

Provider Manual: Qualified Health Plans and Essential Plans

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INTRODUCTION TO FIDELIS CARE

Fidelis Care was founded in 1993 on the belief that all New Yorkers should have access to affordable, quality health insurance. Today, as part of the Centene family of health plans, Fidelis Care provides coverage for children and adults of all ages and at all stages of life, including Qualified Health Plans (Metal-Level products) and Essential Plans. Fidelis Care continues to offer the State-sponsored Child Health Plus and Medicaid programs, as well as Medicare Advantage, Dual Advantage, Managed Long Term Care (MLTC) programs - Fidelis Care at Home, and Medicaid Advantage Plus.

Fidelis Care is operational in all 62 counties of the State. For a current listing of programs, eligibility guidelines, and counties of operation, please visit our website at fideliscare.org.

Fidelis Care's mission is to transform the health of the community, one person at a time. We are committed to working with providers to ensure members always receive the highest quality care and service.

Fidelis Care is a Prepaid Health Services Plan (PHSP).

Provider Manual Use and Interpretation

The Provider Manual is designed to help participating providers and their employees in understanding Fidelis Care policies and procedures, and their role as network providers. Information in this Manual is not intended to alter or modify the benefits to which the member is entitled. If and when operational policies change, the Manual will be updated accordingly. The most current version is always available on fideliscare.org.

Providers may consult with Fidelis Care's Chief Medical Officer or his/her designee with questions regarding which services are or are not included.

HOW FIDELIS CARE WORKS WITH PROVIDERS AND MEMBERS

Provider Relations Division

The Provider Relations Division is dedicated to fostering strong, long-term partnerships with all contracted providers. This relationship begins with an initial orientation and is followed by continuing education on policies, procedures, and issues that concern healthcare delivery within the guidelines of Fidelis Care.

Quality Health Care Management Division

The Quality Health Care Management Division (QHCM) evaluates the quality and appropriateness of healthcare services provided to Fidelis Care members. Case Managers can assist with authorizations and care coordination.

Member Services Division

The Member Services Division is available 24 hours a day, 7 days a week, to help members and to respond to questions or concerns regarding their healthcare coverage. This includes information regarding covered benefits, choosing or changing a primary care provider, orienting members to our Plan, and member responsibilities. Member Services also solicits feedback from members as to their satisfaction with services provided by Fidelis Care. It is always our goal to address member concerns or complaints quickly and efficiently.

Claims Division

The Claims Division processes and pays claims for covered services provided in accordance with the provider's contract and Fidelis Care policies and procedures. Working with QHCM, the Claims Division also collects encounter data for services.

Assessing Provider Satisfaction

On an annual basis, Fidelis Care conducts a Provider Satisfaction survey to assess provider satisfaction with Fidelis Care. The survey includes questions that relate to satisfaction with utilization management/authorization processes, administrative policies, network adequacy, Call Center, and Provider Relations. The survey results are analyzed and reported in various forums and actions are taken to address opportunities. Fidelis Care encourages providers to participate in the Provider Satisfaction Survey.

How to Contact Fidelis Care

The easiest and fastest way to access information regarding membership and eligibility, claims information, and primary care physician assignment, is through Fidelis Care's Provider Portal, Provider Access Online, on <https://www.fideliscare.org/>

Provider Access Online is easily accessible through the Provider section of our website.

The online registration process takes only a few minutes and providers typically have full access to the Portal within 5-7 business days. Providers and their staff members can log in using a secure user name and password 24 hours a day, 7 days a week.

For all other information, including contacting your Provider Relations Representative, the Quality Care Incentive (QCI) Program, or authorizations and care coordination, please call: 1-888-FIDELIS (1-888-343-3547).

Regional Offices

As a Statewide health plan, Fidelis Care is committed to maintaining a local, regional presence for our members and providers. Regional and satellite office locations are as follows:

<p>New York City Regional Office</p>	<p>95-25 Queens Boulevard Rego Park, New York 11374</p> <p>Fax: (718) 896-1920</p>
<p>Suffern Satellite Office</p>	<p>400 Rella Blvd Suite 116 Suffern, New York 10901</p> <p>Fax: (845) 368-0301</p>
<p>Albany Regional Office</p>	<p>31 British American Blvd. Latham, New York 12210</p> <p>Fax: (518) 427-9584</p>
<p>Poughkeepsie Satellite Office</p>	<p>25 Market Street Suite 100 Poughkeepsie, New York 12601</p> <p>Fax: (845) 483-1296</p>
<p>Buffalo Regional Office</p>	<p>480 CrossPoint Parkway Getzville, New York 14068 Fax: (716) 564-2374</p>
<p>Rochester Regional Office</p>	<p>100 WillowBrook Office Park Suite 100 Fairport, New York 14450</p> <p>Fax: (585) 383-8128</p>
<p>Syracuse Regional Office</p>	<p>5010 Campuswood Dr. East Syracuse, NY 13057</p> <p>Fax: (315) 448-2236</p>

How to Contact Fidelis Care’s Dental, Pharmacy, and Vision Providers

Fidelis Care provides certain benefits through third-party benefits management organizations. Providers should contact the benefits managers below to obtain authorizations and arrange treatment as indicated.

Dental	DentaQuest (855) 343-4267
Pharmacy	Caremark (800) 345-5413
Vision	Davis Vision (800) 773-2847

How to Contact eviCore Healthcare

Fidelis Care engaged eviCore healthcare* (eviCore) as a prior authorization program to manage **outpatient high-technology Radiology services, non-Obstetrical Ultrasounds, diagnostic Cardiology services, and Radiation Therapy** services being rendered on or after October 1, 2017.

Authorization Program: Radiology, Cardiology, and Radiation Therapy
eviCore healthcare
(866) 706-2108 – phone
(800) 540-2406 – fax
* https://www.evicore.com/healthplan/fideliscare

How to Contact National Imaging Associates, Inc. (NIA)

Fidelis Care has engaged National Imaging Associates, Inc. (NIA) to provide Utilization Management for outpatient rehabilitative and habilitative physical medicine services (**physical therapy (PT), occupational therapy (OT) and speech therapy (ST)**), *including services rendered in the home*, for services being rendered on or after October 1, 2019.

Authorization Program: Physical Medicine (PT, OT, ST Therapy)
National Imaging Associates, Inc. (NIA)
(800) 424-4952 – phone (Authorization Requests)
(800) 327-0641 – phone (NIA Provider Service Line)
(800) 784-6864 - fax

[*https://www1.radmd.com/radmd-home.aspx](https://www1.radmd.com/radmd-home.aspx)

HOW TO CONTACT TurningPoint Healthcare Solutions, LLC.

Fidelis Care has engaged TurningPoint Healthcare Solutions, LLC. to implement a prior authorization program for **orthopedic surgical procedures** and **spinal surgical procedures**, *in both inpatient and outpatient settings*, for services rendered on or after December 23, 2019.

Authorization Program: Orthopedic Surgical Procedures and Spinal Surgical Procedures

TurningPoint Healthcare Solutions, LLC

Web Portal Intake: <http://www.myturningpoint-healthcare.com>

Telephonic Intake: (347) 396-3591 | (855) 378-3135

Facsimile Intake: (646) 989-1921

Other Useful Numbers

New York State Child Abuse Reporting Hotline	(800) 342-3720
Early Intervention Program (EIP)	(800) 577-2229 (New York City)
Early Childhood Direction Center	(800) 462-7653 (New York State)
Vaccines for Children (VFC)	(800) 543-7468 or (800) KID-SHOTS
Women Infants and Children Program (WIC)	(800) 522-5006
NYS HIV Counseling, Testing and Other Services Hotline	(800) 872-2777
NYS AIDS Institute	(800) 541-AIDS
Domestic Violence Hotline	(800) 942-6906 (English) (800) 942-6908 (Spanish)

MEMBER RIGHTS AND RESPONSIBILITIES**Member Rights**

Members have rights pursuant to Federal and State law and the applicable program contract. These rights are summarized below. Additionally, member rights and responsibilities are outlined in the Fidelis Care Member Handbook provided to all members upon enrollment.

A Fidelis Care member has the right to:

- Receive information about Fidelis Care, our services, our practitioners and providers, and member rights and responsibilities. For more information, please visit the Fidelis Care website at <https://www.fideliscare.org/> or contact Customer Service 24 hours, 7 days a week at 1-888-FIDELIS (1-888-343-3547) TTY: 711.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Have your information remain confidential throughout the Fidelis Care organization. The following are ways Fidelis Care keeps your information confidential:
 - Fidelis Care staff members are prohibited from discussing confidential information in public places, such as elevators or outside of Fidelis Care offices.
 - When discussing your confidential information on the telephone, staff members are required to use appropriate safeguards to confirm they are speaking with someone who has the right to your confidential information.
 - All electronic transmissions contain limited identifiable information and are protected by encryption when sent outside of the organization.
 - Paper documents are stored in secure locked areas and destroyed when no longer needed.
- Participate with practitioners in making decisions about your health care.
- A candid discussion with your practitioners or providers about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- Voice complaints or appeals about Fidelis Care and the care or services we provide. Complaints may be communicated by contacting Customer Service 24 hours, 7 days a week at 1-888-FIDELIS (1-888-343-3547) TTY: 711.
- Make recommendations regarding our Member Rights and Responsibilities Policy.

A Fidelis Care member has the responsibility to:

- Supply information (to the extent possible) that Fidelis Care and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your practitioners.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

THE PROVIDER'S ROLES AND RESPONSIBILITIES

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control.
- Providers shall immediately notify Fidelis Care's Chief Medical Officer, in writing:
 1. if their ability to practice medicine is restricted or impaired in any way, or
 2. if their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor or is limited in any way, or
 3. if any adverse action is taken, or
 4. an investigation is initiated by any authorized Local, State or Federal agency, or
 5. of any new or pending malpractice actions, or
 6. of any reduction, restriction or denial of clinical privileges at any affiliated hospital.
- Providers shall comply with all Fidelis Care administrative, patient referral, quality assurance, utilization management, and reimbursement procedures.
- Providers shall not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, or source of payment and shall observe, protect, and promote the rights of members as members and any other category protected by law.
- Providers shall cooperate and participate in all Fidelis Care peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by Fidelis Care.
- Providers shall comply with all final determinations rendered by Fidelis Care peer review programs, or external arbitrators for grievance procedures consistent with the terms and conditions of the provider's agreement with Fidelis Care.
- Providers shall notify Fidelis Care in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) calendar days advance notice is requested.
- Providers shall notify Fidelis Care at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with Fidelis Care or as required by the provider's agreement with Fidelis Care.
- At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat Fidelis Care members.
- Providers agree to maintain standards for documentation of medical records and confidentiality for medical records (as per Section 7 of this manual).
- Providers agree to retain medical records for ten (10) years after the last date of service or, in the case of a minor, for six (6) years after the patient reaches the age of majority, or the length of time required by applicable law.
- Providers may freely communicate with members about all treatment options, regardless of benefit coverage limitations.

Informed Consent

The provider will adhere to all Federal and State law requirements for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent.

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to Federal and State laws, rules and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by Federal or State laws, rules, and regulations.

Medical records of recipients enrolled in foster care programs shall be disclosed to local social service officials in accordance with the New York State Social Service Law.

Medical records of all Fidelis Care members shall be confidential and shall only be disclosed to and by the provider's personnel as necessary to provide medical care and quality, peer, or complaint and appeal review of medical care under the terms of the applicable program contract as required in accordance with applicable laws and regulations.

You Can Help Protect Patient Confidentiality

Protecting your members' privacy is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following these simple measures:

- Avoid discussing cases within earshot of other patients or visitors.
- If voices can be heard easily through exam room walls, consider adding soundproof panels or piping in soft music.
- Arrange office space to allow privacy for members who are paying bills and making appointments.
- Make sure computer screens that contain patient information are protected from general view.
- Be sure all patient care is provided out of sight from other members (for example; weighing, lab draws).
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.
- Ask your members to sign an Authorization to Release Information prior to releasing medical records to anyone.
- Have a protocol for sending confidential information via fax.

New York State Confidentiality Law and HIV

Public Health Law (Article 27-F) requires AIDS and HIV-related information to be kept strictly confidential. The law strictly limits disclosure of HIV-related information. When disclosure of HIV-related information is authorized by a signed release, the person who has been given the information MUST keep it

confidential. Re-disclosure may only occur pursuant to another authorized release. The law only applies to people and facilities providing health or social services, and provides that:

- Confidential HIV-related information is any information that indicates that a person has had an HIV-related test, has HIV-infection, HIV-related illness, AIDS or has been exposed to HIV, the virus that causes AIDS.
- An HIV-related test is any lab test that could indicate a person has HIV.
- Any person, no matter what age, can consent to an HIV test, but the person **MUST** demonstrate understanding of what the test is for, what the results mean, and options for care and treatment.
- Disclosure of HIV-related information is generally permitted only after a release and consent form, approved by the New York State Department of Health, is signed by the patient authorizing the release of the HIV-related information.
- HIV-related information may be disclosed without a specific HIV release signed by the member when (1) the medical professionals treating the member need to discuss HIV information with each other or with their supervisors in order to provide care, (2) a hospital shares HIV information with the patient's insurance company because the information is necessary to pay for the care, (3) a physician needs to inform the patient's *sexual or needle sharing* partner, (4) a physician needs to inform a person who is legally authorized to consent to healthcare for the individual, (5) the information is needed to supervise, monitor or administer a health or social service, (6) the information is requested by an agency or prospective foster or adoptive parent, (7) in the care of a minor, the information is requested by the parent or guardian, (8) a court orders disclosure, (9) the information is being provided to supervisory or medical staff if he/she is in jail, prison or on parole.

HIV Related Testing

No physician or other person authorized pursuant to law may order an HIV-related test without first having obtained written or oral informed consent. When the test being ordered is a rapid HIV test, such informed consent may be obtained orally and shall be documented in the subject of the test's record.

Informed consent shall include providing information to the person to be tested. Information necessary to obtain informed consent may be provided through electronic, written or oral means and shall include:

1. HIV causes AIDS and can be transmitted through sexual activities and by needle-sharing by pregnant women to their fetuses, and through breastfeeding infants;
2. There is treatment for HIV that can help an individual stay healthy;
3. Individuals with HIV or AIDS can adopt safe practices to protect infected and uninfected people in their lives from becoming infected or multiply infected with HIV;
4. Testing is voluntary and can be done anonymously at a public testing center;
5. The law protects the confidentiality of HIV-related test results;
6. The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and

7. The law allows an individual's informed consent for HIV-related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

Consent may be for a single test, for a period of time determined by the subject of the test, or be open-ended, so long as the subject of the test may revoke consent for future tests at any time. Each additional time that an HIV test is being ordered, the physician or other person authorized to order an HIV test shall orally notify the subject of the test or, if the subject is not able to consent, the person authorized to consent for the subject that the test will be conducted and this notification will be noted in the subject's medical record.

With respect to positive results, in addition to explaining the test result to the person who consented to the test, the person who orders the test shall be responsible, directly or through a representative, for ensuring post-test counseling, referrals and linkage to care as appropriate. When confirmed positive results are being provided, the person ordering the test or his or her representative shall provide or arrange for an appointment for follow-up care for HIV. For persons who test positive, post-test counseling shall address:

1. Strategies for coping emotionally with the test results;
2. Discrimination issues relating to employment, housing, public accommodations, healthcare and social services;
3. The importance of taking precautions to prevent HIV transmission to others;
4. The ability to release or revoke the release of confidential HIV-related information;
5. HIV reporting requirements for the purposes of epidemiologic monitoring of the HIV/AIDS epidemic;
6. The importance of contacts being notified to prevent transmission, and allowing early access of exposed persons to HIV testing, health care, and prevention services, and a description of notification options and assistance available to the protected individual;
7. An assessment of the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner pursuant to law;
8. The requirement that known contacts, including a known spouse, will be reported and that protected persons will also be requested to cooperate in contact notification efforts of known contacts and may name additional contacts they wish to have notified with the assistance of the provider or authorized public health officials;
9. Non-disclosure of the protected individual's name or other information about them during the contact notification process;
10. The provider's responsibility for making an appointment for newly diagnoses persons to receive follow-up HIV medical care;
11. The availability of medical services and the location and telephone numbers of treatment sites, information on the use of HIV chemotherapeutics for prophylaxis and treatment and peer group support, access to prevention, education and support services and assistance, if needed, in obtaining any of these services; and
12. Prevention of perinatal HIV transmission.

For general information, to report a breach of confidentiality, or to obtain forms and referrals, call:

New York State Department of Health
HIV Confidentiality Hotline
1-800-962-5065

Or write:

Special Investigation Unit
New York State Department of Health
ESP Corning Tower, #308
Albany, NY

Enrollee Complaints and Grievance Procedures

All Fidelis Care providers must respect Member Rights as outlined in Section 2 of the Provider Manual. In addition, providers should participate in, and are obligated to cooperate with, the resolution of any member complaint or grievance that may arise relating to the services they provided to a Fidelis Care member. Any concerns identified by members with Fidelis Care, a provider, or any of a provider's personnel with respect to the provision of all services, are handled in accordance with Fidelis Care's complaint and grievance procedures.

Advance Directives

All new Fidelis Care members are told of their right to formulate oral or written advance instructions regarding health care treatment. The PCP is responsible to ask members if they have executed any advance directives. All participating providers are required to comply with all the laws related to advance directives and must provide care and treatment according to the wishes of the member. For additional information go to https://www.health.ny.gov/professionals/patients/patient_rights

Health Care Proxy

A copy of the Health Care Proxy should be kept with the Physician, the Health Care Agent and the person and any other family member(s) or friend(s) that the person chooses.

PRIMARY CARE SERVICES

Responsibilities of the Primary Care Provider

The scope of services expected of a Primary Care Provider (PCP) includes those that are determined by a provider to be necessary and appropriate to promote, preserve, and restore optimal health. The PCP agrees to as needed:

- Provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat conditions not requiring the services of a specialist; arrange inpatient care, consultations with specialists, and laboratory and radiological services when necessary; coordinate findings of consultants and laboratories; and interpret such findings to the patient or the patient's family subject to confidentiality provisions, and maintain a current medical record for the patient.
- Provide services normally performed in the provider's practice and provide care that conforms to acceptable medical practice standards.
- Providers will provide periodic assessments and member education, as clinically necessary, including preventive care measures, based upon the "Clinical Guidelines" outlined in Appendix VIII.
- Admit and refer members to hospitals that participate in Fidelis Care's network, except in emergencies or when it is medically unsafe for the member to go to a participating hospital.
- Maintain medical records that meet the medical record standards enumerated in Section 7 of this manual.
- Send copies of member medical records, reports, treatment summaries and other related documents to Fidelis Care and other participating providers upon request.
- Submit claim forms and encounters electronically within ninety (90) days of the date of service using appropriate procedure and diagnosis codes.
- Maintain professional credentials and liability insurance acceptable to Fidelis Care.
- Comply with all utilization management (UM) protocols as outlined in this Provider Manual. Refer to Appendix I for the Fidelis Care Authorization Grid Detail. For UM procedures, refer to Section 8 Emergency and Inpatient Services, Section 11 Referral and Pre-Authorization, Section 18 Authorizations for Non-Participating Providers and Section 19 Behavioral Health. Contact Fidelis Care's Quality Healthcare Management (QHCM) Department at 1-888-FIDELIS 1-888-343-3547 for authorization. (Refer to Section 11 and Section 18 of this manual).
- Work closely with Fidelis Care to resolve any problems, complaints, and disputes that may arise between provider, member, and Fidelis Care.
- Treat members with respect and honor the member's right to know and fully understand his or her diagnosis, prognosis and expected outcome of the recommended medical or surgical treatment, and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.

- Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment or any other basis prohibited by applicable federal, state, or local civil rights laws.
- Abide by Fidelis Care policies and procedures relating to member complaints, peer review, quality assurance, and utilization review.
 - Member Complaints: Refer to Section 2 Member Rights; Section 14 Member Grievances and Complaints.
 - Peer Review: Refer to Section 3 Provider Roles and Responsibilities; Section 9 Provider Credentialing and Termination; Section 10 Health Care Performance Evaluation.
 - Utilization Review: Refer to Section 8 Emergency and Inpatient Services; Section 11 Referral and Pre-Authorization; Section 18 Authorizations for Non-Participating Providers; Section 19 Behavioral Health; and, Appendix I Authorization Grid Detail.
- Notify Fidelis Care's Provider Relations Department, 30 days in advance, of any changes in information included on the Provider Application, e.g., changes in address or office hours, on-call arrangements, etc.
- Report and participate in the various State-mandated programs, such as reporting of communicable diseases, participation in immunization registries, lead testing, and reporting consistent with New York State Public Health Law and New York State Regulations.

Member Access to Services

Office Hours

Under New York State Department of Health Guidelines, Fidelis Care primary care providers must practice at least 16 hours a week at a primary care site and be available at least 4 hours on two separate days of the week. If you cannot meet these criteria, please contact your Fidelis Care Provider Relations Specialist.

Appointment Availability, Waiting Time

All Fidelis Care providers must have an appointment system that meets the following standards for appointment availability for primary care services:

Situation	Timeframe
Emergency Care	Immediately upon presentation at a service delivery site
Non-life-threatening emergency mental health or substance abuse visit	Emergency appointment within 6 hours
Urgent Care	Within 24 hours
Urgent mental health or substance abuse visit	Within 48 hours
Non-urgent sick visits	Within 48-72 hours as clinically indicated

Mental health or substance use disorder follow up visits*	Within 5 days or as clinically indicated
Follow-up visits (pursuant to an emergency or hospital discharge)	Within 1 week
Non-urgent mental health or substance use disorder visit**	Within 1 week
In-plan mental health or substance abuse, initial routine	Within 10 business days
Initial family planning visit	Within 2 weeks
Non-urgent mental or substance abuse visit with a PCP	Within 2 weeks
Initial PCP office visit for newborns	Within 2 weeks of hospital discharge
Behavioral Health Specialist referrals (non-urgent):	Within 2 weeks for PROS programs (other than clinic) Within 2-4 weeks for CDT, IPRT, rehab for residential SUD***
Routine, non-urgent, or preventive appointments	Within 4 weeks
Well child care	Within 4 weeks
Specialists referrals (non-urgent)	Within 4-6 weeks
Follow-up visit mental health or substance abuse visit, routine	Within 30 days
Adult baseline and routine physicals	Within 12 weeks from enrollment (adults ≥ 21 yrs.)
Initial prenatal visit	Within 3 weeks during 1 st trimester, within 2 weeks during 2 nd trimester, within 1 week during 3 rd trimester

* With participating provider, is pursuant to emergency hospital discharge or release from incarceration, and contractor is informed of such release

**With participating mental health and/or substance use disorder outpatient clinic provider, including PROS (Personal Recover Oriented Services) clinic

***CDT – Continuing Day Treatment, IPRT – Intensive Psychiatric Rehabilitation Treatment, SUD – Substance Use Disorder

Waiting times within a primary care site should meet the following standards:

- The standard for returning a member call is 30 minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider. The message must direct the member to a live voice. The primary care provider is responsible for arranging on-call and after-hours coverage to ensure 24-hour telephone access to all members.
- Members with appointments should not be made to wait longer than one hour. Walk-in members with urgent needs should be seen within one hour, and walk-in members with non-urgent needs should be seen within two hours, or scheduled for an appointment consistent with the above scheduling guidelines.

24-Hour Telephone Coverage

The PCP is responsible for arranging on-call and after-hours coverage to ensure 24-hour telephone access to all members.

All Fidelis Care providers are required to maintain 24-hour, 7-day-a-week telephone access for their members. The standard for returning a member call is 30 minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider, e.g., a direct beeper connection. The message must direct the member to a live voice.

Providers shall notify Fidelis Care, in writing, at least 30 calendar days in advance of any change in their office address, telephone number, or office hours.

Fidelis Care is required to conduct 24-Hour Access and Appointment Availability studies of our providers annually and submit the results to the New York State Department of Health and each Local Department of Social Services (LDSS). In addition, the New York State Department of Health conducts their own survey.

Fidelis Care 24-Hour Phone Coverage

Fidelis Care has implemented an after business hours member information and assistance program. Protocols exist to contact registered nurses and/or medical directors if indicated.

Required Reporting to Local Department of Health

PCPs and other providers in the Fidelis Care network are expected to report positive TB test results and active cases of TB to the New York City Department of Health (NYCDOH) or Local County Department of Health (CDOH), as required by State and City Health Codes. In New York City, reports to NYCDOH must include information on HIV+ status, IV drug and other substance abuse, and the status of the case. For additional information go to: <https://www1.nyc.gov/site/doh/providers/health-topics/tuberculosis.page>

Fidelis Care also expects the PCP and other providers to cooperate with the NYSDOH or CDOH in identifying case contacts and arranging for or providing services and follow-up care. Fidelis Care encourages all providers to consult with their respective County Health Departments on TB treatment and preventive therapy. Information forms for reporting and consultation in New York City can be obtained by calling the TB Hotline for Physicians at (212) 788-4162. For additional information, contact the New York State Department of Health at 1-518-474-7000. Fidelis Care has a mechanism in place whereby services needed are coordinated by a Case Manager who will work with all of the members on the Health Care Team servicing the member. Contact the QHCM Department to obtain such services at 1-888-FIDELIS (1-888-343-3547) - authorization prompt. For additional information, go to: <https://www1.nyc.gov/site/doh/providers/reporting-and-services/notifiable-diseases-and-conditions-reporting-central.page>

Provider Leaves the Network

If a member's healthcare provider leaves the Fidelis Care network of providers, or is terminated for reasons other than imminent harm to member care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Fidelis Care shall permit the member to continue an ongoing course of treatment with the member's current healthcare provider during a transitional period and upon a previously agreed reimbursement rate.

The transitional period shall continue up to ninety (90) calendar days from the date of notice to the member of the provider's disaffiliation from the network or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery.

The care shall be authorized by Fidelis Care for the transitional period only if the healthcare provider agrees to accept reimbursement at rates applicable prior to the start of the transitional period, as payment in full, to adhere to quality assurance requirements, to provide medical information related to such care, and to adhere to the organization's policies and procedures. This is consistent with the transition of care provision in the previous agreement.

New Member

If a new member has a life-threatening or degenerative disease or disabling condition, Fidelis Care shall allow the new member to continue an ongoing course of treatment with the member's current healthcare provider for a period of up to sixty (60) days effective from the date of enrollment. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of post-partum care directly related to the delivery.

The transitional period applies only if the healthcare provider agrees to accept reimbursement, at rates established by Fidelis Care, as payment in full, to adhere to the organization's quality assurance requirements and to provide medical information related to such care and to adhere to the organization's policies and procedures.

In no event shall this requirement be construed to require Fidelis Care to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the member's contract.

Primary Care Provider Selection

In general, Fidelis Care prefers that PCPs practice in the areas listed below. Because managed care programs include members with life threatening or disabling and degenerative medical conditions, specialist and sub-specialist providers may function as PCPs when such an action is considered by Fidelis Care to be medically appropriate. As an alternative, Fidelis Care may restrict its PCP network to primary care specialties only and rely on standing referrals to specialists and sub-specialists for members who require regular visits to such providers.

The types of providers eligible to serve as PCPs are providers who specialize in:

- Family Practice
- General Practice
- General Pediatrics
- General Internal Medicine
- Obstetrics and Gynecology (subject to Plan and State Department of Health qualifications)
- Nurse Practitioners may also function as PCPs, subject to their scope of practice limitations under New York State Law.

SPECIALTY PROVIDER SERVICES

Participating specialists shall provide appropriate, quality medical care to Fidelis Care members. Members may seek care from specialists for specific services based on evaluation, diagnosis, and direction of care. Specialists play a critical role by providing efficient care within their area of expertise.

Responsibilities of Specialty Care Providers

- Provide services normally performed in the provider practice specialty and provide care that conforms to accepted medical and surgical practice standards in the community.
- Report findings and recommendations to the referring provider by telephone and in writing.
- Admit and refer members to hospitals that participate in Fidelis Care's network, except in emergencies.
- Maintain medical records that meet the medical record standards listed in Sections 3 and 7 of this manual.
- Send copies of member medical records, reports, treatment summaries, and other related documents to Fidelis Care and other participating providers, upon request.
- Submit claim forms for services electronically within ninety (90) calendar days of the date of service.
- For covered services, seek reimbursement only from Fidelis Care.
- Maintain professional credentials and liability insurance acceptable to Fidelis Care.
- Accept peer review of professional services provided to Fidelis Care members.
- Maintain admitting privileges with at least one hospital that participates in Fidelis Care's network.
- Work closely with Fidelis Care to resolve any problems, complaints, and disputes that may arise between the provider, member, and Fidelis Care.
- Treat members with respect and honor the patient's right to know and fully understand his or her diagnosis, prognosis, and expected outcome of the recommended medical or surgical treatment or medication, and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.
- Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment, or any other basis prohibited by applicable Federal, State or Local civil rights laws.
- Abide by agreements made with Fidelis Care as a result of member complaints, peer review, quality assurance, and utilization review.
- Immediately notify Fidelis Care's Chief Medical Officer, in writing, if provider's ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice

actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital. (See Section 3 of this Provider Manual).

- Immediately notify Fidelis Care's Chief Medical Officer of any adverse actions or sanctions taken by State agencies and any changes in information included on the Provider Application, (e.g., changes in address or office hours, malpractice actions, on-call arrangements).
- At provider sites where participating providers share office space with non-participating providers, only participating providers can treat Fidelis Care members without authorization.

Verification of Member Eligibility

Prior to providing services at each visit, the provider's office must verify the member's current eligibility by either using the Integrated Voice Response (IVR) or Provider Access Online. **Failure to verify eligibility at the time of service may result in denial of payment for services rendered.**

To obtain eligibility or status claims, please go to www.fideliscare.org to access Provider Access Online. To verify eligibility, call 1-888-FIDELIS (1-888-343-3547) to access the IVR.

Services to be Rendered

Appropriate evaluation and treatment of a member may require a specialist provider to order certain diagnostic tests.

Effective October 1, 2017, Fidelis Care requires providers to obtain prior authorization from eviCore Healthcare for members in all products, except Fidelis Care at Home (FCAH), for outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services. For a full list of the procedure codes that require prior authorization through eviCore Healthcare, visit: <https://www.evicore.com/healthplan/fideliscare>.

Effective October 1, 2019, Fidelis Care requires providers to obtain prior authorization from National Imaging Associates, Inc. (NIA) for **outpatient rehabilitative and habilitative physical medicine services, including services rendered in the home, for physical therapy (PT), occupational therapy (OT), and speech therapy (ST)**. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Qualified Health Plans (*Metal-Level products*), Fidelis Care at Home (FCAH) (*Managed Long Term Care*), HealthierLife (HARP), and Essential Plan (EP). Prior authorization is required for all services rendered by a therapy provider after the initial evaluation. Prior authorization is not required for PT, OT, and ST performed in an Inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay. Non-therapy providers (MD, Chiropractors, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care for all Fidelis Care Members. For more information, visit [Fidelis Care Physical Medicine Prior Authorization Quick Reference Guide for Providers](#).

Effective December 23, 2019, Fidelis Care requires providers to obtain prior authorization through TurningPoint Healthcare Solutions for members undergoing **musculoskeletal surgical procedures**, in both inpatient and outpatient settings. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Medicare Advantage (MA), Dual Advantage (DUAL), HealthierLife (HARP), Qualified Health Plans (*Metal-level Products*), Essential Plan (EP), and Medicaid Advantage Plus (MAP). Emergency-related procedures do not require authorization. Before rendering services, providers are required to check the list of services requiring prior authorization from TurningPoint Healthcare Solutions, which is available at [Musculoskeletal Surgical Procedures Requiring Prior Authorization](#)

The specialist is required to provide any relevant documentation with all treatment information to the member's PCP and referring provider. It is the specialist's responsibility to coordinate all treatment with the member's PCP in order to ensure effective case management. If the specialty referral occurs in a hospital-based specialty clinic, it is the responsibility of the hospital to ensure that consultation reports are forwarded to the PCP in a prompt and efficient manner.

WOMEN'S HEALTH PROVIDER RESPONSIBILITIES

Direct Access To Obstetrics and Gynecological (OB/GYN) Services

As required by New York State law, each female member of Fidelis Care has unrestricted access to at least two annual exams for primary and preventive obstetric and gynecological services from a qualified provider of her choice in the Fidelis Care network. The member also has unlimited access to primary and preventive OB/GYN services required as a result of such an exam, or as the result of an acute GYN condition. In addition, the member has unrestricted access to a qualified provider of OB/GYN services in the Fidelis Care network for any care related to pregnancy. Consequently, a referral from the member's Physician is not required for these services. The specialist must, however, discuss the services and treatment plan with the Physician.

Members must have access to a live individual after hours for emergency consultation and care.

OB/GYN And Nurse Midwife Provider Responsibilities Reporting to Fidelis Care's BabyCare Program

Fidelis Care's BabyCare Program is a single-point, coordinated health program with our member and your patient that begins during the prenatal period and continues through the postpartum office visit. The design of the program is both preventative and educational. The goals are to improve birth outcomes and wellness promotion. A BabyCare nurse or associate contacts each pregnant woman and serves as a resource to help her have a healthy baby.

Preventive Care

Providers are responsible for delivering preventive gynecological services to female members, including but not limited to, cervical cancer screening and mammography screening services. Additionally, providers should treat any gynecological-related clinical condition.

Prenatal Care/Delivery/Postpartum

OB/GYN providers and nurse midwives shall deliver prenatal care to pregnant members according to American College of Obstetricians and Gynecologists (ACOG) standards and New York State's Prenatal Care Standards for Managed Care Plans.

OB/GYN providers and nurse midwives shall perform all in-hospital deliveries and provide all subsequent inpatient and outpatient follow-up care.

Providers are responsible for sending records of all treatment and outcomes to the member's Physician, and for coordinating any follow-up care when necessary.

Appointment Systems

Participating OB/GYN and nurse midwives shall schedule appointments with members within three (3) weeks during the first trimester; two (2) weeks during the second trimester; and within one (1) week thereafter, unless the member's condition is urgent, whereby the appointment should be scheduled using appropriate clinical judgment.

Maternity Admissions

Pregnancy-related complications admission (Ante-partum admissions)

When a pregnant member presents due to a medical condition, i.e., eclampsia, hyperemesis, etc., and delivery is not imminent, the hospital should call the Fidelis Care QHCM Department for authorization for inpatient admission or other treatment unless the patient presents with an emergent condition. In this instance, the hospital should assess and stabilize the member, and then notify the Fidelis Care QHCM Department.

OB Delivery Information

The hospital must call the QHCM Department within two (2) business days after delivery with the following maternal and newborn admission information for authorization and case management:

- Mother's name
- Mother's ID number (if applicable)
- Admission date and time
- Delivery method (normal spontaneous, C-section etc.)
- Newborn information:
 - 1) Gender
 - 2) Date of birth
 - 3) Birth weight
 - 4) APGAR score
 - 5) Nursery (NICU, newborn etc.) For newborns admitted to the NICU, please provide the working diagnosis, and name and telephone number of the physician of primary responsibility
 - 6) Gestation by week

STANDARDS FOR MEDICAL RECORD DOCUMENTATION

Medical Records, whether electronic or on paper, communicate the member's past medical treatment, past and current health status, and treatment plans for future healthcare. Good documentation facilitates communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment.

Fidelis Care standards are as follows:

- A. Fidelis Care requires that providers maintain medical records in a manner that is current, detailed, legible and organized and permits effective and confidential member care and quality review. A separate, distinct medical record is required for each member.
- B. Fidelis Care requires that providers have an organized medical record keeping system.
- C. Content of the Medical Record -- Primary care medical records must reflect all services provided directly by the Physician, all ancillary services and diagnostic tests ordered by the Physician, and all diagnostic and therapeutic services for which the member was referred by the Physician (e.g. home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports). Specific content standards are as follows:

1. Adequacy of the Medical Records Filing System (includes maintenance of confidentiality, procedures for review of diagnostic test results, etc.).
 - a. Medical Records are stored in a secure location not accessible to members
 - b. There is a unique medical record for each member identified by a medical record identifier (either name or number) on each page
 - c. Records are organized with a filing system to ensure easy retrievability
2. Adequacy of Medical Record Keeping
 - a. Identifying information present on each page of the medical record
 - b. Biographical data is identified on each entry
 - c. The provider is identified on each entry
 - d. All recorded entries are dated
 - e. The record is legible

Clinical Content

- f. Significant illnesses and medical conditions are indicated on the problem list.
 - g. Medication history (past and current) must be reviewed at each visit, documented and dated. Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record.
 - h. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operation, and childhood illnesses.
3. Retention of Medical Records

Medical records must be retained for at least ten (10) years for adults, and six (6) years from the age of majority for children.
 4. Confidentiality
 - a. Access to medical records is permitted only to those individuals who are part of the team providing healthcare to the individual. Such information contained in the

medical record may be provided to Fidelis Care for purposes directly connected with the performance of Fidelis Care's obligations. Access may additionally be permitted consistent with the HIPAA/HITECH and all other State and Federal regulations.

- b. The healthcare provider's Notice of Privacy Practices must describe the individual's rights regarding: receipt of a copy of their personal medical record; practices regarding disclosure of their Protected Health Information; ability to request modification of their personal medical record; and, all other rights provided in the HIPAA/HITECH and all other State and Federal regulations.
 - c. Confidentiality of HIV-Related Information: Providers must develop policies and procedures to assure confidentiality of HIV-related information, as required by Article 27-F of the New York State Public Health Law. These policies must include:
 - Initial and annual in-service education of the providers' staff and/or contractors.
 - Identification of those staff members allowed access, and the limits of their access to HIV-related information.
 - A procedure to limit access to trained staff (including contractors).
 - A protocol for secure storage (including electronic storage).
 - Procedures for handling requests for HIV-related information.
 - Protocols to protect persons with or suspected of having HIV infection from discrimination.
5. Fidelis Care's Process for Improving Medical Records
- a. Letters sent to providers that include specific deficiencies identifying the compliance issues and a suggested action plan for improvement.
 - b. Suggested models of records such as forms, problem lists or medication allergies documentation forms.
 - c. Re-education information, highlights of best practices or blinded records that meet Fidelis Care's standards particularly well.

Fidelis Care uses medical record review staff to conduct onsite reviews. Providers and their office staffs receive verbal feedback and education, which includes, but is not limited to, Fidelis Care's requirements, various Department of Health reporting requirements, medical record documentation, and member education. Providers receive a written report card following the onsite review.

Access to Medical Records

Copies of medical records must be made available, without charge (unless otherwise noted), to other participating providers, consultants, or physicians involved with the member's care and treatment. Copies of medical records must also be made available upon request, and without charge (unless otherwise noted), to Fidelis Care (e.g., Chief Medical Officer, Quality Health Care Management Staff) for quality assurance and utilization review activities. The handling of medical records must comply with all Federal and State laws and regulations regarding confidentiality of member records.

Copies of medical records must be made accessible to the Local Department of Social Services (LDSS), New York State Department of Health, and/or the Centers for Medicare and Medicaid Services (CMS) upon request.

EMERGENCY SERVICES

Assessment of an Emergency Medical Condition

Authorization is never required prior to providing services for emergency medical conditions.

Consistent with Federal and State law, an Emergency Medical Condition is defined by using a Prudent Layperson Standard, which is as follows:

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity - including severe pain - that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child, or in the case of a behavioral health condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of the person.

INPATIENT SERVICES – Medical and Surgical Emergent/Urgent Admissions

Notification is required for unscheduled medical and surgical hospital admissions following stabilization. Fidelis Care requires notification of the member's hospital admission within two business days. This applies to emergency transfers from one acute care hospital to another when the treating hospital cannot provide the needed care and the patient's clinical status makes it unsafe to wait until the next business day to obtain pre-authorization for the transfer from Fidelis Care. Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547). Follow the voice prompts for "authorizations" to connect to the Authorization Call Center from 8:30AM-5:00PM Monday through Friday. Notifications can be accepted after hours, holidays, and weekends. Use the standard toll free number and follow the voice prompt as noted above.

Inpatient Emergency Admissions

Fidelis Care follows National Committee for Quality Assurance (NCQA) guidelines for timeliness of Utilization Management (UM) decisions. Emergency inpatient admissions are considered "Urgent Concurrent" requests and must be addressed within 24 hours. In situations where initial Inpatient authorization requests are not accompanied by sufficient clinical documentation, Fidelis Care will contact the facility to request the necessary information. If Fidelis Care is unable to obtain the information within 72 hours (3 calendar days) of receipt of the initial request, the inpatient admission will be subject to denial for lack of sufficient clinical information.

Clinical information for an Inpatient Emergency Admission, should be faxed to **Fidelis Care ER eFax at: 347-868-6411**.

BEHAVIORAL HEALTH EMERGENCIES

If the member presents or is brought to the hospital with a behavioral health emergency or requires immediate treatment related to drug or alcohol use, the hospital should:

- Stabilize and otherwise secure the member's health and safety
- Verify the member's Fidelis Care eligibility

- Contact Fidelis Care's Behavioral Health Unit

For assistance with Behavioral Health issues, contact 1-888-FIDELIS

A provider or member can contact the Fidelis Care Behavioral Health unit through the toll free Fidelis Care number 1-888-FIDELIS (1-888-343-3547). Follow the voice prompts to connect to the Behavioral Health Case Manager from 8:30AM-5:00PM Monday through Friday. On-call emergency services are available after hours, holidays and weekends. Use the standard toll free number and follow the voice prompt to reach the on-call services. No prior authorization is required for emergent admits, though notifications of such admissions will be responded to on the next business day.

Transfer of a Fidelis Care Member to another Hospital

Prior authorization from Fidelis Care is required to transfer a member from one hospital to another. Fidelis Care will not authorize transfers unless:

- The facility that the patient is in cannot provide the care and services the patient's medical condition requires.
- The member's attending provider has authorized the transfer,
- A physician at the receiving facility has accepted the patient and the accepting facility has the resources available to care for the member, and
- All statutory and regulatory requirements for the transfer of a member from one institution to another are met.

Fidelis Care's QHCM Department can assist in arranging for pre-authorized transportation for pre-authorized transfers if necessary.

Transfer to a non-participating facility requires approval of the Chief Medical Officer or designee and will only be approved if needed care is not available at a participating facility.

The receiving institution is under the same obligation to notify Fidelis Care with clinical information so that concurrent review can take place.

Concurrent Review

In order for Fidelis Care to track and monitor the care of our members who have been hospitalized, Fidelis Care conducts concurrent review on selected patient hospitalizations. Fidelis Care will contact the hospital's utilization department to request clinical information on the patient's need for continual hospitalization. Failure to submit the requested information may result in an adverse determination.

The purpose of the concurrent review is to:

1. Ensure the level of service provided is consistent with the need for continued hospitalization,
2. Assist in the coordination of services after discharge,
3. Monitor the quality of care provided in the acute care setting as part of the Fidelis Care quality assurance program.

On occasion, a member of the Fidelis Care Case Management staff will need to visit the hospital to review the chart for either quality or utilization purposes.

PROVIDER CREDENTIALING AND TERMINATION

PROVIDER CREDENTIALING

Subject to limited exceptions, Fidelis Care is required to credential each health care professional, prior to the professional providing services to Fidelis Care members.

Provider Responsibilities

Providers shall immediately notify Fidelis Care's Chief Medical Officer, in writing, if their ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital.

Provider Rights

Review information submitted to support their credentialing application – This includes information from outside sources. However, Fidelis Care does not need to disclose references, recommendations or peer-review protected information.

Correct erroneous information – In the event that a Fidelis Care's Credentialing Specialist discovers inconsistent information in the application/reapplication, the Specialist will reach out to the provider for correct information with a request for a response within 15 business days. In the event that the practitioner discovers incorrect information in the application/reapplication after exercising the above right, the practitioner may then contact the Fidelis Care's Credentialing Specialist via letter or email and request that the application/reapplication be updated. Fidelis Care will process and document receipt of the corrected information in the file within 15 business days.

Receive the status of their credentialing or re-credentialing application upon request – Fidelis Care will share what documentation is outstanding to complete the application/reapplication and/or will inform the provider when the application/reapplication will be reviewed by the Fidelis Care Credentialing Committee (CR). Fidelis Care will respond to the practitioner's request by phone or via email.

Credentialing/Re-Credentialing Process

Fidelis Care's credentialing process uses standards set forth by the New York State Department of Health and National Committee on Quality Assurance (NCQA), including primary verification of training/experience, office site visits, etc. Each provider will be re-credentialed at least every three (3) years. It is the provider's responsibility to ensure that Fidelis Care has the correct service address(es) to contact when re-credentialing is due. If a provider fails to re-credential, the provider would be terminated and any claims following that date would not be paid without prior authorization. Fidelis Care's Credentials Committee reviews credentialing information and recommends appointment to the panel.

It is the applicant's responsibility to supply all requested documentation in a form satisfactory to the Credentials Committee. Fidelis Care's Provider Application or the CAQH ProView Application Form is required, in addition to applicable credentialing documents/ certifications. Applications lacking supporting documentation shall not be considered by the Committee.

Fidelis Care will process the initial application and present for Committee review within sixty (60) calendar days upon receipt of a completed application and contract. The practitioner will be notified in writing of the Credentials Committee's decision within that time.

During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, Fidelis Care will notify the practitioner of the missing information, and will make every effort to obtain such information as soon as possible.

Practitioners considered to have non-routine or unusual circumstances may require additional time for review.

Fidelis Care will make every effort to make a determination regarding participation status as soon as possible and will notify the practitioner in writing as to whether he/she is credentialed after the Credentials Committee review and decision.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization, or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Credentialing of Ancillary Staff Working in a Participating Provider's Office

Each provider must require that all ancillary staff be appropriately licensed, registered, or certified in their field, and that such staff practice in accordance with all applicable laws and regulations. Providers must also provide appropriate supervision to ancillary staff and ensure that ancillary staff's responsibilities do not exceed those responsibilities set forth in applicable New York State laws and regulations for such practices.

Under certain circumstances, ancillary staff working in a participating provider's office and providing care to Fidelis Care members must also be credentialed by Fidelis Care. It is the responsibility of the participating provider to notify Fidelis Care when any of the following professionals are hired/contracted to provide services:

- Nurse Practitioners
- Physical Therapists/Occupational Therapists
- Certified Nurse Midwives
- Physician Assistants

OMH-Licensed/OASAS Certified Behavioral Health Providers and HCBS Providers

Fidelis Care will accept State issued HCBS providers, OMH and OASAS-certified providers with OMH and OASAS license and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. The contract shall collect and will accept program integrity related information as part of the licensing and certification process. Fidelis Care requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

PROVIDER TERMINATION

Policy Statement

It is the policy of Fidelis Care to provide due process to providers who are terminated by Fidelis Care consistent with Section 4406-d of the New York State Public Health Law. Accordingly, Fidelis Care has a

hearing procedure in place allowing providers, in certain circumstances, to appeal a proposed decision terminating their participation with Fidelis Care.

Fidelis Care will immediately remove any provider from the network who is unable to provide healthcare services due to a final disciplinary action.

Providers who are excluded or terminated by the Department of Health (DOH) Medicaid Program will be excluded from participation in the Fidelis Care Metal-Level Network panel.

Definitions

Healthcare Professional – a person licensed, registered, or certified pursuant to Title 8 of New York’s Education Law.

Quality Concerns – concerns regarding the healthcare professional’s competence or professional conduct which adversely affect, or could adversely affect the health or welfare of a Fidelis Care member or any other patient of a healthcare professional.

Clinical Privileges – the ability to furnish medical care to persons enrolled in Fidelis Care, as determined by Fidelis Care.

Members – any subscriber, enrollee, member, patient, designated representative or, where appropriate, prospective enrollee of Fidelis Care.

Applicability

The hearing procedure is available in the following circumstance:

- When Fidelis Care proposes to terminate a participating healthcare professional’s contract with Fidelis Care prior to the termination date of the contract.

The hearing procedure is not available in any other circumstances, including but not limited to the following:

- An initial denial of a healthcare professional’s application for clinical privileges;
- When Fidelis Care decides not to renew a healthcare professional’s contract.
- When the termination involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice.

Fidelis Care will not terminate or refuse to renew a contract solely because a healthcare professional has:

- Advocated on behalf of a member.
- Filed a complaint against Fidelis Care.
- Appealed a decision of Fidelis Care.
- Provided information to a member regarding a condition or course of treatment, including the availability of other therapies, consultations, or tests.

- Provided information to a member regarding the provisions, terms, or other requirements of Fidelis Care's products as they related to the member.
- Made a report to an appropriate governmental body regarding the policies or practices of Fidelis Care that the healthcare professional believes may negatively impact upon the quality of, or access to, patient care.
- Requested a fair hearing or review as provided herein.

Procedure

When Fidelis Care receives information that raises quality concerns regarding a healthcare professional who has been granted clinical privileges, it will initiate a review and a notation will be placed in the healthcare professional's record. Review will also be initiated when Fidelis Care decides to terminate a healthcare professional, except where the decision to terminate involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice.

If the results of the review indicate that action is required which requires a hearing, the healthcare professional will be notified in writing regarding the proposed action. Such notice shall include the following:

- The proposed action.
- The reasons for the proposed action.
- A statement that the healthcare professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by Fidelis Care;
- The time limit, not less than thirty (30) calendar days, for requesting a hearing.
- A statement that the hearing will be held within thirty (30) calendar days after the date the hearing request is received.
- A summary of the hearing rights.

If the healthcare professional does not request a hearing within thirty (30) calendar days of the date of the notice, the proposed action will be final and non-arbitrable and the provider will have no additional appeal rights. If a hearing request is received, the healthcare professional will be apprised, in writing, of the place, time, and date of the hearing and provided a list of the witnesses expected to testify at the hearing on behalf of Fidelis Care. The healthcare professional will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Hearing dates and times may be granted at the discretion of Fidelis Care, but within thirty (30) days of the healthcare professional's request for a hearing.

The hearing panel shall be comprised of at least three (3) persons appointed by Fidelis Care. At least one member of the panel will be a clinical peer in the same discipline and the same or similar specialty as the healthcare professional under review. The hearing panel may consist of more than three (3) persons, provided however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel. If the healthcare professional participates in the Medicare Advantage program, the hearing panel shall be comprised of a majority of individuals who are clinical peers in the same discipline and the same or similar specialty as the healthcare professional under review.

The healthcare professional shall have the following rights at the hearing:

- The right to call, examine and cross-examine witnesses.
- The right to present evidence that is deemed relevant by the hearing panel. The determination of relevancy shall be determined solely by the panel.
- The right to submit a written statement at the close of the hearing.

After the hearing panel has convened, deliberated, and rendered a decision, it will notify the healthcare professional, in writing, of the decision not more than fifteen (15) business days after its adjournment. The notification will include a statement of the basis for the decision. Decisions will include one of the following and will be provided in writing to the healthcare professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. The decision of the hearing panel is final and is not subject to further review or arbitration.

A decision by the hearing panel to terminate a healthcare professional shall be effective not less than thirty (30) calendar days after the receipt by the healthcare professional of the hearing panel's decision. In no event will the termination be effective earlier than sixty (60) calendar days from the receipt of the initial notice provided to the healthcare professional. The date of receipt will be presumed to be five (5) calendar days from the date of the initial notice.

Unless the decision to terminate the healthcare professional involves imminent harm to patient care, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice, Fidelis Care would consider allowing a member to continue an ongoing course of treatment with the professional as outlined in section, 4.6, "Provider Leaves the Network" in this Provider Manual.

The healthcare professional's record will be noted with the appropriate status determination and all hearing correspondence.

When the decision of the hearing panel will adversely affect the clinical privileges of a healthcare professional for a period longer than thirty (30) calendar days, Fidelis Care must notify the New York State Board of Medical Examiners within fifteen (15) calendar days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified as required.

Subject to the due process rights described above, Fidelis Care reserves the right to terminate the participation status of any participating provider, without cause, upon ninety (90) calendar days prior written notice delivered to the provider, or as otherwise required under the terms of the provider contract.

In the event that a provider's license, certification or registration is restricted, revoked, surrendered, or suspended by any State in which they may hold a license, the provider may be terminated without the right to an appeal. In addition, such action may be taken should restrictions, suspension, revocation or termination occur for the provider:

- Malpractice Coverage
- DEA Registration
- Medicaid or Medicare Privileges - Qualified & Approved

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice, is not eligible for a hearing or a review, and such termination shall not be subject to arbitration.

Fidelis Care's Duty to Report

Fidelis Care is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.

2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member's health.

HEALTHCARE PROFESSIONAL PERFORMANCE EVALUATION

Fidelis Care is committed to providing members with access to quality services. As a part of our efforts to improve quality, we periodically conduct Quality Performance studies in conjunction with the Clinical Advisory Committee, which is comprised of participating Fidelis Care physicians.

Any profiling data used to evaluate the performance or practice of a Healthcare Professional shall be measured against stated criteria and an appropriate group of Healthcare Professionals serving a comparable patient population. In these circumstances, each Healthcare Professional shall be given the opportunity to discuss the unique nature of the Healthcare Professional's patient population, which may have a bearing on the Healthcare Professional's profile, and to work cooperatively with Fidelis Care to improve performance.

Fidelis Care is required to provide information used to evaluate the performance of providers, and any profiling data. It is important to note that the staff at Fidelis Care is committed to working in partnership with providers in order to assure that quality care is delivered to members. Report cards are used as a way to provide feedback, educate and identify areas for improvement. In addition, Fidelis Care has several programs that focus on preventive health and management of certain chronic conditions. *Fidelis Care encourages providers to refer members to work with the staff of those programs. Currently the programs available are Case Management (medical and behavioral health), BabyCare, Asthma, and Diabetes Programs.*

The care delivered to members by providers is reported on an annual basis to the New York State Department of Health (NYSDOH) through the Quality Assurance Reporting Requirements (QARR) and to the National Committee on Quality Assurance (NCQA) through the Healthcare Effectiveness Data and Information Set (HEDIS). Quality is measured using encounter/claim data that may be supplemented by medical record reviews to determine the percentage of members receiving preventive care and care for certain chronic diseases and services. Additional studies and medical record reviews are initiated by the NYSDOH throughout the year targeting specific areas such as prenatal care.

QARR/HEDIS measures are also used in overall performance evaluation of a practice.

REFERRAL PROCESS

Physician Referrals within Plan Network

Physicians may refer members to any Specialty Care Physician (Specialist) or ancillary provider within the Fidelis Care network. Except as noted below, Fidelis Care communicates to members directing them to see their primary physician for their health care needs and that the physician will assist with a referral if they need to see a specialist. Fidelis Care does not require that a member return back to his/her primary physician for a referral to a different participating specialist if a participating specialist recommends that he/she be treated by another specialist. Fidelis Care does not require physicians to notify the plan when a member is referred to a participating specialist. To ensure coordination of care, Fidelis Care does recommend that a specialist notify the member’s primary physician when a referral to another specialist is made.

Fidelis Care does not cover care provided by non-participating providers, except for medically necessary emergent care, without prior authorization by the Chief Medical Officer or designee. Please refer to Section 18 for more information.

Direct Access

Fidelis Care communicates to members that it isn’t necessary to see their primary physician before seeking care from a participating specialist provider. However, when a member does have a primary physician, it is recommended that the member consult with that physician before seeking the services of a specialist. For assistance in identifying a participating provider, members may contact Fidelis Care at 1-888-343-3547.

<p>Alcohol and Substance Abuse Services</p>	<p>No authorization is required for outpatient services. Except in an emergency, all inpatient services require prior authorization from Fidelis Care. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than forty-eight (48) hours or the next business day.</p>
<p>Behavioral Health Services</p>	<p>Most outpatient services do not require prior authorization. Providers should review the most current version of the Prior Authorization grid (Appendix I) to confirm whether or not a specific service requires authorization. Except in an emergency, all inpatient services require prior authorization. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than forty-eight (48) hours or the next business day.</p>
<p>Dental Services</p>	<p>Members may self-refer to dental providers within the dental network of Fidelis Care. Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547) for more information. Members</p>

	<p>can also contact DentaQuest directly at 1-800-516-9615.</p> <p>Not all plans cover Dental Services. Please verify member coverage.</p>
Eye Care/Vision Services	<p>Members may self-refer to vision providers within the vision network of Fidelis Care. Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547) for more information. Members can also contact Davis Vision directly at 1-800-601-3383.</p> <p>Not all plans cover Vision Services. Please verify member coverage.</p>
Obstetrics and Gynecology	<p>Members may self-refer to a participating Fidelis Care provider for primary and preventive obstetric and gynecological services and unrestricted services for care related to pregnancy. Refer to Section 15 of this manual for information about family planning.</p>
TB Diagnosis and Treatment	<p>Members may self-refer for the diagnosis and treatment of TB by public health agency facilities.</p>
Urgent Care Centers	<p>Members may self-refer to participating (in-network), free-standing urgent care facilities. Services received from a non-participating urgent care facility are not covered. See page 11.4 for more information.</p>

General Information

Please refer to the authorization grid (Appendix I) to determine which services require prior authorization. Note that in order to determine medical necessity, clinical information is needed. Fidelis Care will make at minimum, two (2) attempts to obtain necessary clinical information from a facility or provider. Once all of the clinical information needed to determine medical necessity is received, an authorization number will be assigned and the facility/provider will be notified.

Fidelis Care's QHCM Department is staffed to provide authorization by telephone 8:30 AM to 5:00 PM Monday through Friday except on holidays. For non-urgent services, requests received after business hours (5:00 PM), will be processed the next business day. For urgent situations that cannot wait until the next business day, please call 1-888-FIDELIS (1-888-343-3547) for urgent access.

Services Requiring Prior Authorization

- Fidelis Care requires prior authorization for services listed in Appendix (I)
- Effective 10/1/2017, outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services, require prior authorization from **eviCore healthcare**. For a complete list of procedures that require prior authorization from eviCore healthcare, visit: <https://www.evicore.com/healthplan/fideliscare>.

- Effective December 23, 2019, orthopedic surgical procedures and spinal surgical procedures, in both the inpatient and outpatient setting, require prior authorization from **TurningPoint Healthcare Solutions**. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of procedures that require prior authorization from TurningPoint Healthcare Solution, visit:
<https://www.fideliscare.org/Portals/0/Providers/EducationalMaterials/2019-FidelisCare-TurningPointCPTCodeList-English.pdf>

Pharmacy Services Requiring Prior Authorization

Members who have a metal-level plan have prescription drug coverage through Fidelis Care.

- The Fidelis Care Formulary or Preferred Drug List is located on the website at:
<https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services>
 - Please note: Drugs listed on the formulary with a PA indicator require you to contact Fidelis Care to obtain a prior authorization.

Drugs administered in the doctor's office, which are on the authorization grid Appendix (I), will require prior authorization by Fidelis Care.

Referrals to Non-Participating Providers

A participating Fidelis Care provider may not refer to a non-participating provider. If a participating provider believes a patient needs care that is not available from another participating provider, a physician should call the Fidelis Care prior authorization number at 1-888-FIDELIS (1-888-343-3547) to request approval for care. The Chief Medical Officer or designee will review the request.

The Primary Physician as a Specialist

A Fidelis Care physician who practices primary care and has training in a sub-specialty may be credentialed in that specialty and participate as a specialist in Fidelis Care's network. Such providers are called "Dual Providers."

Dual Providers, who wish to provide specialty services to their own Fidelis Care patient, must obtain an authorization from Fidelis Care's Quality Health Care Management (QHCM) Department at 1-888-FIDELIS (1-888-343-3547), prior to providing specialty services, unless the provider is credentialed as a Dual Provider with Fidelis Care. The Authorization Number and Taxonomy Code should be included on the bill for specialty services.

Referral to Specialty Care Centers

Should the member present with a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, a referral may be made to an accredited or designated specialty care center with expertise in the condition. The decision to make such referrals is made by Fidelis Care's Chief Medical Officer or designee after consultation with the member's primary physician. In no event shall Fidelis Care be required to permit a member to elect to use a non-participating specialty care center, unless Fidelis Care does not have an appropriate specialty care center within the network.

Degenerative and Disabling is defined as any chronic or acute disease entity that, despite appropriate medical intervention, will destroy the body's integrity, leading to patient's dependence on others for activities of daily living (ADL) and eventually to death.

Life threatening is defined as a situation in which the patient's medical condition is such that any delay in treatment would result in the patient's death.

Considerations for Specialty Care Providers

The specialist plays an integral role in the delivery of quality services to our members. As recipients of referrals from the primary physician, it is important to keep in mind the following:

- Participating specialty care providers are expected to keep the primary physician informed of the member's clinical condition. If the member requires ongoing treatment, a report should be sent to the primary physician at the conclusion of the treatment.
- In the event that the member requires additional treatment (e.g. hospitalization, surgery, etc.), the specialist should keep the primary apprised.
- Should the member need the services of another participating specialist or ancillary provider, the specialist should contact the primary physician as soon as possible informing them of the referral to another specialist.

Urgent Care Centers

An Urgent Care Center (also known as an Urgent Care Facility) is a type of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site. Once the acute illness or trauma has been treated, ongoing care should be provided by the primary care physician or appropriate network specialist provider. Urgent care facilities are not intended for well care, chronic disease management, or services able to be provided timely by the primary care physician. Such facilities are also not intended to be used as emergency rooms and are not subject to the Emergency Medical Treatment and Labor Act (EMTALA).

Fidelis Care does not require participating (*in-network*) Urgent Care Centers to obtain an authorization in order for Fidelis Care to pay for the visit.

Fidelis does not cover visits to non-participating (out of network) Urgent Care Centers for Metal Level Plan and the Essential Plan members.

Urgent Care Centers are expected to perform only the services needed to address the urgent medical condition. Since Urgent Care Centers do not perform Emergency Services, all of Fidelis Care's authorization requirements apply to services performed in Urgent Care Centers. Urgent Care Centers are expected to review the authorization grid and obtain authorizations for applicable services, which can be found here: <https://www.fideliscare.org/en-us/providers/authorizationgrids.aspx>

Physicians and other providers who are in Fidelis Care's network working in an Urgent Care Center will only be reimbursed for Fidelis Care members if the Urgent Care Center is also in Fidelis Care's network.

Physicians (or other practitioners) with an "Emergency Medicine" specialty designation are expected to treat Fidelis Care members in an Emergency Room (which may be in-network or out-of-network), or an in-network Urgent Care Center. Even if the Emergency Medicine physician is in Fidelis Care's network, a claim for a visit in an out-of-network Urgent Care Facility will not be paid without an authorization. Authorizations will only be granted for Out-of-Network Urgent Care Center visits when the member is out of the Fidelis Care service area.

Services provided at Urgent Care Centers must be billed using Place of Service 20. Services rendered in a non-Urgent Care Center, billed with place of service 20, are not reimbursable.

PRIOR AUTHORIZATION PROCESS

Purpose for Prior Authorization

- Give providers eligibility information based on Fidelis Care's currently available data.
- Confirm that particular services are a covered benefit under Fidelis Care.
- Allow Fidelis Care to evaluate the medical necessity and appropriateness of the proposed treatment.
- Provide Fidelis Care an opportunity to suggest alternative treatments.
- Provide appropriate authorization to allow reimbursement to the provider for treatment.
- Enable the Case Management nursing staff to track the member's care and coordinate services where necessary.

Process to Obtain Prior Authorization

Procedures requiring prior authorization by Fidelis Care are listed below. The prior authorization request must be generated by a Fidelis Care provider and authorized by Fidelis Care's Quality Health Care Management (QHCM) Department. We recommend that a request be sent at least five (5) calendar days before the anticipated date of service.

The following information will be required to process a service for prior authorization:

- Member name/date of birth
- Member's Fidelis Care ID number
- Ordering provider's name, servicing provider's name and hospital/ambulatory center name if indicated
- Diagnosis
- Current Procedural Terminology (CPT) codes of the procedure, surgery, or service being requested
- Anticipated date and time of procedure
- Necessary clinical information supporting need for procedure, surgery, or service.
The Medical Director may request additional information.

Provider submission of service authorization requests can be accomplished as follows:

- Telephonically: 1-888-FIDELIS (1-888-343-3547)
- Fax: 1- 800-860-8720 (Medical)
- Fax 1-718-896-1784 (Behavioral Health)
- Fax: 1-877-533-2405 (Pharmacy)
- Fax: 1-347-868-6411 (Inpatient Emergency Admissions)
- On the Fidelis Care Provider Portal (Note- some restrictions apply)

Authorization Processing Timeframes

Type of Review	Type of Communication	Receiver of Communication	Process Time
Prior Authorizations	Telephone and in writing within 3 Business Days of <u>receipt of necessary information.</u>	Member or Designee and Practitioner/ Provider	<p>3 business days. Additional info must be requested within 3 business days. Provider has 45 calendar days to submit info. If info received within 45 days, decision must be made within 3 business days of receipt of this additional information.</p> <p>If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</p>
Expedited* Prior Authorization	Telephone within 72 hours of <u>receipt of request</u> if we have all necessary info. Written notice follows within 1 calendar day of decision.	Member or Designee and Practitioner/ Provider	<p>Within 72 hours. Additional info must be requested within 24 hours. Provider has 48 hours to submit the additional information.</p> <p>We must make a decision and provide notice within 48 hours of the earlier of our receipt of the information OR the end of the 48 hour period.</p>
Concurrent	Telephone and in writing within 1 Business Day of receipt of all necessary information.	Member or Designee and Practitioner/ Provider	<p>1 business days. Additional info must be requested within 1 business day. Provider has 45 calendar days to submit info. If info received within 45 days, decision must be made within 1 business day of receipt of this additional information.</p> <p>If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</p>

Expedited* Concurrent	Telephone within 24 hours of receipt of request. Written notice provided within 1 business day if all necessary info was included and within 3 calendar days if all necessary info was not included.	Member or Designee and Practitioner/ Provider	<p>Within 24 hours, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment.</p> <p>If the request is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent prior authorization timeframes apply.</p>
Home Health Care Reviews - following an inpatient (IP) admission	Telephone and in writing within one business day of receipt of necessary info. If the day following the request falls on a weekend or holiday, we will provide notice within 72 hours of receipt of necessary info.	Member or Designee and Practitioner/ Provider	<p>Following an IP admission, determination within 1 business day of receipt of necessary info (if the day following the requests falls on a weekend or holiday, we will make a determination and provide notice to You within 72 hours of receipt of necessary info).</p> <p>*We will not deny coverage while our decision is pending.</p>
Inpatient Substance Use Disorder Treatment	Telephone within 24 hours of receipt of request. Written notice provided within 1 business day.	Member or Designee and Practitioner/ Provider	<p>Within 24 hours, if the request for coverage is made at least 24 hours prior to discharge from the IP substance use disorder treatment.</p> <p>We will provide coverage for the IP substance use disorder treatment while our determination is pending.</p>
Retrospective	In writing within 30 calendar days of receipt of request.	Member or Designee and Practitioner/ Provider	<p>Within 30 calendar days of receipt of the request. Additional information must be requested within 30 calendar days. Provider has 45 calendar days to submit info.</p> <p>We will make a decision and provide notice in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45 day period.</p>
Reconsideration	In writing and by phone if adverse determination is upheld.	Member or Designee and Practitioner/ Provider	Must occur within 1 Business Day of <u>receipt of request</u> for prior authorization, and concurrent determinations

*An expedited review must be conducted when Fidelis Care or the provider indicates that delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review. If Fidelis Care denies the member's request for an expedited review, Fidelis Care will notify the member that the request will be handled under standard review timeframes.

As an NCQA-accredited health plan, Fidelis Care follows NCQA guidelines for authorization processing timeframes in addition to adhering to regulatory turnaround times outlined above. In cases where the NCQA processing timeframe is more stringent than the regulatory timeframe, Fidelis Care will adhere to the NCQA timeframes:

NCQA Turnaround Times

Type of Review	Type of Communication and Total Processing Time Required
Pre-Service (Prospective) Non-urgent	NCQA: Decision within 15 calendar days. May be extended up to 15 calendar days. Electronic or written notification within 15 calendar days.
Pre-Service (Prospective) Expedited	NCQA: The organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. The organization may extend the timeframe due to lack of information, once, for 48 hours. NCQA considers 72 hours equivalent to 3 calendar days.
Concurrent (Extension of Care) Expedited	NCQA - Concurrent Urgent = ER admits, Rehab admits & concurrent rehab. Verbal notification of decision within 24 hrs. extend up to 48 hours with request for information. NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.
Retrospective	NCQA - For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request. Electronic or written notice of the decision to provider & member within 30 days of request.

Service Authorization Request Determination and Notification

All cases are evaluated for the appropriate level of care and medical necessity based on the clinical findings and plan of care submitted to Fidelis Care. All cases are reviewed using nationally accepted guidelines (e.g. Milliman Care Guidelines, American Society of Addiction Medicine (ASAM), CMS National and Local Coverage Determinations) or guidelines developed by Fidelis Care. Any case not meeting guidelines will be reviewed by a Chief Medical Officer or designee.

All cases are evaluated for the appropriate level of care and medical necessity. **“Medically Necessary”** means health care and services which are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Fidelis Care will provide the member (or their designee) and provider with verbal (telephonic) and written notification of the determination regarding the requested service, procedure or surgery.

- Approved authorizations: notification will include a description of the service and/or number of visits along with the date(s) of service/approval timeframe.
- Adverse determinations: If the Medical Director concludes, after review of all information submitted, that the service is not medically necessary or the level of care is not appropriate for the member's condition, a denial notice will be issued in accordance with the Subscriber Contract
- Denials also are issued when the clinical information submitted is insufficient to make a utilization determination
- Reconsideration of adverse determination: When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted

by the member's health care provider and the clinical peer reviewer making the initial determination.

- Exception: Retrospective reviews that result in an adverse determination are not eligible for reconsideration.

Fidelis Care must send a notice of determination on the date review timeframes expire. If Fidelis Care fails to make a determination within the time periods prescribed in this section, it shall be deemed to be an adverse determination subject to appeal.

A notice of adverse determination is in writing and includes:

- a. The reasons for the determination, including the clinical rationale, if any;
- b. Instructions on how to initiate internal appeals (standard and expedited appeals);
- c. How to initiate an external appeal; and
- d. Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make the determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by Fidelis Care, in order to render an appeal decision.
- e. Description of Action to be taken.
- f. Statement that Fidelis Care will not retaliate or take discriminatory action if appeal is filed.
- g. Process and timeframe for filing/reviewing appeals, including member's right to request an expedited review.
- h. Member's right to contact DOH, with 1-800 number, regarding their concern.
- i. Fair Hearing notice including aid to continue rights.
- j. Statement that notice is available in other languages and formats for special needs and how to access these formats.

Reversal of Prior Authorized Treatment

Fidelis Care may reverse a prior authorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when:

- a) relevant medical information presented to Fidelis Care or utilization review agent upon retrospective review is materially different from the information that was presented during the prior authorization review; and
- b) the information existed at the time of the prior authorization review but was withheld or not made available; and
- c) Fidelis Care or UR agent was not aware of the existence of the information at the time of the prior authorization review; and had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Financial Incentives

Fidelis Care is committed to providing members with the best and most appropriate care possible. Utilization management decisions are based only on the appropriateness of care and existence of coverage. At no time does Fidelis Care directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives offered or compensation rewarded to individuals, as UM decision makers, to encourage underutilization of services.

Provider Request for Clinical Criteria

Providers may request a copy of the clinical criteria used to render a utilization management decision, free of charge.

Providers are notified of their right to obtain clinical criteria via:

- a. Utilization Management notifications (adverse determinations) include an appeal rights attachment.
- b. The provider portal or provider bulletin.

Requests can be submitted by calling 1-888-FIDELIS (1-888-343-3547) and speaking with a Call Center representative.

The applicable clinical criteria will be mailed to the requesting provider within 15 business days.

BILLING AND CLAIMS

The billing guidelines contained within this section adhere to industry standards as defined by Center for Medicare and Medicaid Services (CMS); National Correct Coding Initiative (NCCI); National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); the American Medical Association's (AMA) Current Procedural Terminology Manual (CPT-4); Healthcare Common Procedure Coding System (HCPCS); and International Classification of Diseases 10th Revision (ICD10).

GENERAL CLAIMS AND BILLING GUIDELINES

Claims are processed Mondays through Fridays and clean claims are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A "**Clean Claim**" is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 Form. The following data elements are required for a claim to be considered a clean claim:

CMS-1500 and UB-04 Data Elements	CMS-1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Sex	X	X
Member Name/Address	X	X
Fidelis Care Member ID Number	X	X
Coordination of Benefits (COB)/other insured's information	X	X
Date(s) of Service	X	X
ICD- Diagnosis Code(s), valid and coded to the appropriate digit	X	X
ICD – Procedure Code (s) (if applicable)		X
CPT-4 Procedure Code(s)	X	X
HCPCS Code(s)	X	X
Service Code Modifier (if applicable)	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and Total Charges	X	X
Provider Name	X	
Provider Address/Phone Number	X	
National Provider Identifier (NPI)	X	X
Tax ID Number	X	X
Fidelis Care Provider Number – For Paper Claims Only	X	X
Fidelis Care Payer ID Number 11315 – For EDI Claims Only	X	X
Hospital/Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X
Revenue Code(s) and corresponding CPT/HCPCS Codes (outpatient services)		X
Principal, Admitting, and Other ICD-10 Diagnosis Codes		X

Present on Admission (POA) Indicator (if applicable)		X
Attending Physician Name and NPI	X	X

Instructions for Submitting Claims

The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB-04 claim form.

Electronic Claims Submission

Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org. The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

Direct Claims Submission

Providers can submit claims electronically for all lines of business directly. To submit directly to Fidelis Care, please complete the eCommerce Request Form.

Timely Filing

All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to enrollees must be submitted within ninety (90) days. Acceptable reasons for a claim to be submitted late are: litigation, primary insurance processing delays, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Fidelis Claims Editing Software

Fidelis Care uses Change Healthcare claims editing software to automatically review and edit health care claims submitted by physicians and facilities.

Paper Claims Submission

All paper claim submissions must be typed and submitted on red claim forms. Black and white claim forms and handwritten claim forms will be accepted.

Mailing Addresses for Paper Claims Submission:

	Essential Plans:	Metal-Level Products:
UB-04 Institutional Claims	Fidelis Care PO Box 806 Amherst NY 14226-0806	Fidelis Care PO Box 724 Amherst NY 14226-0724
CMS-1500 Claims	Fidelis Care PO Box 898 Amherst NY 14226-0898	

Coordination of Benefits Claims: CMS-1500 UB-04	COB Fidelis Care PO Box 905 Amherst NY 14226-0905
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NOTE:

Participating providers may not under any circumstances bill a Fidelis Care member (except for deductibles, co-payments, or co-insurance) for applicable lines of business for any services rendered under an agreement with Fidelis Care unless the provider has advised the member, prior to initiating service, that the service is not covered by Fidelis Care for that specific member's product line of business, and has obtained the member's written consent agreeing to personally pay for the service.

Claim Forms

Physician Services

Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims and encounter information for services within ninety (90) calendar days of the date of service using the CMS-1500 claim.

Hospital Providers

Claims can be submitted electronically, refer to section 12.1. Claims for hospital services must be submitted on a UB-04 claim form within ninety (90) calendar days of the date of service or the date of discharge.

Ancillary Providers

Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims for home healthcare services, durable medical equipment (DME), respiratory care, physical, occupational and speech therapies on a CMS-1500 or UB-04 claim form within ninety (90) calendar days of the date of service.

- For the following services, please attach the appropriate documentation to the claims:
Hysterectomies - Claims should include a copy of the consent form.
- Any services defined as “By Report” must be submitted with an invoice to assist with adjudication and payment.
- Supplies, drugs, and DME – Claims must include an unaltered manufacturer's invoice* for HCPC codes that require a report.

***Claims Requiring Manufacturer’s Invoice**

Claims that require a manufacturer’s invoice for payment consideration (e.g. “By Report” (BR) procedure) must be submitted with all of the following required information in order to be validated as an acceptable invoice:

- **Manufacturer’s Name**
- **Provider Name**
- **Item with Description**
- **Acquisition Cost on the invoice**
- **Invoice Date**

Some examples of **unacceptable** invoices are: altered manufacturer's invoice, purchase orders, sales orders, order confirmations, packing slips and delivery receipts.

Note, any claim received by Fidelis Care that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice, will be denied.

Claims Procedures

Claims are processed Mondays through Fridays and clean claims are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A "**Clean Claim**" is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on CMS-1500 and UB-04 Form.

Please follow the guidelines below in completing and submitting claim forms for services rendered:

- Always include the National Provider Identifier and Tax Identification number on each claim.
- Complete a single claim form for each patient encounter.
- Submit a separate claim form for each Provider and for each site where services were rendered.

Provide all the information requested, including:

- Member name
- Date of birth
- Fidelis Care member ID number
- Accident or injury related indicator
- Authorization number on form
- All valid Diagnosis Codes by number (ICD-10)
- Present on Admission (POA)
- Date(s) of service
- Place of service
- Quantity/Units
- Valid Procedure Code (CPT 4 and HCPC)
- Charges
- Treating physician's name, address, telephone number
- National Provider Identifier (NPI)
- Taxonomy Codes
- COB information
- Federal Tax Identification Number (TIN)
- National Drug Code (NDC), when applicable

Please note the following applicable place of service codes:

1	Pharmacy	21	Inpatient Hospital	52	Psychiatric Facility Partial Hospitalization
3	School Based	22	Outpatient Hospital (Effective 1/1/2016: Defined as On Campus – Outpatient Hospital)	53	Community Mental Health Center
4	Homeless Shelter	23	Emergency Room - Hospital	54	Intermediate Care Facility/Mentally Retarded
5	Indian Health Service Free-standing Facility	24	Ambulatory Surgical Center	55	Residential Substance Abuse Treatment Facility
6	Indian Health Service Provider-based Facility	25	Birth Center	56	Psychiatric Residential Treatment Center
7	Tribal 638 Free-standing Facility	26	Military Treatment Facility	57	Non-residential Substance Abuse Treatment Facility
8	Tribal 638 Provider-based Facility	31	Skilled Nursing Facility	60	mass immunization setting, such as public health center
11	Office	32	Nursing Facility	61	Comprehensive Inpatient Rehabilitation Facility
12	Patient's Home	33	Custodial Care Facility	62	Comprehensive Outpatient Rehabilitation Facility
13	Assisted Living Facility	34	Hospice	65	End Stage Renal Disease Treatment Facility
14	Residence with shared living areas	41	Ambulance-Land	71	State or Local Public Health Clinic
15	Mobile Unit	42	Ambulance Air or Water	72	Rural Health Clinic
17	Walk-in Retail Health Clinic	49	Independent Clinic	81	Independent Laboratory
19	Off Campus-Outpatient Hospital (effective 01/01/16)	50	Federally Qualified Health Center	99	Other Unlisted Facility
20	Urgent Care Facility	51	Inpatient Psychiatric Facility		

National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Service (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate claim payment. These policies are based on coding conventions defined in the American Medical Association's (AMA) CPT Manual, National and Local Coverage Determinations (NCD and LCD), coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. These standards set the coding requirements that all plans and providers must follow in order to secure reimbursement for all lines of business. Claims that are found to be noncompliant with these guidelines may be returned and/or denied.

Please visit the sites below for additional information:

NCCI Edits - <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

AMA - <http://www.ama-assn.org/ama>

NCD - <http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx>

LCD - <http://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx>

Claim Processing During Member Grace Period

Metal-Level Products

a) Government Subsidized Plans

Members receiving an Advance Premium Tax Credit (APTC) are entitled to a ninety (90) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be processed and paid in accordance with this section. Claims for services rendered during the subsequent sixty (60) days will be pended by Fidelis Care; however members will continue to be responsible for copays, coinsurance, and deductibles. Pended claims will be processed if delinquent payments are received prior to the end of the grace period. If a member fails to pay their premium within ninety (90) days their policy will be cancelled and pended claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Providers will be notified in writing if claims are pended for premium nonpayment. Additionally providers will be notified when eligibility is verified online or by calling Provider Services.

b) Nonsubsidized Plans

Members who do not qualify for an APTC, are entitled to a thirty (30) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be pended by Fidelis Care; however members will continue to be responsible for copays, coinsurance, deductibles, etc. Pended claims will be processed if delinquent payments are received prior to the end of the grace period. If a member fails to pay their premium within thirty (30) days their policy will be cancelled and pended claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Essential Plans

Members who fail to pay their premiums are given a 30-day grace period to pay their outstanding balance. During this time members are considered eligible for services and

Fidelis Care will continue to pay claims for dates of service within the grace period. If the member fails to pay the amount owed by the end of the grace period, their coverage will terminate. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Coordination of Benefits (COB)

If a Fidelis Care member has more than one health plan, Fidelis Care will coordinate the benefits with the other carrier(s) to ensure that Fidelis Care's liability does not exceed more than 100% of Fidelis Care's allowable expenses. This effort involves coordinating coverage and benefits, where appropriate, for illnesses, injuries, and accidents covered by:

- Personal Automobile coverage
- Workers' Compensation
- Veteran's Administration
- No Fault
- Other Health Insurance Plans

Payments Involving COB

In the event a claim is initially filed with Fidelis Care for which another carrier is determined to be the primary payer, the provider will be notified on a remittance advice to file with the primary insurer.

All participating providers agree to provide Fidelis Care with the necessary information for the collection and coordination of benefits when a member has other coverage. The provider will be required to do the following:

- Determine if there is duplicate coverage for the service provided;
- Recover the value of services rendered to the extent such services are provided by any other payor; and
- File the claim with Fidelis Care along with the primary carrier's Explanation of Benefits (EOB) attached for reconsideration within ninety (90) calendar days of receiving the primary carrier's explanation of benefits.

Fidelis Care will coordinate benefits up to Fidelis Care's allowable as secondary payer. Fidelis Care is not responsible for payment of benefits determined to be the responsibility of another primary insurer.

Electronically submitted claims for Coordination of Benefits will not be accepted. Instead, please mail all claims related to Coordination of Benefits to:

UB-04 or CMS-1500
COB Fidelis Care PO Box 905 Amherst NY 14226-0905

Billing requirements for Assistant Surgeon & Surgical Assist Claims

Participating surgeons may utilize the services of an assistant surgeon when the complexity of the surgical procedure deems it appropriate. Assistant surgeon is only permitted when the service is recognized as allowing an assist. When multiple complex surgeries are being performed, the surgeon can be the primary surgeon on some of the surgeries and the assist on others. These services can be billed on the same claim.

- A surgeon may not assist on his/her own surgery.

Assistant Surgeon performed by a physician:

- Modifier 80, 81 or 82 should be used.
- The assistant surgeon should be billed on a separate CMS-1500 claim form.
- When multiple complex surgeries are being performed, the assistant surgeon can be the assistant surgeon on some of the surgeries and the primary surgeon on others. These services can be billed on the same claim (they will be identified as different CPT codes).
- These modifiers must be billed by a physician. They cannot be billed by physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist.

Surgical assist performed by a PA, NP or other qualified health professionals:

- Must be billed by the physician. Claims submitted by the PA, NP, or clinical nurse specialist will be denied.
- Modifier AS should be used.
- Only one (1) claim line should be billed with the surgical CPT code and AS modifier.
- **Medicare Only** – The AS modifier should be billed by PA, NP or other Qualified Health professionals for Medicare Claims using their own NPI.

Modifiers 52, 53, 73, 74 and Reimbursement Rate

Claims received by Fidelis Care in 2018 and forward, billed with modifier 52, 53, 73 or 74, containing a date of service in 2017 and forward, will have the following reimbursement reduction applied to the claim:

Reimbursement:

Modifier 52 – Reduced Services:

50% of base rate

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual CPT code and the addition of modifier 52.

Modifier 53 – Discontinued Procedure:

50% of base rate

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to the extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance is reported by adding modifier 53 to the CPT code reported for the discontinued procedure.

Modifier 73 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia:

50% of base rate

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation, but **prior** to the administration of anesthesia. The intended procedure that is prepared for but cancelled can be reported by the usual procedure code with the addition of modifier 73.

Modifier 74 – Discontinued Out-Patient Hospital/Ambulatory surgery Center (ASC) Procedure After Administration of Anesthesia: 50% of base rate

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate the surgical or diagnostic procedure **after** the administration of anesthesia. Under these circumstances, the procedure started but terminated can be reported with its usual procedure code and the addition of modifier 74.

Payments and Reimbursements

Fidelis Care reimburses providers for services that are billed correctly to Fidelis Care on a weekly basis. Clean claims are paid within the guidelines stipulated by Section 3224-a of the New York State Insurance Law.

Payments to Specialty Providers

Each specialist provider will receive a check reflecting payment for covered services provided to eligible members and correctly billed to Fidelis Care. The check may be made payable to the individual provider or to a designated medical or professional group.

Multiple Specialty Providers

It is important for providers with multiple specialties to submit the appropriate taxonomy code when submitting claim forms. This will ensure accurate payment and the appropriate application of cost-sharing when applicable.

NOTE:

Any changes in a provider's status, address, corporate name, or other changes should be reported to Fidelis Care immediately to ensure prompt and accurate reimbursement.

Remittance Advice

Electronic Remittance Advice and 835 are available. For providers who have a user ID/password on the Secure File Delivery system, a Remittance Advice should be obtained by going to fideliscare.org. Click on the Quick Navigation Link and search for Provider Access Online or go to the site's Provider section and locate the link for Provider Access Online. Providers may also connect directly to <https://secure.fideliscare.org/files/logon.aspx>. For providers who have not established a user id/password, please contact your local provider relations specialist for assistance.

The Remittance Advice identifies which members and services are covered by a particular check. Claims are listed in alphabetical order according to the member's last name. Each item in the listing includes the following:

- Fidelis Care claim number as assigned by Fidelis Care
- Member's name
- Member's Fidelis Care ID number
- Provider's name
- Date of service
- Procedure code

- Patient account number
- Denied amount
- Allowed amount
- Member deductible, copay and coinsurance amounts if applicable

The Remittance Advice should be examined to reconcile payments from Fidelis Care with accounts receivable records.

Electronic Fund Transfer (EFT)

Providers can request to receive payments electronically and are encouraged to do so by completing an application request at:

<https://www.fideliscare.org/Apps/eft/Default.aspx>

Suggestions to Expedite Claims

- Have correct and complete information on the claim form.
- Verify member eligibility
- Do not submit duplicate claims. Initiate an inquiry if payment is not received within forty-five (45) days after billing date.
- Provide Coordination of Benefits information before claim is filed.
- Include your NPI and TIN on all claims submitted.
- Electronic submission is the best way to expedite claims (refer to section 12.1 in this manual). However, if you must submit paper claims, please mail claims routinely. By mailing claims routinely throughout the month, you will assure faster turnaround and avoid an end of the month backlog.
- Include the Authorization Number on the claim and/or attach authorization claims form.

Fidelis Care Claim Inquiry

To status claims submitted over thirty-five (35) days please go to [fideliscare.org](https://www.fideliscare.org) to access Provider Access Online. You can also contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547) Monday through Friday, 8:30AM to 5:00PM.

Stop payment and reissue of checks

To request a stop payment and reissue of a check, the request must be sent in writing to the following address:

**Attn: Finance Department – Provider Reimbursement
Fidelis Care
95-25 Queens Blvd
Rego Park, NY 11374**

The written request must have the following information:

- A completed and notarized affidavit (affidavit form, refer to Section 12B of this manual)
- The contact person and phone number
- Verification of the correct remittance address for the check
- Who the check was made payable to, if known

Please note that if the check has been cashed, an additional Affidavit form will need to be obtained, signed, and notarized.

Corrected Claim

Corrected claims must be submitted within sixty (60) days of the remittance advice for that claim.

A **Corrected Claim** is a claim that has any changes made to an original claim previously submitted that include but not limited to a change of the following:

- Date of Service
- Place of Service
- Procedure Codes - including adding or removing modifiers
- Diagnosis Billed
- Units per service
- Dollar amounts
- Provider status changed
- Provider specialty change
- Provider tax id# change

Submission of Corrected Claims

When submitting a Corrected Claim, the original claim number must be submitted and the claim frequency type code must be a 7 (replacement of prior claim) or 8 (void if original payment). Please go to Fidelis Care's website for additional information

Overpayments/Underpayments

If your claim is overpaid/underpaid, please request an adjustment by submitting an Administrative Review Form (Section 12A) and a copy of the payment voucher that indicates the payment. If Fidelis Care agrees with your request for adjustment due to an overpayment, the overpayment will be withdrawn from a future payment. Do not return the check containing the overpayment.

If Fidelis Care identifies that an overpayment has been made to a provider, Fidelis Care shall provide a thirty (30) calendar days written notice to physicians (unless otherwise noted) before engaging in additional overpayment recovery efforts. Such notice will state the member name, service date, payment amount, proposed adjustment, and a reasonable specific explanation of the proposed adjustment.

If a provider disagrees with the payment determination, please attach documentation supporting additional payment along with an Administrative Review form (Section 12A) and submit your request within sixty (60) days of the remittance advice.

No payment

If a provider disagrees with the no payment determination, please attach documentation supporting payment along with an Administrative Review form (Section 12A).

Coding

Billing with the appropriate procedure and diagnosis codes aids in accurate and timely payment reimbursement.

Quick Guide to Claims Processing

QUESTION	PROFESSIONAL AND FACILITY SERVICES
Where do I direct billing questions?	1-888-FIDELIS (1-888-343-3547) Provider Services Department
Where do I submit claims?	Refer to the Fidelis Care website at fideliscare.org for information about submitting claims electronically
Which forms may be used for billing?	Professional – CMS-1500 Facility – UB-04
Which patient identifier(s) should be used?	Fidelis Care Identification Number
What is the time frame for submitting the claim?	Ninety (90) calendar days from the date of service
How do I check on the status of a claim	To status claims please go fideliscare.org to access our secure Provider Portal
What is the time frame for payment of a completed and clean claim?	Thirty (30) calendar days after receipt of a clean claim submitted electronically Forty-five (45) calendar days after receipt of a clean claim submitted via paper (In accordance with NY Insurance Law Section 3224-a)
What is the appeal process if you believe a claim has been underpaid or wish to appeal a denied claim?	Please refer to Section 13, PROVIDER APPEALS

AFFIDAVIT OF LOST / STOLEN / DESTROYED CHECK

_____ deposits and says:
(Name of Payee's Representative)

1. That the payee, _____, has not received Check No. _____, in the amount of \$ _____, and that the check has been lost/destroyed/stolen on or about ____ / ____ / ____.
2. That the payee requests that Fidelis Care notify the bank to place a stop payment on Check No. _____, and that Fidelis Care issue a duplicate check in lieu of such stopped check.
3. That neither the payee nor any person acting under orders, authority, or control of the payee has attempted or will attempt to negotiate Check No. _____.
4. That if Check No. _____ is negotiated, the payee hereby agrees to complete and sign an affidavit of forgery for such check.

Signed by _____, as _____, of the payee.
(name) (title)

Payee Signature

The foregoing affidavit was acknowledged before me, the undersigned Notary Public, by _____ this _____ day of _____, 20____.
(name of payee)

Notary Public

Send this 'Affidavit of Lost / Stolen / Destroyed Check' to:

Attn: Provider Reimbursement – Provider Reimbursement
Fidelis Care
95-25 Queens Blvd
Rego Park, NY 11374

PROVIDER APPEALS

This section deals with appeals from two kinds of denials: (i) denials for lack of medical necessity, discussed in Part I, and (ii) administrative denials or alleged underpayments discussed in Part II.

Part I. Denial of Payment For Lack of Medical Necessity

Fidelis Care will not reimburse treatment that is not medically necessary. Decisions denying claims for medical necessity, i.e. clinical denials, are made only by Fidelis Care's Chief Medical Officer or a Medical Director. Providers, members, or the member's designee may appeal Fidelis Care's decisions regarding the medical necessity of treatment as described below.

Appealing a Determination Based on Medical Necessity

Standard Appeals

If Fidelis Care denies payment for a claim due to a lack of medical necessity, the provider, member, or member's designee may appeal the denial.

The appeal must be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the provider and member, and contain instructions regarding request for appeals. A provider may file an appeal for a retrospective denial.

An appeal is initiated by contacting Fidelis Care's Chief Medical Officer or designee either in writing or by telephone. Verbal appeals must be followed up by written appeal. Fidelis Care strongly urges that all appeals be made in writing and include the following documentation: the member's medical records for the treatment at issue, an appeal or a summary of that treatment prepared by the provider's utilization management department, and a copy of the original denial letter from Fidelis Care. All appeals for medical necessity should be sent to:

Fidelis Care Appeals Department
490 CrossPoint Parkway
Getzville, NY 14068
Phone: 718-896-6500 ext. 13159
Fax: 718-393-6779

If the original denial letter is not available, the appeal should indicate the dates of service at issue, the member's name, and Fidelis Care member ID number. Although this documentation may be forwarded following filing of the appeal, Fidelis Care may deny the appeal if such written documentation is not provided and Fidelis Care is unable to assess the clinical basis for the appeal.

Fidelis Care will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal and will respond to the appeal.

Fidelis Care must make a standard appeal determination as fast as the member's condition requires, and no later than thirty (30) calendar days from receipt of the appeal. This time may be extended for up to fourteen (14) calendar days upon member or provider request; or if Fidelis Care demonstrates more information is needed and delay is in best interest of member and so notifies member.

If Fidelis Care requires additional information to conduct a standard internal appeal, then Fidelis Care shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.

Fidelis Care's written determination regarding the appeal will be mailed to the member, the member's designee and the provider within two (2) business days of the determination of the appeal. Fidelis Care will indicate the reasons for its decision and, if the appeal is denied, the clinical rationale for upholding the clinical denial. The written notice of determination includes a notice of the member's right to an external appeal and a description of the external appeal process. (See section below on External Appeals), and the member's right to request a fair hearing.

Each notice of the final adverse determination will be in writing, dated, and include:

- a. The basis and clinical rationale for the determination.
- b. The words "final adverse determination"
- c. Fidelis Care contact person and phone number
- d. Member coverage type
- e. Name and address of UR agent, contact person and phone number
- f. Health service that was denied, including facility/provider and developer/manufacturer of service as available.
- g. Statement that enrollee may be eligible for external appeal and timeframes for appeal. If health plan offers two levels of appeal, cannot require member to exhaust both levels.
- h. Must include clear statement in bold that member has four (4) months from the final adverse determination to request an external appeal and choosing second level of internal appeal may cause time to file external appeal to expire. Providers acting on their own behalf have forty-five (45) calendar days to request an external appeal.
- i. Standard description of external appeals process attached
- j. Summary of appeal and date filed
- k. Date appeal process was completed
- l. Description of member's fair hearing rights if not included with initial denial
- m. Right of enrollee to complain to the Department of Health at any time with 1-800 number
- n. Statement that notice available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

The physician reviewing the appeal will be different from the physician or Medical Director who first reviewed and determined that the treatment was not medically necessary. If the appeal determination is adverse (denial upheld) it is considered a final adverse determination (FAD).

If Fidelis Care fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

Fidelis Care and the member may jointly agree to waive the internal appeal process; if this occurs, Fidelis Care will provide a written letter to this effect with information regarding filing an external appeal to the member within twenty-four (24) hours of the waiver agreement.

No additional internal appeals are available. However, providers may seek external appeals as described below.

Members or a designee may see their case file. The member may present evidence to support their appeal in person or in writing.

Expedited Appeals

A provider, member, or member's designee may seek an expedited appeal in the event of the following:

- If Fidelis Care determines that continued or extended healthcare services, procedures or treatments or additional services for a member undergoing a continued course of treatment prescribed by a healthcare provider is not medically necessary.
- If the provider believes an immediate appeal is necessary, provided that the initial determination regarding a lack of medical necessity was not retrospective (for example, appeals of elective admissions or surgeries).
- When Fidelis Care honors the member's request for an expedited review, or if Fidelis Care denies the member's request for an expedited review, Fidelis Care must provide notice by phone immediately, followed by written notice in two (2) calendar days.
- Fidelis Care will render a decision as fast as the member's condition requires and within two (2) business days of receipt of necessary information but no more than three (3) business days of receipt of appeal. This time may be extended for up to fourteen (14) calendar days upon member or provider request; or if Fidelis Care demonstrates more information is needed and delay is in best interest of the member and so notifies member. If the provider is not satisfied with Fidelis Care's response to the expedited appeal, the provider or member may further appeal the decision through the standard appeal process described above or the external appeal process as described below.

Written Notice of final adverse determination concerning an expedited UR appeal shall be transmitted to the enrollee within twenty-four (24) hours of rendering the determination.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

Fidelis Care will make a clinical peer reviewer available within one (1) business day.

Fidelis Care will render a decision within two (2) business days of receiving all information necessary to process the appeal. If the provider is not satisfied with Fidelis Care's response to the expedited appeal, the provider may further appeal the decision through the standard appeal process described above.

Written notice of a final adverse determination concerning an expedited appeal shall be transmitted to the member within twenty-four (24) hours of rendering the determination. The notice will include the description of the right to further appeal through the standard appeal process. Reasonable efforts will be made to provide verbal notice to member and provider at the time the determination is made.

External Appeals

Pursuant to Article 49 of the New York State Public Health Law, an external appeal process is available through the State Department of Financial Services. The time period to file an external appeal is within four (4) months from the receipt of the Final Adverse Determination (FAD) of the first level appeal. Providers acting on their own behalf must file external appeals within sixty (60) calendar days. The external appeal decision will be rendered in thirty (30) calendar days and within seventy-two (72) hours for an expedited external appeal. An external appeal may be expedited when the patient has not received the service. The application to request an external appeal will accompany the FAD.

In order to qualify for an external appeal, the following circumstances must be met:

- The service or treatment was denied as medically unnecessary, experimental/ investigational, or out-of-network service or referral;
- The appeal is for service or procedure that was otherwise covered under the contract;
- The member has exhausted the internal utilization review process, unless a waiver is signed;

- The appeal must be requested by the member or the member's designee within four (4) months of receiving the final determination of the first level internal appeal or within sixty (60) calendar days if a provider is acting on their own behalf.
- To appeal an experimental/investigational, clinical trial, out-of-network service or out-of-network referral denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.
- To appeal to an experimental/investigational denial, the member's attending physician must attest that (a) standard health services or procedures have been ineffective or would be medically inappropriate or (b) there does not exist a more beneficial standard health service or procedure covered by the health care plan and the member's physician must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure.
- To appeal a clinical trial denial for which the member is eligible, the member's physician must attest that there exists a clinical trial that is open, the patient is eligible to participate, and the patient has or will likely be accepted. The clinical trial must be a peer-reviewed study plan which has been : (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.
- To appeal an out-of-network denial of service, the physician must attest that the out-of-network health service is materially different from the alternate in-network service recommended by the health plan, and based on two (2) documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health services and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health services.
- To appeal an out-of-network referral denial to a Non-Participating provider, the physician must certify that the Participating Provider recommended by Fidelis Care does not have the appropriate training and experience to meet the member's health care needs, and recommend a Non-Participating Provider with the appropriate training and experience to meet the member's particular health care needs who is able to provide the requested health care service. The out-of-network provider's name, address and training and experience must be included.
- To appeal a rare disease treatment denial, a physician other than the member's treating physician must attest that the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service and that the requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of service. The physician must also attest that they do not have a material financial or professional relationship with the provider of the service AND (a) the patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network OR (b) the patient's rare disease affects fewer than 200,000 U.S. residents per year. If the provision of the service requires approval of an Institutional Review Board, include or attach the approval.

If a member needs to file an external appeal, they may obtain a copy of the New York State Department of Health External Appeal form by calling Fidelis Care Member Services at 1-888-FIDELIS (1-888-343-3547) or by downloading the application from <http://www.dfs.ny.gov/insurance/extapp/extappl.pdf>

An application for external appeals can be found in Section 13 A – External Appeal Instructions and Application and is included in the FAD letter sent to members as well.

Medical Necessity Denials from subcontracted Utilization Review (UR) agents (any agent conducting UR services on behalf of Fidelis Care members) are subject to the same appeal rights described above.

Provider External Appeal Rights

A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Fidelis Care.

Fidelis Care is responsible for the full cost of an appeal for a concurrent adverse determination that is overturned.

Fidelis Care and the provider must evenly divide the cost of a concurrent adverse determination that is overturned in-part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of Fidelis Care. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application and the designation.

Part II. Requesting Reconsideration of Administrative Denials or Paid Amount

A provider may at times disagree with Fidelis Care as to the amount payable for a claim or group of claims. Where a provider believes an underpayment has occurred, the provider shall request reconsideration through the procedure described in this Section 13 (Part II).

Examples of administrative denials are denials based on the timeliness of the claim submission, existence of co-insurance, member eligibility, lack of a required preauthorization, or other errors in the claim.

A provider can request reconsideration of a claim that was denied exclusively because it was not submitted in a timely manner. The provider must demonstrate that the late submission was due to an unusual occurrence and that the provider has a pattern of timely claim submission. Penalties of a dollar liability of up to 25% reduction in claim payment can be imposed by Fidelis Care.

They are not adverse determinations regarding the medical necessity of the treatment rendered or proposed, and as such, are not clinical denials. However, the provider may seek reconsideration of an administrative denial, or of claims the provider believes has been underpaid or otherwise incorrectly paid, as follows:

- The provider should explain clearly the reason for the appeal and provide supporting documentation.
- Requests for reconsideration shall be submitted with the form contained in Section 12A of this manual.

Where Fidelis Care does not receive a request for reconsideration within sixty (60) calendar days of the date the claim was denied, partial-/under-payment the administrative denial shall be deemed final and without further recourse. Similarly, if Fidelis Care does not receive a request for reconsideration of a paid amount within sixty (60) calendar days of the payment of the claim, the provider shall be deemed to have waived all rights to assert that an underpayment has been made. Fidelis Care will render a decision within

thirty (30) business days of receiving all information necessary to process the request for reconsideration. Providers have no further appeal rights if the administrative denial is upheld.

Claim Denials for Invoice

In some cases Fidelis Care may need to deny a claim because a copy of the manufacturer's invoice is required for claims processing. Providers may send a copy of the invoice via fax or mail to the contact information below. Please be sure to include the member's name and member ID, as well as the claim number associated with the invoice request:

By Mail - Fidelis Care

Attn: Claims Reconsideration
480 CrossPoint Parkway
Getzville, NY 14068

By Fax -

Refer to Provider Manual Section Thirteen (13) B for the 'Provider Invoice Fax Form'.
1-877-247-9187 | Attn: Claims Reconsideration (*this fax is for invoice purposes only*)

For Corrected Claims, please see Section 12

Where Fidelis Care does not receive a request for reconsideration within sixty (60) calendar days of the date the claim was paid or denied, the claim determination shall be deemed final and without further recourse, and shall not be subject to arbitration or review by a court of law.

Section Thirteen A

Provider COB/ Resubmission/ Appeal /Reconsideration / Form

This form is only applicable if a claim has been processed and a remittance advice has been issued from Fidelis Care.

Use this form as part of the Fidelis Care Appeal / COB/ Reconsideration process to address a previous claims adjudication decision. **NOTE:** All claim requests for reconsideration and claims disputes must be received within **60 calendar days**, or per your contract terms, from the date of the remittance. All fields below are required information. Failure to complete this form in its entirety may result in a delay or denial of your reconsideration/appeal request.

Do not use this form if submitting a Corrected Claim.

MEMBER NAME:	_____	MEMBER ID:	_____
CLAIM NUMBER:	_____	DOS:	_____
PROVIDER NAME:	_____	NPI OR TIN	_____
NAME OF REQUESTOR:	_____	DATE OF REQUEST	_____

Please check **ONE** box to indicate if your request is a COB, Appeal or Reconsideration Resubmission:

COB RESUBMISSION: You are resubmitting a claim that is Coordination of Benefits (COB) related **and** supporting data.

Examples include but are not limited to:

- Copy of claim form **and** Primary Explanation of Benefits (EOB) from another payer
- Copy of claim form **and** Copy of Subrogation or Worker’s Compensation Notice of Decision
- Copy of claim form **and** Copy of other insurance carrier eligibility data.

REQUIRED: Brief description of your reason for the COB Resubmission:

APPEAL: The action you take if you disagree with the coverage and/or payment decision

An appeal is a formal written request to Fidelis Care for reconsideration of a medical, payment, or contractual adverse decision.

Types of claim denials that would be an appeal include but are not limited to:

- | | | |
|--------------------------------|------------------------------------|-------------------------|
| • Authorization denial dispute | • Denial requiring medical records | • Clinical edit review |
| • Invoice pricing dispute | • Claim pricing disputes | • Timely filing dispute |

REQUIRED: Brief description of your reason for the Appeal Request:

RECONSIDERATION: The action you take if the claim(s) was/were originally submitted with incorrect/insufficient information.

Examples include but are not limited to:

- Eligibility update
- PCP update
- Retraction Request

REQUIRED: Brief Description of your reason for the Reconsideration Request:

Please include relevant information and any supporting medical or clinical documentation with this form and mail to:

Product	Mailing Address
Medicaid Managed Care Child Health Plus Fidelis Care at Home (MLTC) HealthierLife (HARP)	Fidelis Medicaid PO Box 10500 Farmington, MO 63640-5001
Qualified Health Plans Essential Plan	Fidelis MarketPlace P.O. Box 10600 Farmington, MO 63640-5002
Medicare Advantage Dual Advantage Medicaid Advantage Plans	Fidelis Medicare P.O. Box 10700 Farmington, MO 63640-5003

Fidelis Care will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (you will be notified by a letter) or overturn our original decision and any additional payment due will appear on your remittance advice.

Request for Claim Reconsideration of Claim Denial for Invoice

Fax Number 1-877-247-9187

Member Name: _____ Member ID: _____

Provider Name: _____

National Provider Identifier or Tax Identification Number: _____

Name of Requestor: _____ Date of Request: _____

Please limit each form to 1 member with same provider and 3 claims per form.

Claim# _____ Date of Service _____

Claim# _____ Date of Service _____

Claim# _____ Date of Service _____

Comments:

Note: Requests for claim reconsiderations must be submitted within 60 days of the date of the remittance advice (RA) for the claim at issue. For all requests, attach a copy of the original claim and remittance advice. Failure to provide sufficient documentation may result in denial of your request. Requests for claims reconsiderations not submitted within 60 days of Fidelis Care’s adjudication will not be reconsidered and the decision shall be final, unable to be appealed, and not subject to arbitration or review by a court of law.

Please make copies as necessary and submit your fax request for a claim reconsideration of the manufacturer’s invoice(s) to Fidelis Care at the following fax number:

1-877-247-9187

MEMBER GRIEVANCES AND COMPLAINTS

All Fidelis Care members have a right to file a complaint at any time if they are dissatisfied with Fidelis Care, a Fidelis Care provider, or with the care or services they have received. If a complaint involves a physician or provider, a Provider Relations Representative will contact the provider to discuss the complaint. The findings will be reported to the Quality Healthcare Management (QHCM) Department for consideration as to action or disposition.

Members are advised to call Customer Service to file a complaint. Fidelis Care will attempt to resolve complaints immediately by taking prompt corrective action and educating members regarding Fidelis Care policies and procedures. The substance of the complaint and the agreed upon disposition will be documented.

Complaints are submitted in writing or recorded by Fidelis Care staff on behalf of members. All complaints are logged and acknowledged by Fidelis Care in writing. Complaints relative to the delivery of healthcare services will be referred to Fidelis Care's QHCM Department for investigation.

A member or designee has 180 business days after the date of the incident to file a grievance/complaint. Complaint Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered healthcare professionals who did not make the initial determination - at least one of whom must be a clinical peer reviewer.

Upon the member's request, Fidelis Care will expedite the complaint process if a delay would risk the member's health.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file and in the provider's Total Quality Profile on an annual basis.

NOTE: Members may always file a complaint with the New York State Department of Financial Services or Consumer Assistance Program.

Complaints:

If a member has a problem or dispute with care or services, the member may file a complaint with Fidelis Care. Any concerns that require a thorough review from the Plan or that are received in writing, will be responded to within 60 days of receipt and any complaint that comes in the mail will be handled according to the following procedure. Fidelis Care is always available to assist a member in filing a complaint, complaint appeal, or action appeal. A Customer Service Representative can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, Fidelis Care can help with this.

A member can call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609

Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If the member needs assistance filing a Grievance or Appeal, they may also contact the state independent Consumer Assistance Program at:

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org

Website: www.communityhealthadvocates.org

Filing a Complaint with the Plan:

To file by phone, the member should call Customer Service at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30AM to 8:00PM. If the member contacts Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, the member will be notified. The member can write Fidelis Care with his or her complaint or call the Customer Service number and request a complaint form. It should be mailed to Attn: Customer Service Department, Fidelis Care New York, 95-25 Queens Boulevard, Rego Park, NY 11374.

If Fidelis Care does not solve the problem right away over the phone or if Fidelis Care receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Fidelis Care will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint, but the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Fidelis Care will send the member a letter with the reasons for the decision. When a delay would risk a member's health, Fidelis Care will make a decision within forty-eight (48) hours of when Fidelis Care has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Fidelis Care will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Fidelis Care is unable to make a decision about a complaint because we don't have enough information, a letter will be sent to the member.

Complaint Appeals:

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Fidelis Care. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member will sign and return the form to Fidelis Care. The member may make any needed changes before sending the form back to us.

Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one (1) or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about the complaint.

If Fidelis Care has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member's health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the

member or their designee can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

Action Appeals:

If a member disagrees with Fidelis Care's decision with a Service Authorization Request, a payment denial, or timeliness of an action taken by Fidelis Care, the member or their designee can file an action appeal. The member has sixty (60) business days after hearing from Fidelis Care to file an appeal. The action appeal must be in writing. If the appeal is by telephone, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member must sign and return the form to Fidelis Care. The member may make any changes to the form before sending it back to us. After receipt of the action appeal, an acknowledgement letter will be sent within fifteen (15) calendar days.

If Fidelis Care has all the information needed, the member will know our decision within thirty (30) calendar days. If a delay would significantly increase the risk to the member's health, the member or their designee can request an expedited review of the action appeal, which will be decided within two (2) business days. The timeframe for deciding an action appeal can be extended for up to fourteen (14) calendar days if the member or his/her designee requests one or if Fidelis Care determines that the extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.

The member will be given the reasons for Fidelis Care's decision and clinical rationale. Fidelis Care will attempt to reach the member with the action appeal decision by phone. If the member is still not satisfied with Fidelis Care's decision, the member or someone on his or her behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125. Filing an action appeal is the member's right, and the Fidelis Care will not retaliate or take any discriminatory action against the member because they filed an action appeal.

An action appeal should be made in writing within sixty (60) business days of receipt of the letter to:

Attn: Quality Health Care Management
Fidelis Care
95-25 Queens Boulevard
Rego Park, N.Y. 11374
Phone#: 1-888-FIDELIS (1-888-343-3547)
Fax#: 1-800-374-9808

Independent Dispute Resolution Process

Fidelis Care or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at <https://www.dfs.ny.gov/>. The IDRE will determine whether Fidelis Care's payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

FAMILY PLANNING SERVICES

Fidelis Care covers family planning services and certain other reproductive health care services. Starting January 1, 2019, Fidelis Care members will obtain family planning and reproductive health benefits directly from Fidelis Care. Members do not need a referral and should present their Fidelis Care Member ID card. Previously, these services were provided to members by Medicaid Fee for Service or other third party vendors. There are no changes to our members' covered family planning and reproductive health benefits. However, the changes in how members obtain these benefits from Fidelis Care are listed below by product.

Product	Entity providing coverage through 12/31/2018:	Entity providing coverage as of 1/1/2019:
NYS of Health Exchange Essential Plan 1&2	Unified, IPA	Fidelis Care
NYS Essential Plan 3&4	NYS Medicaid FFS	Fidelis Care
New York State of Health Exchange, Metal Level Products	Unified, IPA	Fidelis Care

Members can obtain the following family planning services through Fidelis Care: birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. Members can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to their test results. Screenings for cancer and other related conditions are also included in family planning visits.

Fidelis Care has notified its primary care providers, obstetricians, and gynecologists, and certain other specialties, that Fidelis Care covers reproductive and family planning services as a standard benefit. **Providers should begin billing Fidelis Care directly for any such services provided on or after January 1, 2019.** Fidelis Care recognizes that the exchange of medical information, when indicated in accordance with generally accepted standards of professional practice, is necessary for the overall coordination of member care and will assist primary care providers in providing quality care to Fidelis Care members. Fidelis Care acknowledges that medical record information maintained by network providers may include information relating to family planning services.

Non-Network Fidelis Care Providers

Members enrolled in **Essential Plan 3 and Essential Plan 4** can also use their New York State (NYS) Medicaid card to get covered family planning services from any doctor, clinic, or drug store that accepts NYS Medicaid. They do not need a referral. If a member has any questions or needs information about these services, they can call the **New York State Growing Up Healthy Hotline at 1-800-522-5006** for information. Also, the New York State Department of Health will mail new members a letter with information and a listing of State-approved Medicaid providers.

Members enrolled in a **Metal-Level Product, Essential Plan 1 or Essential Plan 2** can also use their Health Benefits Exchange Subscriber Identification Card to get covered family planning services through Unified Independent Practice Association, LLC. For questions about this benefit, members and providers can call **Unified IPA, LLC at 1-800-342-2641**.

ENROLLMENT AND ELIGIBILITY

ALERT:

Verification of membership is not to be construed as authorization for services.

Enrollment of Recipients

Fidelis Care functions related to enrollment focus on:

- Effectuating and managing health insurance coverage
- New member orientation
- Member identification
- Identification and documentation of third party insurance

When Fidelis Care is notified of an enrollment, or an enrollment is verified by New York State, Fidelis Care will send the new member a Member Handbook, identification card, and a Summary of Benefits. Additionally, a Health Risk Assessment (HRA) form is included, and the member is asked to complete the HRA and return it to Fidelis Care in the return addressed envelope provided.

The HRA form given to new members is a standardized tool. The Member Services Department receives the HRA and forwards each case to a Special Triage Nurse for review. When appropriate, a member is referred for Case Management or Health and Disease State management. Each HRA is entered into a database and a report is sent directly to the member's PCP.

Verification of Member Eligibility

All providers must verify a member's eligibility at each visit. This can be accomplished as follows:

- Providers can verify the member's current eligibility by either using the Fidelis Care Provider Access Online by going to www.fideliscare.org or using the Integrated Voice Response (IVR), by calling 1-888-FIDELIS (1-888-343-3547).

Fidelis Care will reimburse providers only for services rendered to currently eligible members. **It is the responsibility of the provider to verify eligibility prior to providing services.**

The hospital, physician, or office must verify eligibility/current enrollment each time a member presents or is referred for service. Possession of a Fidelis Care member Identification (ID) Card is not sufficient to verify current eligibility or identity.

Sample Member ID Card, see Appendix X.

Member Grace Periods

Metal-Level Products

Members who fail to pay their premiums are placed into a grace period until payment is received. During this time members are considered eligible for services, but claims may be pended depending on the length of delinquency. If payment is not received by the end of the grace period, coverage is terminated and the member is financially responsible for services received. For additional information on claim processing, please refer to Section 12.

Essential Plans

Members who fail to pay their premiums are given a 30-day grace period to pay their outstanding balance. During this time members are considered eligible for services and Fidelis Care will continue to pay claims for dates of service within the grace period. If the member fails to pay the amount owed by the end of the grace period, their coverage will terminate. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Misuse of ID Card

If you suspect that an individual is misusing a Fidelis Care ID Card, by using a card that has been lost or stolen or by borrowing another person's card, please report the incident to Fidelis Care's Special Investigation Unit (SIU) Fraud Hotline at 1-800-533-2400.

PRODUCT INFORMATION

Fidelis Care's Metal-Level Products

Following the implementation of the Patient Protection and Affordable Care Act, Fidelis Care offers Metal-Level Products covering Essential Health Benefits as defined by the Federal Government and New York State. Fidelis Care is offering a standard set of plan designs that are described below in the Product Overview section. Members can enroll through the New York State of Health: The Official Health Plan Marketplace or directly through Fidelis Care.

Product Overview

Fidelis Care offers Metal-Level Products

Metal-Level Products are standardized products that fall into various "metal" levels based on their design and the level of cost sharing required: Platinum, Gold, Silver, Bronze, and Catastrophic Coverage.

<u>Product Type</u>	Metal-Level Products
<u>Provider Panel</u>	Fidelis Care Metal-Level Network
<u>Primary Care Physician (PCP)</u>	Members joining Fidelis Care's "metal-level" plans are not required to choose a PCP
<u>Inpatient Hospital Services</u>	Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.
<u>Alternate Level of Medical Care</u>	Continued Care in a hospital pending placement in an alternate lower level of care.
<u>Ambulatory Services</u>	Outpatient hospital services are provided through ambulatory care facilities including hospital outpatient departments (OPDs), and treatment centers (D&Ts or free-standing clinics), and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health, Child/Teen Health Plan (C/THP) services, and ambulatory care facilities.
<u>Preventive Health Services</u>	<p>There are three levels of preventive care:</p> <ul style="list-style-type: none"> • Primary, such as immunizations, aimed at preventing disease; • Secondary, such as disease screening programs aimed at early detection; • Tertiary, such as physical therapy, aimed at restoring function. <p>*Preventive services with an A or B rating from the USPSTF, and those provided according to recommendations from ACIP or Bright Futures are covered in full and are not subject to cost-sharing by the member. <u>Please note that in some cases, cost-</u></p>

	<p><u>sharing may apply to certain services provided during the same preventive service visit (i.e. lab work)</u></p>
<p><u>Health Care Services Covered through Fidelis Care</u></p>	<ul style="list-style-type: none"> • Physician Services • Nurse Practitioner Services • Midwifery Services • Preventive Health Services • Wellness Services • Second Medical Surgical Opinion • Laboratory Services • Radiology Services • Smoking Cessation Products • Rehabilitation Services • EPSDT/(Child Teen Health Program) • Home Health Services • Hospice • Emergency Services • Durable Medical Equipment • Audiology - hearing aid services and products when medically necessary • Emergency Transportation ** See below for process • Non-Emergency Ambulance Transportation** See below for process • Pediatric Dental Services (coverage for adults is included in the Gold & Silver Enhanced, Gold & Silver Wellness and Silver products) • Pediatric Vision Services (coverage for adults is included in the Gold & Silver Enhanced, Gold & Silver Wellness and Silver One products) • Acupuncture (12 visits per year are covered for the Gold & Silver Wellness and Silver One products) • Prosthetics • Mental Health and Substance Abuse Services • Short-term Residential Health Care Facility Services • Family Planning • Reproductive Health Services
<p><u>Transportation</u></p>	<p>Ambulance and Pre-Hospital Emergency Medical Services Fidelis Care covers Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.</p> <p>“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p>

<p><u>Transportation (con't)</u></p>	<ul style="list-style-type: none"> • Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. <p>Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.</p> <p>Non-Emergency Ambulance Transportation:</p> <p>Fidelis Care covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care Facility. • From an acute Facility to a sub-acute setting. <p>Limitations/Terms of Coverage:</p> <p>Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Fidelis, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.</p> <p>Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when a medical condition is such that transportation by land ambulance is not appropriate; and the medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance.</p>
<p><u>Non-covered Services</u></p>	<ul style="list-style-type: none"> • Cosmetic surgery, unless medically indicated • Routine hygienic foot care in the absence of a pathological condition for those 21 years and older unless member is a diabetic • Residential Health Care Facilities services for an individual determined to be in a permanent status
<p><u>Referrals/Authorizations</u></p>	<p>Referrals are not required for visits to a specialist. Prior authorizations may be required for certain services. Please refer to the Fidelis Care Authorization Grids for details: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids</p> <p>Effective December 23, 2019, orthopedic surgical procedures and spinal surgical procedures, in both the inpatient and outpatient setting, require</p>

	<p>prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of procedures that require prior authorization from TurningPoint Healthcare Solution, visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/EducationalMaterials/2019-FidelisCare-TurningPointCPTCodeList-English.pdf</p> <p>Effective October 4, 2021, Ear, Nose, and Throat (ENT) surgical procedures performed in inpatient, outpatient, physician’s office, and in-home settings, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-ENT.pdf</p> <p>Effective October 4, 2021, cardiac surgical procedures performed in inpatient, outpatient, physician’s office, and in-home settings, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-Cardiac.pdf</p> <p>Effective October 1, 2021, prior authorization has been delegated to National Imaging Associates, Inc. (NIA) for radiology and radiation therapy services. Medicaid Managed Care, Child Health Plus, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Provider/Submit-Authorization-Requests</p>
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Essential Plans

The **Essential Plans** were designed to bridge a gap between Medicaid and Metal Marketplace coverage with the goal of providing more affordable healthcare and expanding the Marketplace enrollment. These plans cover all of the essential health benefits covered under the Qualified Health Plans offered on the Marketplace, with no annual deductible and low out-of-pocket costs.

<u>Product Type</u>	Essential Plan 1 & 2
<u>Provider Panel</u>	Fidelis Care Essential Plans Network
<u>Primary Care Physician (PCP)</u>	Members joining the Fidelis Care Essential Plans are not required to choose a PCP
<u>Inpatient Hospital Services</u>	Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.
<u>Alternate Level of Medical Care</u>	Continued Care in a hospital pending placement in an alternate lower level of care.
<u>Ambulatory Services</u>	Outpatient hospital services are provided through ambulatory care facilities including hospital outpatient departments (OPDs), and treatment centers (D&Ts or free-standing clinics), and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health and ambulatory care facilities.
<u>Preventive Health Services</u>	<p>There are three levels of preventive care:</p> <ul style="list-style-type: none"> • Primary, such as immunizations, aimed at preventing disease; • Secondary, such as disease screening programs aimed at early detection; • Tertiary, such as physical therapy, aimed at restoring function. <p>*Preventive services are not subject to Cost-Sharing (Copayments, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”). <u>Please note that in some cases, cost-sharing may apply to certain services provided during the same preventive service visit (i.e. lab work)</u></p>

<p><u>Health Care Services Covered through Fidelis Care</u></p>	<ul style="list-style-type: none"> • Physician Services • Nurse Practitioner Services • Midwifery Services • Preventive Health Services • Wellness Services • Chiropractic Care • Second Medical Surgical Opinion • Laboratory Services • Radiology Services • Smoking Cessation Products • Rehabilitation Services • Habilitation Services • Home Health Services • Hospice • Emergency Services • Durable Medical Equipment • Audiology - hearing aid services and products when medically necessary • Emergency Transportation ** See below for process • Non- Emergency Ambulance Transportation** See below for process • Prosthetics • Mental Health and Substance Abuse Services • Short-term Residential Health Care Facility Services • Skilled Nursing Facility • Pharmacy / Prescription Drugs • Gym Reimbursement • Diabetic Equipment, Supplies and Education • Foot Care Services – when medically necessary • Family Planning • Reproductive Health Services • Dental • Vision Care
<p><u>Transportation</u></p>	<p>Ambulance and Pre-Hospital Emergency Medical Services Fidelis Care covers Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.</p> <p>“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> <ul style="list-style-type: none"> • Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the

<p><u>Transportation (con't)</u></p>	<p>case of a behavioral condition, placing the health of such person or others in serious jeopardy;</p> <ul style="list-style-type: none"> • Serious impairment to such person’s bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. <p>Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.</p> <p>Non-Emergency Ambulance Transportation:</p> <p>Fidelis Care covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care Facility. • From an acute Facility to a sub-acute setting. <p>Limitations/Terms of Coverage:</p> <p>Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Fidelis Care, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not covered.</p> <p>Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when a medical condition is such that transportation by land ambulance is not appropriate; and the medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:</p> <ul style="list-style-type: none"> • The point of pick-up is inaccessible by land vehicle; or • Great distances or other obstacles (e.g., heavy traffic) prevent timely transfer to the nearest hospital with appropriate facilities.
<p><u>Non-covered Services</u></p>	<ul style="list-style-type: none"> • Cosmetic surgery, unless medically indicated • Routine hygienic foot care in the absence of a pathological condition, unless member is a diabetic • Convalescent and Custodial Care
<p><u>Referrals/Authorizations</u></p>	<p>Referrals are not required for visits to a specialist. Prior authorizations may be required for certain services. Please refer to</p>

	<p>the Fidelis Care Authorization Grids for details: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids</p> <p>Effective December 23, 2019, orthopedic surgical procedures and spinal surgical procedures, in both the inpatient and outpatient setting, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of procedures that require prior authorization from TurningPoint Healthcare Solution, visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/EducationalMaterials/2019-FidelisCare-TurningPointCPTCodeList-English.pdf</p> <p>Effective October 4, 2021, Ear, Nose, and Throat (ENT) surgical procedures performed in inpatient, outpatient, physician's office, and in-home settings, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-ENT.pdf</p> <p>Effective October 4, 2021, cardiac surgical procedures performed in inpatient, outpatient, physician's office, and in-home settings, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-Cardiac.pdf</p> <p>Effective October 1, 2021, prior authorization has been delegated to National Imaging Associates, Inc. (NIA) for radiology and radiation therapy services. Medicaid Managed Care, Child Health Plus, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:</p> <p>https://www.fideliscare.org/Provider/Submit-Authorization-Requests</p>
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<u>Product Type</u>	Essential Plan 3 & 4
<u>Provider Panel</u>	Fidelis Care Essential Plan Network
<u>Primary Care Physician (PCP)</u>	Members joining Fidelis Care Essential Plans are not required to choose a PCP
<u>Inpatient Hospital Services</u>	Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.
<u>Alternate Level of Medical Care</u>	Continued Care in a hospital pending placement in an alternate lower level of care.
<u>Ambulatory Services</u>	Outpatient hospital services are provided through ambulatory care facilities including hospital outpatient departments (OPDs), and treatment centers (D&Ts or free-standing clinics), and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health, Child/Teen Health Plan (C/THP) services, and ambulatory care facilities.
<u>Preventive Health Services</u>	There are three levels of preventive care: <ul style="list-style-type: none"> • Primary, such as immunizations, aimed at preventing disease; • Secondary, such as disease screening programs aimed at early detection; • Tertiary, such as physical therapy, aimed at restoring function. • Preventive services are not subject to Cost-Sharing (Copayments, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”). <u>Please note that in some cases, cost-sharing may apply to certain services provided during the same preventive service visit (i.e. lab work)</u>
<u>Health Care Services Covered through Fidelis Care</u>	<ul style="list-style-type: none"> • Physician Services • Nurse Practitioner Services • Midwifery Services • Preventive Health Services • Wellness Services • Second Medical Surgical Opinion • Laboratory Services • Radiology Services • Chiropractic Services • Smoking Cessation Products • Rehabilitation Services

	<ul style="list-style-type: none"> • Habilitation Services • Home Health Services • Hospice • Emergency Services • Durable Medical Equipment • Audiology - hearing aid services and products when medically necessary • Emergency Transportation ** See below for process • Non- Emergency Ambulance Transportation** See below for process • Prosthetics • Mental Health and Substance Abuse Services • Short-term Residential Health Care Facility Services • Skilled Nursing Facility • Pharmacy / Prescription Drugs • Gym Reimbursement • Diabetic Equipment, Supplies and Education • Preventative Dental Care • Vision Care • Dental • Non-prescription Drugs • Foot Care Services – when medically necessary • Orthopedic Footwear • Family Planning • Reproductive Health Services
<p><u>Transportation</u></p>	<p>Ambulance and Pre-Hospital Emergency Medical Services Fidelis Care covers Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.</p> <p>“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> <ul style="list-style-type: none"> • Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; • Serious impairment to such person’s bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. <p>Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.</p>

<p><u>Transportation (con't)</u></p>	<p>Non-Emergency Ambulance Transportation:</p> <p>Fidelis Care covers non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> • From a Non-Participating Hospital to a Participating Hospital. • To a Hospital that provides a higher level of care that was not available at the original Hospital. • To a more cost-effective acute care Facility. • From an acute Facility to a sub-acute setting. <p>Limitations/Terms of Coverage:</p> <p>Benefits do not include travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by Fidelis Care, even though prescribed by a Physician. Non-ambulance transportation such as ambulette, van or taxi cab is not Covered.</p> <p>Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when a medical condition is such that transportation by land ambulance is not appropriate; and the medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:</p> <ul style="list-style-type: none"> • The point of pick-up is inaccessible by land vehicle; or • Great distances or other obstacles (e.g., heavy traffic) prevent timely transfer to the nearest hospital with appropriate facilities. <p>In addition to the non-emergency ambulance transportation benefit above, members are eligible for non-emergency transportation, which includes personal vehicle, bus, taxi, ambulette, and public transportation to medical appointments.</p>
<p><u>Non-covered Services</u></p>	<ul style="list-style-type: none"> • Cosmetic surgery, unless medically indicated • Convalescent and Custodial Care • Routine hygienic foot care in the absence of a pathological condition, unless member is a diabetic
<p><u>Referrals/Authorizations</u></p>	<p>Referrals are not required for visits to a specialist. Prior authorizations may be required for certain services. Please refer to the Fidelis Care Authorization Grids for details: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids</p> <p>Effective December 23, 2019, orthopedic surgical procedures and spinal surgical procedures, in both the inpatient and outpatient setting, require prior authorization from TurningPoint Healthcare Solutions. This program includes the following Fidelis Care health insurance products:</p>

Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of procedures that require prior authorization from TurningPoint Healthcare Solution, visit:

<https://www.fideliscare.org/Portals/0/Providers/EducationalMaterials/2019-FidelisCare-TurningPointCPTCodeList-English.pdf>

Effective October 4, 2021, Ear, Nose, and Throat (ENT) surgical procedures performed in inpatient, outpatient, physician's office, and in-home settings, require prior authorization from **TurningPoint Healthcare Solutions**. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:

<https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-ENT.pdf>

Effective October 4, 2021, cardiac surgical procedures performed in inpatient, outpatient, physician's office, and in-home settings, require prior authorization from **TurningPoint Healthcare Solutions**. This program includes the following Fidelis Care health insurance products: Medicaid Managed Care, Child Health Plus, Medicare Advantage, Dual Advantage, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:

<https://www.fideliscare.org/Portals/0/Providers/Expansion-Coding-to-Policy-Crosswalk-Cardiac.pdf>

Effective October 1, 2021, prior authorization has been delegated to **National Imaging Associates, Inc. (NIA)** for radiology and radiation therapy services. Medicaid Managed Care, Child Health Plus, HealthierLife, Qualified Health Plans, Essential Plans, and Medicaid Advantage Plus. For a complete list of requiring prior authorization visit:

<https://www.fideliscare.org/Provider/Submit-Authorization-Requests>

Authorizations for Non-Participating (Non-Par) Providers

It is the policy of Fidelis Care to direct the care of members to participating providers. The primary physician, specialists or facility, and Quality Health Care Management (QHCM) staff have responsibilities to make every effort to minimize the use of non-participating providers.

I. Non-Emergency Services by non-participating providers are considered out-of-network (OON) services and must meet all of the following:

- 1) The services to be provided are Covered Benefits.
- 2) Fidelis Care does not have a participating provider, within an appropriate geographic area, or with the appropriate training and experience to meet the particular health care needs of the member.
- 3) An authorization request is submitted to Fidelis Care prior to the service, and the service is authorized by Fidelis Care.

If a new member has an existing relationship with a health care provider who is not a member of the Fidelis Care provider network, Fidelis Care shall permit the new member to continue an ongoing course of treatment by the non-participating provider during a transitional period of up to sixty (60) days from the effective date of enrollment, if the conditions outlined in parts I(1), I(3), II and III of this Section of the Provider Manual are met.

If the new member has entered her second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery up until sixty (60) days postpartum. If the new member elects to continue to receive care from such non-participating provider, such care shall be authorized by Fidelis Care for the transitional period only if the conditions outlined in sections I(1), I(3), II and III of this document are met.

All out-of-network (OON) services are subject to prior authorization review in accordance with the procedures outlined in Section 8 Emergency and Inpatient Services, and Section 11 Referral and Pre-Authorization.

II. Responsibilities of the Primary Physician :

- Treating physicians have authority to make referrals to participating providers for medically necessary services. Physicians will consult the Fidelis Care Provider Directory and use participating specialists and facilities. Authorization is only required for services listed on Fidelis Care's Authorization Grid Detail. See Appendix I.
- If the treating physician believes the member should receive care from a non-participating specialist or facility, the physician must request authorization from QHCM's Utilization Management Department by calling 1-888-FIDELIS (1-888-343-3547) and provide supporting clinical information.

III. Responsibilities of Specialist:

- The Specialist has authority to make referrals for medically necessary services. The Specialist will consult the Fidelis Care Provider Directory and use participating specialists and facilities whenever possible. When the Specialist elects to refer the member to a participating specialist or facility, authorization is only required for those services listed on Fidelis Care's Authorization Grid Detail. See Appendix I.
- If the Specialist believes the member should receive care from a non-participating specialist or facility, the Specialist must request authorization from QHCM's Utilization Management

Department by calling 1-888-FIDELIS (1-888-343-3547) and provide supporting clinical information.

IV. Responsibilities of Quality Health Care Management (QHCM):

When QHCM receives a request for out-of-network provider:

- QHCM advises of any participating providers who can meet the member's needs.
- If QHCM receives a request for a non-participating provider to be used, the request is referred to the Medical Director for review.
- Fidelis Care's Medical Director will review the request for medical necessity and will discuss care with the member's referring provider as indicated.
- QHCM will notify the member that services are available within the Fidelis Care Network. QHCM will provide the member with the names of at least three (3) participating providers who can provide the requested services along with their office locations and contact information. If indicated, Fidelis Care will ensure that the member receives assistance in making an appointment.
- QHCM will contact the referring provider with the decision to either approve or deny the request for an out of network provider. See Section 8 Emergency and Inpatient Services or Section 11 Referral and Pre-Authorization of this manual for additional information.

INTRODUCTION

This addendum to the Fidelis Care Provider Manual (hereafter called the Manual) was created to assist participating Behavioral Health (BH) providers and their office staff in understanding Fidelis Care's policies and procedures regarding behavioral health. It applies *only* to those providers that are directly contracted with Fidelis Care to provide behavioral health services to Fidelis Care members.

Nothing stated in this manual is intended to alter or modify the benefits the member is entitled to or the executed agreement between the provider and Fidelis Care. In the event of a dispute or conflict between the manual and an executed contract, the terms of the provider agreement and the regulations of the Marketplace govern.

FIDELIS CARE'S BEHAVIORAL HEALTH DEPARTMENT

The Behavioral Health Department is part of the Quality Health Care Management Department and is staffed by certified clinical staff as well as paraprofessional associates.

A provider or member may contact the department through the toll free number 1-888-FIDELIS (1-888-343-3547) by following the voice prompts to connect directly to Behavioral Health. The Department operates each weekday from 8:30 AM to 5:00 PM. On-call emergency services are available after hours, holidays, and weekends by dialing the same toll free number and following the voice prompts to reach the on-call services.

All adverse determinations are reviewed and made by the Behavioral Health Department's Medical Director, a psychiatrist, in consultation with the provider and the clinical case manager.

I. BEHAVIORAL HEALTH REFERRALS

A. Who may refer?

1. Member Self-Referral

- a. Marketplace members may self-refer to a participating Fidelis Care Behavioral Health (BH) provider for treatment.
- b. Providers should note that except in the case of an emergency or a valid self-referral by a member, all inpatient and certain intensive and/or specialized outpatient services require authorization by the Behavioral Health Department. Routine outpatient behavioral health services delivered by participating providers do not require authorization. Providers should consult the most current authorization grid (appendix I) available on the Fidelis Care website or provider portal for details.

2. Provider or Member Calls to the Behavioral Health Department:

- a. Members may call Fidelis Care directly to receive a referral(s) to participating providers from staff in the Behavioral Health Department.
- b. Behavioral Health providers should contact the BH department to register, and obtain authorization for required elective (or non-emergent) member care. For emergency situations, the provider should treat the member and notify the BH Department as soon as is practical, but no later than 48 hours, or the next business day, after evaluation/treatment of the member and stabilization of acute symptoms.

B. Services That Require Preauthorization:

ALL COVERED NON-EMERGENT INPATIENT AND CERTAIN AMBULATORY SERVICES REQUIRE AUTHORIZATION BEFORE THEY OCCUR. This includes:

1. Services or visits beyond those already authorized;
2. Any change in level of care;
3. Psychological or neuropsychological testing;
4. Developmental pediatric testing
5. Outpatient Electro-convulsive therapy (ECT).
6. Intensive outpatient treatment
7. Partial hospitalization
8. Autism services

Providers must preauthorize these services with the Fidelis Care Behavioral Health Department prior to the delivery of care. Failure to authorize services may result in coverage denial and non-payment for services.

C. Types of Behavioral Health Referrals and Services

1. Routine Referral and Services:

- Definition: The member is not in imminent danger and further deterioration resulting in crisis is not likely to occur before he/she is seen.
- Procedure: Preauthorization is not required. Providers should deliver the services and bill Fidelis Care according to their provider agreement. Claims will be monitored on a regular basis and Fidelis Care will follow up with providers as warranted concerning problematic patterns.
- Standard: The provider must schedule an initial evaluation appointment so that the member will be seen within two weeks of the initial member contact.

2. Urgent Referral and Services:

- Definition: Significant deterioration and/or stressors exist contributing to the member's inability to cope. Unless some support or intervention is provided within a few days, further deterioration or crisis is likely to occur.
- Procedure: The provider must call to request a preauthorization for a new member prior to rendering any service for those services subject to authorization (see authorization grid for details).
- Standard: Provider must provide face-to-face intervention within 24 hours of the member's request for care.

3. Emergent Referral and Services:

- Definition: Clear and present danger exists for the member, another person, or the environment if immediate intervention does not occur.
- Procedure: No authorization or referral is required for emergent care. Provider must call within 48 hours of the initial service to initiate the review process for authorization.
- Standard: Provider must provide face-to-face intervention within 90 minutes of the initial member contact. In rural areas this may not be feasible. In the event of imminent danger, local police, sheriff, crisis services or ambulance may need to be used so that the member can be safely transported to a clinician for evaluation within a time frame reasonable for the circumstances.

D. Behavioral Health Authorization Procedures and Clinical Guidelines

1. Information Necessary for All Behavioral Authorizations:

The following information is essential for the Behavioral Health Department to process an authorization request:

- a. Member name and Fidelis Care ID number;
- b. Current address and phone number of the member. If the member is a child, the parent or guardian's name(s) and phone number(s);
- c. Initial date of service (and time of admission as indicated);
- d. Requested length of stay/treatment;
- e. Requested frequency of treatment (as applicable);
- f. Place of service and phone number;
- g. Admitting/ attending and treating providers (as applicable);
- h. Diagnosis based on the DSM version in current use;
- i. Requested treatment/procedures;
- j. History (medical, psychiatric, substance abuse, developmental, social and occupational, as applicable);
- k. Functional assessment;
- l. Mental status exam and risk assessment; and
- m. Indications for the requested level of care.

2. Procedures for Authorization for Outpatient Mental Health Treatment:

- a. Outpatient mental health requests for which authorization is required are accepted by either a case assistant or BH clinician. The initial screen, if initially processed by a case assistant, will be referred to clinical case manager when:
 - There is evidence of acute and dangerous symptomatology; and
 - Pediatric referrals including, but not limited to, child abuse and neglect issues.

The clinical case manager receiving the request will perform an initial assessment to determine the most appropriate, course of action, or referral for the provision of necessary care.

- b. Initial authorizations with an in-network provider are for 1 initial evaluation and up to 19 follow up sessions.
- c. To obtain additional mental health visits, the provider requests additional visits by contacting the Behavioral Health Call Center prior to the expiration of the visits and/or time frame already authorized.
- d. Clinical case managers will review the request and will provide continued authorization of care based on:
 - Medical necessity;
 - Treatment progress; and/or
 - Change in the treatment plan due to lack of progress.
- e. You will be notified by phone and mail within one business day of the authorization decision for continued service requests. In the event an agreement is not reached between the case manager and the provider, the case manager will refer the case to the Fidelis Care physician advisor for review.

3. Clinical Guidelines for Outpatient Mental Health:

All members presenting for evaluation and/or treatment of mental health must have an evaluation to determine the appropriate level of care. Mental health evaluators and therapists must have experience in the evaluation and treatment of the identified disorder and meet the following standard:

Initial mental health evaluators and therapists providing the ongoing mental health care must be licensed mental health professionals with a minimum of a Master's Degree in a mental health discipline, or if not licensed, they must be supervised by a licensed mental health professional.

Outpatient Mental Health Psychotherapy Guidelines:

- a. Documentation must indicate a member/family assessment at the start of the treatment that includes a risk factor assessment. Ongoing notes must reflect any movement toward stated behavioral, observable goals within a stated time frame. Changes in diagnosis or treatment plan must be documented.
- b. A plan for termination and discharge plan must be made during the assessment period. The only exception to this will be therapeutic stabilization and medication management for chronic conditions.

- c. Referral for medication assessment must be made in a **timely** manner for diagnosis such as panic disorder and depression. There must be collaboration between the medicating physician and the psychotherapist.
- d. Standard of care for individual sessions is at least 30 minutes. Medication management sessions can be of shorter duration. The standard of care for group sessions is 60 to 90 minutes.
- e. Psychotherapy should not occur within 24 hours following an ECT treatment or while the member is significantly cognitively impaired. Psychotherapy is not indicated for a member who is actively abusing drugs or alcohol and cannot reliably contract for abstinence while attending the treatment. Focus of intervention with the member should be transitioning the member into substance abuse treatment within a defined number of sessions.

4. Procedures for Authorization for Acute Inpatient Care:

All inpatient requests are considered emergent (except Inpatient Rehabilitation for Chemical Dependency).

- a. A managed care organization must be informed as to the nature and scope of care rendered to its members in order to effectively manage that care. In the case of inpatient urgent/emergent admissions, the determination of medical necessity must be made as soon as possible. Fidelis Care requires notification of all such admissions within forty-eight (48) hours of admission to the hospital.
- b. All urgent or emergent admissions to an institution are subject to review for medical necessity and for appropriateness of providing care in that specific setting by the Behavioral Health Department. The standard applies to par (contracted) and non-par (non-contracted) entities. This is to monitor care rendered to members and identify areas for performance improvement and quality.
- c. Once the plan is notified of an urgent or emergent admission, timely submission of clinical information is expected. Clinical information helps the plan facilitate discharge planning and other needed services such as Behavioral Health high risk and intensive high-risk case management. Failure to supply timely submission of clinical information will result in the case being administratively denied as per the guidelines below.
- d. Milliman Behavioral Care Guidelines and American Society of Addiction Medicine (ASAM) Placement Criteria will be used to determine the appropriate level of intervention and the medical necessity for services. The checklist below covers the clinical data required to determine medical necessity for this type of care and to monitor progress in the care.

5. Clinical Guidelines for Admission and Continued Stay for Acute Inpatient Care

Adult Criteria - For all members referred to an Inpatient level of care, there are two major dimensions: "Seriousness of the Illness" and the "Intensity of the Treatment".

1. For admission and continued stay in an acute care facility, the case must meet at least one of the "seriousness of the illness" criteria and at least one of the "intensity of treatment" criteria.
 - a. Seriousness of the Illness Criteria:
 1. A continued life threatening danger to self or others is demonstrated by a suicidal and/or homicidal specific attempt or plan with means to accomplish.
 2. Acute psychotic thoughts that likely constitute a danger to self or others if the member acts on them.
 3. Intensification of severe psychiatric symptoms despite intensive outpatient treatment as a treatment response to the member's deteriorating condition.
 4. Presence of life-threatening behaviors that cannot be safely treated on an outpatient or partial hospital basis.
 5. A loss of impulse control which is life threatening.
 - b. Intensity of Treatment Criteria:
 1. Detoxification program where medication and skilled nursing are required to control withdrawal symptoms that are life-threatening.
 2. ECT, initial and subsequent, when outpatient ECT cannot be safely administered.
 3. Administration of IM/IV medications daily.
 4. Isolation, restraint, or seclusion procedures are required for the safety of the member.
 5. 24 hour medication supervision for pharmacotherapy and/or concomitant medical conditions where severe side effects are possible.
 6. Suicide and homicide precautions or close observation and step-down precautions are required for the safety of the member.
2. In addition to meeting the above criteria, the initial admission **must not meet** any of the following conditions.
 - a. The admission is for "custodial care" to treat a chronic condition without any evidence of an acute exacerbation of symptoms.
 - b. The admission is "voluntary" and being considered in lieu of incarceration.
 - c. Fear of relapse and use of chemicals is the primary reason for seeking inpatient admission.
 - d. Admission is solely for the need of an alternative environment, supportive living, or residential treatment.
3. For continued stay, none of the following circumstances will be present:

- a. Member is non-responsive to the acute care treatment with no change in clinical status (or has exhibited additional serious symptoms) and there is no change in the treatment plan after 7 days that indicates a clinical explanation for such stasis.
- b. Continued stay solely because there is no alternative placement or disposition plan.
- c. Treatment and the length of stay are dictated by a research protocol or program design, not the needs of the member.
- d. Refusal of active treatment intervention by the member or family when treatment is medically advised.
- e. Therapeutic passes greater in length than 12 hours, or within 48 hours after the admission, where member shows the ability to function in a less structured environment.

6. Child Admission and Continued Stay Criteria for Acute Inpatient Care:

1. For admission or continued stay at an acute care facility, at least one of the following "seriousness of the illness" and one of the "intensity of treatment" criteria must apply:
 - a. Seriousness of the Illness Criteria:
 1. Current and persistent life-threatening danger to self or others is demonstrated by a specific suicidal and/or homicidal attempt or plan with means to accomplish this plan.
 2. Current dangerous behavior such as self-mutilation and significant risk-taking where lesser levels of care will not adequately contain the adolescent or child.
 3. Acute psychotic thoughts that likely constitute a danger to self or others if the member acts on these thoughts.
 4. Intensification of severe psychiatric symptoms that impede normal development, despite intensive outpatient treatment as a treatment response to the member's deteriorating condition.
 5. Presence of life-threatening behaviors that are not safely treated on an outpatient or partial hospital basis.
 6. Presence of other behaviors or symptoms to such a degree that non-acute residential services or partial hospitalization would be insufficient due to:
 - a. Repeated running away from home (other than to an acquaintance or structured shelter or runaway program) that poses a clear risk to physical safety;
 - b. Ritualistic/obsessive compulsive behavior;
 - c. Verbal aggression coupled with a history of violence and severe aggression; or
 - d. Explosive behavior without provocation, or serious loss of impulse control.

- b. Intensity of Treatment Criteria:
 1. Detoxification program where medication and skilled nursing are required to control withdrawal symptoms which are life-threatening.
 2. ECT, initial and subsequent, when outpatient ECT cannot be safely administered.
 3. Administration of IM/IV medications daily.
 4. Isolation, restraint, or seclusion procedures are required for the safety of the child/adolescent.
 5. 24 hour medication supervision for psychopharmacotherapy and/or concomitant medical conditions where severe side effects are possible.
 6. Suicide and homicide precautions or close observation and step-down precautions are required for the safety of the child/adolescent.
 7. Rapid in-depth, assessment, and treatment of family dysfunction that has failed to improve with intensive outpatient attempts at remediation.
2. In addition to meeting the above criteria, the admission **must not meet** any of the following conditions:
 - a. The admission is for "custodial care" to treat a chronic condition without any evidence of an acute exacerbation of symptoms.
 - b. The admission is "voluntary" and is being done in response to criminal charges or in lieu of incarceration.
 - c. Fear of relapse and use of chemicals is the primary reason for seeking inpatient admission at this time.
 - d. Inability to function in a regular school environment is the sole reason for admission, with the goal being to attain a special school placement.
 - e. Admission is solely for the need of an alternative environment, supportive living, or residential treatment option.
3. Fidelis supports the following national standards for timely adolescent/child evaluation when admitted to an acute psychiatric care setting:
 - a. Within 24-hours of admission:
 1. Contact with family to determine, at a minimum, the history of the presenting problem and what measures have been taken to address the problem.
 2. History of the present illness and previous recent treatment, including a substance abuse history.
 - b. For continuing care (Within three days after admission):

1. Assessment of the following: substance abuse, eating disorders, physical/sexual abuse, school functioning.
2. Face to face family meeting. (The standard of care for family involvement in treatment is twice weekly family sessions.)
3. Assessment of developmental strengths and limitations of the child/adolescent.
4. Coordinate current care with any community provider who had been treating the child or adolescent prior to admission.
5. Initiate formal discharge plan.

7. Inpatient/Partial Hospitalization Discharge Procedures:

- a. A discharge plan should begin when a member is admitted to an acute care hospital, residential facility or partial hospitalization program. The admitting provider should relay information regarding expected length of stay and disposition to facility staff at the time of admission. A Fidelis Care BH Case Manager will assist in coordination of discharge plans.
- b. Once the member is ready for transition to the next level of care, the attending physician (and/or a designated professional member of the treatment team) will:
 1. Provide a written discharge plan with a copy for the member;
 2. Inform the member of any post discharge aftercare appointments;
 3. Collaborate with the aftercare treatment providers as indicated;
 4. Forward a copy of the discharge summary to the post-discharge provider; and
 5. Give the member specific information for appropriate self-help groups such as AA/NA/CA (e.g. meeting times, locations, contact, if possible).

8. Post Inpatient/Partial Hospitalization Discharge Standards:

The Fidelis Care Behavioral Health Department strongly advocates for the discharged member to be seen within 3 to 7 days post-discharge from the inpatient treatment setting. This is a "quality indicator of care" measure that will be monitored by Fidelis Care for purposes of reporting to the New York State Department of Health. As part of the oversight procedure, BH case managers and case assistants will be making aftercare calls to the appropriate provider to determine if the member has actually attended their post-discharge appointments.

For those members who do not keep their aftercare appointments, the aftercare case manager assisting with post hospital transition will intervene and attempt to reinforce the discharge plan, offering support and encouragement to the member to follow up with the necessary aftercare to prevent regression and relapse.

II. CASE MANAGEMENT AND COORDINATION ACTIVITIES

A. Collaboration/Coordination of Care

1. Effective working relationships between providers and other treatment partners and service sites will result in improved continuity and coordination of care, increased quality, efficiency and effectiveness of services, and increased member satisfaction. All collaboration efforts should be documented in the medical record.
2. *Why Coordination with Primary Care Physicians (PCPs) is Necessary:*
Members may remain untreated or under-treated if PCPs do not recognize members at risk for or with active mental or addictive disorders. Physical symptoms or general medical co-morbidity complicates most behavioral conditions. Psychotropic medications may interact adversely with other medications or cause physical side effects. Medical laboratory or physical examinations may be necessary for members on psychotropic medications. The PCP may prescribe psychotropic medications themselves. For all these reasons, close collaboration between behavioral healthcare providers and PCPs is necessary for member safety and optimal quality of care.
3. Behavioral healthcare providers should communicate with the member's PCP:
 - a. For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment;
 - b. When the PCP's support for a treatment plan would enhance member satisfaction and/or compliance;
 - c. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and
 - d. When PCP has requested immediate feedback.
4. Fidelis Care Behavioral Health may conduct site visits to selected providers' offices to provide education and perform a chart review to verify that coordination of care is occurring and clinical documentation is meeting industry standards.

B. High Risk Case Management Overview

1. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and tailors services to meet an individual member's needs. When there is a high potential for recurrence or exacerbation of the member's symptoms, and/or the high potential for rapid re-hospitalization, such high-risk members may benefit from more intensive case management activities.
2. Providers can assist in identifying members who may benefit from high-risk case management using the following screening criteria:
 - a. All members who have been hospitalized for inpatient psychiatric treatment within the last year;
 - b. Anyone who has received chemical dependency treatment who has a serious psychiatric condition and/or history of a serious medical condition; and
 - c. Anyone presenting in an emergency room with behavioral health symptoms but not admitted.

3. If a member is identified as high risk, the member has the right to agree or not agree to participate in the case management process. If the member agrees to participate, the Behavioral Health Case Manager (in consultation with the provider) will conduct a member assessment and work with the member and provider to develop a care plan that will include, but not be limited to, mutually agreed upon goals, measurable objectives, and action steps toward goal achievement.
4. For members who have received inpatient care in the recent past, the plan for high risk follow-up should optimally be presented to the member during the current hospital admission process and again prior to the member's discharge from the inpatient facility. The goal of the inpatient treatment team should be to gain the member's understanding and cooperation in working with the team to prevent further hospitalizations.
5. Care plan implementation includes referring the member to appropriate providers or facilities, monitoring the services to ensure that those being provided are addressing the member's specific behavioral health care needs, and ensuring compliance with the treatment plan by measuring progress against defined short-term and long-term goals. This may include follow-up with the member and providers by calling and/or visiting, monitoring claims activity, documenting progress in the treatment plan, and re-evaluating and revising the treatment plan as necessary.
6. The Behavioral Health case manager will work with the provider to provide the member and family information to make empowered decisions regarding:
 - a. The disease process;
 - b. Available benefits; and
 - c. Available community resources.

III. ADMINISTRATION POLICIES/PROCEDURES

A. Coverage by another Provider

1. Independent Providers:

- a. Services are only to be rendered by the provider named in the authorization process. Only participating Fidelis Care providers will be approved by the Fidelis Care Behavioral Health Department to render routine or urgent services.
- b. Providers should not schedule routine services to be rendered by another provider (e.g., vacation, time off) unless approved in advance by the Fidelis Care Behavioral Health Department. In the event a member requires treatment and the approved provider is not available, the Fidelis Care Behavioral Health Department must be contacted to arrange for covering treatment by another participating provider.
- c. If a covering provider submits a claim for urgent services without authorization, the claim will be denied. Authorization expectations should be clearly explained to the covering provider and arrangements made for reimbursement directly between you and the covering provider in the event an authorization is not obtained.

2. Agency Providers:

If a behavioral health agency is under contract with Fidelis Care and has met all credentialing standards, authorized services may be provided by any of the agency's participating facilities or

staff providers. Prior notification to Fidelis Care is not required as long as the facility or staff provider serving the Fidelis Care member has met all professional credentialing standards.

IV. Determining Level of Care for Behavioral Health Services

A. Determining Appropriate Level of Care:

All members referred for evaluation and/or treatment must have an evaluation completed to determine the appropriate level of care. Further authorization of services is dependent on the outcome of the review between the evaluator and the clinical case manager.

1. Outpatient Services:

- a. Treatment provided by professional staff;
- b. Supplemented by self-help groups
- c. 1 to 3 hours/day for up to 3 days/week;
- d. Uses a multidisciplinary team to provide individualized physical, psychiatric and/or addiction treatment (It is preferable that all services are provided in the context of a chemical dependency environment.); and
- e. Primary treatment modality is group. (Family and individual counseling sessions should be based on an individualized treatment plan. Individual counseling should be available for dual-diagnosed members and other members based on their clinical needs.)

2. Intensive Outpatient/Partial Hospitalization Services:

- a. Used as an alternative to inpatient treatment;
- b. Treatment provided by professionals with daily physician availability, if needed;
- c. Intensive outpatient is more than 3 hours per day, 3 to 5 days per week; and
- d. Partial hospital service is 4 or more hours per day, 5 days per week, and will count as acute intensive care requiring physician supervision.

3. Inpatient Services:

1. Medically supervised by multidisciplinary staff;
2. Conjunctive treatment available for members with dual diagnoses;
3. Length of stay determined by criteria for admission and discharge; and
4. May be used as an adjunct to inpatient detoxification to prepare for step-down to a lower level of care.

B. Managing the Member with Dual Diagnoses (MH & CD):

Most benefit plans differentiate coverage/benefits for mental health and chemical dependency treatment. The benefit that will be applied will be determined based on the primary diagnosis using DSM-IV criteria and level of care guidelines.

- a. Members requiring confinement in a locked psychiatric department must have their psychiatric symptoms stabilized before addiction treatment can begin. The treating physician and psychiatric department should be experienced with detoxification.
- b. Members presenting with withdrawal must go through detoxification before further treatment can be provided. The member must be sufficiently stable from a psychiatric perspective and motivated to cooperate while in the detoxification program.
- c. Once psychiatrically stable, members may receive treatment in an addictions program. While engaged in the acute and/or core phases of addiction treatment, psychiatric services should be provided through the addictions program. Upon completion of the core addiction treatment, members in need of further outpatient mental health treatment will be referred to the appropriate mental health provider.

V. Determining Medical Necessity

A. Quality Management and Peer Review Committee

The Fidelis Care Quality Management and Peer Review Committee reviews all protocols, criteria, guidelines, and procedures utilized in the Medical Management Program at a minimum of once yearly. These pre-established criteria are used for decision-making related to the clinical or medical appropriateness of care, least restrictive yet acceptable safety level of care, appropriate setting of care, and appropriate provider of care.

Updated criteria are obtained from the following sources as they become available and incorporated into Fidelis Care's Policies and Procedures Manual and the Medical Management Program Description. Criteria as described in the clinical section of this manual include:

1. American Society of Addiction Medicine "Patient Placement Criteria-II" (ASAM PPC-II): This document is copyrighted and is available for purchase from ASAM by calling 1-800-844-8948.
2. Fidelis Care utilizes Milliman criteria to determine medical necessity for inpatient psychiatric and detox treatment and other nationally recognized standards for mental health and chemical dependence practice.

Medically necessary treatments are defined as services that are:

1. Provided for the diagnosis or care and treatment of a disease or condition defined by the standard diagnostic classification system of the Diagnostic and Statistical Manual (DMS);
2. Essential for the care and treatment of the behavioral health condition, indicating treatment is essential since no less restrictive level of care can provide the clinical intervention required to ensure the safety and effective treatment of the member;
3. Adequate for the care and treatment of the behavioral health condition indicating treatment is considered adequate if the assessment and treatment plan are clinically appropriate, comprehensive, and active, with timely monitoring and revision;
4. Considered generally acceptable medical practice based on national standards of clinical practice and current clinical research; and

5. Have a reasonable expectation of being successful in alleviating symptoms and/or improving member functioning.

B. General Criteria for Behavioral Health Utilization Management Review

The following are required to support medical necessity and the adequacy of the treatment plan:

1. A comprehensive assessment of previous behavioral health treatment plans;
2. Evaluation of the outcome of the prior treatments;
3. Documentation that the proposed treatment plan for the current level of care addresses the specific clinical presentation of the member and is not a repetition of a previously failed plan of treatment (If a repetition of a past failed treatment is recommended, what specific indicators suggest that it will be effective this time?); and
4. Clear identification of the target symptoms, goals, and objectives of treatment include objective measures that can be assessed within a specified time frame.

The following should be present to validate the medical necessity for continued care:

1. Progress in diminishing the target symptoms is evident and measurable;
2. Treatment is active and realistic in its goals and flexibly revised if the member's condition does not improve within an expected time frame;
3. Family and social supports have been assessed in a substantive manner with the member and family participating in the treatment program to the extent that they are capable; and
4. Discharge planning is initiated during the assessment phase of treatment.

The following should be present to validate the readiness of the member for discharge to a lower level of care:

1. The member's level of functioning has improved to the extent that clinical stability can be maintained in a less restrictive treatment setting and the member does not require 24 hour supervision; and
2. Improvement in the following areas:
 - a. Increased control over the expression of thoughts and feelings and demonstrated appropriate behavior and increased self-control;
 - b. Identification, if not implementation, of appropriate coping strategies for reducing stressors;
 - c. Member has made a commitment to the after care plan for treatment;
 - d. Re-established relationships with significant others and activities that are necessary in order to maintain adequate functioning;
 - e. Adherence to the prescribed medication regime and recognition of the need to continue to such adherence (The member is aware of potential side effects and the necessity to

report these to continuing care provider independently or with the help of a significant other.); and

- f. The member is accepting the recommendation for continuing care. The member has made a commitment to the aftercare plan for continued treatment at a lesser level of care. .

VI. Confidentiality

1. For guidelines, refer to the section on Member/Provider Confidentiality in Chapter 2 of this manual.
 - a. **Collaboration of care with the PCP or other specialist can occur only with the member's expressed permission, except in clinical situations that threaten the life of the member or someone else. When this degree of danger exists, providers can contact the PCP directly without member authorization. It is recommended in all other circumstances that the provider have on-file a signed release of information to the PCP or other specialist.**
 - b. **Release of Information to Other Health Care Providers**

Based on State and Federal mandates, confidentiality of members must be protected by providers. Providers are encouraged to have members sign a release of information form for all parties involved in collaboration efforts including but not limited to: Primary Care Physicians, other medical providers, and other behavioral health providers. A sample release of information form can be found in the Fidelis Care Provider Manual.

TELEHEALTH and TELEMEDICINE – OCTOBER 2019

This section of the Fidelis Care Provider Manual provides information to providers rendering care via telehealth modalities as defined by the New York State Department of Health to Medicaid Managed Care, Child Health Plus, Medicare Advantage and Dual Advantage, HealthierLife (HARP), Qualified Health Plans (Metal-Level Products), and the Essential Plan. Providers are responsible for the submission of accurate claims that align with the scope of their contracted services with Fidelis Care and this section does not address all issues related to reimbursement for health services provided to Fidelis Care members. Other factors may supplement, modify, or supersede this section. These factors include, but are not limited to: regulatory requirements including state and federal laws, provider agreements, product benefit coverage and/or other reimbursement standards.

General Information

Pursuant to New York State (NYS) Public Health Law (PHL) Article 29-G, as recently amended, and Social Services Law (SSL) Section 367-u, aligned with NYS Medicaid, Fidelis Care has expanded coverage of telehealth services to include:

1. Additional originating and distant sites;
2. Additional telehealth applications (store-and-forward technology, and remote patient monitoring); and
3. Additional practitioner types.

This section of the Fidelis Care Provider Manual outlines updated telehealth coverage and reimbursement policy. This information is intended to serve only as a general reference regarding Fidelis Care's coverage and reimbursement for the modality of telehealth delivery of benefits that are already covered in the applicable insurance products. This section does not specify or permit the reimbursement of benefits not otherwise covered in the benefit package and does not address all issues related to reimbursement for health care services provided to Fidelis Care enrollees. Providers should refer to (at a minimum) sections three, seven, and twelve of the provider manual that describe guidelines for billing, claims submission, and defined standards required of providers participating with Fidelis Care.

The following information applies to Article 28 facilities and private practitioners effective March 1, 2019. As additional state guidance is issued from The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, Fidelis Care's policies will be reviewed and updated in accordance with new information as it becomes available.

Definition of Telehealth

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Fidelis Care member. Telephone conversations, e-mail or text messages, and facsimile transmissions between a practitioner and a Fidelis Care member or between two practitioners are not considered telehealth services and are not covered by Fidelis Care when provided as standalone services. Remote consultations between practitioners, without a Fidelis Care member present, including for the purposes of teaching or skill building, are not considered telehealth and are not reimbursable. In addition, the acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable.

While Fidelis Care has aligned with NYS Medicaid coverage expansion of telehealth services, such telehealth services should not be used by a provider if they may result in any reduction to the quality of care required to be provided to a Fidelis Care member or if such service could adversely impact the member. Telehealth is designed to improve access to needed services and to improve member health.

Telehealth is not available solely for the convenience of the practitioner when a face-to-face visit is more appropriate and/or preferred by the member.

Originating Site

The **originating site** is where the member is located at the time health care services are delivered to him/her by means of telehealth. The originating site must be located within the fifty United States or United States' territories. Originating sites previously included facilities licensed under Article 28 (general hospitals, nursing homes, and diagnostic and treatment centers) and private physician's or dentist's offices located within the state of New York.

The list of allowable originating sites reads as follows:

1. Facilities licensed under Article 28 of the PHL (general hospitals, nursing homes, and diagnostic and treatment centers);
2. Facilities licensed under Article 40 of the PHL (hospice programs);
3. Facilities as defined in Subdivision 6 of Section 1.03 of the Mental Hygiene Law (MHL) (includes clinics certified under Articles 16, 31 and 32);
4. Certified and non-certified day and residential programs funded or operated by OPWDD;
5. Private physician's or dentist's offices located within the state of New York;
6. Any type of adult care facility licensed under Title 2 of Article 7 of the SSL;
7. Public, private and charter elementary and secondary schools located within the state of New York;
8. School-age child care programs located within the state of New York;
9. Child daycare centers located within the state of New York; and
10. The member's place of residence located within the state of New York or other temporary location within or outside the state of New York.

Additionally, consistent with CMS guidelines, authorized originating sites also include:

1. Rural Health Clinics
2. Federally Qualified Health Centers
3. Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
4. Skilled Nursing Facilities
5. Community Mental Health Centers
6. Renal Dialysis Facilities
7. Homes of beneficiaries with End-Stage Renal Disease getting home dialysis
8. Mobile Stroke Units

Distant Site

The **distant site** is any secure location within the fifty United States or United States' territories where the telehealth provider is located while delivering health care services by means of telehealth. Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent (including, but not limited to 45 CFR Parts 160 and 164 [HIPAA Security Rules]; 42 CFR Part 2; PHL Article 27-F; and MHL Section 33.13).

Telehealth Applications (Telemedicine, Store-and-Forward, Remote Patient Monitoring)

Fidelis Care has covered both remote patient monitoring provided by Certified Home Health Agencies (CHHAs) for their patients and telemedicine for a number of years. At this time, Fidelis Care is expanding coverage of telehealth to include store-and-forward technology, additional originating sites, and additional practitioners.

Telemedicine

Telemedicine uses two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site. The totality of the communication of information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.

Store-and-Forward Technology

Store-and-forward technology involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.

1. Store-and-forward technology aids in diagnoses when live video or face-to-face contact is not readily available or not necessary.
2. Pre-recorded videos and/or static digital images (e.g., pictures), excluding radiology, must be specific to the member's condition as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, blood pressure, heart rate, weight, blood sugar, blood oxygen levels and electrocardiogram readings. RPM may include follow-up on previously transmitted data conducted through communication technologies or by telephone. Follow-up is included in the monthly time component.

The following considerations apply to RPM:

1. Medical conditions that may be treated/monitored by means of RPM include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.
2. RPM must be ordered and billed by a physician, nurse practitioner or midwife, with whom the member has or has entered into a substantial and ongoing relationship. RPM can also be provided and billed by an Article-28 clinic, when ordered by one of the previously mentioned qualified practitioners.
3. Members must be seen in-person by their practitioner, as needed, for follow-up care.

4. RPM must be medically necessary and shall be discontinued when the member's condition is determined to be stable/controlled.

5. Payment for RPM while a member is receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to PHL Section 3614 (3-c)(a) – (d) and will only be made to that same CHHA.

Telehealth Providers

This section addresses the telehealth payment policy for the following provider types:

1. Physicians;
2. Physician assistants;
3. Dentists;
4. Nurse practitioners;
5. Registered professional nurses (only when such nurse is receiving patient- specific health information or medical data at a distant site by means of RPM);
6. Podiatrists;
7. Optometrists;
8. Psychologists;
9. Social workers;
10. Speech language pathologists;
11. Audiologists;
12. Midwives;
13. Physical therapists;
14. Occupational therapists;
15. Certified diabetes educators;
16. Certified asthma educators;
17. Genetic counselors;
18. Credentialed alcoholism and substance abuse counselors (CASAC) credentialed by OASAS or by a credentialing entity approved by such office pursuant to Section 19.07 of the MHL;
19. Providers authorized to provide services and service coordination under the Early Intervention (EI) Program pursuant to Article 25 of PHL (Note: The EI Program will issue program-specific guidance regarding the use of and reimbursement for EI services delivered via telehealth.)
20. Hospitals licensed under Article 28 of PHL, including residential health care facilities serving special needs populations;
21. Home care services agencies licensed under Article 36 of PHL;
22. Hospices licensed under Article 40 of PHL;

The following applies to practitioners providing services via telehealth:

1. Practitioners providing services via telehealth must be licensed or certified, currently registered in accordance with NYS Education Law or other applicable law, participating in a Fidelis Care product that reimburses for telehealth and enrolled in NYS Medicaid.
2. Telehealth services must be delivered by providers acting within their scope of practice.
3. Reimbursement will be made in accordance with existing policy related to supervision and billing rules and requirements. Notwithstanding, this policy does not address all issues related to reimbursement in a particular case, and other factors affecting reimbursement may supplement, modify, or supersede this policy.
4. When services are provided by an Article 28 facility, the telehealth practitioner must be credentialed and privileged at both the originating and distant sites in accordance with Section 2805-u of PHL. The law can be viewed at the following link:

<http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO> (Select LAWS; select PBH; select Article 28; select 2805u)

Confidentiality

All services delivered via telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to: 45 CFR Parts 160 and 164 (HIPAA Security Rules); 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Additionally:

1. HIPAA requires that a written "business associate agreement" (BAA), or contract that provides for privacy and security of protected health information (PHI) be in place between the telehealth provider and the supporting telehealth vendor.
2. Privacy must be maintained during all patient-practitioner interactions.
3. All existing confidentiality requirements that apply to medical records (including, but not limited to: 45 CFR Part 160 and 164; 42 CFR Part 2; PHL Article 27-F, and MHL Section 33.13) shall apply to services delivered by telehealth, including the actual transmission of service, any recordings made during the telehealth encounter, and any other electronic records.

Patient Rights and Consents

The practitioner shall provide the member with basic information about the services that he/she will be receiving via telehealth and the member shall provide his/her consent to participate in services utilizing this technology. Telehealth sessions/services shall not be recorded without the member's consent. Culturally competent translation and/or interpretation services must be provided when the member and distant practitioner do not speak the same language. If the member is receiving ongoing treatment via telehealth, the member must be informed of the following patient rights policies at the initial encounter. Documentation in the medical record must reflect that the member was made aware of the policies outlined below.

Patient rights policies must ensure that members receiving telehealth services:

1. Have the right to refuse to participate in services delivered via telehealth and must be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
2. Are informed and made aware of the role of the practitioner at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care;
3. Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed;
4. Have the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;
5. Have the right to be informed of all parties who will be present at each end of the telehealth transmission; and
6. Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

Failure of Transmission

All telehealth providers must have a written procedure detailing a contingency plan in the case of a failure of transmission or other technical difficulty that renders the service undeliverable via telehealth. Policies

and procedures must be available upon audit. If the service is undelivered due to a failure of transmission or other technical difficulty, a claim should not be submitted.

Billing Rules for Telehealth Services

Modifiers to be Used When Billing for Telehealth Services	Description	Note/Example
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system	Note: Modifier 95 may only be appended to the specific services covered by Medicaid and listed in Appendix P of the AMA's CPT Professional Edition 2018 Codebook. The CPT codes listed in Appendix P are for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio-visual telecommunication system.
GT	Via interactive audio and video telecommunication systems	Note: Modifier GT is only for use with those services provided via synchronous telemedicine for which modifier 95 cannot be used.
GQ	Via asynchronous telecommunications system	Note: Modifier GQ is for use with Store-and-Forward technology
25	Significant, separately identifiable evaluation & management (E&M) service by the same physician or other qualified health care professional on the same day as a procedure or other service	Example: The member has a psychiatric consultation via telemedicine on the same day as a primary care E&M service at the originating site. The E&M service should be appended with the 25 modifier.

Place of Service (POS) Code to be Used when Billing for Telehealth Services POS Code	Description
02	The location where health services and health-related services are provided or received, through telehealth telecommunication technology. When billing telehealth services, providers must bill with place of service code 02 and continue to bill modifier 95, GT or GQ.

General Billing Guidelines

Generally, Fidelis Care follows NYS Medicaid FFS billing guidance and methodologies for Article 28 facility based payments, including the allowable and disallowable combinations of service delivery subject to reimbursement. Additionally, Fidelis Care’s billing guidelines adhere to industry standards as defined by the Center for Medicare and Medicaid Services (CMS); National Correct Coding Initiative (NCCI); National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); the American Medical Association’s (AMA) Current Procedural Terminology Manual (CPT-4); Healthcare common Procedure Coding System (HCPCS); and International Classification of Diseases 10th Revision (ICD10).

In addition, only one clinic payment will be made when both the originating site and the distant site are part of the same provider billing entity. In such cases, only the originating site should bill Fidelis Care for the telemedicine encounter. The CPT code billed should be appended with the applicable modifier (GT or

95). (e.g., Hospital X has multiple sites for primary and specialty care. A member at one of the primary care sites requires a telemedicine consultation with a specialist located at a distant site within the system of Hospital X.)

For individuals with Medicare and Medicaid, if Medicare covers the telehealth encounter, Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by state law. If a service is within Medicare's scope of benefits (e.g., physician), but Medicare does not cover the service when provided via telehealth, Medicaid will defer to Medicare's decision and will not cover the telehealth encounter at this time.

For additional billing and claiming guidance, please see Section Twelve part 1 and 2 of the Fidelis Care Provider Manual.