



Provider Manual



Comprehensive Care Management is pleased to welcome you as a participating provider. CCM is a not-for-profit managed care organization, affiliated with Beth Abraham Family of Health Services. We are certified under Article 44 of the New York State Public Health Law to operate in all five counties of NYC, and Westchester, Nassau and Suffolk.

We recognize the critical role you play in providing our members with high quality medical care and service. Participating providers include acute care facilities, diagnostic and treatment centers, skilled nursing facilities, outpatient care centers, and community based practices that offer a full range of primary, preventive, inpatient, and specialty services. CCM also has agreements with home health care providers, durable medical equipment, pharmacy, dental and other health related services.

Participating providers provide health care services for all members in accordance with the same standards and priority, regardless of the type of coverage. Members choose a Primary Care Provider (PCP) who is responsible for managing and coordinating all aspects of their medical care.

CCM places great value on the member-provider relationship. The ability to communicate effectively in the member's primary language, treat the member with dignity and cultural sensitivity and provide access in a timely manner is integral to the success of CCM's managed care programs.

This Provider Manual is a reference tool designed for you and your staff regarding CCM policies and procedures. A copy of this manual is available upon request. Any updates and changes related to provider services will be communicated in writing to participating providers. It is important that you read the information and retain it with this manual, so changes can be incorporated into your practice. The CCM website will be periodically updated to include new programs, policies, directories and new CCM locations. If you have any questions about CCM, please call our toll-free Provider Relations number at 1-800-761-5602.

Thank you for participating in our network. We look forward to working with you and your staff.



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Chapter 1 – Overview of CCM Programs: PACE, Select, Direct, MAP

1. Overview

CCM offers a choice of Medicare and Medicaid managed care programs for frail adults who qualify for nursing home placement using the NYS assessment tool. They may reside in their home, assisted living facility, or a nursing home. CCM also offers plans for Medicare recipients who live in the community and do not require a nursing home level of care. The PACE and Select plans cover comprehensive long term home care, rehabilitation, transportation, vision, dental, and other services necessary to manage the member's care in a non-institutional setting for as long as possible. Additionally, PACE and Direct plans cover acute hospital, medical, surgical and behavioral health services and pharmacy. Please see below for a brief description of each program. A full list of Plan benefits is included in the Appendices.

2. CCM Care Management Model

CCM's goal is to improve the health and quality of life for members with complex medical and social needs. The members' care is planned and provided by a team of skilled health professionals who work with the PCP and the member to coordinate services across a continuum of health care settings. Members' care is monitored by a nurse care manager who reviews medical documentation, consults with the PCP and other team members, and refers the member for medically necessary services.

3. PACE: Program of All-Inclusive Care for the Elderly.

A fully integrated Medicaid / Medicare program providing comprehensive medical, long term care, nursing and ancillary health related services coordinated by an interdisciplinary team. The cornerstone of the PACE model is the Center, where members receive primary care at the diagnostic and treatment center, rehabilitation, and social day care. As the largest PACE program in the country, CCM operates 14 Centers throughout our approved service area. Members must be 55 or older, qualify for nursing home level of care, and be able to live safely in the community upon enrollment into CCM.

4. Select: A Medicaid Managed Long-Term Care program

A special program authorized by New York State as a Managed Long Term Care Plan. Select is a community-based program that provides long term home health care, dental, vision, and health related covered services coordinated by a care manager. Select does not pay for physician and hospital services; these services are available directly through the member's

Medicare or Medicaid eligibility. Members must be 18 or older, qualify for nursing home level of care, and be eligible for Medicaid coverage.

5. **Direct**: A Medicare Advantage plan and an Institutional Special Needs plan for Medicare beneficiaries who are institutionally qualified and living in the community as well as members living in a contracted long term care facility. Direct covers hospital and medical services including vision, pharmacy and skilled intermittent nursing care at home. Members must choose a PCP from CCM's provider network to coordinate their care. Residents in contracted nursing homes are also eligible for participation. These residents are followed by a Clinical Care Supervisor who is a nurse practitioner, is based at the facility and provides care in conjunction with the physician.
6. **Select/Direct**: A combined program that pays for and coordinates both Medicaid and Medicare covered services for members as described in the above Plans.
7. **Medicaid Advantage Plus (MAP)**: A program that combines Medicare Benefits and long term care benefits for beneficiaries who are nursing home equivalent but are living in the community. The program provides the full range of Medicare and Medicaid services coordinated by a Nurse Care Manager. The benefit plan and eligibility is similar to PACE but is not center based offers more flexibility in choice of providers and a lesser degree of direct care provided at the Center.

Chapter 2 – Benefit Plan

Through CCM's managed care plans, we offer our members many choices of benefit packages designed to meet their health needs. Our Medicare and Medicaid products offer some or all of the benefits described below. Eligible members may enroll in any of these plans, depending on their level of care needs, with PACE and MAP offering the highest level of care management. Regardless of the plan the member enrolls in, he or she will have their care coordinated by a care manager who will assist with all aspects of their health care needs.

1. **Dental Benefits**

Members may access dental services directly without a PCP referral through the services of Healthplex contracted dental providers. PACE, Select and MAP members will be assigned to a Primary Care Dentist. Emergency dental services provided by a non-contracted dentist are covered. CCM managed care programs and dental health benefits naturally complement one another because both emphasize prevention and cost-effectiveness. CCM works with Healthplex to ensure adequacy of network dental providers, appropriate reimbursement for dental services and access to the full range of preventive, primary, and specialty oral health services. Primary care dentists, as well as dental specialists are listed in the Provider Directory. The directory is available at www.ccmny.org.

2. **Optometry and Audiometry**

Routine yearly visual exams, screening for glaucoma and hearing screening will be accessed by CCM Members without a referral through contracted network providers. CCM has delegated management of vision/eye care providers to VSP. These providers, with assistance from CCM Care Managers will coordinate benefits according to the defined benefit structure. Vision care providers and audiology services are listed in the Provider Directory.

3. **Hospital Services**

3.1 **Inpatient Admissions**

All non-emergency inpatient admissions require precertification from the CCM Medical Management Program. The precertification process for admissions is carried out by hospital personnel as defined in the Medical Management section of this manual and Quick Reference Guide.

CCM Medical Management Specialists, in coordination with admitting physicians and hospital based physicians (hospitalists) will be in

charge of coordinating and conducting Continued Stay Reviews, providing appropriate referrals for extended care facilities and coordinating all services required for adequate discharge. CCM Care Managers assist in coordinating all services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding Primary Care Providers.

4. Mental Health Services

Members requiring mental health services will be required to call Member Services. Telephonic access is available 24 hours a day, 7 days a week.

Mental health inpatient services as well as Detoxification Programs are available after coordination for emergency admissions or mental health provider's evaluation has taken place.

MAP members are allowed one self referral for mental health and one self referral for substance abuse each year.

5. Pharmacy

CCM contracts with Medco, a nationally recognized pharmacy benefits manager. CCM members enjoy access to hundreds of participating pharmacies throughout the country. Medco also offers a mail order option for maintenance medications.

Some drugs have quantity limits or require pre-authorization or are subject to step therapy. The Medco contacts and forms are available on our web site, www.ccmny.org.

6. Home Health Care, Transportation, DME

CCM, through Beth Abraham Long Term Home Health Care Program, contracts with a variety of providers to provide medically necessary services to members who reside in the community. If a member requires an authorization for any of these services, the provider should call CCM's Medical Management Department at 1-800-695-1035. Authorization is required for non-emergency ambulette services and is provided for members with limited mobility. 24 hours notice is required for ambulette scheduling.

7. Member Eligibility and Verification of Coverage

Each CCM member will receive a CCM identification (ID) card containing the member's name, member number, PCP name, and information about their benefits. Members should present their cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage. Providers should refer to the member's ID card for the appropriate telephone number to verify eligibility in the CCM Plan,



deductibles, coinsurance amounts, copayments, and other benefit information (see Attachment 1 for card samples).

You may obtain information on CCM member eligibility by calling the Provider Services telephone number listed in the Quick Reference Guide

(Attachment 2) Monday through Friday from 9:00a.m. – 5:00p.m. Eastern Time.

8. Member Copayments

If there are copayments or coinsurance associated with a service, and the member has Medicaid, the provider should bill New York State Medicaid. If the member does not have Medicaid, the member is obligated to pay the copayment or coinsurance amounts. In order to ensure reimbursement, providers should always ask members, at the time of service, about their medical coverage. In the event that the provider is unable to ascertain benefit or copayment status at the time of service, the provider may, as appropriate, contact Provider Services for clarification.

Medicaid Advantage Plus (MAP) is an integrated Medicare Advantage and Medicaid Managed Long Term Care program, which incorporates the Medicaid reimbursement of Covered Services. Providers **MUST NOT** bill New York State Medicaid except for certain services that are carved out. Providers must not bill the member for any portion of the Medicaid benefit.

If you have questions about how to bill properly or how to determine the appropriate co-payment, co-insurance or deductible, please contact Provider Services at 1-800 – 761-5602.

Chapter 3 – Participating Provider Responsibilities

1. Role of PCP

CCM requires that members choose a contracted physician to coordinate their health care needs. These physicians are known as Primary Care Physicians (PCPs). If a member does not select a PCP within 30 days of enrollment, one is assigned by CCM. The PCP is responsible for providing or authorizing covered services for members, and works with CCM staff to coordinate all care the member receives. The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, and community resources.

PCPs are generally physicians of Internal Medicine, Family Practice, and Geriatrics.

Members may change their designated PCP at any time by contacting Member Services listed in Attachment 2.

2. Role of Specialists

A specialist is any licensed participating provider who provides specialty medical services to members. A PCP may refer a Member to a specialist as deemed medically necessary. (see Attachment 2 for Specialist services requiring notification/pre-authorization)

3. Access and Availability Standards

3.1 24-Hour Coverage

PCPs are expected to provide coverage for CCM members 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers. Participating providers can consult their CCM Provider Directory, check the website at www.ccmny.org, or contact the Member Services with questions regarding which providers participate in the CCM network.

CCM supports a 24-hour, 7 days a week nurse triage service that is also available to members and providers to provide health information and immediate advice. Please call 1-877-CCM-8500.

3.2 Emergency Care

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain)

such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a behavioral condition, placing the health of the individual or others in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Members are always covered for medical emergencies. If a member needs health care services for an emergency condition, he/she is instructed to call 911. The member, provider or any other health care provider is not required to call CCM before the provision of emergency care, including emergency admission. CCM will not deny reimbursement for emergency medical or behavioral health services provided that such services are medically necessary to stabilize or treat an emergency condition.

3.3 Member Access to Services

The following appointment availability goals should be used to ensure timely access to medical care and behavioral health care:

- Routine physicals – within 3 months of enrollment
- Routine non-urgent, preventative care - As soon as possible, no longer than one month
- Emergency care – immediately upon presentation
- Urgently Needed Services - Within one day
- Non-urgent “sick” visit - Within 48-72 hours of request, as clinically indicated
- Specialist referrals (non urgent) – within 4-6 weeks of request
- Non urgent mental health or substance abuse visits – within 2 weeks of request
- Follow-up visits pursuant to an emergency of hospital discharge, mental health or substance abuse – within 5 days of the request, or as clinically indicated

The member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

After hours access shall be provided to assure a response to emergency phone calls within thirty minutes, response to urgent phone calls within one hour. Individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services or call 911.

Adherence to Member access and availability guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination and bi-annual surveys. Variations from the policy will be reviewed by the VP for Medical Affairs for educational and/or counseling opportunities and tracked for provider re-credentialing.

4. Closing of Provider Panel

When closing a practice to new CCM Members, participating providers are required to:

- a. Give CCM 60 days prior written notice that the practice will be closing to new members as of a specified date,
- b. Keep the practice open to new CCM members who were patients before the practice closed, and
- c. Give CCM prior written notice of the re-opening of the practice, including a specified effective date.

5. Provider Performance Standards and Compliance Obligations

When evaluating the performance of a participating Provider, CCM will review at a minimum the following areas:

Quality of Care — measured by clinical data related to the appropriateness of a member care and member outcomes;

Efficiency of Care — measured by clinical and financial data related to a member's health care costs;

Member Satisfaction — measured by the members' reports regarding accessibility, quality of health care, member-provider relations, and the comfort of the practice setting.; and

Administrative Requirements — measured by the participating provider's methods and systems for keeping records and transmitting information.

6. **Provider Compliance to Standards of Care**

CCM's participating providers must comply with all applicable laws and licensing requirements. In addition, participating providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment.

Participating providers must also comply with CCM's standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity) and
- All federal, state, and local laws regarding the conduct of their profession.

Participating providers must also comply with CCM policies and procedures regarding the following:

- Pre-authorization and notification requirements and timeframes;
- Participating provider credentialing requirements;
- Referral Policies;
- Care Management Program referrals;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of member medical record information to fulfill the business and clinical needs of CCM;
- Cooperating with efforts to assure appropriate levels of care;
- Maintaining a collegial and professional relationship with CCM personnel and fellow participating providers;
- Providing equal access and treatment to all CCM members; and
- Using evidence based medicine to develop in-office protocols and treatment plans for common diagnoses.

6.1 **Compliance Process**

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization;

- Failure to obtain preauthorization from CCM for admissions and other services requiring prior authorization;
- Member complaints/grievances that are determined against the provider;
- Underutilization, overutilization, or inappropriate referrals;
- Inappropriate billing practices; and
- Non-supportive actions and/or attitude.

Participating provider noncompliance is tracked on a calendar year basis. Corrective actions may be required if areas or patterns of noncompliance are found.

Participating providers acting within the lawful scope of practice are encouraged to advise patients who are members of CCM about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered or treatments not covered by CCM), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment; and

The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

6.2 Marketing

Participating providers may not develop and use any materials that market CCM without the prior approval of CCM in compliance with Medicare and Medicaid requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS.

6.3 Laws Regarding Federal Funds

Payments that Participating Providers receive for furnishing services to CCM Members are, in whole or part, from Federal funds. Therefore, Participating Providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil

Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

6.4 Sanctions under Federal Health Programs and State Law

Participating Providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the Participating Provider.

Participating Providers must disclose to CCM whether the Participating Provider or any staff Member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of New York, the federal government, or any public insurer. Participating Providers must notify CCM immediately if any such sanction is imposed on Participating Provider, a staff Member or subcontractor.

7. Medical Records

7.1 Medical Record Review

A CCM representative or designee may visit the Participating Provider's office to review the medical records of CCM Members to obtain information regarding Medical Necessity and quality of care. Whenever possible, reasonable advance notice will be given to the Provider. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below. The Vice President for Medical Affairs and the QI Committee will review the medical record audits quarterly. The results will be used in the re-credentialing process.

CCM is required to review a random sample of medical records in order to meet HEDIS requirements. CCM or designee will notify the office when the reviews are due and will request that a copy of the chart be mailed to the CCM office unless there is a high volume of charts requested. If there are more than 10 charts, CCM or designee will visit the office to do the review.

7.2 Standards for Medical Records

Participating providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the members' medical chart.

7.3 Providers must comply with CCM medical record guidelines.

Medical records must be readily accessible and available for review by CCM personnel.

A separate medical record must be maintained for each CCM member.

Medical records must include entries that are current, legible, signed and dated by the person making the entry.

The medical record must include relevant information concerning emergency room treatment, services rendered by specialists, and any hospitalizations.

PCP medical records must include, as appropriate:

- patient identification,
- consent forms,
- medical history,
- record of immunizations,
- allergies and any adverse reaction,
- physical examination reports,
- diagnostic procedures/test results,
- diagnosis or medical condition,
- consultative findings,
- medical orders,
- pertinent psychosocial assessment,
- case management information,
- instructions to Member,
- documentation of services required and referrals made, progress notes and
- follow-up plans.

In addition, participating providers must document in a prominent part of the member's current medical record whether or not the member has executed an advance directive.

Advance directives are written instructions, such as appointment of a health care proxy or durable powers of attorney for health care,

recognized under the law of New York, and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

7.4 Confidentiality of Member Records

Participating providers are expected to ensure the confidentiality of medical records for CCM Members. Information contained in the medical record should only be disclosed in a manner that complies fully with HIPAA standards and all state and federal laws concerning confidentiality of the Member's protected health information. Participating providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws and ensure that staff is knowledgeable about and compliant with HIPAA regulations.

8. Informed Consent and HIPAA Compliance

All participating providers must provide information to members necessary to give informed consent prior to the start of any procedure or treatment. In addition, all participating providers are subject to the confidentiality requirements outlined in Article 27-F of the Public Health Law. Under the terms of Article 27-F, providers are obligated to:

- Conduct initial and annual in-service education of staff and contractors;
- Identify staff allowed access to confidential information and the limits of that access;
- Establish procedures to limit access to confidential information to trained staff (including contractors);
- Develop protocols for secure storage of confidential information (including electronic storage); and
- Develop procedures for handling requests for member information.

9. Provider Credentialing

The Credentialing/Re-credentialing processes are components of the organization's Quality Improvement Program. These processes were designed to protect members and provide continued assurance that potential and/or current participating providers meet the requirements necessary for the provision of quality care and service.

CCM may delegate the responsibility of implementing the credentialing/re-credentialing activities to a CCM designee.

Credentialing is required for all physicians who provide services to CCM members and all other health professionals and facilities that are permitted to practice independently under State law, with the exception of Hospital based health care professionals. CCM does not discriminate in terms of participation or reimbursement against any physician or health care professional that is acting within the scope of his or her license.

Hospitals and other facilities must be licensed by and demonstrate good standing with state and federal regulatory agencies. In addition, each facility must be accredited by a recognized and relevant accrediting agency, such as JCAHO, Commission on Accreditation of Rehabilitation Facilities, American Association for Accreditation of Ambulatory Surgery Facilities and Centers for Medicare and Medicaid Services certified.

Additional information regarding CCM's credentialing and recredentialing policies is available upon request.

9.1 Initial Credentialing

Procedures for initial credentialing include submission of a written or universal CAQH application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare and Medicaid; and office site visits survey as appropriate.

Credentialing files are considered confidential and access to them is strictly limited. Participating providers may access their own file and certain government/regulatory entities have access as stipulated by applicable law.

9.2 Recredentialing

Participating providers must be recredentialed every three years. The three year recredentialing cycle begins with the date of the initial Credentialing Committee decision. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance indicators. All providers must complete a re-credentialing application including an attestation by the applicant to the correctness and completeness of the application.

Additional information regarding CCM's credentialing and recredentialing policies is available upon request.

9.3 Site Visits

A structured initial site visit review will be conducted for each PCP and obstetrician/gynecologist. The site visit criteria and the review tool will, at minimum, include an assessment of accessibility, adequacy of the examination and waiting rooms, availability of appointments, and adequacy of medical record keeping practices.

9.4 Confidentiality

At all times, information relating to a provider obtained in the credentialing/re-credentialing process is considered confidential.

9.5 Monitoring and Off-Cycle Recredentialing

On an ongoing basis, CCM monitors lists of practitioners who have been sanctioned and/or who opt-out of accepting Federal reimbursement from Medicare and from New York State, and sanctions/limitations on licensure.

On an ongoing basis, CCM conducts monitoring and resolution of beneficiary grievances.

In the event that information is obtained by CCM that may indicate a need for further inquiry, the Credentialing Committee retains the right to conduct an off-cycle review of a practitioner's credentialing status. The information will be made available to the Credentialing Committee for review and recommendation.

Notwithstanding the above, practitioners who have had their licenses revoked or suspended, or who have been excluded from participation in the Medicare/Medicaid programs will be terminated immediately. The Credentialing Committee will be notified of this action at the next meeting.

9.6 Terminations and Appeal Process

The Credentialing Committee has responsibility for making recommendations about a provider's status to the Quality Improvement Committee. Such recommendations include suspension and/or termination of a participating provider.

9.7 Formal Disciplinary Action

In the event that the Credentialing Committee recommends suspension or termination of a participating provider and the Quality Improvement Committee concurs, written notification is sent to the provider. The provider may then request a hearing in accordance with applicable law.

9.8 Appeal of Disciplinary Decisions

The provider may appeal any formal disciplinary action. Requests for appeal must be submitted in writing, and sent by certified mail, return receipt requested.

Chapter 4 – Medical Management

Participating providers must comply and cooperate with all CCM Medical Management policies, procedures and programs.

1. **Specialist Referral Guidelines**

PCPs should refer CCM members to contracted network specialists. To ensure continuity of care, if a member desires to receive care from a different specialist, the PCP should try to coordinate specialty referrals within the list of contracted network specialists. When no additional physician within the required specialty is contracted in the network, PCP will notify CCM for further directions.

2. **PCP Responsibilities**

If a member self-refers, or the PCP is making a referral to a specialist, the PCP should check the CCM Provider Directory to ensure the specialist is a participating provider in the CCM network. The Provider Directory is available on-line at www.ccmny.org.

The PCP should provide the specialist with the following clinical information:

- Members name;
- Referring PCP;
- Reason for the consultation;
- History of the present illness;
- Diagnostic procedures and results;
- Pertinent past medical history;
- Current medications and treatments;
- Problem list and diagnosis; and
- Specific request of the specialist.

The PCP should notify CCM regarding the specialist referral in order for CCM to enter an authorization for payment. The notification form should include the following information:

- PCP Name;
- Member Name;

- Member's ID number;
- Specialist's Name;
- Primary Diagnosis; and
- "Consult only" or "consult and management."

3. **Specialist Responsibilities**

After a consultation with a CCM member, specialists must:

Communicate with the PCP after the initial evaluation to discuss the member's condition and any recommendation for treatment or follow up care and send the PCP the consultation report including medical findings, test results, assessment, treatment plan and any other pertinent information.

4. **Non-Participating Providers**

All requests for services with a non-participating provider must be submitted to CCM's Medical Management staff for authorization.

Circumstances under which an authorization will be approved to a non-participating provider include:

- If it is determined that there is no participating provider who can provide the covered services required for the member;
- If a currently enrolled member is in active treatment with a provider who terminates his/her participation in the CCM network; and
- If a newly enrolled member joins CCM and is under active treatment at the time of enrollment with a provider who does not participate in the CCM network.

5. **Direct Access Services**

There are a number of services that members may access without a referral from their PCP or prior authorization from CCM, as long as the member obtains these services from a participating provider. Those services are discussed below in this section.

Members may access the following preventive services from a participating provider without a referral from a PCP:

- Screening mammographies;
- Influenza vaccinations;

- Routine and preventive women's health services (such as pap smears); and.
- Family planning services (only Medicaid Advantage Plus).

MAP members can self-referral for one mental health visit and one substance abuse a year.

In addition, members may not be charged a copayment for influenza or pneumococcal vaccinations.

6. Prior Authorization

Prior authorization is the process by which CCM's Medical Management Department reviews your request for a patient to receive inpatient or outpatient treatment at a hospital, ambulatory care facility, physician's office, or other healthcare setting for a range of procedures determined by CCM to require prior authorization. A list of these services is provided in Chapter 7, Attachment 2 of this manual or on the provider portal at www.ccmny.org. Prior authorization also allows CCM to identify members for pre-service discharge planning and to register them in our specialized programs such as disease management or care management.

7. Process/Responsibility

The participating PCP or specialist who will be providing the service to the member shall make requests for services requiring prior authorization.

Requests can be made by contacting the CCM Medical Management Department in the following ways:

- Telephone request should be called in to the telephone number for Medical Management located in Attachment 2.
- Faxed requests should be sent on a completed Consult Request Form to the toll free fax number for Medical Management. A copy of this form is provided on our website at www.ccmny.org; and
- By mail to the CCM Medical Management Department address located in Attachment 2.

Coverage determinations are based on Medicare coverage guidelines, nationally recognized criteria, or locally developed CCM clinical coverage policies. A coverage determination requires the provision of information to CCM regarding the clinical condition and treatment or services proposed for the member. There are three components to coverage determinations:

- Whether the patient is an eligible CCM member,

- Whether the service is a covered service under CCM and
- Whether the service is medically necessary.

8. **Notification Requirements**

Timeframes for notification: You must notify CCM's Medical Management Department within the required timeframes.

- 8.1 Elective Services** – 14 days prior to a scheduled service (both inpatient and outpatient) whenever possible. If notification cannot be made 14 days prior to the service, it should be made as soon as medically possible prior to the scheduled service.
- 8.2 Urgent Services** – CCM should be notified prior to urgent services/admission being rendered, when possible. If circumstances do not allow for notification prior to urgent services being rendered, then notification must occur within one business day.
- 8.3 Emergent Services** – Although no authorization is required, CCM should be notified within one business day of emergent services/hospital admission.
- 8.4 Inpatient Admission Notification**

For continuity of care, PCPs or the admitting hospital facilities should notify CCM if they are admitting a CCM member to a hospital or other inpatient facility.

To notify CCM of an admission, the PCP or the admitting hospital should call CCM and provide the following information:

- Notifying PCP or hospital;
- Name of admitting PCP;
- Members' name, sex, and CCM ID number;
- Admitting facility;
- Primary diagnosis; and
- Reason for admission.

9. **Concurrent Hospital Review**

CCM will review all member hospitalizations within 48 hours of admission to confirm that the hospitalization and/or procedures were medically necessary. If CCM concludes that certain services may not have been necessary, the

CCM Clinical Affairs VP, CCM Medical Management Coordinator or any other physician designee, will speak with the participating providers responsible to discuss the situation and potential future options for handling similar cases.

You will be given a certified length of stay when you receive admission authorization following your request for prior authorization. You must notify us if your patient requires an extended length of stay, additional consultations, or special discharge planning that you did not originally anticipate. You must notify us to update the authorization at the telephone number located in Attachment 2.

The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to the member,
- Assessing the member's clinical condition and ongoing medical services and treatments to determine benefit coverage,
- Considering the social situation of the member and the safety of a possible discharge,
- Notifying providers of coverage determinations in the appropriate manner and within the appropriate time frame,
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting,
- Identifying the member for referral to covered specialty programs, such as Care Management, Behavioral Health and Disease Management.

10. Discharge Planning

The CCM Medical Management Coordinator will assist participating providers and hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, the CCM Medical Management Coordinator will discuss discharge planning with the participating provider, member, and family. CCM's interdisciplinary approach provides additional clinical resources to coordinate the member's transition to the appropriate care setting, for example rehabilitation, skilled nursing facility, or home health care.

11. Skilled Nursing Facility Services

A skilled nursing facility is an institution that provides skilled nursing or skilled rehabilitation services. It can be a stand alone facility, or part of a hospital or other health care facility. A skilled nursing facility does not include institutions

that mainly provide custodial care, such as convalescent nursing homes or rest homes.

Skilled nursing facility care means a level of care ordered by a physician that must be given or supervised by licensed health care professionals.

In the process of working with the healthcare team, particularly the PCP, hospital discharge planners and/or the CCM staff may encourage the appropriate transfer of a member to a lower level of care at some point in the member's hospitalization. The Medical Management staff will assist in the placement of members into skilled nursing facilities based on the member's eligibility and approved medical management decision-making criteria in the Medical Management Guidelines. Participating skilled nursing facilities, when available and able to provide the required service, are utilized in this process.

Requirements:

- The patient must need daily skilled nursing or skilled rehabilitation care, or both
- Prior authorization through the CCM Medical Management Department is required for all admissions into a Skilled Nursing Facility

12. Home Health Care

Home health care is skilled nursing care, rehabilitation therapies and certain other health care services that the member gets in the home for the treatment of an acute illness or injury. If your patient needs home health care services, CCM Medical Management staff will arrange these services for your patient, if the eligibility requirements are met.

13. Durable Medical Equipment

The Medical Management staff will assist in the process of evaluating and authorizing the use of durable medical equipment (DME) by members for the purpose of providing medically necessary services. The Medical Management staff will evaluate a member's illness, injury, degree of disability and medical needs for the proper and timely authorization of DME. The Medical Management staff will authorize and monitor the medical necessity and appropriateness of DME and authorize usage by members according to the member's eligibility, benefit coverage and the consistent and appropriate application of medical management decision-making criteria. Participating providers will supply the DME to the Members.

Authorizations for selected DME are typically made for up to two (2) months at a time. The Medical Management staff conducts monthly assessments of

the member's eligibility and benefits and of the cost of the equipment (to ensure that rental cost does not exceed purchase price).

14. Outpatient Services Review

Outpatient review involves the retrospective evaluation of selected outpatient procedures and therapies to determine medical necessity and appropriateness. Outpatient treatment plans for members with complex or chronic conditions may be developed.

15. Second Medical or Surgical Opinion

A member may request a second opinion if the member:

- disputes reasonableness decision;
- disputes necessity of procedure decision; or
- does not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, a member should first contact his or her PCP to request a referral. If the member does not wish to discuss their request directly with the PCP, he or she may call CCM for assistance. Members may obtain a second opinion from a participating provider within the CCM network. The member may be responsible for the applicable copayments.

16. Medical Criteria

Qualified professionals who are members of the CCM Quality Improvement Committees and the Board of Directors will approve the medical criteria used to review medical practices and determine medical necessity. CCM uses standard criteria, to guide the precertification, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria. For more information or to receive a copy of these guidelines, please contact CCM.

CCM may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to participating providers through the CCM physician newsletters and available on our website under Providers tab.

CCM has established the Medical Advisory Committee to allow physicians to provide guidance on medical policy, quality assessment and improvement programs and medical management procedures. The Committee is chaired by CCM's Vice President for Medical Affairs and includes additional practicing physicians who participate in CCM. The committee members reflect diversity in medical specialty, geography and ethnicity.

The goals of the Medical Advisory Committee are to ensure that practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of the enrolled population;
- Are developed in consultation with participating physicians; and
- Are reviewed and updated periodically.

The guidelines will be communicated to providers, and, as appropriate, to members. Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply will be consistent with the guidelines.

If you would like to propose a discussion topic to be considered for discussion by CCM's Medical Advisory Committee, please contact the Vice President for Medical Affairs at 718 519-5230.

17. Pharmacy Benefit (Medicare Part D) for CCM Direct Members

CCM PACE, Direct and MAP members will obtain all Medicare Part D covered medications using the Medco Pharmacy Network. Members must present their CCM identification card and copays attached to their plan. PACE members do not have any copayment.

CCM offers a very comprehensive 4-tier Formulary that addresses all medically necessary drugs. CCM's Formulary can be accessed at www.ccmny.org.

17.1 Medications Requiring Prior Authorization

Certain medications require authorization before they are dispensed to members to determine if their use follows acceptable medical practice or if they are being taken for a covered condition. In some cases, clinical documentation is necessary to review medication requests. CCM's delegated Pharmacy Benefits Manager reviews all requests promptly and follows Medicare requirements in communicating its decision to the physician or, when applicable, to the member. To obtain authorization for medications, providers should:

- Call Medco 1-800-922-1557 and provide the necessary information, or
- Complete the general prior authorization form for the medication and send it to Medco by fax at 1-800-837-0959.

Providers are encouraged to call for prior authorization to expedite the review process and allow for transition coverage where applicable.

17.2 Formulary Exceptions

In certain cases, a provider may determine that a member requires a non-covered prescription. When this occurs, the provider may request an exception from the formulary by completing an Exception Request Form or by calling Medco. The Exception Request Form may be faxed to 1-800-837-0959. The formulary exception request form is available on our website, www.ccmny.org.

17.3 Specialty Pharmacy

CCM providers must obtain all Medicare Part B covered medications for CCM beneficiaries through the Specialty Pharmacy Division of Medco, our contracted pharmacy vendor. Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service, either by or under the physician's direct supervision. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service then the drug may not be covered by Part B. In some instances, these medications may be oral medications (e.g. selected oral chemotherapeutic agents that contain the same ingredient as the injectable or infusible dosage forms that would not be considered as self-administered.) Medicare Part B also covers a limited number of other types of drugs as shown in the attached chart.

CCM providers shall prescribe, as usual, a Medicare Part B covered medication, adding a comment, if necessary, to highlight Medicare Part B coverage (e.g. "For treatment of ___ - cancer"). The provider will then contact Medco at 1-800-922-1557. to request the medication be sent to their office. Medco will provide the necessary directions as to how to proceed with the request.

Select Part B medications will require prior authorization and will be administered by Medco using CCM criteria.

18. Timeframes

18.1 Prescription Drug Coverage Determinations

Standard coverage decisions will be rendered within 72 hours of being requested.

Expedited coverage decisions will be rendered with 24 hours of being requested.

18.2 Medical Coverage Determinations

Standard decisions will generally be rendered within 14 days of being requested. CCM is allowed a 14-day extension if the time is needed review additional documentation.

Expedited coverage decisions will be rendered within 72 hours of being requested by a physician.

19. Clinical Trial Coverage

A clinical trial is a way of testing new types of medical care (e.g. how well a new cancer drug works). Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose or treat diseases. Consistent with CMS policy, CCM covers the cost of routine Member care in clinical trials qualified under the CMS guidelines to the same extent it reimburses routine care for Members not in clinical trials and in accordance with the limitations outlined below.

- Providers will not routinely be required to submit documentation about the trial to CCM, but CCM can, at any time, request such documentation to confirm that the clinical trial meets current standards for scientific merit and has the relevant institutional review board approval(s).
- All applicable CCM requirements for authorization and referrals must be met.
- All applicable Plan limitations for coverage of out-of-network care will apply to routine Member care costs in clinical trials.
- All Medical Management rules and coverage policies that apply to routine care for Members not in clinical trials will also apply to routine patient care for Members in clinical trials.

20. New Technologies

CCM continually reviews and assesses existing and improved technology for health care services benefit applications. This includes medical and behavioral health procedures, pharmaceuticals and devices. CCM criteria may change and/or expand because of these revisions and will be reflected in CCM policy and procedure changes. The CCM Medical Director is available for discussion of individual cases, which may benefit from improved technological changes.

Additionally, there is a process for participating providers to submit new technology for coverage review. Please contact CCM for more information.

21. Care Management



CCM will assist in managing the care of members with acute or chronic conditions that can benefit from ongoing clinical coordination and care management in conjunction with the PCP. CCM providers shall assist and cooperate with CCM's care management programs. The objectives of CCM's Care Management Program are as follows:

- Implement procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health;
- Make best efforts to conduct a health assessment of all new members within 90 days of the effective date enrollment;
- Identify members with complex health care needs who would benefit from medical care management interventions;
- Identify and recommend alternative care options and prevent hospitalization when feasible; and
- Monitor clinical services through close contact with physicians, ancillary service providers, CCM care management team, and document the member's on-going care needs.

The Care Management Program includes, but is not limited to:

Defining and tracking quality and performance indicators;

- Implementing measures that contribute to improving quality of care and cost-effective management of targeted conditions;
- Encouraging preventive care strategies to keep members healthy;
- Promoting member education and behavioral modification that improve outcomes; and
- Monitoring outcomes and program effectiveness.

Members are educated about available programs through the enrollment process, marketing materials, and discussions with participating providers. CCM will actively identify members who could benefit from care management and ensure they are enrolled in the care management program.

22. Physician Collaboration

The cornerstone of the CCM Care Management program is effective collaboration with participating primary care physicians. These collaborative relationships will include:

Identification of individuals appropriate for disease management, working with participating physicians and office staff;

Development and implementation of member-specific care plans, using evidence-based treatment regimens that will be coordinated by the physician and care manager;

Patient education, focused on supporting self-care management and monitoring; and

Care manager feedback to physicians regarding patient status and clinical needs.

23. Pre-Authorization Lists and Forms

Attachment 2

24. Services Requiring Prior Authorization

Inpatient Admissions

All hospital admissions, except in an emergency, including:

- Surgical admissions
- Medical admissions
- All outpatient surgery, except in an emergency
- All Skilled Nursing Facility (SNF) admissions
- All Rehabilitation facility admissions
- All Sub acute admissions
- All elective mental health and substance abuse admissions

CCM requires notification of all emergent admissions. Authorization for post stabilization of services should be obtained within as soon as clinically possible.

Every attempt should be made to notify CCM prior to an urgent admission. Should this not be clinically feasible, authorization should be obtained within one business day of admission.

- Organ Transplants and Transplant Evaluations
- Dialysis Treatments
- Reconstructive Procedures that may be considered cosmetic

- Radiology Services
 - CAT scans
 - MRI
 - MRA
 - PET scans
 - Nuclear Medicine Studies (including EMG / Nuclear Cardiology)
 - Radiation Therapy
- All Home Health Care Admissions
- Rehabilitative Therapies (required after the evaluation visit)
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
- Pain Management
 - Implantation of pumps for pain management
 - Spinal cord stimulators
- Sleep Disorders
 - Sleep Studies
 - Surgical treatment of sleep disorders
- Dental Services that are considered medical in nature, except in an emergency.
- Requests for nonparticipating physicians and providers of non-emergent services to be reimbursed at the in-network level of benefit.
- Services that may be considered investigational or experimental.
- Durable Medical Equipment (DME)
- Medical Injectables and select Medicare Part B Drugs

Chapter 5 – Timely Filing and Prompt Payment of Claims

Participating Providers should submit claims to CCM as soon as possible after service is rendered, using the standard CMS-1500 or UB-04 Claim Form, or electronically as discussed below. Services billed beyond 90 days from date of service are not eligible for reimbursement as stipulated in your contract.

Please contact the CCM Provider Service Line 1-800-761-5602 with any questions you may have on our claims process.

To expedite claims payment, the following fields are required to meet prompt payment guidelines for clean claims.

- Member name
- Member's date of birth and sex
- Member's CCM ID number
- Description of service
- ICD-9 Diagnosis Codes to the greatest degree of specificity
- CPT-4 Procedure Codes
- Date of services
- Charge for each service
- Provider's Tax Identification Number
- Name/address of Participating Provider
- Provider NPI
- Place of Service

1. **Prompt Payment of Claims**

Network providers will be paid according to the terms of their contract.

Non-network providers will be paid according to Medicare/Medicaid claims processing methodology and guidelines.

2. **Claims Submission – Electronic**

CCM encourages all providers to submit claims to us electronically and sign up to receive EFT, (electronic funds transfers) for payment. Electronic claims submission and payments can offer you the following benefits:

1. More efficient claims payment
2. Improved cash flow
3. Increased convenience: one universal form to complete for all carriers
4. Greater reliability than paper systems
5. Decreased postage and mail time
6. Reduced paperwork for office staff.

Providers may elect to submit claims through Claims Net. You can register to use this free service and get information by going online to www.claimsnet.com/ccm or phone 972-458-1701 ext. 121. The CCM payer ID is CCM1.

CCM will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to CCM should comply with those requirements.

3. **Coordination of Benefits**

Some Members may have health insurance coverage through another insurance carrier that is required to pay before Medicare and/or Medicaid. If a Member has coverage with another plan that is primary to CCM, please submit a claim for payment to that plan first. The amount payable by CCM will be determined by the amount paid by the primary plan and Medicare secondary payer law and policies. Please submit a copy of the primary carrier's Explanation of Payment with your claim to CCM.

4. **Balance Billing**

You may not bill a Member for a non-covered service unless:

You have informed the Member in advance that the service is not covered

– and –

The Member has agreed in writing to pay for the non-covered service.

5. **Claims Inquiries or Disputes**



If you have questions regarding the status of a claim or other inquiries, contact the CCM Provider Service Line at 1-800-761-5602.

You may dispute a claims payment decision by requesting a claim review. All disputes must be submitted within 60 days of the date of the denial letter according to the time frames indicated in the contract of the participating provider's agreement with CCM.

The below procedures are applicable for the participating provider who wishes to submit a Provider dispute for evaluation and review by CCM.

All Provider disputes must be in writing and must include the following:

- Provider name,
- National Provider Identifier (NPI)
- Provider contact information,
- The CCM member's identification number;
- The specific item in dispute;
- Clearly stated reason for contesting the determination and the justification as to why the service should be paid or approved; and
- Copies of all relevant information and supporting documentation required for review of the provider's concerns e.g. claims include claim number, medical records, authorizations, etc.

The Provider must either fax the above information to the fax number indicated in Attachment 2, for Provider Services, or mail the information to the address designated for Provider Services in the Quick Reference Guide.

5.1 Dispute Review Process and Timeframes

CCM will thoroughly review the provider's request and all supporting information and documentation. Written determination of resolution of a dispute will be issued within 30 business days of receipt in accordance with your contract. If the resolution requires a claim payment, the payment will be issued within 10 business days of the determination.

If additional information is needed, a request will be sent to the provider within 15 business days. To resolve the dispute, the provider has 30 business days from the date of requested information to submit additional information or the dispute will be closed.

5.2 Dispute Resolution

If CCM decides in the provider's favor on a request for payment, CCM will pay for the service no later than 10 business days from the date of the determination.

If CCM decides against the provider, CCM will notify the provider in writing as to the rationale for the decision.

6. Member Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two different types of complaints they can make. All participating providers must cooperate with CCM's appeals and grievances process.

An "appeal" is the type of complaint a member makes when the member wants CCM to reconsider and change an initial decision (by CCM or a participating physician) about what services are necessary or covered or what CCM will pay for a service.

A "grievance" is the type of complaint a member makes regarding any other type of problem or dissatisfaction with CCM or a participating provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, or a breach of the member's rights are considered grievances.

6.1 Resolving Grievances

If a CCM member has a grievance about CCM, a provider or any other issue, participating providers should instruct the member to contact Member Services at 1-877-226-8500. If an immediate resolution is not possible, CCM will acknowledge the member's grievance in writing. CCM will contact providers concerning grievances related to their practice and will request a response to the member complaint. Grievances will be decided within 30 days after filing and CCM will send the member a written notice describing CCM's actions to resolve the complaint, the reasons for our decision, and information about the appeal process as appropriate to the member's plan. Participating providers are expected to cooperate with CCM on any grievance investigation related to the services provided to the member.

6.2 Adverse Determination

Adverse determinations are denials of coverage for proposed or actual medical services that, based on available information, do not meet accepted criteria for coverage. Only a physician may make an adverse determination. Providers are notified in writing of adverse

determinations. The notice includes service/treatment being denied, dates of service being denied, the reasons for the denial and instructions on how to initiate standard, expedited, and external appeals including time frames for filing/reviewing appeals.

6.3 Resolving appeals

A member may appeal an adverse determination by CCM or a participating provider concerning authorization for, or termination of coverage of, a health care service. A member may also appeal an adverse determination by CCM concerning payment for a health care service. A member's appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by CCM within 30 calendar days, or sooner if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

Participating providers are expected to cooperate with CCM in providing necessary information to decide on the appeal within the required time frames. Participating providers must provide the pertinent medical records and any other relevant information to CCM generally within three (3) days. In some instances, participating providers must provide the records and information within 24 hours in order to allow CCM to make an expedited decision.

If a participating provider decides not to perform a service that is requested by the member, the member should be advised to call CCM Member Services to request a formal denial and appeal rights.

If CCM upholds the denial a written notice of final adverse determination is sent to the member, and, as appropriate, the member's provider. The notice includes a summary of appeal and date filed, a description of the health care service that was denied, a statement describing the basis and clinical rationale for the denial, a statement that the member may be eligible for external appeal and the form and instructions for requesting an external appeal.

A special type of appeal applies only to hospital discharges. If the member thinks CCM coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization, Inc. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that CCM coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from CCM.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing members with a written notice at least two days before their services are scheduled to end. If the member thinks the coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization, Inc. The notice will provide information on how to appeal the coverage decision and time frames for requesting continued coverage. If the member misses the deadline for appealing to the Quality Improvement Organization, Inc., the member can request an expedited appeal from CCM.

6.4 Further Appeal Rights

If CCM denies a Medicare Advantage member's appeal in whole or part, it will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of CCM. This organization will review the appeal and, if the appeal involves authorization for health care, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. CCM will inform the member of all other rights if the IRE issues an adverse decision.

PACE and Select members must request an internal appeal within 45 days of notice of a denial. CCM Appeals Panel will investigate the circumstances of the denial, review clinical criteria relied upon in making the decision, consult with specialists as appropriate and make a determination to uphold (agree with) the denial, or reverse the initial denial. If the denial is upheld, the member has further external appeal rights. A member with both Medicare and Medicaid coverage may choose either the New York State Fair Hearing process or Medicare's external appeal process. If the member requests, CCM staff will assist the member to file their appeal and forward the appeal accordingly.

7. Fraud and Abuse Prevention

CCM is committed to preventing and detecting any fraud, waste, or abuse in the organization. To this end, CCM maintains a vigorous compliance program and strives to educate our workforce on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments.

The Federal False Claims Act establishes liability under a number of circumstances. Some examples include any person or entity who:

- Knowingly presents or causes a false claim to be presented to the federal government for payment or approval;
- Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Knowingly conceals and/or improperly avoids or decreases an obligation to pay or transmit money or property to the federal government;
- Conspires to commit a violation of the liability sections of the Act.

7.1 Anti-Kickback Statute

The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward the referral of business payable or reimbursable under the Medicare or other federal health care programs.

The individual or entity may be excluded from participation in Medicare or other federal health care programs.

7.2 Beneficiary Inducement Law

Prohibits offering remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier;

Creates liability of civil monetary penalties of up to \$10,000 for each wrongful act.

8. Code of Conduct

CCM adheres to a Code of Conduct which governs the conduct of employees and those independent contractors and others affiliated with the Bethco system. (see attachment 3 for additional information)

Quality Improvement Program

CCM is dedicated to providing appropriate, quality care and services in an efficient and cost-effective manner. We accomplish this by maintaining the focus of all levels of the organization on the assessment and improvement of all aspects of care.

The overriding principle of CCM's Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improving care and service to meet or exceed our members' expectations. CCM considers our participating providers essential to our efforts to deliver high quality, cost effective care to the members. We encourage your participation in our quality improvement efforts and welcome your feedback on any aspect of the program.

The Board of Directors of CCM has the authority and responsibility to establish, maintain and support the QIP on a continuing basis. The Quality Improvement Committee (QIC) meets to ensure that the QIP is implemented and there are adequate resources to fulfill its mission. The Medical Director of CCM serves as the Chairperson of the QIC. The Medical Director reports directly to the Board of Directors quarterly concerning activities of the QIC.

The CCM Medical Director is directly responsible for the management of all quality improvement and utilization management activities. In this capacity, the Medical Director works closely with administrative and clinical personnel to address and resolve quality and utilization concerns.

9. Quality Improvement Committee

The composition of the QIC is directly correlated with its charter of responsibilities, which is to:

- Oversee CCM's QI activities which include member rights and satisfaction, medical record audits, utilization management, medical management, contract oversight, credentialing, monitoring of access and availability and clinical studies
- Develop, prioritize, and evaluate an annual work plan
- Set and monitor performance standards and measurable clinical indicators for important aspects of care and services
- Set thresholds or factors that trigger further evaluation of care and service by analyzing data, trends and monitoring outcomes
- Assess the effectiveness of corrective actions and implement processes to sustain improvements

- Improve organizational communication through an integrated committee structure, formalized reporting, mechanisms for sharing information and engagement of staff, providers and members in quality improvement activities

10. Members' Rights

CCM members have the right to timely, high quality care, and treatment with dignity and respect. Participating providers must respect the rights of all CCM members. Specifically, CCM members have been informed that they have the following rights:

11. Timely, Quality Care

- Choice of a qualified PCP and hospital
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their PCP and referrals and recommendations to specialists when medically necessary
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists
- To actively participate in decisions regarding their health and treatment options
- To receive urgently needed services when traveling outside CCM's service area or in CCM's service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating provider
- To request information regarding the financial condition of CCM

12. Treatment with Dignity and Respect

- To be treated with dignity and respect and to have their right to privacy recognized
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care
- To confidential treatment of all communications and records pertaining to the member's care

- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision)
- To complete an Advance Directive, living will or other directive to the member's medical providers

13. Member Satisfaction

CCM periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating providers. Survey information is reviewed by CCM and results are shared with the participating providers.

14. Services Provided in a Culturally Competent Manner

CCM is obligated to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating providers must cooperate with CCM in meeting this obligation.

15. Advance Directives

CCM members have the right to complete an "Advance Directive" statement. This statement indicates, in advance, the member's choices for treatment to be followed in the event the member becomes incapacitated or otherwise unable to make medical treatment decisions. CCM suggests that participating providers have Advance Directives forms in their office and available to members.

16. Member Complaints/Grievances

CCM's objective is to provide members with formal and informal processes for resolving complaints, genuine and perceived concerns and for verbalizing compliments. The concerns may relate to service, quality of care, benefits or any aspect of member satisfaction. Member Services staff have the responsibility of logging member concerns and providing this information to appropriate CCM staff for follow-up. CCM tracks all complaints and grievances to identify areas of improvement. This information is reviewed by the Credentialing Committee, the Quality Improvement Committee and reported to the CCM Board of Directors.

Chapter 6 – Attachments

Attachment 1: Member ID Cards

	Member Services: 1-877-226-8500 (TTY: 1-800-650-2774)	
	Direct Complete	
Member ID: MemberID Name: <First Name> <Last Name>	Policy/Group #: Policy Issuer ID: Issuer ID	Send Medical Claims To: Comprehensive Care Management ATTN: Claims Department 1250 Waters Place Tower 1, Suite 802 Bronx, New York 10461 Except for emergencies, all covered services must be provided by a network provider. Most services require prior authorization from Medical Management. This card does not guarantee coverage. Provider Services (Claims Status): 1-800-761-5602 Medical Management: 1-800-695-1035 (TTY: 1-800-650-2774) Pharmacy Customer Service: 1-800-596-4923 (TTY: 1-800-716-3231) Pharmacy Technical Help Desk: 1-800-922-1557 (TTY: 1-800-716-3231) www.ccmny.org
PCP: PCP name PCP #: PCP Phone	RxBin: RxBin RxPCN: RxPCN Amy RXGrp: RXGrp Data	
Co-Pays: PCP: PCP Amt Specialist: Spec Amt ER: ER Amt		
		
PBP Num		

	Member Services: 1-877-226-8500 (TTY: 1-800-650-2774)	
	PACE	
Member ID: MemberID Name: <First Name> <Last Name>	Policy/Group #: Policy Issuer ID: Issuer ID	
PCP: PCP name PCP #: PCP Phone	RxBin: RxBin RxPCN: RxPCN Amy RXGrp: RXGrp Data	
PACE Site Location: address1 address2		
PBP Num www.ccmny.org		

	Select	SOC Date
	Member ID	
Because living at home is a better alternative		
New York Managed Long Term Benefits Only		
Full Name		
Medicaid No		
Medicare No		
Member Services: (888) 878-8701		
www.ccmny.org		

Send Medical Claims To: Comprehensive Care Management ATTN: Claims Department 1250 Waters Place Tower 1, Suite 802 Bronx, NY 10461	Send Pharmacy Claims To: Medco Health Solutions, Inc. P.O. Box 14718 Lexington, KY 40512 www.medco.com
Except for emergencies, all covered services must be provided by a network provider. Services require prior authorization (excluding emergency services) from Medical Management. Please contact the CCM Nurse Manager to coordinate member's care. This card does not guarantee coverage.	
Provider Services (Claims Status): 1-800-761-5602 Medical Management: 1-800-695-1035 (TTY: 1-800-650-2774) Pharmacy Customer Service: 1-800-596-4923 (TTY: 1-800-716-3231) Pharmacy Technical Help Desk: 1-800-922-1557 (TTY: 1-800-716-3231)	

MEMBERS: Please carry this card at all times. Show this card before you receive any covered Managed Long Term Care services. You do not need to show this card before you receive emergency care. If you have an emergency, call 911 or go to the nearest emergency room. If you have questions, call Member Services at 888-878-8701.
Physicians: This individual is enrolled in a New York State approved Managed Long Term Care plan that provides coverage for long term care. Physician services will be paid directly by Medicaid-fee-for-service or Medicare. If the member has Medicare and/or other private insurance, their benefits are not affected by their Managed Long Term Care coverage. Please do not attempt to collect a co-pay or deductible from this individual.
Hospitals: This individual is enrolled in a New York State approved Managed Long Term Care plan that provides coverage for long term care. Please notify us of any inpatient activity incurred by this member as we are responsible for discharge planning. Pre-admission certification is not required. Your claim will be paid directly by Medicaid, Medicare and/or other private insurance. <ul style="list-style-type: none"> Submit claims within 90 days to: CCM CLAIMS PROCESSING UNIT, 1250 Waters Place, Tower 1, Suite 802, BRONX, NY 10461

Attachment 2: Provider Quick Reference Guide



Comprehensive Care Management Corporation

A Member of the Beth Abraham Family of Health Services

QUICK REFERENCE GUIDE

Service	Contact Information	Hours of Operation	Purpose
Member Services for PACE and DIRECT	1-877-226-8500	7 days a week 8 AM to 8 PM	Eligibility, benefits, general questions, referrals to CCM
Member Services for SELECT	1-888-878-8701	M – F 9 AM to 5 PM	Eligibility, benefits, authorization, referrals to CCM
Provider Service Line	P: 1-800-761-5602 F: 1-718-944-2149	M – F 9 AM to 5 PM	Provider issues, claim questions
Medical Management	P: 1-800-695-1035 F: 1-800-421-7042	M – F 9 AM to 5 PM	Check status of authorization, queries on specialty referrals
Medco – Pharmacy Member Services	P: 1-800-922-1557 F: 1-800-837-0959	24 hours, 7 days a week	All Pharmacy related issues
Healthplex - Dental Services	1-800-468-9868	7 days a week 8 AM to 6 PM	Healthplex administers all primary and medically necessary specialty dental care.
Vision Service Plan(VSP) Wellness Eye Exams/ Primary Eye Care	1-800-877-7195	7 days a week 8 AM to 8 PM	VSP is primary for providing routine eye exams, dispensing materials such as lenses and frames.

1.1 Eligibility / Claims / Specialty Services

Eligibility	To check eligibility for a CCM member, please call the Member Services number for the appropriate program.
Claims Please submit claims within 90 days of the date of service to remain compliant with CCM’s timely filing process.	<p>Electronic Claims Submissions: Please register through our on-line registration site at www.claimsnet.com/ccm to begin submitted claims electronically. Detailed instructions and a personal follow-up from a Claimsnet representative to ensure that your account is set up for your satisfaction are available. If you have any questions, please call (972) 458-1701 ext. 121.</p> <p>Paper Claims Submissions (use CMS 1500 or UB-04 forms): CCM 1250 Waters Place, Tower 1, Suite 602 Bronx, NY 10461 Attention: Claims</p>
General Instructions	<p>Authorizations: Please allow 14 days for approval of a standard authorization request and 48 hours for an urgent request.</p> <p>Transportation: If the member requires non-emergency transportation, please contact 800-695-1035 at least 2 business days prior to the appointment.</p>

CCM Participating Laboratories

Contracted Laboratories	Location	Phone / Fax	Counties Served
Bendiner & Schlessinger, Inc	140 58 th Street, Suite 8D, Brooklyn, NY 11220	P: 212-353-5148 P:212-353-5124 F: 718-439-3072	Kings, SI



Montefiore Medical Center	111 E. 210 Street, Bronx, NY 10467	P: 718-405-4000	Bronx, New York, Westchester
Sunrise Medical Laboratories, Inc.	240 Motor Parkway, Hauppauge, NY 11788	P: 631-435-1515 F: 631-435-1552	Bronx, New York, Kings, Queens, Westchester, Nassau, Suffolk, SI

2 CCM participating provider network can be accessed at <http://www.ccmny.org>

PACE		
URGENT AUTHORIZATION REQUESTS AND ADMISSION NOTIFICATIONS	SERVICES REQUIRING AUTHORIZATION	SERVICES REQUIRING NO REFERRAL or AUTHORIZATION
To Notify CCM of planned or unplanned hospital admissions or observations; hospital must contact Medical Management via phone or fax at the numbers listed above within 48 hours of admission or service	Providers requesting authorizations for their patients should call Medical Management at 800-695-1035. Please allow 14 days for approval of standard authorizations, and 48 hours for urgent requests.	Members may self-refer for the following services. If transportation is needed, the member or provider must contact CCM at 800-695-1035 to make arrangements. Please notify us at least 2 business days prior to the appointment.
		Emergency and Urgent Care
You may also call the Medical Management Department at 800-695-1035 for other unplanned services requiring authorization.	Elective Surgery	Emergent transportation services
	Investigational Treatment	Urgent or emergent services provided in an emergency room, urgent care center or consultant's office.
	Out of Network Services	Primary Care
	Skilled Nursing Facility	PCP office visits and treatment provided by the member's assigned PCP
	Transplantation evaluation and services	Diagnostic tests and procedures provided by the member's assigned PCP
	Therapies - Physical, Speech or Occupational Therapy - after initial evaluation	
	MRA, MRI, PET, SPECT	
SELECT		
SERVICES COVERED	Nutrition-	Therapies – 1st Visit Home or outpatient



	Private Duty Nursing	Physical; Occupational and Speech - First Visit with the PCP or Specialist Script.
Care management	Home Delivered or Congregate Meals	
Home Care (nursing, home health aide, physical, speech and occupational therapy, medical social services)	Social Day Care	SERVICES REQUIRING AUTHORIZATION
Adult Day Health Care	Social Environmental Supports, including home improvements and modification, appliances and assistive devices	Providers should call the Medical Management Department at 800-695-1035 to request authorization for the following services. Please notify CCM with 2 business days prior to the appointment if the member needs transportation.
Personal Care	REFERRAL OR NOTIFICATION REQUIRED	
Durable Medical Equipment, Medical / Surgical Supplies, Prosthetics and Orthotics	Acupuncture	Certified Home Health Care
Personal Emergency Response System	Dental	Out of Network Services
Non-emergent Transportation for scheduled health-related appointments	DME	Therapies – after 1st Visit Home or outpatient - FOR MEDICAID PTS ONLY
Podiatry	Hearing aid batteries	- Physical
Dental Care	Optometry	- Occupational
Optometry Exams and Eyeglasses	Orthotics / Prosthetics	- Speech
Home - Physical, Occupational and Speech Therapy or other therapies	Podiatry	All other services are covered by Medicaid or Medicare directly. CCM will cover any co-pay or co-insurance amounts with evidence of payment by the primary payer. For Medicare Part B Patients, please bill Medicare for the following services: Acupuncture, Podiatry, Outpt PT, OT, ST.
Audiology Exams, Hearing Aids and Batteries	Transportation	
Respiratory Therapy - including preventive, maintenance, and rehabilitative airway-related techniques and procedures		



DIRECT	
URGENT AUTHORIZATION REQUESTS AND ADMISSION NOTIFICATIONS	REFERRAL OR NOTIFICATION REQUIRED
To Notify CCM of planned or unplanned hospital admissions or observations; hospital must contact Medical Management via phone or fax at the numbers listed above within 48 hours of admission or service	Please complete a Consultation Form and fax it to 800-421-7042 notifying CCM that this service has been ordered. For members whose benefits include transportation, CCM will coordinate the transportation services. Please notify us 2 business days prior to the appointment.
You may also call the Medical Management Department at 800-695-1035 for other unplanned services requiring authorization.	Emergency and Urgent Care – notification within 48 hours of visit
	Emergent transportation services.
SERVICES REQUIRING AUTHORIZATION	Urgent or emergent services provided in an emergency room or urgent care center or consultant office.
Providers please call the Medical Management Department at 800-695-1035 to request an authorization for the following services.	Primary Care
	PCP office visits and treatment provided by the members' assigned PCP.
Behavioral Health – after 1st visit Alcohol and Substance Abuse – after 1st visit	Diagnostic tests and procedures provided by the member's assigned PCP
Cardiac and Pulmonary Rehabilitation	
Chiropractic	Specialists
Cosmetic Procedures (if medically necessary)	Office visits and treatment with a PCP script.
Durable Medical Equipment	Diagnostic tests and procedures provided in the specialist's office.
Home Health Care	Podiatry – first visit with a PCP script
Hyperbaric Oxygen Therapy	
Inpatient admissions – Behavioral Health, Substance abuse	Ancillary
Inpatient admissions – Medical	Therapies – Occupational, Physical and Speech Therapy, first visit with a PCP or Specialist script
Inpatient Rehabilitation	
Investigational Treatment	Laboratory
IV Infusion – Home	Laboratory tests ordered by a participating provider .
Non emergency transport	Lab tests performed by the participating PCP assigned to the member.
Orthotics / Prosthetics	Lab tests performed by a participating specialist.
Out of Network Services	Lab tests consistent with CLIA guidelines performed at a CCM participating laboratory
Outpatient hospital / Surgeries	
Pain Management	Radiology
Podiatry – after 1st visit	All radiology services excluding MRA, MRI, PET, and SPECT.
Radiology – MRA, MRI, PET, and SPECT	All Mammograms.
Skilled Nursing Facilities	Diagnostic Ultrasounds
Sub Acute Behavioral Services	
Therapies – after 1 evaluation visit.	
Occupational .	
Physical.	
Speech	
Transplantation evaluation and services	



Attachment 3: CCM Code of Conduct

BETHCO SYSTEM COMPREHENSIVE CARE MANAGEMENT CORPORATION

CODE OF CONDUCT

This Code of Conduct governs the conduct of employees and those independent contractors and others affiliated with the Bethco system that the Compliance Officer has designated as covered by the Compliance Program.

- We will comply with applicable laws and regulations and with the Compliance Program, and will strive to act in a manner that will reflect positively on the Bethco system and its component entities.
- We will furnish the highest practical level of care to patients and residents.
- We will treat patients and residents, and their families, with dignity and respect.
- We will respect resident rights.
- We will ensure that patient or resident health care information is held in strict confidence, except as otherwise mandated by law.
- We will timely, accurately, and completely document all care that we give.
- We will bill Medicare, Medicaid and other payers only for care that we actually provide and that has been properly documented.
- We will not accept or pay kickbacks, or offer or accept any payment for referrals.
- We will not use our position to improperly benefit us, our relatives, friends or a business in which we have an interest, and we will promptly report potential conflicts of interest.
- We will treat all our partners fairly and with respect – unions, vendors, supporters.
- We will show respect for the environment and our community.
- We will treat our co-workers with respect.
- We will work with our colleagues and supervisors to correct problems as they occur and we will promptly report suspected wrongdoings to our supervisor or to the compliance officer. There will be no retaliation for making a good-faith report of possible improper behavior.
- Important telephone numbers for reporting compliance issues are listed below:

Compliance Officer

Lori Lahn

347-640-6090

Compliance Hotline 718-519-4057

