members about the program and encourage them to call the Rapid Response and Outreach Team directly to self-enroll. During this enrollment call, a Bright Start® Care Connector will explain the program to the member, explain their resources available, answer questions and provide useful information to help them prepare for pregnancy, delivery, and parenthood.

If during subsequent prenatal visits you discover that a maternity member has not yet self-enrolled in Bright Start®, practitioners can refer the member to the program by completing the Member Intervention Request Form. It can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program > Member Intervention Request Form.

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For any questions, the Rapid Response and Outreach Team's contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program.

Educational materials

Bright Start® materials focus on education. Once registered, mothers-to-be will receive a welcome letter and information on how to access educational materials and join our Keys to Your Care text reminder program.

Antenatal/antepartum care

Targeted questions screen pregnant women for risk factors associated with depression. Your office may receive calls regarding those members who screen positive or who are judged to be at risk during any other intervention. Obstetrical (OB) Nurse Care Managers will assist you with triage and referrals to the member's behavioral health provider or to emergency services as required.

The following antepartum services are available:

- Skilled nursing visits, which may include:
 - o 17-alpha hydroxyprogesterone caproate injections for women who have a history of preterm delivery
 - o Self-injection techniques for insulin, heparin, and others
 - o Home blood glucose, blood pressure, and urine monitoring
 - o Betamethasone injections (initial set only, repeat injections require medical director approval)
- Nutrition consults/evaluations
- Social service evaluations
- Durable medical equipment (DME)

Bright Start® postpartum services

Postpartum home skilled nursing visits are approved when medically necessary. These visits must be prior authorized and include:

- Wound/incision checks and wound care as needed
- Bilirubin checks and home phototherapy
- Infant assessments
- Blood pressure checks
- IV antibiotics
- Home physical therapy

Lactation support coverage

Lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum periods, is covered during an inpatient maternity stay as part of an inpatient admission and through the OB postpartum visit and/or pediatrician well-baby visit.

Breast pump coverage: Bright Start® associates are available to provide members initial breast-feeding support by telephone and can evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB provider).

Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network provider:

- Detained newborn
- Infants with feeding problems that interfere with breastfeeding (for example but not limited to cleft palate/cleft lip)

Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME provider with no member cost-sharing.

Prior authorization for home phototherapy

Prior authorization is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be prior authorized.

Rapid Response and Outreach Team (RROT)

This team is designed to address the needs of members in accessing needed health care by identifying and decreasing barriers to such care. The Rapid Response and Outreach Team also gives support to providers and their staff, providing assistance and follow-through for members experiencing barriers to their health care. This team performs three functions on behalf of Plan members and providers:

- Receiving inbound calls from members and providers
- Conducting outbound outreach activities
- Providing care coordination support

Physicians are encouraged to call the Rapid Response and Outreach Team if they believe a member would benefit from complex care management.

The Rapid Response and Outreach Team's contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program.

Complex Care Management (CCM)

Adults and children requiring Complex Care management can be referred to the CCM program by their practitioner. This program serves members identified as needing comprehensive and disease-specific assessments and reassessments, along with the development of member-centered prioritized goals that are

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incorporated into the member-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and the member's primary care provider (PCP) and/or supporting service providers when applicable with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed mental health or substance use disorder professionals.

Members in the Complex Care Management program are routinely screened for the following:

- All members receive a comprehensive initial assessment that meets National Committee for Quality Assurance (NCQA) requirements.
- Adolescents ages 11 through 17 and adult members age 18 and older receive a depression screening to assess for symptoms of depression. Based on the depression score, the member may be offered education and referred to the appropriate behavioral health services.
- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

The Rapid Response and Outreach Team's contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program.

Care Coordination

Triggered through ongoing data mining combined with in-person referrals, Care Coordination programs address members' health care needs while assessing for and addressing social needs and barriers while providing hands-on coordination.

Providers needing care management and/or care coordination for Plan members should contact the Rapid Response and Outreach Team.

Health and wellness activities

The Plan offers health and wellness education, prevention health reminders, and on-demand symptom counseling. Reminders for preventive health services and education for health promotion-related activities and other preventive health services, along with access to the health services to address needs as they arise. The Plan connects members with services from community-based organizations to augment covered services available under the health care benefit and to assist with social determinants of health issues. Access to community resources and programs occurs in a variety of ways:

- A community resource directory to search services available in the member's area, including resources for shelter, food, clothing, and utilities.
- Community events: Partner with community organizations to promote health-behavior learning opportunities, such as nutritional classes at local supermarkets, health screenings, and educational presentations.

In addition, the Plan offers all participants self-management tools that are derived from the most recent evidence-based medicine available to ensure relevancy, accuracy, and reliability of all health directives through StayWell, an NCQA-certified health and wellness products provider.

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These interactive resources allow members to enter specific personal information and provide immediate, individual results based on the information. These tools can assist in determining risk factors, providing guidance on health issues, recommending ways to improve health, and covering topics such as:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Program participation

Participation in Population Health programs are offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified upon Plan enrollment, for specific Population Health-related needs, through systematic risk stratification. The Plan systematically restratifies members on a quarterly basis. Members are also identified through material and telephonic outreach by the Plan. Members are encouraged to let the Plan know if they have a chronic health condition or special health need or if they are receiving on-going care. A new member assessment is included in the member's welcome packet to help identify current health conditions and health care services. Based upon their responses to the initial health assessment, members are identified for participation in the appropriate care management program.

"Let Us Know" Program

Providers are encouraged to refer members to the Population Health program as needs arise or are identified. If you recognize a member with a special, chronic, or complex health condition who may need the support of one of our programs, please contact the Rapid Response Outreach Team. Providers can also complete our Let Us Know Member Intervention Request Form and fax it to our Rapid Response Outreach Team for members who have missed appointments, may need transportation services, or may need further education on their treatment plan or chronic condition.

This form can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program > Member Intervention Request Form.

Members are also referred to the Population Health programs through internal Plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Infants receiving care in the NICU

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- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Members with polypharmacy use
- Pregnant members
- Members with high trauma exposure
- Members in need of long-term services and supports to avoid hospital or institutional admission

The Rapid Response and Outreach Team's contact information can be found at

www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program.

Integrating Behavioral and Physical Health Care

Members with mental health and substance use disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. The Plan understands that coordination of care for these members is imperative. To meet this need, the Plan has a fully integrated Medical Management department. Under this collaboration, the Plan's integrated platform will seamlessly coordinate member care across the physical and behavioral health and social service areas. Additionally, the Plan complies with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Plan staff will work with the involved primary care and behavioral health providers to develop an integrated plan of care for members in need of physical and behavioral health care coordination. Care Managers ensure that communication between the two disciplines, providers and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers work to coordinate with substance use disorder providers and community resources, with the appropriate member consent as needed. Care Managers will proactively and regularly follow up on required physical and behavioral health services, joint treatment planning, and provider-to-provider communication to continuously review and assess member needs and update care plans as warranted.

Person-centered plan of care

Through the Population Health program, the Plan works with practitioners, members, their natural supports, and outside agencies as appropriate to develop a person-centered plan of care for members with special or complex health care needs. Our methodology is to empower the member to take the lead in identifying and prioritizing their goals and interventions. The Plan's plan of care specifies mutually agreed upon goals, medically necessary physical and behavioral health services, any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The person-centered plan of care also takes into account the cultural values and any special communication needs of the member, family, and/or the child. Additionally, social determinants of health as identified by the member are addressed. Social determinants of

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health include factors such as socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to health care.

The Plan's care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and their family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

Through the Plan's Population Health program, the member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to see to it that members and their families (as clinically appropriate) are fully informed of all covered and noncovered treatment options, as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, all available treatment options should be presented to the member (regardless of whether the Plan provides coverage for those treatments), including the option to refuse treatment.

Member-centered plans of care for members with special health care needs are reviewed and updated at every contact; every 12 months, at a minimum; or as determined by the Member's PCP based on the PCP's assessment of the member's health and developmental needs. The revised plan of care is expected to be incorporated into the member's medical record following each update.

Coordinating care through transitions and discharge planning

One of the most important functions of a health plan is to assist in coordination of care during transitions. This includes but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab
- Changes in health status due to presentation of a new chronic, sometimes life-threatening condition
- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition
- Changes in a living situation to obtain more independence or because of a need for greater support
- Caregiver and family changes

During inpatient transitions, members are supported through the Population Health department. Members receive outreach calls soon after discharge. These calls are strategically placed to help ensure the member has the appropriate resources in place and that the member schedules and keeps a follow-up appointment with their provider.

Preventive health initiatives

The Population Health department offers population-based initiatives with the objective of improving patient health outcomes through adherence to nationally recommended preventive health guidelines. These initiatives use various member and provider reminders and tools to improve utilization of preventive health services.

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Preventive health outreach

We promote recommended preventive services and tests to targeted member populations. The objective of these population-based initiatives is to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. We may vary the topics and timing as new evidence-based recommendations are issued for preventive screenings and immunizations. We will identify missing preventive care services so that providers can address care gaps during office visits. Our outreach programs include:

- Breast, cervical, and colorectal cancer screening
- Pediatric, adolescent, and adult immunization
- Influenza and pneumococcal immunizations

Vaccine Information Statements (VIS)

A VIS is an information sheet produced by the Centers for Disease Control and Prevention (CDC), in compliance with the National Childhood Vaccine Injury Act of 1986, which requires that a VIS be used to inform vaccine recipients or their parents about the benefits and risks of vaccines. A VIS must be provided, prior to administration, for any vaccine that is covered under the Vaccine Injury Compensation Program. The following VIS forms must be used:

- DTaP
- Td
- MMR
- Polio
- Hepatitis B
- Hib
- Varicella
- Pneumococcal conjugate

Practitioners must also record which VIS was given, the date the VIS was given, and the VIS publication date.

For copies of VIS forms, visit the CDC website at [CDC Vaccines & Immunizations](https://www.cdc.gov/vaccines/imz/).

Lead screening and prevention

The CDC is focused on the prevention of lead exposure in children in order to eliminate dangerous lead sources in children's environments before they are exposed. They maintain that the effects of lead exposure in children cannot be corrected. Even low levels of lead in blood have been shown to affect learning disabilities and behavioral problems.

Through yearly outreach, providers are advised to try to prevent the occurrence of blood lead levels of 5µg/dL and above in children by:

- Testing children between ages 9 and 12 months, again prior to age 24 months, and thereafter based on risk, if children have not yet been tested

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- Screening children and their family members who have been exposed to high levels of lead or whose homes were built before 1978
- Screening children who should be tested under their state and local health screening plan

Cultural Competency and Responsiveness

Embedded in all Plan efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider networks.

Cultural competency terms and definitions

Providers should be aware of the following terms and their definitions:

Cultural competence

The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.

Culture

As defined by the CDC, refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Competence

As defined by the U.S. Department of Health and Human Services, implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deafness and hearing impaired, sexual orientation, homelessness, and geographic location.

Cultural responsiveness

The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Culturally and linguistically appropriate practices

Seek to advance health equity, improve the quality of health care, and reduce health care disparities by assessing, respecting, and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Individuals with Limited English Proficiency (LEP)

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

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Low Literacy Proficiency (LLP)

In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write, and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve their goals and develop their knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory impaired

A person who is hearing impaired or visually impaired.

Cultural and linguistic requirements

Plan providers are required to offer translation services to LEP member's needs upon request and to accommodate members with other sensory impairments. The Plan contracts with a competent telephonic interpreter service provider. If you need more information on using this telephonic interpreter service, please contact Provider Services. Health care providers who are unable to arrange for interpretation services for an LEP, LLP, or sensory impaired member should contact Member Services, and a representative will help locate a professional interpreter to communicate in the member's preferred language.

The Provider Services and Member Services department's contact information can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

When a member uses the Plan's interpretation services, the provider must sign, date, and complete documentation in the medical record in a timely manner to reflect the use of services.

Additionally, providers are strongly encouraged to follow the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services, Office of Minority Health:

Principle Standard

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

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Communication and Language Assistance

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Conduct ongoing assessments of the organization's CLAS related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or disputes.

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Additional tips to support members with LEP and other interpretation needs include:

- Establishing written policies to provide interpretive services for Plan members upon request.
- Routinely documenting preferred language or format, such as Braille, audio, or large type, in all member medical records.

Enhancing cultural competency in health care settings

The Plan encourages providers and their staff to report their race and ethnicity, the languages they speak, and the language services available through the practice. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

The provision of culturally appropriate care requires understanding of the social and cultural differences of the patient population served and the impact culturally appropriate care can have on patient satisfaction and adherence during a medical encounter. Cultural awareness and ongoing education are important when it comes to improving the quality of care, health outcomes, and addressing racial and ethnic disparities in culturally diverse patient populations.

Cultural competency training

Providers are also encouraged to complete the free eLearning cultural competency training offered by HHS Office of Minority Health titled “A Physician's Practical Guide to Culturally Competent Care.” This training offers up to nine CEUs and can be accessed by logging in at: cccm.thinkculturalhealth.hhs.gov.

For additional Cultural Competency resources and training, including CME offerings, please visit www.amerihealthcaritasnext.com > Pick Your State > For Providers > Provider Training.

Additional Resources

[National Institutes of Health: Clear Communication](#)

[The Health Literacy & Plain Language Resource Guide \(PDF\)](#),

[The Fenway Institute: The National LGBTQIA+ Health Education Center](#)

[Health Literacy Universal Precautions Toolkit](#)

[National Center for Cultural Competence](#)

Pharmacy

Overview

The Plan strives to provide members with high-quality and cost-effective drug coverage. AmeriHealth Caritas Next and First Choice Next administers the Plan prescription drug benefit. OptumRx, our pharmacy benefits manager and the Plans delegated entity, handles the claims processing of the Plan prescription drug benefit. As part of our commitment to comprehensive coverage, we offer a range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The AmeriHealth Caritas and First Choice Next Pharmacy and Therapeutics (P and T) Committee oversees our pharmacy policies and procedures and promotes the selection of clinically appropriate, safe, effective, and economically advantageous medications for our members. The P and T Committee objectively appraises, evaluates, and selects drugs and/or drug classes for the formulary; evaluates, analyzes, and reviews policies and procedures to ultimately educate and inform health care providers about drug products, usage, and

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committee decisions; and evaluates, analyzes, and reviews protocols and procedures for the use of, and access to, nonformulary drug products. The Committee is comprised of internal and external clinical pharmacists and physicians in a variety of specialties. The P&T Committee meets on no less than a quarterly basis to review and update the formulary. Before you prescribe drugs to members, we recommend that you review the member's Evidence of Coverage. In it you will find information about our prescription drug programs, formulary, and prior authorization process.

The Evidence of Coverage can be found at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Prescription drug guidelines

The Plan continuously monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures support safe prescribing patterns for our prescription drug programs, such as step therapy, age limits, quantity limits, and prior authorization.

Prescription drug programs

Members with the Plan prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the member's health benefit plan. The formulary is reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the Health Insurance Marketplace. As a result, the formulary is updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

For details about each program, please refer to the members Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Specialty drug services

Some medications are considered specialty drugs and must be obtained at a specialty pharmacy. The Plan provides specialty drug services through a variety of designated in-network specialty pharmacies. These pharmacies specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services and education for members. For a complete list of participating specialty pharmacies, please use the Online Pharmacy Locator located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug > Online Pharmacy Locator.

Medications may be added to our specialty drug program from time to time. Our in-network specialty pharmacies can dispense up to a 30-day supply of medication at one time, and the supply is delivered via mail to either the member's home or their provider's office in certain cases. Although this program supplies medication to the member via mail delivery, this is NOT part of the pharmacy mail-order plan benefit. Extended-day supplies and copayment savings do not apply to designated specialty drugs.

Participating providers can request fulfillment of specialty pharmacy drugs through any network Specialty pharmacy. Specialty pharmacies supply specialty drugs eligible under the Plan's member's prescription drug benefit by processing claims through OptumRx.

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Benefits of using Specialty pharmacies include refill reminders, ongoing patient education and support, consultation with pharmacists for providers and members, and confidential and convenient ordering and delivery.

Participating pharmacy network

Members should take their member ID card to a pharmacy that participates in the OptumRx network. Many retail pharmacies in the U.S. are part of this network, including large chains and independently owned pharmacies. When members are traveling in the U.S., participating pharmacies will accept member ID cards and dispense medications based on the member's pharmacy benefits.

For a complete list of pharmacies, please visit the Online Pharmacy Locator located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug > Online Pharmacy Locator.

Retail pharmacy, Mail-order pharmacy and Specialty pharmacy

Providers can use our Online Pharmacy Locator for all in network pharmacy needs whether a member needs a local pharmacy, a pharmacy when they are traveling, a pharmacy to mail their prescriptions to their home, or a specialty pharmacy.

The Online Pharmacy Locator can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug > Online Pharmacy Locator.

Drug formulary information

Look-up tools, including a printable formulary document, searchable drug list, and formulary guides are available to help members and practitioners understand their specific drug program, drug restrictions and formulary. The formulary is occasionally subject to change. If a change negatively affects a medication the members is taking, we will provide written notice to the member before the change takes effect. We will work with the member and their prescriber to transition to another covered medication if the member is on a long-term prescription.

For the most up-to-date formulary information, please visit www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug.

Self-injectable drugs

Most self-injectable drugs are covered under the pharmacy benefit. However, injectables that cannot be administered without medical supervision, that are required by law to be covered as a medical benefit, or that are required for emergency treatment, will continue to be covered under the medical benefit at the appropriate level of cost-sharing.

Preventive medications

Please refer to the members Evidence of Coverage for a list of some preventive medications may be covered at no cost for members. The Evidence of Coverage can be found at www.amerhealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Pharmacy prior authorization

Prior authorization requirements

We require prior authorization of certain covered FDA-approved drugs for specific medical conditions. The approval criteria were developed and approved by the P and T Committee and are based on information from the FDA, manufacturers, medical literature, actively practicing consultant physicians, and pharmacists.

Using criteria approved by the P and T Committee, The Plan pharmacy prior authorization department evaluates requests for these drugs based on clinical data and information submitted by the prescriber and available prescription drug history. Clinical pharmacist reviews will include contraindications, dosing and length of therapy appropriateness, and evaluation of other clinical options previously used.

If the request is not approved, the drug will not be covered for your patient, and they will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the appropriate level of cost-sharing according to their benefit.

For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, please visit www.amerhealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug.

When submitting requests, it is important to complete all prior authorization forms and to promptly respond to outreach efforts when there is missing information.

Please note: The list of drugs requiring prior authorization is subject to change. Changes to the list will be published as the need arises.

The Plan's pharmacy prior authorization department reviews prior authorizations for drugs on the formulary that require prior authorization.

Pharmacy prior authorization procedure

For pharmacy-related services, participating providers can request prior authorization by:

- Submitting an electronic prior authorization (ePA) through your electronic health record (EHR) tool software.
- Submitting through either of the following online portals:
 - [CoverMyMeds](#)
 - [Surescripts](#)

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- Submitting a secure electronic prior authorization request via the pharmacy prior authorization function in NaviNet. Through a single sign-on to NaviNet, you can access the Pharmacy Prior Authorization portal to check on real-time status of pharmacy prior authorization requests and obtain news and announcements about pharmacy-related items (formulary updates, criteria updates, etc.).
- Faxing a completed Pharmacy Prior Authorization Form:
 - For medical pharmacy drug prior authorization requests (buy-and-bill), please complete the printable Healthcare Common Procedure Coding System (HCPCS) Authorization Form.
 - For all other pharmacy prior authorization requests, please complete the printable Pharmacy Prior Authorization Request Form.
- Calling the Pharmacy Clinical Prior Authorization department for verbal authorization requests, Monday through Friday, 8 a.m. to 6 p.m. ET.

Both the Healthcare Common Procedure Coding System (HCPCS) Authorization Form and the Pharmacy Prior Authorization Request Form can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

For pharmacy prior authorizations after business hours, weekends, and holidays, please call the 24/7 Pharmacy General Assistance number.

The Pharmacy's contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Appealing a decision

If a request for prior authorization or exception results in a denial, the member, or the provider on the member's behalf (with the member's consent), may file an appeal within 180 days of receiving the denial. Both the member and the requesting provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that the provider be involved to provide any additional information on the basis of the appeal. For more information about appeals, please see Member Grievances and Appeals section of this Provider Manual.

Expiration of prior authorization

Prior authorizations will include an expiration date at the time of the approval when applicable. If your patient needs to continue the drug therapy after the expiration date, you will need to submit a new request.

Plan Quality Management

Overview

We consider our relationship with our network providers a partnership because we share a common goal in improving the quality of care our members receive. Our role is to assist providers in providing care to our members, and to provide the tools and information they need to maintain a high standard of care. Our Quality Management (QM) department was developed according to this mission.

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QM program goals and objectives

The overall goal of the QM program is to improve the health outcomes, quality, and safety of physical behavioral health care, and services provided to members by establishing a comprehensive quality management structure and program that:

- Improves access to care and quality of services provided to members
- Reduces health care disparities
- Addresses medical, behavioral, psychosocial functional, and unmet resource needs of the membership
- Ensures member satisfaction with services
- Reviews utilization trends, and establishes expectations and thresholds
- Efficiently collects, analyzes, and reports data
- Implements strategies to manage risk

The objectives of the QM program are to systematically develop, monitor, assess, and take action to improve access to care, quality and appropriateness of care, and quality of services for all members, including those with special health care needs through the following mechanisms and activities:

- Maximizing utilization of collected information about the quality of clinical care, physical and behavioral health outcomes and service, and identifying clinical and service improvement initiatives for targeted interventions
- Validating adequate physical health, behavioral health, and delegated service practitioner and provider availability, accessibility, and diversity to effectively serve the membership
- Maintaining timely and thorough credentialing/recredentialing processes so that the health plan's network is comprised of qualified practitioners
- Overseeing the provision of quality services by delegated entities providing services on behalf of the Plan
- Communicating priorities and performance status to participating practitioners through provider profiling and information dissemination:
 - Coordinating services between various settings and levels of care, network practitioners, and community resources to enable continuity of care and promote optimal physical, psychosocial (healthy opportunities/SDOH), and functional wellness and address unmet resource needs
 - Designing and implementing programs to coordinate care and maximize health outcomes for members with complex and/or special health needs
 - Optimizing utilization management so that care rendered is based on established clinical criteria and clinical practice guidelines, and complies with contractual, regulatory, and accrediting agency standards
 - Employing assessments and interventions to identify and correct over-, under- and misutilization of member benefits and services

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- o Utilizing results from member and practitioner/provider satisfaction measures when identifying and prioritizing quality activities
- o Implementing and evaluating local, regional, and national programs and community partnerships to effectively address chronic illnesses affecting the membership
- o Designing and implementing outreach and health education activities that lead to healthy lifestyles
- o Maintaining compliance with evolving NCQA accreditation standards
- o Communicating results of clinical, physical, behavioral, and service measures and quality initiatives to practitioners, providers, and members
- o Identifying and implementing activities that promote member safety in the least-restrictive environment
- o Documenting and reporting monitoring activities (internal and delegated) to appropriate committees
- o Analyzing data, including SDOH, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to members
- o Facilitating the delivery of culturally competent health care to reduce health care disparities and inequities
- o Coordinating care and transitions of care for members who receive multiple services, whose benefits end, and during transitions from pediatric to adult care
- o Evaluating the effectiveness of the QM program

QM program activities

Through our QM program, we monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to members by participating practitioners/providers. We identify meaningful clinical and service issues that are likely to impact enrolled members and establish performance indicators, goals, and benchmarks that correspond to topics falling within the scope of the QM program.

The mechanisms used to identify meaningful clinical and service issues include, but are not limited to:

- The results of analysis of demographics, claims, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions.
- The results of data from internal performance-monitoring activities and satisfaction survey results.
- Data from disputes and appeals and direct input from members, providers, and Plan staff.

Through ongoing review of performance data* with respect to established goals, benchmarks, and formal annual evaluations of the effectiveness of the QM program, the Plan confirms that existing clinical quality, network, and service improvement initiatives remain appropriate and identifies new topics for inclusion in the program.

**Providers must allow the Plan to use performance data in plan QM programs for internal purposes only.*

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Member safety activities

The QM department is responsible for coordinating activities and programs designed to improve processes and systems that promote member safety. Initiatives focus on promoting member knowledge about medications, home safety, and hospital safety. Activities may include, but are not limited to, the following:

- Create member newsletter articles that improve knowledge about clinical safety, and facilitate informed decisions based on safety at least biannually.
- Use community service programs to raise awareness regarding member safety.
- Assess members for potential safety issues during screenings using concurrent review and care management teams.
- Review appeals/grievances and satisfaction data, as well as potential quality of care cases, to identify systems issues that may contribute to inadequate member safety.
- Use proactive follow-up systems to facilitate timely care for complex care management and disease management programs.
- Address discrepancies between clinical performance and practice guidelines.
- Improve continuity and coordination of care between practitioners or sites of care to avoid miscommunication or delays in care that can lead to poor outcomes.
- Track adverse-event reporting to identify systems issues that contribute to inadequate safety.

Member grievance process

The QM department investigates all quality-of-care and service grievances. All quality-of-care and service grievances are triaged, categorized, analyzed, and reported on a semi-annual basis. Recommendations are used for provider improvement activities. Grievances are also reviewed from a quarterly, as well as a rolling year, perspective for identification, and analysis of potential provider outliers. An outlier is defined as a practitioner, facility, ancillary provider, or pharmacy provider against whom there are three or more grievances or a grievance that is assigned a severity level of two or higher. Members may file a grievance by calling Member Services at the number listed on their ID card, by sending their grievance in writing.

For information regarding Member Grievances, please refer to the member's Evidence of Coverage. The Evidence of Coverage can be located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Monitoring of continuity and coordination of care

The Plan annually monitors and takes action, as necessary, to improve continuity and coordination of care between care settings across the health care network for all populations served. The Plan uses information at its disposal to facilitate continuity and coordination of medical and behavioral health care across its delivery system. Opportunities for improvement are identified, and interventions are implemented to improve coordination of care across these different settings.

Continuity and coordination of care services is the facilitation, across transitions and settings of care, to facilitate:

- Patients getting the care or services they need

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- Providers getting the information they need to provide the care patients need

Transitions in care refers to members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include movement of members between practitioners (e.g., primary care and specialists, behavioral health practitioner, and primary care), and movement across settings of care (e.g., hospital to skilled nursing facility).

Our goal is for members to receive seamless, continuous, and appropriate care. On an annual basis, we collect data about the coordination of care across settings or transitions in care. Data is also collected related to the coordination between medical and behavioral health care. A quantitative and causal analysis of data is conducted to facilitate the identification of improvement opportunities. Based on the results of the analysis, we identify opportunities to improve continuity and/or coordination of care and implement appropriate initiatives to address opportunities for improvement.

Examples of different settings include:

- Outpatient facilities — rehabilitation centers, physician offices, surgery centers, urgent care centers, emergency centers, home health, and hospice
- Inpatient facilities — hospitals (acute or rehab), skilled nursing facilities, extended care facilities, and inpatient hospice

Open lines of communication between medical and behavioral health providers are critical to the effective management of a member's clinical care. Examples of the type of data collected to improve coordination of care and promote collaboration between medical and behavioral health care include:

- Exchange of information
- Appropriate diagnosis, treatment, and referral (when required) of behavioral health disorders commonly seen in primary care
- Appropriate use of psychopharmacological medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders, including members with severe or persistent mental illness
- Primary and secondary preventive behavioral health programs

Examples of the type of data collected to promote the identification of improvement opportunities and facilitate the design and implementation of improvement initiatives include:

- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications

The QM department works with the Plan's Population Health department to monitor the coordination of the care of members when they move from one setting to another, such as when they are discharged from a hospital. Without coordination, such transitions often result in poor quality care and risks to patient safety.

Practitioner Credentialing and Recredentialing

Practitioners requiring credentialing and recredentialing include, but may not be limited to, the list below:

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- Advanced Practice Registered Nurse (APRN)
- Advanced Practice Nurse (APN)
- Board-Certified Behavioral Analyst (BCBA)/Board-Certified Assistant Behavioral Analyst (BCaBA)
- Certified Nurse Midwife (CNM)
- Certified Nurse Practitioner (CNP)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Doctor of Audiology (AuD)
- Doctor of Chiropractic (DC)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Psychology (PsyD)
- Independently Practicing Licensed Psychologist
- Licensed Addiction Counselor (LAC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Professional Counselor (LCPC)
- Medical Doctor (MD)
- Doctor of Optometry (OD) who provides care under the medical benefit
- Physician Assistant (PA)
- Registered Dietician (RD)

Practitioners who do not need to be credentialed include the following:

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in freestanding facilities and provide care for organization members only because members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens).
- Locum tenens practitioners who do not have an independent relationship with the organization are outside the National Committee for Quality Assurance's scope of credentialing.

- Practitioners who do not provide care for members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Council for Affordable Quality Healthcare (CAQH) and online credentialing

The Plan works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a universal provider data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, practitioners submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. There is no charge to practitioners to participate and to submit CAQH applications. Practitioners not already enrolled are able to register for CAQH at www.caqh.org.

We strongly encourage each practitioner to participate with CAQH. Each practitioner must give approval for the Plan to pull the credentialing application from CAQH. Through CAQH, each practitioner determines what entity is eligible to receive their credentialing information.

Practitioners who have elected “universal” status need not do anything in order for the Plan to receive their information. If you do not have broad distribution permissions, please select AmeriHealth Caritas Next or First Choice Next for us to receive your application.

Practitioners participating with CAQH or those who wish to participate with CAQH:

- Register for CAQH at www.caqh.org.
- Grant authorization to your Account Executive to view your information for AmeriHealth Caritas Next and/or First Choice Next via the CAQH website www.caqh.org.

Individual practitioner application

For individual practitioners who choose not to enroll in CAQH, the application process requires submission of a completed application. The application must include evidence, such as copies of diplomas, licenses, insurance riders, and documentation of privileges. Contact your Account Executive for more information on credentialing.

Individual practitioner credentialing and recredentialing

The following criteria must be met, as applicable, in order to evaluate a qualified health care practitioner:

- Current, active, unrestrictive medical licensure, not subject to probation, proctoring requirements, or disciplinary action to specialty. A copy of the license must be submitted along with the application.
- Current, active, unrestrictive Drug Enforcement Administration (DEA) license, if applicable. (DEA licenses are not transferrable by location and must contain the address where the practitioner is treating Plan members.)

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- Evidence of professional liability insurance with limits of liability commensurate with state requirements
- Individual NPI Number
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
 - The National Practitioner Data Bank (NPDB)
 - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
 - Federation of Chiropractic Licensing Boards (CIN-BAD)
 - System for Award Management (SAM)/Excluded Parties List System (EPLS)
 - Social Security Death Master File (SSDMF)
 - Any other relevant state sanction and licensure databases as applicable
- Proof of the provider's medical school graduation, completion of residency, and other postgraduate training
- ECFMG Certificate for foreign medical school graduates
- Evidence of specialty board certification, if applicable
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the practitioner in the past five years
- Work history containing current employment over the past years, as well as explanation of any gaps in work history.
- Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable
- Explanation to any affirmative answers to the disclosure questions on the application
- Practitioners who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with the Plan. PCPs must have the ability to admit Plan members as part of their hospital privileges. As an alternative, those practitioners who do not have hospital privileges may enter into an admitting arrangement agreement with a participating practitioner who is able to admit.

All practitioners are recredentialed a minimum of every 36 months. All items noted above under Credentialing, with the exception of education and work history, are also required at the time of recredentialed.

All applications and attestation/release forms must be signed and dated within 120 days prior to the Credentialing Committee or Medical Director Approval date. Additionally, all supporting documents must be current at the time of the decision date.

As part of the initial and recredentialed application process for individual practitioners, the Plan will:

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- Request information on practitioner and provider sanctions prior to making a credentialing or recredentialing decision. Information from the National Practitioner Data Bank (NPDB), HHS Office of Inspector General (Medicaid/Medicare exclusions), System for Award management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Social Security Death Master File (SSDMF), and Excluded Parties List System (EPLS) will be reviewed as applicable.
- Perform primary source verification on required items submitted with the application as required by NCQA, state, and federal regulatory bodies.
- Conduct a performance review of grievances, quality of care issues, and utilization issues at the time of recredentialing.
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing.
- Safeguard all credentialing and recredentialing documents by storing them in a secure location, only accessed by authorized Plan employees.
- Make outreach attempts to applicants via phone or email regarding information missing from the application packet. The credentialing process is halted until all information is received.

Presentation to the Medical Director or Credentialing Committee

Upon receipt of a complete application and completion of primary source verifications, the file of the individual practitioner applying for initial credentialing or recredentialing is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All nonroutine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

The Plan will notify applicants of its recommendation in accordance with state and federal regulations. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (except for NPDB reports and peer references).

Professional provider organization and facility application process

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

- Ambulatory surgery center (ASC)
- Community-based intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Community mental health (CMH) center/CMH program/CMH provider
- Comprehensive outpatient rehabilitation facility (CORF)
- Dialysis center
- Durable medical equipment (DME)/medical supplies

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- Federally qualified health center (FQHC)/rural health center (RHC) for behavioral health care only
- Freestanding radiology center
- Home health agency/home health hospice
- Hospice
- Hospital
- Portable X-ray suppliers/imaging center
- Psychiatric hospital
- Psychiatric residential treatment facility (PRTF)
- Rehabilitative agency
- Residential care facility
- Residential substance use disorder (SUD) treatment program
- School-based wellness center
- Screening center
- Skilled nursing facility (SNF)
- Sleep center/sleep lab

Contact your Account Executive for credentialing documents or call Provider Services. The Provider Services department contact information can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Credentialing/recredentialing for facility and professional provider organizations

The Plan verifies credentialing and recredentialing criteria for all facility and professional provider organizations. Recredentialing occurs at least every 36 months. Facility and professional provider organization providers must meet the following criteria:

- Complete the facility application with the signature and current date from the appropriate facility officer.
- Attest to the accuracy and completeness of the information submitted to the Plan.
- Documentation of any history of disciplinary actions, loss or limitation of license, or loss, limitation, or cancellation of professional liability insurance.
- Have a current, active, unrestrictive facility licensure that is not subject to probation, suspension, or other disciplinary action limits.
- The Plan will confirm that the facility is in good standing with all state and regulatory bodies and has been reviewed by an accredited body as applicable.

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- Current accreditation with a Plan-recognized accrediting body, if applicable. If not accredited, a CMS state survey is required. If the provider does not have either accreditation or a CMS state survey, a plan site visit must be conducted.
- Evidence of professional liability insurance with limits of liability commensurate with state requirements
- Group NPI number
- Satisfactory review of any quality issues, sanctions, and/or exclusions imposed on the provider and documented in the following sources:
 - The National Provider Data Bank (NPDB)
 - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
 - System for Award Management (SAM)
 - Excluded Parties List System (EPLS)
 - Any other relevant state sanction and licensure databases as applicable.

Delegated credentialing

It is the Quality Assurance and Performance Improvement (QAPI) team's responsibility to oversee delegated activities. The Plan delegates credentialing to entities with more than 100 providers. Prior to joining into a delegation agreement, a predelegation audit is completed. The Plan will review policies and procedures, files, and Credentialing Committee minutes to determine compliance. Annual audits are completed once we have a signed contract. Monthly rosters are submitted by the delegate for new or terminated providers. Semiannual full rosters are submitted by the delegate as required by NCQA.

Adding a new service or site

Facility providers who are adding a new service must complete Part II of the initial credentialing application and submit it with required attachments to the attention of their designated Account Executive. The Account Executive will notify the provider if a site visit is necessary. Facility providers who are adding a new site must submit an application and supporting documentation to Credentialing for that new site to be credentialed.

Presentation to the Medical Director or Credentialing Committee

Upon receipt of a complete application and completion of primary source verifications, the provider's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All nonroutine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

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The Plan will notify applicants of its recommendation in accordance with state and federal regulations. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Recredentialing involves periodic review and reverification of credentials of network providers. The credentialing database houses all provider information and a report is run to ensure each provider organization, facility, and practitioner is recredentialed at a minimum of every 36 months. As part of this process, the Plan periodically reviews provider information from the following databases:

- National Provider Data Bank (NPDB)
- The Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Medicaid and Medicare Exclusions System for Award Management (SAM)
- Excluded Parties List (EPLS)

Providers are required to disclose, at the time of discovery, any criminal convictions of staff members related to the delivery of health care or services. Information must also be reported at the time of application for or renewal of network participation (credentialing and recredentialing). Providers are also obligated to provide such information to the Plan at any time upon request.

The recredentialing process includes an up-to-date re-examination of all materials.

Practitioner credentialing rights

The criteria, verification methodology, and processes used by the Plan are designed to credential and recredential practitioners and providers in a nondiscriminatory manner, regardless of race, ethnic/national identity, gender, age, sexual orientation, specialty, or procedures performed.

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

- Review the information submitted to support their credentialing application, except for recommendations, and peer-protected information obtained by the Plan.
- If the Credentialing department identifies information that materially differs from what the practitioner submitted, the practitioner will be notified and given 10 business days to submit corrections. Corrections may be submitted by email, fax, phone, or by calling Provider Services. Receipt of corrected information will be documented in the practitioner's credentialing file.
- Be informed, upon request, of the status of their credentialing or recredentialing application. The Provider Services department will share all information with the provider except for references, recommendations, or peer-review protected information (e.g., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Provider Services Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.

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- Be notified within 30 calendar days of the Credentialing Committee or Medical Director review decision.
- Appeal any recredentialing denial within 30 calendar days of receiving written notification of the decision.
- Upon written request from the health care professional to the Provider Services department, all credentialing application and primary source verification policies and procedures will be made available for review.

To request or provide any of the above, the practitioner should contact the Plan Provider Services department. The Provider Services department contact information can be found in the Provider Reference Guide located at www.amerihhealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Site visits resulting from receipt of a grievance and/or ongoing monitoring

- The Provider Network Management department may identify the need for a site visit due to receipt of a member grievance regarding the provider's office environment.
- At the discretion of the Plan, a site visit may occur to address the specific issue(s) raised by a member. Follow-up site visits are conducted as necessary.
- For on-site reviews occurring due to a member grievance, the on-site review must demonstrate that the practitioner meets the Plan's quality, privacy, and record keeping standards.
- If the Plan standards are not met, the Account Executive, in conjunction with the office representative, develops an individualized written corrective action plan (CAP) with the practitioner's office to ensure that the area of concern is addressed. The representative from the practitioner's office reviews and indicates acceptance by signing and dating the CAP.

Follow-up procedure for initial deficiencies

- The Provider Network Account Executive must submit the signed corrective action plan (CAP) to the Plan within one week of the visit.
- Each follow-up contact and visit is documented in the provider's electronic file.
- The Provider Network Account Executive schedules a re-evaluation visit with the provider office within 30 days of the initial site visit to review the site and verify that the deficiencies identified in the CAP were corrected.
- The Provider Network Account Executive reviews the results of the follow-up visit (including a re-review of previous deficiencies) with the office contact person.
- If the site meets and/or exceeds Plan standards, a Site Visit Evaluation form is signed and dated by both the Provider Network Account Executive and the office. This indicates successful completion of the CAP.
- If the site does not meet Plan standards, the Provider Network Account Executive follows the procedure outlined below for Follow-up procedure for continued or secondary deficiencies, below.

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Follow-up procedure for continued or secondary deficiencies

- The Provider Network Account Executive will re-evaluate the site monthly, up to three times (from the first site visit date).
- If, after four months, there is evidence that the deficiency is not being corrected or completed, the office will receive a failing score unless there are extenuating circumstances.
- Continued failure to correct identified deficiencies addressed in the CAP will result in appropriate disciplinary action, including and up to termination of the provider's participation in the network.

Provider termination

Providers must make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to members who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

Provider termination with cause

We may terminate the Professional Provider Agreement immediately upon notice to the provider in accordance with the Agreement for cause including, but not limited to:

- Provider's violation of any applicable law, rule, or regulation
- Provider's exclusion from participating in Medicaid and/or Medicare programs
- Provider's failure to meet and maintain our credentialing requirements including, but not limited to, maintaining the requisite professional liability insurance coverage
- Provider action that, in our reasonable judgment, constitutes gross misconduct
- Provider's action that we determine places the health, safety, or welfare of any member in jeopardy
- Repeated violation of the provider's nondiscrimination obligations arising under the Agreement
- Closure or cessation of the provider's practice
- Any actions by the provider seeking bankruptcy or insolvency protection

We will not sanction, terminate, or fail to renew a provider's participation for any of the following reasons:

- Discussing the process that we, or any entity contracting with us, use or propose to use to deny payment for a health care service
- Advocating for medically necessary and appropriate care with or on behalf of members, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests
- Discussing our decision to deny payment for a health care service
- Filing a grievance on behalf of, and with the written consent of, a member or helping a member file a grievance

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- Any reason that is otherwise prohibited by federal and state law

Participating Provider Office Standards

Use of Artificial Intelligence – Guidelines for Providers

Responsible Use of Artificial Intelligence

Artificial Intelligence (“AI”) is any technology that can simulate human intelligence and includes, without limitation, machine learning, natural language processing, deep learning, and generative AI. Providers may use AI tools, as appropriate, to improve efficiency and quality in the performance of health care services for their patients, including for routine and repeatable tasks such as research, document summarization, charting, and similar activities. All use of AI tools must be responsible, secure, and consistent with all applicable federal and state legal and contractual requirements, ethical rules, professional standards, and these guidelines.

Restrictions

Providers **shall not** use AI voice generators, chatbots, or similar voice technologies to communicate with AmeriHealth Caritas Next or First Choice Next. The prohibition includes communications for all administrative tasks and, for the avoidance of doubt, includes communications related to prior authorization, concurrent authorization, eligibility verification, claims disputes and other billing inquiries. As a result of this prohibition, any communications made with the use of AI will not be considered valid for purposes of calculating Provider’s metrics.

Providers **shall not** use AI as the decision maker for any outcome that leads to a negative impact for a Plan member. A qualified medical professional must be the ‘human-in-the-loop’ for any such decision. A negative impact includes denials (full or partial), reductions, modifications, or delays in service and can stem from things like appeals, utilization management, and prior authorization reviews.

Providers **shall not** use AmeriHealth Caritas Next or First Choice Next confidential information as inputs to AI tools unless expressly authorized in writing by the Plan’s Legal department. Plan information may not be used to train, fine-tune, or improve any AI model without prior written authorization from the Plan.

Transparency and Review

Provider shall maintain documentation relating to its use of AI and provide such information to the Plan or appropriate State or Federal regulatory agencies and Plan members as may be necessary for compliance by the Plan with applicable State or Federal law or other applicable agreements with AmeriHealth Caritas Next or First Choice Next’s government clients.

Responsibility for Services

Providers are responsible for implementing mechanisms and safeguards consistent with the degree and nature of the risks posed by AI to ensure all applicable laws and regulations are followed, including ongoing (human or otherwise) monitoring and, when appropriate, human intervention.

Provider remains fully responsible for all treatment, services, diagnostics, etc. regardless of whether AI tools are used.

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Access and availability standards

The Quality Management (QM) department, in collaboration with Provider Network Management, establishes an annual access and availability plan to address the sufficiency of the Plan's provider network in number, type, and geographic location of practitioners who practice primary and specialty care, in accordance with relevant regulatory and accreditation standards. The cultural needs of the Plan members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Provider Network Management department.

Through the QHP Member Experience survey, the QM Program also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Access standards for PCPs and specialists are as follows:

Appointment availability

PCPs

- Emergent/Immediate — 24 hours per day, seven days per week
- Urgent — One business day
- Routine and Regular (Well or Preventive) Care — 15 business days

Specialists/chiropractors/podiatrists

- Emergent/Immediate — Members should call **911** or go to the nearest emergency room.
- Urgent — One business day
- Routine — 30 business days
- OB/GYN Routine — 30 business days

Mental health providers (nonmedication prescribers and medication prescribers)

- Emergency — Within 15 minutes of presentation at a service delivery site
- Urgent, non-emergency — Within one hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or the contractor
- Non-Life-Threatening Emergency — Within six hours
- Routine Mental Health Services (In Follow-Up to Intake Assessment and Upon Determination) — Twenty-one (21) calendar days of the request for an appointment
- Initial Visit for Routine Care — 10 business days

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Availability

Coverage must be provided 24 hours per day, seven days per week, for our members. The covering practitioner must be a participating provider. Providers who use answering machines for after-hours service are required to include:

- Urgent/emergent instructions as the first point of instruction
- Information on contacting a covering provider
- Telephone number for after-hours provider access

After-hours phone response

For an urgent/emergent problem, provider should respond within 30 minutes. Auto-response messages should direct callers with emergent needs to dial **911** or go to their nearest emergency room.

Participating behavioral health providers must use an answering service that will answer all calls and forward member to a provider on-call or instruct the member to go to a crisis center or have an answering service that directs the member to call the Suicide and Crisis Lifeline at 988 at all times when the office is closed 100% of the time.

Member Rights and Responsibilities

Member rights

A member has the right to:

- Receive information about the health plan, its benefits, services, included or excluded, from coverage policies, and network providers' and members' rights and responsibilities. Written and web-based information provided to the member must be readable and easily understood.
- Be treated with respect and be recognized for their dignity and right to privacy.
- Participate in decision-making with providers about their health care. This right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.
- Make recommendations about our member rights and responsibilities policies by contacting Member Services.
- Choose providers, within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information; the member also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.

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- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; immigration status; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic or any other category protected by federal, state, or local laws).
- Formulate advance directives. The Plan will provide information concerning advance directives to members and providers and will support members through our medical record-keeping policies.
- Obtain a current directory of network providers, on request. The directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a grievance or an appeal about the health plan or care provided with the applicable regulatory agency and receive an answer from the health benefit plan to those grievances and appeals within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. The member also has the right to know that their provider cannot be penalized for filing a grievance or appeal on the member's behalf.
- Members with chronic disabilities have the right to obtain help and referrals to providers who are experienced in treating their disabilities.
- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms that the member understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the member's medical record. The Plan does not direct providers to restrict information regarding treatment options.
- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency medical conditions.
- Call **911** in a potentially life-threatening situation without prior approval from the Plan, and to have the Plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the Plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.

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- Receive prompt notification of terminations or changes in benefits, services, or the provider network.
- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member responsibilities

A member has the responsibility to:

- Communicate, to the extent possible, information that the Plan and network providers need to care for them.
- Follow the plans and instructions for care that they have agreed on with their providers; this responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand their health problems and participate in developing mutually agreed-on treatment goals to the degree possible.
- Review all benefits and membership materials carefully and follow health plan rules.
- Ask questions to ensure understanding of the provided explanations and instructions.
- Treat others with the same respect and courtesy they expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

Medical Record Requirements

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

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the rendering of covered services to the member.

Providers are required to make medical records accessible to all appropriate government agencies, including but not limited to the state's Department of Insurance and their respective designees for the purpose of quality assurance, investigation of grievances, enforcement, or other activities related to compliance with applicable laws.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Each provider furnishing services to members is required to maintain and share, with other PCPs, specialists, and behavioral health providers, as appropriate, a member health record in accordance with professional standards and state and federal law.
- Elements in the medical record are organized in a consistent manner, and the records must be kept secure.
- Patient's first and last name and identification number are on each page of record.

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- All entries specify location, date, and times of service provision, and are legible.
- Identification of the type of service being provided.
- All entries are initialed or signed by the author, including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical examination are documented, including serious accidents, operations, and illnesses.
- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking and history of alcohol use and substance use (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient’s chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action and treatment are consistent with the diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service are noted.
- Health care education provided to patients, family members, or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan’s Preventive Health Guidelines.
- Member’s response to staff interventions is noted.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.

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- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers
- The time frame for documentation completion is identified.
- Process to ensure units of service billed for payment are based on services provided, with substantiating documentation.
- A provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

Medical Record Audits and Requests

The Plan conducts medical record reviews to capture HEDIS® data not obtained through claims submission, and for other reasons. Medical records may be audited year-round. This effort is part of health plan operations and within plan expectations for participating providers. Record requests will be made in writing, with at least five business days' advance notice for records requested for on-site audits.

The QM department will conduct random quality reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality reviews will be forwarded to the certifying or accrediting entity.

A quality review could include, but is not limited to, interviews with the member and the member's parents or legal guardian, designated case manager, and/or provider staff. A review of case files, staff personnel records, compliance with provider standards with state and federal code, and organizational policies and procedures and documentation.