

Provider Manual

# Contents

[INTRODUCTION: Welcome to Total Senior Care 3](#_bookmark0)

[What Is Total Senior Care? 4](#_bookmark1)

[Health Insurance Portability and Accountability Act (HIPAA) 5](#_bookmark2)

[Care Management in Total Senior Care 5](#_bookmark3)

[Individual Assessment of Needs and Development of Care Plans 6](#_bookmark4)

[Enrollment and Assessment](#_bookmark5) 7

[Voluntary](#_bookmark6) Disenrollment 8

[Involuntary Disenrollment 8](#_TOC_250000)

[Total Senior Care Member Card 9](#_bookmark7)

[Covered Services 10](#_bookmark8)

[PACE Center Services 10](#_bookmark9)

[Outpatient Medical Services 10](#_bookmark10)

[Hospital Inpatient and Emergency Services 11](#_bookmark11)

[Nursing Home Care 12](#_bookmark12)

[Home Care Services: 12](#_bookmark13)

[Other Services 12](#_bookmark14)

[Exclusions and Limitations 14](#_bookmark15)

[Emergency and Urgent Care 15](#_bookmark16)

[Urgently Needed Care 15](#_bookmark17)

[Participant Rights, Grievances and Appeals 16](#_bookmark18)

[Participant Rights 16](#_bookmark19)

[Grievance and Appeals 17](#_bookmark20)

[The Grievance Process 17](#_bookmark21)

[The Appeal Process](#_bookmark22) 18

[Denial of Appeals 18](#_bookmark23)

[Quality Initiatives 18](#_bookmark24)

[AUTHORITY AND RESPONSIBILITY 19](#_bookmark25)

[SCOPE 19](#_bookmark26)

[Quality Improvement Process: 20](#_bookmark27)

[CREDENTIALING 21](#_bookmark28)

[H](#_bookmark29)[ospitals 21](#_bookmark28)

[Nursing Facilities 22](#_bookmark30)

[Physicians 23](#_bookmark31)

[Other Providers of Care (Home Care Agencies, Transportation Providers,](#_bookmark32)

[Providers of Specific Services such as Durable Medical Equipment) 24](#_bookmark32)

[Changes in Provider Status 24](#_bookmark33)

[Claims and Service Authorization](#_bookmark34) 25

[Provider Relations](#_bookmark35) 26

[Appendices… 26](#_bookmark36)

Appendix A 27

Appendix B 29

## INTRODUCTION: Welcome to Total Senior Care

This Provider Manual is a guide to Total Senior Care, a new model of health care for seniors in Cattaraugus County, Allegany County, and Chautauqua County. The program’s model is known as PACE – Program of All Inclusive Care for the Elderly.

Total Senior Care is a coordinated, comprehensive managed healthcare program that is designed to meet the needs of its participants, including medical care, pharmacy coverage, hospital and LTC services, and services to keep participants healthy and living securely in the community. PACE is an authorized choice for Medicare and Medicaid covered seniors.

Total Senior Care operates under an agreement with the Centers for Medicare and Medicaid Services, and New York State Department of Health. It is also a New York State certified managed care organization.

This manual contains information for all Total Senior Care providers and will serve as a guide on your participation with Total Senior Care. In the event information contained in this manual differs from your provider agreement, your provider agreement takes precedence. As updates and changes to this provider manual are necessary, the changes will become effective sixty (60) days following publication of the changes.

Please review this Provider Manual carefully. If you would like more information on anything covered in this manual, please contact us at: (716)379-8474 or (866)939-8613.

Locations and Regular business hours are**:**

PACE Center:

519 North Union Street, Olean, NY 14760 / Monday – Friday, 8:30 a.m. – 4:30 p.m.

Alternative Care Sites:

1 School St., Suite 100, Gowanda, NY 14070 / Monday - Friday, 8:30 a.m. – 3:30p.m.

194 N. Main St., Wellsville, NY 14895 / Monday - Friday, 8:30 a.m. – 3:30 p.m.

358 E. 5th St., Jamestown, NY 14701 / Monday – Friday, 8:30 a.m. – 3:30 p.m.

**TTY/TTD** (800) 662-1220 (866)939-8613 **TTY/TTD** (800) 662-1220

If after regular hours contact is required for arranging for health care, including emergency service, our contact number is the same: (716)379-8474 or (866)939-8613.

We encourage you and your staff to become familiar with the content of the Provider Manual and place it where it will be a useful resource.

Thank you for choosing to be a valuable part of the Total Senior Care network of providers. We welcome you and look forward to serving you.

Sincerely,

Carol L. Mahoney President and CEO

# What Is Total Senior Care?

Total Senior Care is a Program of All-inclusive Care for the Elderly (PACE) that includes medical care, nursing, social services, rehabilitation therapies, prescription and over-the- counter drugs, and other support services. The program was developed specifically for older adults who are eligible for nursing home care but wish to live at home for as long as possible. In Total Senior Care, our staff works closely together as a team to provide a range of services to meet the needs of the whole person. The program provides care in the participant’s home, the PACE Center, physician offices, hospitals, and nursing homes. Total Senior Care is designed to provide each participant with the very best possible care and to coordinate care among all providers.

We encourage our participants to take an active part in their own health care, and we offer comprehensive care that is easy-to-access in their home and community. Once they enroll in Total Senior Care, all medically necessary services are provided and paid for by the program. The PACE team develops a plan of care that outlines the services they receive. The participant frequently sees their care team members so that it is possible to promptly address aspects to changing conditions or needs. Participants usually see their care team at the PACE Center which is a health center and community center designed specifically for this program.

Total Senior Care is for individuals who need long term care services and would like to receive these services at home and in the community for as long as possible. At the time a participant enrolls in Total Senior Care, they must be:

* At least 55 years old and live in the Total Senior Care service area of Cattaraugus County, Allegany County, or Chautauqua County.
* Be a recipient of Medicaid and/or Medicare, or willing to pay privately to be in the program.
* Considered by a clinical assessment to be eligible for nursing home care but be able and choose to remain safely at home with assistance from Total Senior Care.
* Expected to need the long-term care services of the plan for at least 120 days.

# Health Insurance Portability and Accountability Act (HIPAA)

Total Senior Care strives to ensure that all its business and the business of its participating providers is conducted in a manner that safeguards patient /participant information in accordance with regulations enacted by the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA regulations allow the transfer or sharing of a participant’s “Protected Health Information” (PHI) when requested by Total Senior Care to maintain the participant’s medical record, transact business and make decisions. Examples that can contain such protected health information and be included in communication between a provider and Total Senior Care would include: updating a participant’s demographic information, providing service authorization, or resolving a payment dispute. Such communications are considered part of the HIPAA definition of Treatment, Payment or Health care Operations (TPO).

Total Senior Care information systems and administrative policy and procedures are designed to ensure protected health information is managed in a secure and confidential manner.

# Care Management in Total Senior Care

Total Senior Care management process is designed to comprehensively provide or arrange for all that the participant needs to be able to remain healthy and secure in the community, instead of an alternate long-term care situation. Care management includes all the services covered by Medicaid and/or Medicare, and whatever is medically necessary, but often provided or arranged for in a different way than a provider may be accustomed to. Care is managed collaboratively via Total Senior Care’s interdisciplinary team. Each participant’s physical, social, emotional and related care needs are assessed and subsequently reviewed in a team setting where a highly individualized and dynamic plan of care is developed and periodically updated on a routine schedule and as otherwise needed. This plan addresses identified and emerging needs and is the basis for authorization of appropriate and required services.

Potential services include all the services that a participant is eligible for through Medicare and/or Medicaid, plus additional services to help participants. They are provided at the PACE Center, in a participant’s home, and at network provider locations in the community. Many routine services come from the participant’s Care Team who are located at the PACE Center and include primary medical care, nursing, rehabilitation therapies (physical, occupational and speech therapy), social work, and nutrition.

The services from Total Senior Care are based on an individual Plan of Care for each participant.

The plan is updated periodically, based on the Care Team’s regular assessment of each participant‘s

health needs.

The PACE primary care physician is a key member of the Care Team. The primary care physician will see the participant frequently to make sure that both chronic illnesses and acute illnesses are being addressed. In cooperation with other participants of the Care Team, the physician will write medical orders as required for the services in the care plan. The primary care physician also oversees referrals to other medical and healthcare providers, as well as other services such as home care and any admission to the hospital.

All Care Team members work closely together to ensure that participants receive the services as described in the Care Plan. If needs change, the Team assesses the changing needs and modifies the Care Plan as necessary.

Attendance at the PACE center helps us make sure that participants remain as healthy and strong as possible. The participant is included in the care planning process and the Care Team will work with each participant to arrange a schedule for regularly attending the Center, based on each participant’s needs and preferences. Attendance at the day center is not required.

Total Senior Care uses a network of community providers to deliver all the services received in our program. These include, but are not limited to: home care, hospital care, nursing home care, medications and medical specialists. A participant receives all services covered by Total Senior Care from providers in the network. The Total Senior Care Team becomes the link for a participant to these services by providing authorizations, making appointments, providing transportation and consultation upon service or findings from evaluation and tests or procedures. In an emergency, participants are permitted to see a provider who is not in the Total Senior Care provider network.

# Individual Assessment of Needs and Development of Care Plans

Initial assessment of needs is performed prior to enrollment by the primary care physician, registered nurse, social worker, physical and occupational therapist, home care RN, registered dietician, and the recreation therapist. They make use of assessment instruments to identify health problems and deficiencies and propose goals and interventions.

The comprehensive assessment that will result from the individual discipline evaluations includes:

* Physical and cognitive function and ability (this includes all sensory and motor functions)
* Medication use
* Participant and caregiver preferences for care
* Socialization and availability of family support
* Current health status and treatment needs
* Nutritional status
* Home environment, including home access and egress
* Participant behavior
* Psychosocial status
* Medical and dental status
* Participant language

Once assessments are completed, the interdisciplinary care team uses the information to prepare a comprehensive interdisciplinary care plan. On a longitudinal basis, when issues and concerns arise, the Care Plan is reviewed and revised as needed. Interim problems are added to the Care Plan as identified, along with goals and interventions for those problems. As interventions are successful and problems are eliminated or revised, the problem is closed or revised on the Care Plan to reflect the change, and interventions will also be revised accordingly.

The interdisciplinary Care Team conducts a periodic re-assessment and revises the comprehensive care plan at the following intervals:

* No less than every 6 months, including an annual assessment
* At such time as the team has identified a significant change in the participant’s condition
* At the request of the participant or the participant’s caregiver.

# Enrollment and Assessment

A potential participant, or on their behalf, a family member or caregiver can learn about Total Senior Care in many ways. Total Senior Care makes itself known widely as a healthcare choice for seniors in Cattaraugus County, Allegany County, and Chautauqua County to service organizations, inquiry and referral outlets for seniors, county offices involved in senior services, Total Senior Care affiliates and others. Physicians and other health care providers are also an important source of information for potential enrollees. Total Senior Care encourages physicians, their office staff and other provider organizations to inform seniors about the potential valuable service Total Senior Care may provide. Total Senior Care staff can be contacted to provide more information about the program.

An individual or provider (including a prospective member/family that self-refers) may inquire by phone or in person about the program and its services, prior to making a formal referral. Referrals may also be received from the local Department of Social Services for individuals who may be appropriate for the PACE program.

To be eligible an individual must meet all the following criteria:

* Age 55 or older
* Resident of Cattaraugus County, Allegany County, and Chautauqua County.
* Eligible for Medicaid and/or Medicare, or willing and able to pay the portion of the PACE premium that is not covered by the participant’s insurance
* Assessed during the PACE enrollment process and determined to be eligible for nursing facility level of care
* In need of the long-term care services of the plan for at least 120 days
* Able to live safely in the community with the services of the plan.

All enrollments are voluntary, and all prospective enrollees will sign an enrollment agreement as the confirmation of intent to enroll.

At the time of receiving a referral, the Total Senior Care Intake staff provides a description of the program to the prospective enrollee (or the person making a referral on their behalf). As part of the initial interview, the criteria for enrolling in PACE will be discussed and the individual’s likely ability to be eligible for enrollment and will be explored. This will include confirmation about: age, residence in the PACE service area and in a community setting, and eligibility for Medicaid and Medicare and/or the ability and willingness to pay out-of-pocket for a portion of the premium. The discussion will also explore types of assistance the individual needs and how those needs are currently being addressed.

In addition to the individual discipline assessments and care plan development described earlier, an enrollment agreement is completed with the individual. Upon determination of clinical eligibility and financial eligibility, enrollment in Total Senior Care becomes effective on the first of the month following approval to enroll.

# Voluntary Disenrollment

Total Senior Care values its participants and desires to satisfy the concerns or problems of each participant regarding all services received through Total Senior Care. Total Senior Care staff, including the participant’s care team, will work to resolve concerns.

Participants may choose to voluntarily disenroll. When a voluntary disenrollment decision occurs, a participant may either verbally request disenrollment or complete a Disenrollment Form, which will indicate that upon the effective date of disenrollment, they are no longer covered or entitled to services through Total Senior Care. If an individual wishes to continue to receive home and community long term care services under Medicaid he/she will be referred back to New York Medicaid Choice in order to enroll in another New York State Medicaid Managed Long Term Care Plan.

Voluntary disenrollment can also occur if a participant enrolls in any other Medicare or Medicaid prepayment plan (such as another managed care organization or a Medicare Advantage Plan or a Medicare Prescription Drug Plan) or an optional Medicare benefit, including the Medicare hospice benefit.

Until disenrollment takes effect, a participant is still required to continue to use Total Senior Care services. In most cases, the date of a disenrollment is midnight at the end of the last day of the month in which the disenrollment is processed by New York Medicaid Choice. However, if in certain circumstances due to the date when the disenrollment request was made, the disenrollment of an individual with Medicaid may not take effect until the last day of the following month. Participants always receive written notification of the date of their disenrollment, and whenever there is a question about enrollment status, providers can verify coverage by contacting Total Senior Care at: (716)379-8474 or (866)-939-8613.

# Involuntary Disenrollment

Total Senior Care must involuntarily disenroll a participant if:

* The participant moves out of the Total Senior Care service area.
* The participant leaves the Total Senior Care service area for more than 30 days without receiving approval from Total Senior Care.
* At the time of the participant‘s annual re-assessment, the participant ‘s health has improved to the point that assessments demonstrate he/she no longer appears to be at risk for nursing home care and the participant is not deemed nursing home eligible. In this instance, enrollment is discontinued only if it is determined that, in the absence of PACE services, the participant would not be expected to meet the nursing home level of care within six months.

Total Senior Care may also involuntarily disenroll a participant if:

* The participant, a participant of their household or a caregiver jeopardizes the health and safety of the participant, or the health and safety of others, including members of the Total Senior Care team and network.
* The participant, a family member or a caregiver jeopardizes the participant’s health and safety by consistently not complying with or interfering with the care plan or the requirements of the participant’s enrollment agreement.
* The participant fails to pay or make efforts to pay Total Senior Care any amount due for more than 30 days after this amount is to be paid. In such a circumstance, Total Senior Care would only seek disenrollment after the program makes a reasonable effort with the participant to collect the amount.

Finally, an involuntarily disenrollment cannot occur unless there is concurrence by the local Department of Social Services and New York Medicaid Choice.

# Total Senior Care Member Card

Each participant in Total Senior Care is provided with a Total Senior Care enrollment card. If the participant is unable to present the card, please call Total Senior Care at: 716-379-8474 or 1-800-939- 8613 to confirm eligibility. A facsimile of the member card appears below:

Total Senior Care Membership Identification Card





# Covered Services

Total Senior Care includes all the services the participant would receive through Medicaid and/or Medicare, plus any other services that are determined medically necessary. The participant’s care team works to arrange all services described in the Care Plan or are otherwise needed.

Total Senior Care uses a network of community providers to deliver the entire range of services to participants. These include but are not limited to home care, hospital care, nursing home care, medications and medical specialists. Participants are supplied with a directory of the Total Senior Care network providers before joining the program. In addition to the referral and authorization steps indicated above that are performed by the primary care physician, the Total Senior Care Team members will arrange the specific appointments, transportation and advance information on the reason for the visit to the referral provider.

The list of covered services includes:

### PACE Center Services

* Team-based approach to Care Management
* Primary Care Medical Services
* Nursing services
* Social Work services
* Nutritional counseling
* Spiritual or pastoral counseling
* Preventive services (annual flu shots, screenings, and vaccinations as needed)
* Rehabilitation therapies (Physical, Occupational, and Speech Therapy)
* Foot care (podiatry)
* Eye care (optometry) and eyeglasses
* Recreational Therapy
* Personal care and supportive services
* Educational and recreational activities
* Congregate meals
* Arrangements for medical equipment and supplies
* Respiratory therapy and oxygen
* Round trip transportation to the Total Senior Care Center

### 

### Outpatient Medical Services

* Medical specialty services
* Dental care
* Mental health services
* Alcohol and substance abuse services
* Eye care including eye exams, low-vision care, and glasses
* Foot care
* Hearing exams and hearing aids
* Prosthetics and orthotics
* Medications
* X-Rays, lab services, and other diagnostic services
* Renal dialysis

### Hospital Inpatient and Emergency Services

* Semi-private room and board\*
* General medical and nursing services
* Private duty nursing, if medically necessary
* Medical, surgical, intensive care, and coronary care unit services
* Laboratory tests, x-rays, and other diagnostic procedures
* Drugs and biologicals
* Blood and blood derivatives
* Medical supplies
* Surgical care, including the use of anesthesia
* Physical, speech, occupational and respiratory therapies
* Prosthetics and orthotics
* Medical social services and discharge planning
* Ambulance and emergency room services
* Psychiatric, alcohol, and substance abuse services
* Spiritual or pastoral counseling

\*Please note that hospital services do not include a private room, private duty nursing, or non-medical items (including telephone, radio, or television rental) unless they are medically necessary**.** Private room or private duty nursing will be provided at no charge only based on medical necessity when the participant’s condition requires it.

### Nursing Home Care

* Semi-private room and board\*
* Physician and nursing services
* Personal care and supportive services
* Drugs and biologicals
* Physical, speech, and occupational therapies
* Medical social services
* Medical supplies and appliances
* Respiratory therapy and oxygen
* Spiritual or pastoral counseling

### Home Care Services:

* Nursing services
* Rehabilitation therapies
* Physical therapy (PT)
* Occupational therapy (OT)
* Speech therapy (ST)
* Respiratory therapy and oxygen
* Medical social services
* Spiritual or pastoral counseling
* Personal care and home health aide services
* Homemaker and chore services
* Nutritional services and home-delivered meals
* Durable medical equipment
* Medical supplies
* Personal Emergency Response System (PERS)
* Environmental supports, such as home safety modifications

### Other Services

* Prescription medications and over-the-counter drugs
* Transportation to all health appointments

\*Please note that nursing home care does not include a private room, private duty nursing, or non-medical items (including telephone, radio, or television rental) unless they are medically necessary**.** Private room or private duty nursing will be provided at no charge only based on medical necessity when the participant’s condition requires it.

Prescriptions are provided at a pharmacy in the Total Senior Care network that is identified by the participant’s prescription card from Total Senior Care.

As a comprehensive program for frail seniors, services by the program and its network providers can occur in several settings. The following table indicates where the services might occur, and also whether authorization from Total Senior Care is required:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **PACE CENTER** | **HOSPITAL** | **OUT- PATIENT** | **NURSING HOME** | **HOME** | **Follows Care Plan or**  **Requires Authorization** |
| Care management by Interdisciplinary Team |  |  |  |  |  | Care Plan |
| Primary Care |  |  |  |  |  | Care Plan |
| Medical care from specialists |  |  |  |  |  | **Authorization** |
| Nursing services |  |  |  |  |  | Care Plan |
| Social work services |  |  |  |  |  | Care Plan |
| Nutritional counseling |  |  |  |  |  | Care Plan |
| Rehabilitative therapies (physical, occupational, and speech therapy) |  |  |  |  |  | Care Plan |
| Respiratory therapy and oxygen |  |  |  |  |  | **Authorization** |
| Medical equipment |  |  |  |  |  | **Authorization** |
| Medical supplies |  |  |  |  |  | **Authorization** |
| Recreational therapy, educational activities, social activities |  |  |  |  |  | Care Plan |
| Personal care services |  |  |  |  |  | Care Plan |
| Meals |  |  |  |  |  | Care Plan |
| Chore/housekeeping services |  |  |  |  |  | **Authorization** |
| Round-trip transportation by ambulette or ambulance, as needed |  |  |  |  |  | Care Plan |
| Dental Care |  |  |  |  |  | **Authorization** |
| Eye care, including low-vision care, eyeglasses, etc. |  |  |  |  |  | **Authorization** |
| Podiatry |  |  |  |  |  | **Authorization** |
| Audiology/Hearing aids |  |  |  |  |  | **Authorization** |
| Prosthetics and Orthotics |  |  |  |  |  | **Authorization** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE** | **PACE CENTER** | **HOSPITAL** | **OUT- PATIENT** | **NURSING HOME** | **HOME** | **Follows Care Plan or**  **Requires Authorization** |
| Mental health services |  |  |  |  |  | **Authorization** |
| Alcohol/substance abuse services |  |  |  |  |  | **Authorization** |
| Hospital Inpatient services (including semi-private room\*, board, surgical services, all related supplies and equipment) |  |  |  |  |  | **Authorization (unless emergency services)** |
| Lab tests, x-rays, and diagnostic procedures |  |  |  |  |  | **Authorization** |
| Prescription and non- prescription drugs |  |  |  |  |  | Care Plan |
| Environmental supports and home modifications |  |  |  |  |  | Care Plan |
| Personal emergency response system (PERS) |  |  |  |  |  | Care Plan |
| Nursing home care (including semi-private room\*, board, and all related supplies, equipment, and services) |  |  |  |  |  | **Authorization** |

# Exclusions and Limitations

Total Senior Care does not pay for any services that are not authorized by the Care Team, even if it is an included service, unless it is an emergency or Total Senior Care fails to respond to an authorization request within one hour of being contacted. Participants may be liable for the cost of services not authorized by Total Senior Care.

Also, Total Senior Care does **NOT** pay the following services:

1. Inpatient facility private room and/or private duty nursing services (unless medically necessary).
2. Non-medical items for personal convenience in a hospital or nursing home such as telephone charges and radio and television rental (unless specifically authorized by the Care Team as part of the plan of care).
3. Cosmetic surgery, except for surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury. Reconstruction following mastectomy may be paid for by Total Senior Care.
4. Experimental medical, surgical or other health procedures.
5. Services furnished outside of the United States and all its territories, except in limited emergency circumstances.

# Emergency and Urgent Care

Participants are educated and informed that if they believe a problem is an emergency, to call “911” or get help from the Total Senior Care Team or go to the closest hospital or emergency room right away. If there is an emergency medical condition, contact with Total Senior Care is not necessary nor is an authorization before getting care. Further, in an emergency, the provider need not be a member of the provider network. Participants and their families are urged, though, to contact Total Senior Care as soon as possible.

An emergency medical condition is a health problem that happens suddenly or very rapidly, including a sudden illness or injury. To be considered an emergency, the problem will include pain or other symptoms that are so severe that an average person – that is, someone like a Total Senior Care participant without special knowledge of health or medicine – would believe that there would be serious consequences if s/he did not get immediate medical assistance. These consequences could include serious jeopardy to his/her health, damage to his/her bodily functions or organs, or serious disfigurement. (The official New York State definition of an emergency medical condition appears in the footnote below.)1

# Urgently Needed Care

Total Senior Care provides urgently needed services and care to stabilize a participant’s condition following an emergency, or when an unforeseen illness, injury, or condition occurs. Fevers, abdominal pain, nausea and vomiting and difficulties urinating are examples of situations that require Urgently Needed Services. Urgent care means services to treat these kinds of symptoms and their underlying cause, and to prevent a serious change or deterioration into the participant’s health condition due to an illness or injury.

Total Senior Care will also pay for the cost of urgently needed care that occurs when the participant is temporarily away from the Total Senior Care service area and the services cannot be delayed until return. In this instance, the participant must call their Care Team to coordinate and authorize services.

Please note that Total Senior Care does NOT pay for medical care outside of the United States, except in a few circumstances. (For this purpose, the United States includes all 50 states, U.S. territories and the District of Colombia.)

1 An emergency medical condition is a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part of such person; or 4) serious disfigurement of such person.

# Participant Rights, Grievances and Appeals

### Participant Rights

Total Senior Care sets the health, safety and well-being of its participants as the main concern. Participants have certain rights that Total Senior Care makes every effort to ensure. As a provider, you are expected to be aware of these rights, which include the right to:

* Be treated with respect. This is exemplified by the participant being treated with dignity and respect at all times, to have all of information about care kept private, and to get compassionate, considerate care.
* Expect their health care to be received in a safe, clean environment.
* Be free from harm. This includes physical or mental abuse, neglect, physical punishment, use of any physical or chemical restraint that is used for discipline or convenience of staff and that is not needed to treat medical symptoms or to prevent injury.
* Be encouraged to use their rights while enrolled in Total Senior Care.
* Get help, if needed, by using the Medicare and Medicaid complaint and appeal processes, and civil and other legal rights.
* Be encouraged and helped in talking to the program’s staff about changes in policy and

services that should be made.

* Use a telephone while attending the Total Senior Care Center.
* Not have to do work or services for the Total Senior Care program.
* Be protected against discrimination. Discrimination cannot occur based on a participant’s race ethnicity or national origin, religion, age, gender, sexual orientation, mental or physical abilities, and/or source of payment for care.
* Information and assistance. This includes the right to get accurate, easy-to-understand information and to have someone help make informed health care decisions. This also is demonstrated by receiving help to understand the information that is given to a participant where there is a language or communication barrier.
* Have Total Senior Care interpret the information into a participant’s preferred language in a culturally competent manner, if their first language is not English and cannot speak English well enough to understand the information being given.
* Get marketing materials and information about rights as an enrollee in English and in any other frequently used language in the community being served.
* Get a written copy of a participant’s rights from Total Senior Care.
* Be fully informed, in writing, of the services offered by the program.
* A choice of providers within the Network. Women have the right to obtain services from a qualified women’s health care specialist for routine or preventive women’s health care services.
* Access emergency services.
* Participate in treatment decisions.
* Have all treatment options explained in a way that the participant understands, to be fully informed of their health status, and to make health care decisions.
* Have the Total Senior Care staff help the participant create advance directives.
* Participate in making and carrying out the plan of care.
* Be given advance notice, in writing, of any plan to move the participant to another treatment setting and the reason for the change.
* Have health information kept private.
* File a complaint and to receive a full explanation of the complaint process.
* Appeal any treatment decision by the Total Senior Care program, staff, or contractors.
* Leave the program at any time and for any reason if the participant believes that Total Senior Care is no longer the program option for them.
* Have Rights when receiving care from a provider in the Network.

### Grievance and Appeals

A grievance is any complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care that is furnished to the participant by staff or one of the program’s network providers. If a participant expresses dissatisfaction about care or services received as a Total Senior Care participant to a provider, whether or not the source of complaint is the provider, the provider is expected to encourage the participant to voice their grievance verbally or in writing to Total Senior Care. Any Total Senior Care staff person may receive a grievance.

### The Grievance Process

As noted, participant may file a grievance orally or in writing with Total Senior Care. The staff person who receives the grievance will record it, and a staff member will be assigned to oversee the review of the grievance. A written copy of the grievance process is provided to participants at the time the grievance is received. In many cases, a grievance can be resolved at the time the concern is expressed. All grievances will be resolved within thirty (30) days from the time they are received by the program. Total Senior Care sends out a notice when the grievance is resolved. Provider network members will be expected to cooperate with the investigation of any participant’s dissatisfaction that may involve the provider.

### The Appeal Process

Whenever a participant disagrees with the Program’s decision to limit the types of services or amount of care, they may request that the program reconsider its decision by filing an appeal. An appeal can be filed in one of the following types of situations when the participant disagrees with the program’s decision:

* If Total Senior Care denies or limits services requested by a participant or a participant’s

provider;

* If Total Senior Care denies a participant’s request for a referral to a specialist;
* If Total Senior Care reduces, suspends, or terminates a service and the participant believes that there is still a need for this type and/or frequency of service, or
* If Total Senior Care denies payment for a service that a participant received.

An appeal with the plan may be made verbally or in writing using the phone number, fax number or address provided herein. An appeal must be filed within 45 calendar days of the date of the initial decision.

If the participant believes that their life, health, or ability to maintain or regain maximum function could be seriously jeopardized without the disputed health service, the participant should notify Total Senior Care at the time of the appeal. In these instances, Total Senior Care will review the appeal more rapidly, and will respond with the program’s decision within 72 hours of the time the appeal is received. If there is a need to extend the timeframe for making this decision, and additional time can be justified to the NYS Department of Health that the extension would be in the best interest of the participant. In this situation, the timeframe for resolving an expedited appeal can be extended for up to 14 days.

### Denial of Appeals

If the appeal outcome is not totally in favor, there is an ability to request an external appeal for a new and impartial review conducted by an organization that is independent of Total Senior Care. When the participant has both Medicare and Medicaid coverage, a choice can be made as to which appeal process to follow, but they cannot be used at the same time.

If there is neither Medicaid nor Medicare coverage, the participant may complain to the New York State Department of Health.

A Medicaid covered person may request a Medicaid Fair Hearing from the New York Medicaid program within 60 days of the date the appeal decision notice is sent.

If the participant is enrolled in Medicare only, and completed the Total Senior Care internal appeal process, the Medicare external appeal process may be used. Total Senior Care will provide the appeal forms and assist with an appeal to the Medicare Designated Review Agent.

# Quality Initiatives

The goal of the Total Senior Care Quality Assurance/Performance Improvement program is to ensure an effective review mechanism for evaluating, maintaining and improving the quality and appropriateness of services provided by Total Senior Care to its participants through Quality Assessment and Performance Improvement (QAPI) activities and utilization review. Contract providers are expected to be aware that Total Senior Care conducts QAPI activities and to participate in such activities as appropriate. Objectives for the Quality Assurance / Performance Improvement program are to: ensure participant satisfaction; positive participant outcomes; and appropriate/efficient service utilization.

The Plan objectives summarize these goals:

1. To assess and improve the quality of services delivered to members.
2. To assess and improve the effectiveness and efficiency of services in meeting member needs.
3. To identify and correct significant unfavorable trends.
4. To recommend and follow up on plans of action that will lead to improvement.

# AUTHORITY AND RESPONSIBILITY:

The Board of Directors of the Total Senior Care Program has the full legal authority and responsibility for the quality assessment and performance improvement program. The Program Officer and Medical Director have overall responsibility for design and implementation of the QAPI and annual work plan and oversight. They report to the Total Senior Care Board of Directors. The Quality Improvement Manager works in concert with the Program Officer and the Medical Director.

### SCOPE:

Performance improvement opportunities are identified through the analysis of data and trends and in response to Federal and State mandates. Other mechanisms to identify opportunities for improvement include:

* Recognition of themes across departments, committees, disciplines and other areas;
* Examination of sentinel events; a sentinel event is defined as “an unexpected occurrence that caused a participant death or serious physical or psychological injury that included permanent loss of function.” Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.
* Tracking and trending of outcome measures identified in the annual work plan;
* Response to published innovative approaches to care and services;
* Response to staff recommendations;
* Response to Participant Advisory Committee recommendations.

Priority setting for performance improvement initiatives supports the Total Senior Care mission, vision, and values and is based on the following criteria:

* Clinical outcomes for participant health\*
* Outcomes and issues related to participant safety\*
* Consumer satisfaction (participant and caregivers)
* Feasibility
* Relevance to clinical and/or the strategic initiatives of the organization.
* Likelihood that the initiative will have a positive impact
* Ability to provide support and resources to multiple initiatives
* Standards for management of access to an continuity and quality of care
* Utilization and cost of services
* Sentinel events related to participant health and/or safety requires immediate root cause analysis in order to correct the problem and prevent recurrence for this or other participants in similar situations. Identified issues that threaten the health and/or safety of a participant must be addressed immediately in an effort to remove the threat.

The QAPI Plan consists of short- and long-term monitoring of clinical practice improvement, quality control of specific areas, and ongoing measurement. The performance improvement methodology allows for design of new services and redesign of existing services. Leadership and staff receive basic education in performance improvement in orientation and through continuing education.

The process of identifying opportunities and setting priorities occurs annually as part of the review of the QAPI Plan and creation of the annual work plan. This includes problems in health care administration and delivery to participants. Members of the management team and PACE Quality Management and Utilization Management (QM/UM) Committee identify areas for improvement, based on data collected and using the criteria listed above. The Committee then prioritizes the initiatives. In setting priorities, the committee considers issues that have been demonstrated to be high volume, high risk and problem prone. Issues that fit these criteria and will have the most impact on participants and staff performance will be given the highest priority.

A copy of the QAPI Plan and the annual work plan are disseminated annually to staff and network providers as part of the annual staff in-service. Total Senior Care participants are also informed, through the Participant Advisory Council, that this information if available to them upon request.

### Quality Improvement Process:

The Total Senior Care quality improvement process is a problem-solving mode which finds a process to improve, organizes a team that knows the process, clarifies the current knowledge related to the process, uncovers root causes, and selects interventions to improve the process. The improvement cycle includes planning the improvement, collecting baseline data, implementation of interventions, measurement of the results of the interventions and analysis of outcomes, resulting in continuous improvement of the process.

The timeliness of follow-up is dependent upon the following:

* + Severity of the problem
  + Frequency of occurrence
  + Impact of the problem on participant outcome

Total Senior Care has adopted the **P**lan-**D**o-**S**tudy-**A**ct (**PDSA**) model for performance improvement.

* + - **P**lan
    - **D**o
    - **Study**
    - **A**ct
* **F**ind a process to improve
* **O**rganize to improve it
* **C**larify knowledge
* **U**nderstand variation
* **S**elect an improvement
* Pilot the improvement
* Evaluate the pilot
* Standardize the improvement or start over
* Develop and implement mechanisms for sustaining the improvement with appropriate measurement

# CREDENTIALING

Total Senior Care contracts with hospitals, nursing homes, home care agencies physicians, and other professional health care services. Total Senior Care will verify professional credential information from material supplied by a provider who wishes to join the network of providers, public sources, and independent reference sources, notably for physicians, utilizing affiliated hospital departments as available. The Total Senior Care Board of Directors receives the credentialing report from the Contracts Manager/Network Specialist Liaison and approves the provider network. The following specific provisions apply to major categories of network providers.

Effective January 1, 2018, Federal law requires that all Medicaid Managed Care and Children´s Health Insurance Program network providers to be enrolled with State Medicaid programs. As a Total Senior Care provider who is not actively enrolled with the New York State Medicaid program and you are providing services to our Medicaid eligible members. Therefore, you must enroll in Medicaid. Enrollment as a Medicaid provider does not require you to accept Medicaid fee for service patients. The Medicaid provider enrollment process is to ensure appropriate and consistent screening of providers and improve program integrity. In order to enroll, you will need to complete paperwork and submit it to New York State Medicaid.

Please go to https://www.emedny.org/info/ProviderEnrollment/index.aspx and navigate to your provider type to print and review the Instructions and the Enrollment form. At this website, you will also find a Provider Enrollment Guide, a How Do I Do It? Resource Guide, FAQs, and all the necessary forms related to enrollment in New York State Medicaid.

### Hospitals

***Compliance with Licensure and Certification.*** The Hospital shall provide or make available to Total Senior Care the following items prior to the commencement of services under the Total Senior Care provider agreement and at any such time as these items are revised and become available:

1. A copy of the Hospital’s current New York State Department of Health survey(s) and reports

from accreditation bodies, if available.

1. A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services provided by the hospital.
2. A copy of any notice of sanctions imposed upon the Hospital within the past five years by the Medicare or Medicaid program.
3. Current information documenting the appropriate licensure and credentials of all personnel

serving the Hospital’s patients.

1. Documentation of staff health status as required by New York State Health Code.
2. A copy of the Hospital’s audited financial statements for the past two years upon request.

***Reporting Requirements.*** Hospital shall immediately inform Total Senior Care of any significant incident involving a Total Senior Care Participant, including but not limited to the following:

1. Death while admitted to hospital.
2. Transfer of participant to another facility.
3. Discharge from the facility.
4. Contraction of a communicable disease or illness.
5. Error with patient care placing the patient at jeopardy or potential risk.
6. Injury while an admitted patient at Hospital.

### Nursing Facilities

***Compliance with Licensure and Certification.*** A nursing facility shall provide or make available to Total Senior Care the following items prior to the commencement of services under its provider agreement with Total Senior Care. The items include:

1. A copy of the nursing facility’s current license to provide services in New York State, New York State Department of Health, and survey(s) and reports from accreditation bodies, if available.
2. A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services provided by the nursing facility.
3. A copy of any notice of sanctions imposed upon the nursing facility within the past five years by the Medicare or Medicaid programs.
4. Current information documenting the appropriate licensure and credentials of all personnel serving the nursing facility’s patients.
5. Documentation of staff health status as required by New York State Health Code.
6. A copy of the facility’s audited financial statements for the past two years upon request.

**Compliance Plan and Code of Conduct.**The nursing facility warrants to Total Senior Care that it has implemented a Compliance Plan and Code of Conduct, and that implementation includes the presentation of the Code to new employees as part of their orientation, and to all employees on an annual basis.

### Physicians

Total Senior Care credentials and re-credentials all physicians in its network according to National Committee on Quality Assurance (NCQA) credentialing standards.

The governing body responsible for recommending providers to be credentialed to the Total Senior Care Board of Directors is the Total Senior Care Medical Advisory Committee.

To facilitate data collection for physicians for the credentialing process, Total Senior Care utilizes affiliated hospitals which maintain databases of provider information reflecting the data submitted by providers to be stored, maintained and reported on behalf of registered physicians to health plans as authorized by the physician. Physicians who maintain an active, current set of credentialing information on these databases will not need to submit any additional data to Total Senior Care.

If the information is not on file with the affiliated Hospital Credentialing Department, or there is not a current attestation recorded with them, physicians will be required to complete a Total Senior Care participating provider application on forms that Total Senior care will provide. The forms include:

* + A Total Senior Care Credentialing Application
  + Copy of New York State Medical License

The physician shall also provide or make available to Total Senior Care the following items prior to the commencement of services under this Agreement and at any such time as these items are revised and become available:

1. A copy of the Physician’s current New York State Department of Health survey(s), if

applicable, and reports from accreditation bodies, if available.

1. A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services provided by the subcontractor.
2. A copy of any notice of sanctions imposed upon the Physician within the past five years by the Medicare or Medicaid program.
3. Current information documenting the appropriate licensure and credentials of all personnel

serving the Physician’s patients.

1. Documentation of staff health status as required by New York State Health Code.
2. A copy of the Physician’s audited financial statements for the past two years upon request.

### Other Providers of Care (Home Care Agencies, Transportation Providers, Providers of Specific Services such as Durable Medical Equipment)

***Compliance with Licensure and Certification.*** The subcontractor shall provide or make available to Total Senior Care the following items prior to the commencement of services under this Agreement and at any such time as these items are revised and become available:

1. A copy of the subcontractor’s current license to provide services in New York State, New York

State Department of Health survey(s) and reports from accreditation bodies, if available.

1. A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services provided by the subcontractor.
2. A copy of any notice of sanctions imposed upon the Subcontractor within the past five years by the Medicare or Medicaid program.
3. Current information documenting the appropriate licensure and credentials of all personnel

serving the Subcontractor’s patients.

1. Documentation of staff health status as required by New York State Health Code and PACE Regulations for contracted personnel with direct participant contact.
2. A copy of statewide criminal background check for personnel with direct participant contact.
3. A copy of the Subcontractor’s audited financial statements for the past two years upon request.
4. Evidence of compliance with other applicable New York State codes and regulations.

Total Senior Care will expect the same standards of practice, service operation and reporting compliance from providers as required by local, state or national licensing or regulating bodies as part of its credentialing process, and as provided for in its provider agreements.

### Changes in Provider Status

This provision applies to all classes of providers described above. If a Total Senior Care participating provider has a material change that can affect their status to be active in the Total Senior Care provider network, the provider must give notification to Total Senior Care within five (5) days of the occurrence of any of the following events:

* + Provider is disciplined by any state agency.
  + Provider’s business address or telephone number changes, or there is a change of ownership,

or tax identification number.

* + Provider becomes incapacitated such that the incapacity may interfere with care to a Total Senior Care participant.
  + There is any material change or addition to the information and disclosures submitted by the Provider as part of the Total Senior Care credentialing process.
  + Any other act, event, occurrence, or the like which materially affects the provider’s ability to carry out the duties under the provider’s contract with Total Senior Care.

A provider must immediately notify Total Senior Care in writing if any of the following events occur. The events are a basis for termination from the Total Senior Care network:

* + Provider’s license in any state is subject to suspension, revocation, or termination or if the

provider is required to surrender his or her license to practice.

* + Provider is convicted of a felony relating directly or indirectly to the practice of medicine or provision of services.
  + Provider’s professional liability or general liability insurance coverage is reduced below.

$1,000,000 individual / $3,000,000 aggregate is canceled.

* + Provider has been sanctioned by any governmental agency and can no longer participate in Medicare or Medicaid.
  + Physician loses staff privileges at his or her primary admitting facility.
  + Facilities lose JCAHO or similar applicable accreditation, state licensure or are sanctioned by any governmental agency.

# Claims and Service Authorization

Providers are reimbursed in accordance with the terms and conditions set forth in the provider agreement with Total Senior Care. The billing address for all claims/invoices for services is as follows:

PeakTPA

11010 Prairie Lakes Drive, Ste. 175

Eden Prairie, MN 55344

Toll free 1-866-479-5050

Questions regarding claims may be directed to PeakTPA toll free at (866)479-5050. Payment shall be made to network providers consistent with the prompt payment provisions of Section 3224-a of the New York State Insurance Law. No payment will be made for invoices submitted beyond one hundred- twenty (120) days after the end of the month in which services are rendered.

Except in the case of emergency, contracted Providers shall:

* + - Require Total Senior Care Participants to present their identification card and proper identification prior to providing services.
    - Render services to Total Senior Care Participants only upon the written referral of such persons by Total Senior Care.

Questions or concerns regarding prior authorization for services may be directed to the Director of Clinical Services or Program Officer at (716) 379-8474 or (866)-939-8613. The Provider acknowledges that the Participant’s identification card does not constitute complete proof of eligibility. Total Senior Care will confirm eligibility by telephone during normal business hours.

# Provider Relations

Total Senior Care is committed to promoting positive Provider relations and to insuring the best services possible for Participants. Contract monitoring for compliance will occur routinely via the Total Senior Care Contract Manager. At the onset of Provider services, and as necessary thereafter, Total Senior Care will provide orientation and training on Total Senior Care philosophy, relevant policies and procedures, personal qualifications and targeted for Provider employees with direct participant contact with Total Senior Care participants. Total Senior Care seeks optimal integration and coordination of care via Provider education and training.

# Appendices

1. Community Based Primary Care Physicians
2. Notice of Amended Statutes

TOTAL SENIOR CARE, INC. PROVIDER MANUAL APPENDIX A

**COMMUNITY BASED PRIMARY CARE PHYSICIANS**

### Additional Duties and Obligations of the Subcontractor

* 1. The Community Based Primary Care Physician (CBPCP) and office staff will receive PACE orientation to Total Senior Care and the PACE model of care. The CBPCP will sign an acknowledgement that they received and understand the PACE Orientation and Policy and Procedures for use of CBPCP in the PACE Interdisciplinary Team (IDT).
  2. The CBPCP will conduct and complete an initial assessment visit to include complete medical history and physical documented on approved TSC forms.
  3. Reassessment of participants will be conducted as recommended by the Interdisciplinary Team (IDT) based on medical condition and documented appropriately, at least every 6 months, after any significant change in participant’s health status, and as requested by the participant.
  4. The CBPCP will provide written documentation of all office visits to the IDT within seven (7) business days, such visits having been approved by the IDT.
  5. The CBPCP will collaborate with the IDT and PACE participant to establish the participant’s

individual plan of care and to review and modify the plan of care as needed.

* 1. The CBPCP will review advance directives with the participant and relevant family and update as needed with reassessments or changes in condition.
  2. The CBPCP will provide for evaluation and treatment of episodic illnesses and chronic disease exacerbations. This will be the responsibility of the CBPCP in the community office, the emergency room and hospital, and nursing home, in collaboration with the IDT. Documentation of hospital rounds and emergency room visits, and all other visits, will be provided to the IDT within seven (7) business days.
  3. The CBPCP will collaborate directly with Clinic Nursing staff and TSC PCP/Medical Director.
  4. The CBPCP will provide for Nursing Home primary care as part of the individual participant’s plan of care established by the IDT when appropriate and unless transferring care to the TSC PCP/Medical Director.
  5. The CBPCP will participate in QAPI by facilitating data collection and review as requested by TSC under the guidance of the QI Manager and Medical Director.
  6. The CBPCP will assure specialty care has been authorized by the IDT and coordinated by the clinic nursing staff consistent with participant goals and Plan of Care.
  7. The CBPCP will uphold the mission and philosophy of PACE and Total Senior Care by working with the TSC IDT and Medical Director to provide quality care in a cost-effective manner.
  8. The CBPCP will participate in the TSC IDT meetings when their participant’s plan of care is being discussed, developed or modified, or as warranted when there is an incident, hospitalization or change in condition and ad hoc meeting. Participation can be in person or by conference call.
  9. The CBPCP will utilize only TSC approved pharmacies and service providers.

### Additional Duties and Obligations of TSC

* 1. TSC will provide orientation, service authorizations forms and processes to enable communications between the CBPCP and TSC.
  2. TSC will see the participants with the frequency needed to maintain health status as detailed in the Plan of Care. TSC will communicate directly with the CBPCP office as necessary to assure the care is collaborative and integrated in nature.
  3. During regular center hours, TSC will perform a nursing assessment for episodic illness or at the request of a participant or family member. If necessary, TSC will then contact the CBPCP for consultation.
  4. After hours, TSC will be on-call for assessments by phone or will dispatch nursing staff for assessment in person if an urgent need develops. If necessary TSC will then contact the CBPCP for consultation.
  5. In an emergency situation, participants and families will be instructed to call 911 and notify TSC as soon as possible. TSC would then notify CBPCP.
  6. In non-urgent situations, communication with the CBPCP and documentation of the problem will be conducted over the phone by TSC Nursing staff and logged, with clinical notes sent to the CBPAP as necessary.
  7. The TSC PCP/Medical Director will provide back-up coverage to the CBPCP and mediate as necessary.

### Other

* 1. Failure of the CBPCP to uphold the TSC mission and philosophy and follow TSC procedures may result in termination of the CBPCP agreement and transition of participants to the TSC PCP/Medical Director.
  2. A member of the TSC IDT may attend community-based office visits with the participant during physician assessments and follow up consultant visits as deemed necessary by the IDT.

TOTAL SENIOR CARE, INC. PROVIDER MANUAL APPENDIX B

**AMENDED STATUTES**

1. Public Health Law § 4406-c was amended to add a new subdivision 5-c with the previous subdivision 5-c being re-lettered to subdivision 5-d:
   1. Health care professionals are to receive written notice from the MCO at least 90 days

prior to an adverse reimbursement change to the provider’s contract.

* 1. The health care professional may, within thirty (30) days of the date of the notice, give written notice to the MCO to terminate the contract effective upon the implementation of the adverse reimbursement change.
  2. An adverse reimbursement change is one that “could reasonably be expected to have an

adverse impact on the aggregate level of payment to a health care professional”.

* 1. A health care professional under this section is one who is licensed, registered, or certified under Title 8 of the New York State Education Law.

1. Statutory Exceptions to The Notice Requirements:
   1. The change is otherwise required by law, regulation, or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association’s Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
   2. The change is provided for in the contract between the MCO and the provider or the IPA and the provider through inclusion of or reference to a specific fee schedule, reimbursement methodology or payment policy indexing mechanism.
   3. There is no private right of action for a health care professional relative to this provision.
2. Claims Processing Timeframes – Effective January 1, 2010:
   1. The timeframe for payment of claims based on electronic versus paper or facsimile submission was added to INS § 3224-a, which states Claims submitted electronically must be paid within thirty (30) days and paper or facsimile claim submissions must be paid within forty-five (45) days.
3. Overpayment Recovery:
   1. The process for overpayment recoveries in INS § 3224-b (b) was amended to apply to all health care professionals licensed, registered, or certified under Title 8 of the State Education Law, and providers licensed or certified pursuant to PHL Articles 28,36, or 40 or Mental Hygiene Law Articles 19, 31, and 32. The statute requires that MCOs provide the health care professional or provider with an opportunity to challenge the overpayment recovery.
4. Claims from a Participating Hospital Associated with a Non-Participating Health Care Provider Claim; and Claims from a Participating Health Care Provider Associated with a Non-Participating Hospital Claim – Effective January 1, 2010
   1. MCOs are prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a non-participating health care provider treated the member. Likewise, a claim from a participating health care provider cannot be treated as out-of- network solely because the hospital is non-participating with the MCO.
   2. A health care professional under this section is one who is licensed, registered, or certified under Title 8 of the New York State Education Law or comparably licensed, registered, or certified by another state.
5. Enrollee Submission of Claims – Effective January 1, 2011:
   1. Under INS §§ 4305(1) and 4306(n) a member has at least one hundred-twenty (120) days to submit a claim.
6. Credentialing – Effective October 1, 2009:
   1. Provisional credentialing is limited to providers coming from another State within the United States. However, the provisional credentialing rules would apply to an out-of- country provider who is newly licensed in New York State.
7. Rare Disease Treatment – Effective January 1, 2010:
   1. PHL Article 49 was amended to include rare disease treatment. The definition of rare disease treatment is found at PHL§ 4900(7-g); and the established external appeal right for a final adverse determination involving rare disease treatment was added to Section 4910.
8. Home Health Care Determinations – Effective January 1, 2010:
   1. Subdivision 3 of PHL § 4903 was amended to require the MCO to provide notice of determination for HHC services following an inpatient hospital admission within one (1) business day of receipt of the information or, if the request falls on a weekend or holiday, within 72 hours of receipt of necessary information.
   2. An appeal of a denial for HHC services following a discharge from a hospital must be treated as an expedited appeal under PHL § 4904(2).
   3. The term inpatient hospital admission under this section is limited to services provided to a member in a general hospital that provides inpatient care. This may include inpatient services in an Article 28 rehabilitation facility.
9. Provider External Appeal Rights
   1. Public Health Law § 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations and to require MCOs to notify providers of this right.
   2. Payment for an external appeal at PHL § 4914 was amended to include health care provider filing an external appeal of a concurrent adverse determination.
   3. A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of the MCO; an MCO is responsible for the full cost of an appeal that is overturned; and the provider and MCO must evenly divide the cost of a concurrent adverse determination that is overturned in part.
10. Alternative Dispute Resolution (ADR)
    1. A facility licensed under Article 28 of PHL and the MCO may agree to alternative dispute resolution in lieu of an external appeal under PHL § 4906(2). This provision does not

impact a member’s external appeal rights or right of the member to establish the

provider as their designee.

* 1. Which party will bear the cost of the ADR process in lieu of external appeal is a matter between the MCO and the provider.
  2. If the member files an external appeal, the external appeal determination takes precedence over the ADR.

1. Hold Harmless - PHL was amended to add a new section 4917
   1. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable co-pays, from a member for services determined not medically necessary by the external appeal agent. Members are held harmless in such cases.

Revised 6/10 Revised 4/16 Revised 11/17

Revised 2/21