RELIACARE ALLIANCE IPA PROVIDER MANUAL

January 2013

Reliacare Alliance IPA are pleased to welcome you as a participating provider.

We strive to provide for our Client's a network of professional DME and O&P providers that most appropriately and professional service these specialty needs to their membership roster.

As a single source DME and O&P IPA provider, we are able to provider our Clients with services which include:

Credentialing, Network Development and Management, Billing, Authorization and Referral coordination, Provider and Member Services. Such services extended to our Clients enables the Payor to experience an extensive reduction in administrative expenses. Additionally, our focus area of expertise enables our team to deliver the highest quality of service. Since we pride ourselves in our ability to reduce spend and delivery quality care - we expect our providers to be 100% on board with our intentiations.

This manual has been designed as a reference guide. Periodically, Reliacare Alliance IPA will add, revise and delete materials. When changes are made, the revised, updated or any new sections developed will be issued to our providers for placement into the binders. Additionally, updated Provider Manuals will be made available on our website. www.reliacare.com.

The Reliacare Alliance IPA Provider Manual is designed to assist you and your office staff to understand the operations of Company.

This manual is an extension of your ReliaCare provider contract and adds to understanding member eligibility and benefits, claims submission policies and overall plan operations.

We encourage you to keep this provider manual in a convenient and accessible location. Since changes in insurance carrier operations are inevitable over time, remember changes to policies herein are subject to updates and modifications.

If you or your staff have any questions about the information, policies and procedures outlined in this Provider Manual, please feel free to contact the ReliaCare Provider Relations Department Monday to Friday from 9:00am to 5:00pm at (877) 331-5170 or 212-956-9400 locally, or visit our web site at www.reliacare.com.

ReliaCare Alliance IPA (RCA) is a single source solution for an insurer's needs for DME and O&P from access to care to contract administration – we are focused on enhancing our Clients' members' patient experience as it relates to the products and services related to DME and O&P providers.

Durable Medical Equipment (DME): The following definition for DME is from the Centers for Medicare and Medicaid Services (CMS): Durable medical equipment is equipment which:

can withstand repeated use; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of an illness or injury; AND (d) is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

A. *Durability.* --An item is considered durable if it can withstand repeated use, i.e., the type of item, which could normally be rented. Medical supplies of an expendable nature such as, incontinent pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and bags are not considered "durable" within the meaning of the definition. There are other items, which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs, and eyes.

B. *Medical Equipment.* --Medical equipment is equipment, which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (hospitals, medical schools, medical societies) and specialists in the field of physical medicine and

rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

Orthotics and Prosthetics (O&P)

"Prosthetics" include artificial legs, arms, and eyes and "orthotics" include leg, arm, back and neck braces that are ordered by a health care provider, including replacements due to wear, damage, or a change in the person's condition.

GETTING STARTED

ReliaCare operates as your single point of entry to multiple health plans to administer the Plan's DME and O&P network It is you and your staff's responsibility to maintain familiarity with the various plan's member ID cards. These cards provide valuable information that you will need to process the claim associated with their service and often will identify payments that need to be collected in advance of their performance.

Important information to be found on the member's ID card is:

- **Member Name**: identifies the name of the member covered by the plan.
- **Member Number**: number assigned by the insurance carrier unique to the member named on the card.
- **Effective Date of Coverage**: the date the member's coverage became effective. Ongoing eligibility must be verified at point of service.
- **PCP name**: the name of the primary care provider the member has selected at time of enrollment or following a PCP change.
- **PCP telephone number**: the member's selected PCP's office telephone as reflected in the insurance carrier's provider files.
- **Specialist Co-payments:** the fixed dollar amount, which the specialist provider may collect from the member when covered services are rendered.

NETWORK OPERATIONS AND SERVICES

ReliaCare Web Site

Providers and their office staff are encouraged to visit our web site at www.reliacare.com. The website includes current policies and procedures enacted by ReliaCare, as well as other provider reference materials.

We encourage our providers to visit our website and register for access to our provider web portal. Some of the most common inquiries—including member eligibility and claims details—could be addressed with the click of a mouse 24 hours a day, 7 days a week.

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

• Steps for filing an appeal

To learn more about the Web portal, contact ReliaCare Provider Services Monday through Friday, 9:00am – 5:00pm at (877) 331-5170 or locally at 212-956-9400. To request access to the portal, please register by Clicking Here .

PROVIDER ROLE AND RESPONSIBILITY

All ReliaCare participating providers agree to:

1. **Contractual Requirements:** Provider must comply with all contractual, administrative, medical management, quality management, appeals & grievances, and reimbursement policies as outlined in the ReliaCare provider contract, provider manual and circulated updates. Failure to adhere or comply with all contractual/regulatory requirements may result in termination of your contract.

2. **Non-Discrimination:** Provider must not differentiate or discriminate in accepting and treating patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. ReliaCare and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds. Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include State and local government and ADA and Section 504 requirements extend to all programs and services provided by State and local government. Since Medicaid is a government program, health services provided through Medicaid Managed Care must be accessible to all who qualify for the program.
   Public programs and services, when viewed in their entirety, must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-discrimination in policies and procedures and communication. Physical accessibility is not limited to entry to a provider site, but also includes access to services within a site, e.g. exam tables and medical equipment. Communications with individuals with disabilities are required to be as effective as communication with others.

3. **Cultural Sensitivity:** Provider ensures members of various racial, ethnic and religious backgrounds; as well as disabled individuals are communicated with in an understandable manner, accounting for different needs. All efforts must be made to speak with the member in their primary language. Translation services through a family member, friend, or other health care professional that speaks the same language is encouraged. It is the provider's responsibility to ensure the member clearly understands the diagnosis and treatment options that are presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

4. **Ethical Medical Practice:** Provider agrees to:
    a. Provider agrees to provide services within the scope of the provider's license and/or specialty.
    b. Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.
    c. Provider agrees to report to ReliaCare any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

5. **Credentialing and Re-credentialing:**
    a. ReliaCare credentials providers upon acceptance of application and signed participation contract.
    b. ReliaCare re-credentials all participating providers on a three (3) year cycle from date of initial credentialing.
    c. Provider must notify ReliaCare within two business days if their Medicare or Medicaid licensure is revoked or restricted. Notification in two business days is also required when any reportable action is taken by a City, State or Federal agency.
    d. Groups or IPAs must contact the Contracting and Network Development Department as soon as a new associate joins the group or IPA. ReliaCare will provide you the necessary materials to begin the credentialing process for the new providers in the group or IPA.
    e. Any change, addition or deletion of office hours, associate or billing address should be sent in writing within 60 days to ensure accuracy of ReliaCare directories and databases.

6. **Billing Requirements:**
    a. Provider may NOT balance bill members for authorized and/or covered services.
    b. Provider may bill member for co pays not collected at time of service.
    c. Provider agrees that co pays and ReliaCare reimbursement for services constitute payment in full.
    d. Provider agrees to follow CMS and ReliaCare billing guidelines.
    e. A provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member and that ReliaCare does not cover the service.

7. **Medical Records and On-Site Auditing:** ReliaCare participating provider offices must maintain medical records in accordance with good professional medical documentation standards. The provider and office staff must provide ReliaCare staff with member medical records upon request. ReliaCare staff must also have access to member medical records for on-site chart reviews. The provider's office responsibilities are as follows:
    a. Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
    b. Maintaining medical records in a safe and secure manner that ensures member confidentiality and medical record confidentiality in accordance
    c.
    d. with all State and Federal confidentiality and privacy laws, including HIPAA.

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

9. **HIPAA Compliance:** Providers shall have the following procedures in place to demonstrate compliance to HIPAA privacy regulations:
    a. Only necessary patient information should be requested to accomplish the intended purpose required to service, and bill the payor and patient. Please note that privacy regulations allow for the transfer of patient information necessary to conduct business and make decisions about care, to make an authorization determination or to resolve a payment appeal. These situations are considered part of the HIPAA definition of "treatment, payment or health plan operations."

b. Fax machines used to transmit personal health information (PHI) should be maintained in an environment with restricted access to individuals who need the information to perform their jobs. Faxes sent to ReliaCare Alliance IPA should be sent only after the receiving fax number has been verified.
c. Internet e-mail should not be used to transfer files to ReliaCare Alliance IPA unless the file has been properly encrypted.
d. Voicemails may be left for ReliaCare Alliance IPA personnel because the voicemail system is secure and password protected. In spite of this, only the necessary amount of information should be left on voicemail to accomplish the purpose for which it was left.

ReliaCare Alliance IPA - Our Roles and Responsibility

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

The network of providers in that provider's specialty exceeds the number necessary to service ReliaCare's membership volume

Quality of care issues have been recorded against the provider in the past.

Reimbursement: ReliaCare agrees to reimburse provider according to the ReliaCare provider participation agreement signed by both parties. ReliaCare processes claims according to the claims processing rules outlined in this provider manual and CMS processing rules and guidelines.

Policy and Procedure Communication: ReliaCare agrees to advise providers of any administrative, procedural and policy changes in a timely manner through periodic mailings, or telephonically, or via web site at www.reliacare.com.

Member Eligibility: ReliaCare agrees to provide current member eligibility through the AdvancedMD eligibility module. Member eligibility accuracy of a dual eligible may be influenced by enrollment status in Medicaid at the time of services rendered.

Confidentiality: ReliaCare Alliance IPA recognizes that patient-specific confidential information includes, but is not limited to, name, client-unique identifiers (ID numbers),

date of birth, address, phone number, social security number, policy number, place of service and/or treatment, and medical or behavioral health records that are necessary for conducting business. As such, ReliaCare Alliance IPA collects information that is limited to that which is necessary to perform tasks as required. All patient information is secured in private areas with limited access. Provider Complaint and Appeals

If you disagree with any of our policies or services or would like to request a review of an unfavorable determination, they may file a complaint, grievance or appeal.

A complaint is an expression of dissatisfaction with any aspect of services. If you are dissatisfied with any aspect of our practices relating to the delivery of services on behalf of the Client networks that we represent you may file a complaint with Reliacare. You may contact our service center or send us a written notice to Reliacare Alliance, 755 Second Avenue, 2nd Floor, New York, NY 10017.

The complaint and any supporting documentation submitted by you will be investigated by a qualified Service Representative and the results will be communicated in a written decision to you within thirty calendar days of receipt of all necessary information.

This process applies to instances in which Reliacare is not being asked to review or overturn a previous denial of preauthorization or certification of covered services.

External Appeals

Based on New York State Department of Insurance regulations, if services were denied based on medical necessity or a determination that they are experimental or investigational, subsequent to an appeal you may have the right to an external review. You can initiate an external review using the form Empire will send you when our final adverse determination is made.

Please note: Providers may request an External Review only when representing a member on preservice (prospective) appeal or themselves on a post service (retrospective) appeal.

Provider Sanction and Termination

If there is evidence of non-compliance by a provider, e.g. not adhering to pre-authorization of services, quality and services issues with members, in appropriate coding, Reliacare reserves the right to sanction and potentially terminate a provider.

We reserve the right to request a plan of correction and to determine whether or the plan of correction is acceptable If it is acceptable then provider will be monitored for future compliance. If continue non-compliance is indented, Reliacare takes sets to remove provider from the network. Based on the severity of the issue, immediate termination of the provider may take place.

A participating provider does have the right to appeal disciplinary action if the termination was not a result of continued non-compliance, harm to members or any type of HIPAA related occurrences. An appeal may be submitted within 30 days of a providers receipt of notification of termination.

ReliaCare Alliance IPA investigates and resolves complaints concerning issues within the contractual arrangement between the provider and ReliaCare Alliance IPA. Participating providers may submit a complaint in writing and submit it to the ReliaCare Alliance IPA Provider Relations Complaint Committee. The committee member handling your case will send the complaining provider written confirmation of receipt within five (5) business days of receipt. The confirmation will contain:

- The case number assigned to the complaint,
- The provider's name and address,
- The date received,
- A brief description of the complaint, and
- The timeline for resolution.

If more information is needed to reach a resolution the provider will be notified of the required information in writing. All complaints will be investigated and resolved within thirty (30) business days of receipt of all necessary documentation.

Once resolution has been reached, the Provider Relations Complaint Committee will notify the provider of the decision in writing. If the provider is not satisfied with the determination they may file an appeal within thirty (30) business days of receipt of the notification.

PROVIDER DISCIPLINE PROCEDURE

Disciplinary action may be taken against a participating provider in the event of non-compliance with program rules and regulations, quality of care complaints or concerns, unsatisfactory utilization and/or quality management controls, or fraudulent billing or prescribing practices. All disciplinary actions are taken pursuant to the review and decision of the ReliaCare Alliance IPA Credentialing Committee.

Providers may NOT be disciplined for the following reasons:

- Filing a complaint against ReliaCare Alliance IPA,
- Appealing a decision of ReliaCare Alliance IPA,
- Advocating on behalf of a patient,
- Providing requested information to a regulatory agency concerning ReliaCare Alliance IPA, or

- Requesting a hearing or review regarding ReliaCare Alliance IPA practices or decisions.

Depending on the nature and severity of the action being investigated, ReliaCare Alliance IPA may limit, suspend, or terminate their relationship with a participating provider.

In the unfortunate event that disciplinary action must be taken by ReliaCare Alliance IPA against a participating provider, the following procedures will be followed:

LEVEL 1 DISCIPLINARY ACTIONS

Level 1 disciplinary action is taken when a provider is operating outside of established guidelines concerning:

- Obtaining eligibility information for a patient,
- Obtaining pre-authorization of services,
- Following claim coding guidelines,
- Following guidelines concerning site visits, medical record audits, or availability of requested data,
- Maintaining appropriate insurance coverage levels,
- Adhering to access to care standards, and
- Quality issues that do not have an adverse effect on the member.

Participating providers in need of Level 1 disciplinary action will receive a letter under signature of the Chief Operating Officer of ReliaCare Alliance IPA from the Credentialing Committee explaining the findings of the committee and requesting a corrective action plan. If accepted, the corrective action plan will be followed up by the Credentialing Committee and, if no further action is necessary, the case will be closed. The provider will receive a letter from ReliaCare Alliance IPA explaining that the case has been closed and that no further action will be necessary.

If the corrective action plan is not acceptable, the Credentialing Committee will work with the provider to establish an acceptable plan.

If the letter is ignored, the corrective action plan is not acceptable and the provider is not willing to establish an acceptable plan, or the provider remains non-compliant, then Level 2 Disciplinary Action will be initiated.

LEVEL 2 DISCIPLINARY ACTIONS

As stated above, if a Level 1 Disciplinary action is ignored, the corrective action plan is not acceptable and the provider is not willing to establish an acceptable plan, or the provider remains non-compliant then a Level 2 Disciplinary Action will be initiated by the ReliaCare Alliance IPA Credentialing Committee. Level 2 Disciplinary Actions may also be initiated under the following instances:

- Fraudulent eligibility practices are found,
- Fraudulent authorization practices are found, or
- Fraudulent claims practices are found.

Participating providers in need of Level 2 disciplinary action will receive a letter under signature of the Chief Operating Officer of ReliaCare Alliance IPA from the Credentialing Committee explaining the findings of the committee and requesting a corrective action plan. If accepted, the corrective action plan will be followed up by the Credentialing Committee and increased frequency of audits will be initiated. If no further action is necessary, the case will be closed. The provider will receive a letter from ReliaCare Alliance IPA explaining that the case has been closed and that no further action will be necessary.

If the corrective action plan is not acceptable, the Credentialing Committee will work with the provider to establish an acceptable plan.

If the letter is ignored, the corrective action plan is not acceptable and the provider is not willing to establish an acceptable plan, or the provider remains non-compliant then Level 3 Disciplinary Action will be initiated.

LEVEL 3 DISCIPLINARY ACTIONS

As stated above, if a Level 2 Disciplinary action is ignored, the corrective action plan is not acceptable and the provider is unwilling to establish an acceptable plan, or the provider remains non-compliant then a Level 3 Disciplinary Action will be initiated by the ReliaCare Alliance IPA Credentialing Committee. Level 3 Disciplinary Actions may also be initiated under the following instances:

- Excessive patterns of fraudulent eligibility practices are found,
- Excessive patterns of fraudulent authorization practices are found,
- Excessive patterns of fraudulent claims practices are found, or
- Quality issues threaten a patient's safety.

Participating providers in need of Level 3 disciplinary action will receive a letter under signature of the Chief Operating Officer of ReliaCare Alliance IPA from the Credentialing Committee explaining the findings of the committee and requesting a corrective action plan. If accepted, the corrective action plan will be followed up by the Credentialing Committee and increased frequency of audits will be initiated. Once it has been established through audits that the issue(s) have been remedied and no further action is necessary, the case will be closed. The provider will receive a letter from ReliaCare Alliance IPA explaining that the case has been closed and that no further action will be necessary.

If the corrective action plan is not acceptable, the Credentialing Committee will work with the provider to establish an acceptable plan.

If the letter is ignored, the corrective action plan is not acceptable and the provider is unwilling to establish an acceptable plan, or the provider remains non-compliant then Level 3 Disciplinary Action will be initiated. Level 3 Disciplinary Action is at the sole discretion of the ReliaCare Alliance IPA Credentialing Committee up to and including termination of the participating provider's contract with ReliaCare Alliance IPA.

As noted in the provider's contract with ReliaCare Alliance IPA, a letter of termination will be sent to the participating provider outlining the provisions of the contract in regard

to termination, the reason for the termination and outlining the provider's right to appeal the decision. The effective date of the termination will be determined based on the terms of the participating provider's agreement. ReliaCare Alliance IPA will report its findings to the National Practitioner Data Bank and other New York State and federal regulatory agencies as required by law.

Terminated providers have the right to appeal disciplinary actions with the exception of determinations of fraud, terminations resulting from imminent harm to the patient, and/or determinations by a governmental agency or licensing board that preclude the participating provider's ability to practice within the ReliaCare Alliance IPA. Appeals must be received by the ReliaCare Alliance IPA Credentialing Committee within thirty (30) business days of receipt of the notification of termination.

MEMBER BILL OF RIGHTS

Patient Rights:

- Receive considerate, courteous, and respectful care.
- Change providers accordance with the provisions of the member's Evidence of Coverage.
- Be assured that only persons having the qualifications established by Medicare and ReliaCare will provide medical services.
- Receive from the member's physician information necessary to enable the member to give informed consent to services to be rendered or supplies and equipment to be provided.
- To receive appropriate supplies and functional equipment
- Be assured privacy related to the member's medical care program is respected and secured. This shall mean at minimum that a person not directly involved in the member's care may not be present without the member's permission during any portion of the member's case discussion, consultation, examination or treatment.
- Expect all communication, records and other information pertaining to the member's care or otherwise regarding the member's personal condition will be kept confidential except if disclosure is required by law or permitted by the member.
- Member has the right to file a complaint and or make recommendations about the Company

Patient Responsibility:

- To supply information, as applicable and/or possible, in order to enable provider to extend services
- To follow instructions provided, as directed by provider and agreed upon by parties during service session

- To be ageeable to receive the care that is rendered by provider and to work with the assistance of the provider to address health related problems

MEMBER'S RIGHT TO FILE A GRIEVANCE

Patients have the right to file a complaint or grievance without fear of penalty when they feel they have received inappropriate treatment by the Plan or a Plan provider. Examples of grievances are: quality of care, office waiting times, and appointment waiting times. Please consult the Appeal and Grievances section of this manual for further details.

NETWORK CONTRACTING - PROVIDER MAY JOIN OUR NETWORK IN ONE OF THE FOLLOWING WAYS:

We identify and attempt to recruit providers based on a gap in a geographic area. In these scenerio we will send the provider an Application packages requesting the information needed to initiate the providers' participation in our IPA. Our team follows up with the provider to address any questions they may have regarding our company. At this time, we schedule an on-site visit.

Reliacare may receive a request from a provider to join our network. We will send the provider an application and a checklist which includes all of the relevant credentialing information and documentation that is required for us to proceed with the process. Application is prepared and sent to the Credentialing Committee.

When a provider is approved for network participation, Reliacare and the provider fully execute a provider agreement.

SITE REVIEWS:

At all times during the term of Reliacare and a participating provider's agreement, Relicare reserves the right to conduct an on-site visit. Site visits may be conducted as a step in the application process and/or may be conduct as part of a network quality review process

Sites Meeting Standards: If the provider meets the 80% of the applicable standard for the On-Site Assessment Tool, then the application will be submitted to the Credentialing Committee for approval. No further action will be needed and the site will be re-reviewed at the time of recredentialing.

Based on the results of a review and the determination of the Credentialing Committee, a prospective provider may invited to join our network, be removed from our network or be asked to provide a plan of correction if the provider's site does not meet minumum standards.

CREDENTIALING/RECREDENTIALING

Following receipt and acceptance of a completed provider application and signed participating provider contract, ReliaCare credentials allied health providers. ReliaCare's credentials verification process includes but is not limited to:

- Primary source verification of the provider's credentials; Medicare and Medicaid acceptance letter, business license, certificate of authority, evidence of malpractice insurance.
- Verification the provider participates in the Medicare fee-for-service program. ReliaCare does not accept applicants that choose to "opt out" of regular Medicare.
- Demographic information: SSN, DOB, provider specialty, languages spoken, Medicaid number, Medicare number, UPIN number.
- Office information: tax ID, office address, telephone and fax numbers, handicap accessibility, staff language skills.

ReliaCare recredentials providers on a three (3) year cycle from date of initial credentialing. ReliaCare Alliance IPA reserves the right to increase the frequency of recredentialing at its discretion.

AUTHORIZATION PROCEDURES

A ***Prior Authorization Request*** is a request made by a member, or by a provider on the member's behalf, for coverage of a new service or equipment ***before*** the service or equipment if provided. ReliaCare is the intermediary for authorizations between the provider and insurance plan. Authorization requests made after a service or equipment is provided will be denied. Authorizations are required for the following DME/O&P products:

- Custom prosthetics
- Custom orthotics
- Home Equipment, which includes:
    - Standing Systems,
    - Patient Lifts,
    - Hospital Beds,
    - Traction Systems,
    - Oxygen Therapy Equipment,
    - Pneumatic Compression Therapy Equipment,
- Osteogenic Stimulators
- Motorized Wheelchairs

Please Note: *All authorizations and services are subject to the patient's continued eligibility on the actual date of service. If the patient is not a member of their respective*

health plan on the date of service, the prior authorization is no longer valid, and the patient will be responsible for payment of the service. Payments are also subject to benefit and coverage limits.

To request an authorization, please visit the ReliaCare Alliance IPA website at www.reliacare.com and click on **"*I'm a provider*"** section and login with your user id and password. Click on submit new request. Here you can input all the necessary information and attach the additional information necessary to process the request. ReliaCare will forward the request to the plan and return the authorization information for your records prior to the service. If you need additional assistance or would like to download our authorization manual, you may do so under the provider material tab.

PROVIDER OFFICE PERFORMANCE STANDARDS

ACCESS TO CARE

ReliaCare adheres to all access and delivery standards for DME, O&P and consumables as set by the payers with whom we contract. For specific questions concerning turn-around time standards, please contact ReliaCare Alliance IPA Provider Relations at (877) 331-5170 or (718) 237-3000 locally, Monday through Friday, 9:00a – 5:00pm.

ReliaCare enforces compliance with the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access guidelines. ReliaCare providers must accommodate the following types of appointments within the indicated time frames:

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Urgent but non-emergency	Within 24 hours
Non-urgent but in need of attention	Within one week
Routine and preventative care	Within 30 days

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

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

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

CONTINUE (ACCESS OF CARE)

TELEPHONE RESPONSE TIME

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

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

ReliaCare defines these levels of conditions accordingly:

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

PROVIDER REIMBURSEMENT

Because ReliaCare Alliance IPA performs the claims batch and posting process there is a slight delay in the payment between the payer and provider. Once payment is received by ReliaCare Alliance IPA it will be forwarded to the provider within three business days.

RELEASE OF INFORMATION TO MEMBERS

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

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

- Court-appointed committee for an incompetent person,
- Court appointed guardian,
- Other legally appointed guardian.

MEMBERS REQUESTING RECORDS

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

- Name of the physician from whom the information is requested,
- Name and address of the institution, agency, or individual that is to receive the information,
- Member’s full name, address, date of birth, and ReliaCare identification number,
- The extent or nature of the information to be released, including dates of treatment,
- The date of initiation of authorization, and
- Signature of member or qualified person.

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

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member or others, or would have a detrimental effect on the provider’s professional relationship with the patient or his or her ability to provide treatment.

The physician may place reasonable limitations on the time, place, and frequency of any inspections of the patient information. Personal notes or observations may be excluded from any disclosure based on the provider’s reasonable judgment.

NON-COMPLIANCE WITH MEDICAL RECORD REQUESTS

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

COVERAGE AND BENEFIT QUESTIONS

ReliaCare offers health plan members access to their coverage and benefit questions through contact with our member service representatives in our Member Service

Department Monday through Friday, 9:00am to 5:00pm at (877) 331-5170 or locally at (718) 237-3000.

ReliaCare also conducts annual satisfaction surveys. All positive and negative experiences are reviewed and where needed service improvement action plans are initiated.

CURRENT CLIENT SPECIFIC INSTRUCTION

VERIFYING ELIGIBILITY FOR NHP MEMBERS

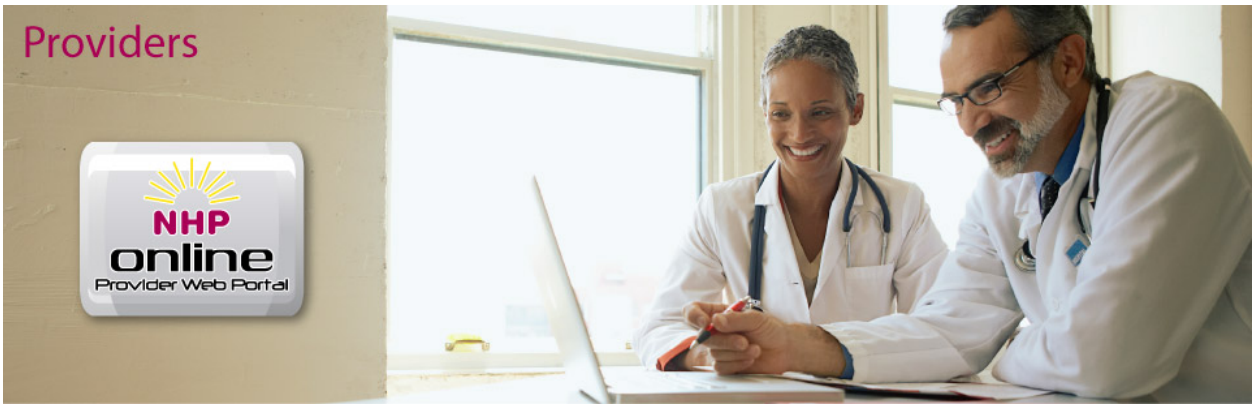
Verifying eligibility and product participation (i.e. Medicare, Medicaid, commercial, etc.) is extremely important in the care and payment process. Eligibility and product participation determines ones coverage status with the insurance carrier. Failure to establish these elements may result in non-reimbursement for services rendered.

1. You must verify a member's eligibility and product participation at the time of service. To verify membership eligibility, please use the AdvancedMD eEligibility verification module outlined on page 19 of this manual.
2. It is the provider's responsibility to request to see the membership card and to check eligibility at the time of service. Insurance carriers do not retrieve membership cards from members when they disenroll or lose coverage; therefore presentation of a membership card is **NOT** a guarantee of eligibility.

To check eligibility for a Neighborhood Health Providers member, go to the following link:

http://www.getnhp.com/providers.html

Once the web page has opened please click on the NHP Online Provider Web Portal button:



This will bring you to the log-in page. To check eligibility, claims status or authorization status you will need to log in with the ReliaCare ID and password:

User ID: reliaNHP

Password:NHPelig212

Once you have successfully logged on you can check status by inputting the necessary member data.

ReliaCare Alliance IPA Power Wheelchair Medical Necessity Form ***Fax completed form to (718) 237-4000***

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03A

MOTORIZED WHEELCHAIRS

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(_ _ _) _ _ _ - _ _ _ _ HICN _____	(_ _ _) _ _ _ - _ _ _ _ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____
PT DOB ___/___/___; **Sex** ___ **(M/F)**; **HT.**_____**(in.)**; **WT.**_____**(lbs.)**	
PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (_ _ _) _ _ _ - _ _ _ _ UPIN # _____	

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

❒ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854**

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 843 (5/97)

I

Instructions for completing the Wheelchair Medical necessity Form

ReliaCare Alliance IPA Prior Authorization/Oxygen Attachment

Providers may submit prior authorization requests by fax to (718) 237-4000.

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Oxygen Attachment Completion Instructions. Providers are required to attach a completed Record of Actual Daily Oxygen use.

SECTION I — PROVIDER INFORMATION

1. Name — Medical Equipment Vendor	2. Medical Equipment Vendor's Medicaid Provider No.
3. Telephone Number — Medical Equipment Vendor	4. Requested Start Date
5. Name — Person Completing Form	6. Title — Person Completing Form
7. Name — Prescribing Physician	8. Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number
9. Address — Prescribing Physician (Street, City, State, and Zip Code)	10. Telephone Number — Prescribing Physician

SECTION II — RECIPIENT INFORMATION

11. Name — Recipient (Last, First, Middle Initial)	12. Recipient Medicaid Identification Number
13. Height and Weight — Recipient Height inches Weight lbs	14. Date of Birth — Recipient
15. Place of Service (choose one) ☐ 11 = Office ☐ 12 = Home ☐ 31 = Skilled Nursing Facility ☐ 32 = Nursing Facility ☐ 99 = Other Place of Service	16. Name and Address — Facility (if applicable)

SECTION III — CLINICAL INFORMATION

17. Estimated Length of Need (1-98 months; 99 = Lifetime) months	18. Diagnosis — Codes and Descriptions Primary — Secondary —

19. Qualifying Test — Enter results of test taken within 60 days prior to the date of submission or requested start date of the PA request. Test results are to be available in the recipient's record or case file. **Note: Criteria for coverage of oxygen-related services include either an oxygen saturation level (SAO_2) of 88 percent or lower or an arterial blood gas level (PO_2) of 55 mm/Hg or lower.**

a) Date / / (MM/DD/CCYY) b) Recipient condition during test (choose one) ☐ At rest ☐ During exercise ☐ During sleep c) Arterial blood gas level (PO_2) mm/Hg d) Oxygen saturation level (SAO_2) %	e) Name, Address, and Credentials — Provider Performing Qualifying Test

ReliaCare Alliance IPA Oxygen Authorization Form (page 2)

PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA)

(Continued)
Page 2 of 2

SECTION III — CLINICAL INFORMATION (cont.)

20. Enter the oxygen liter flow rate / number of hours per day as prescribed by the physician.

a) Liters per minute

b) Hours per day

c) Days per week

d) Continuous

e) PRN, describe circumstances and frequency of use —

21. Type of Oxygen Prescribed	22. Means of Delivery Prescribed
☐ Concentrator	☐ Nasal Cannula
☐ Liquid	☐ Mask
☐ Gaseous	☐ Other (Specify)

23. Indicate portable oxygen and recipient mobility information, if applicable.

a) Is portable oxygen prescribed? ☐ Yes ☐ No ☐ N/A

b) If portable oxygen is prescribed, is the recipient mobile? ☐ Yes ☐ No ☐ N/A

c) If the recipient is mobile and portable oxygen is prescribed, describe to what extent the recipient is mobile.

24. If the recipient's arterial blood gas level (PO_2) is 56 mm/Hg or above or the recipient's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

a) Does recipient have clinical evidence of chronic or recurrent congestive heart failure? ☐ Yes ☐ No ☐ N/A

b) Does recipient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an electrocardiogram or by an echocardiogram, gated blood pool scan, or direct pulmonary artery pressure measurement? ☐ Yes ☐ No ☐ N/A

c) Does recipient have clinical evidence of decubital angina? ☐ Yes ☐ No ☐ N/A

d) Does recipient have erythrocythemia with a hematocrit greater than 56 percent? ☐ Yes ☐ No ☐ N/A

25. Describe the medical condition of the recipient that supports the use of oxygen (e.g., describe why the recipient needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

26. Date of Prescription (MM/DD/CCYY)

27. Prescription as Written

If the prescribing physician signs the PA/OA, Affinity Health Plan will accept it in lieu of the physician's written prescription and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician.

28. **SIGNATURE** — Prescribing Physician	29. Date Signed