



2022 Provider Manual

(Version 1.1.22)

PHP Care Complete FIDA-IDD Plan (Medicare-Medicaid Plan) is a Fully Integrated Duals Advantage Plan for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) that is offered by Partners Health Plan.

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SECTION 1: INTRODUCTION

Welcome

Welcome to Partners Health Plan (PHP). We are proud to be the first fully integrated duals advantage (FIDA) plan approved by the Centers for Medicare and Medicaid Services (CMS), the State of New York Department of Health (SDOH) and the State of New York Office for People with Developmental Disabilities (OPWDD) to serve eligible adults with intellectual and other developmental disabilities (IDD) in all five boroughs of New York City as well as Nassau, Rockland, Suffolk, and Westchester Counties. PHP's FIDA-IDD program provides all Medicare- and Medicaid-covered services to dually eligible people with IDD that are at least 21 years of age and need medical, behavioral, dental, and long-term services and supports (LTSS)—including Office of People with Developmental Disabilities (OPWDD) waiver services—to remain in their homes and communities as long as possible.

Our ability to serve our participants effectively is dependent on the quality of our provider network. By joining our network, you are helping us serve eligible individuals by providing high-quality and accessible services and supports. You are one of the most critical components of our service delivery approach and Partners Health Plan appreciates your participation.

This manual is intended to serve as an extension of our provider agreement. It includes valuable information to help you understand our program and provides helpful tips on how to work with PHP. It should be a valuable resource for you and your office staff. Please visit our website at www.phpcares.org for the most up-to-date information.

About Partners Health Plan

Partners Health Plan, Inc. ("PHP") is a federal 501(c)(3) tax exempt New York not-for-profit corporation aligned with the Downstate New York chapters of the NYSARC, Inc. PHP's sole corporate member is Partnerships for Healthcare Solutions, Inc. ("Partnerships"), which is also a New York not-for-profit corporation. Partnerships has one corporate member, PHSI, Inc., which is also a New York not-for-profit corporation.

PHP is led by invested stakeholders, family members, and advocates with decades of experience in health care, health insurance, and in managing services and supports for people with IDD. These industry leaders have collaborated in a pioneering effort to implement a high-quality managed care program for persons with intellectual and other developmental disabilities and those who support them. In addition, PHP has recently aligned with Care Design NY (CDNY), a New York State IDD Health Home operating in 31 counties from Suffolk to the Canadian border. Regardless of budget cuts and changes in New York's political and economic climate, the Downstate AHRCs/ARCs have worked tirelessly to ensure that compassionate community-based programs for people with IDD continue now and into the future. With more than six decades of experience serving persons with IDD, PHP has the expertise to develop and implement a personalized Life Plan that ensures that each participant

receives the essential medical, dental, behavioral, habilitation, and social services needed to support his or her health, safety, personal preferences, and valued outcomes in a manner that promotes courtesy, respect, and compassion.

Mission and Values

Our Mission

PHP is committed to person-centered care planning that provides support to assist our members in accessing the highest quality healthcare and services, promoting good health and wellness, improving quality of life and supporting each member to live the life they choose.

Our Vision

PHP, as a trusted partner and advocate for people with developmental disabilities and their families, strives to help our members achieve their life goals, improve their personal health and fully participate in their communities of choice.

Guiding Values

- Promote wellness
- Support choice
- Integrate services
- Respect diversity
- Improve quality of life

Partners' objective is to provide a seamless array of supports and services with the individual at the center. We are dedicated to keeping each of our participants healthy, happy, and as independent as possible while they pursue their dreams and valued outcomes in the diverse communities, they call home. Working in close collaboration with families and other members of the community, Partners will continue the proud ARC/ADAPT tradition of supporting the unique needs and wishes of the individuals in their care, fully integrating their supports and services, advocating on their behalf, and assisting participants throughout their lives. Our goals are lofty, but so are the expectations of the people we are committed to supporting.

About Intellectual and Other Developmental Disabilities

According to the New York State Mental Hygiene Law, an intellectual or other developmental disability (IDD) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism that originates before a person attains age twenty-two and is expected to continue indefinitely. Persons with IDD have widely varying degrees of abilities and deficits that often require direct-support professionals to know their unique forms of verbal and non-verbal communication to provide necessary supports. In

addition, many people with IDD display challenging behaviors often associated with an inability to communicate effectively. For example, a person experiencing pain or medical illness may rely on self-injurious behavior as a means of expressing physical discomfort.

The average life expectancy of people with IDD was just 22 years in 1931, compared to 59 years in 1976, 66 years in 1993, and 76 years at present. Currently, the cause of death for all individuals with IDD mirrors that of the general population (i.e., coronary heart disease, type 2 diabetes, respiratory illnesses, and cancer), except for those with Down syndrome, who typically die earlier due to dementia-related causes (over half of those with Down syndrome are expected to live into their 50s and roughly 13 percent will reach age 65). There are approximately six million individuals in the US with an IDD diagnosis and nearly 315,000 are over the age of 65 – a number that is expected to increase to more than 500,000 by 2020.¹

Despite their handicaps, the issues confronting aging persons with IDD are not dissimilar from those of their non-disabled counterparts, including locating safe and affordable housing, living independently, accessing assistance when it is needed, leading productive and meaningful lives, and staying healthy. However, the situation is especially challenging for older adults with IDD owing to an array of issues unique to this population, including aging caregivers, work-related issues, and medical and behavioral health problems.

Physical Health Issues

There are many physical health factors associated with intellectual and other developmental disabilities, and these often manifest in chronic health conditions as persons with IDD age. For example, recent studies have documented higher incidents of disease and death for aging adults with IDD due to a number of health conditions, such as difficulty eating or swallowing, dental disease, gastroesophageal reflux, esophagitis, respiratory disease, and infections (leading cause of death), and constipation. A number of chronic conditions also seem to be more widespread among persons with IDD than in the general population, including non-atherosclerotic heart disease, hypertension, hyperlipidemia, diabetes, obesity, reduced mobility, bone demineralization, and osteoporosis. In addition, thyroid disease, the effects of taking multiple psychotropic drugs, and deaths due to pneumonia, bowel obstruction, and intestinal perforation have a higher prevalence among aging adults with IDD.²

Some specific syndromes and diagnoses are inherent (e.g., epilepsy, sensory problems like poor vision and hearing, poor heart function in people with Down syndrome), while others are avoidable but overrepresented among the developmentally disabled (e.g., obesity, diabetes, poor dental health). Also, symptoms of aging like diminished hearing, the development of cataracts, respiratory difficulties, the onset of menopause, and obesity-related diseases like high cholesterol and diabetes can all occur earlier in those

¹ Laura Walker, Christine Rinck, Ph.D., Vim Horn, M.P.A., and Tom McVeigh, “Aging with Developmental Disabilities: Trends and Best Practices,” University of Missouri Kansas City Institute for Human Development and The Missouri Division of MR/DD (2007); Toby Long and Sarkis Kavarian, “Aging with Developmental Disabilities: An Overview,” *Topics in Geriatric Rehabilitation* 24 (2008).

² Beth Marks and Jasmina Sisirak, “Age-Related Health Changes for Adults with Developmental Disabilities,” University of Minnesota (2009). <http://ici.umn.edu/products/impact/231/20.html>

with Down syndrome than in the general population.

Behavioral Health Issues

In general, older adults are more prone to depression and other behavioral health issues than younger persons and this tendency is even more pronounced among individuals with IDD, although it is frequently under-assessed, under-diagnosed, and left untreated. It is often challenging to identify behavioral health problems among aging individuals with IDD because they are generally less capable of describing and conveying their feelings, and symptoms of conditions like depression may be expressed as physical complaints instead (e.g., headaches). Anti-depressant medication is generally effective in addressing these conditions, but considerable care has to be taken to prevent potentially harmful interactions with other prescribed medications.³

Persons with a dual diagnosis of IDD and a co-occurring behavioral health condition can be found at all ages and levels of intellectual and adaptive functioning. Estimates of the frequency of dual diagnoses vary widely; however, current professional consensus is that 30-40 percent of all persons with IDD have a psychiatric disorder, although this percentage could be as high as 60 percent if aggressive and disruptive behavior is included. The full range of psychopathology that exists in the general population also can co-exist in persons who have IDD.

Professional Competencies for Providers

This section highlights the core competencies, skills, and attitudes necessary to provide high quality care and services to adults with IDD.

Knowledge

- **Clinical Knowledge Specific to IDD:** Clinical knowledge includes causes, symptomology, characteristics, and the natural history of developmental disorders, as well as the specific medical conditions that are known to co-occur with developmental disabilities. Additional topics include diagnostic testing, psychotropic medications, behavioral interventions, use of adaptive equipment, and management of chronic disease.
- **Legal Rights of People with IDD:** This knowledge area includes relevant legislation for people with IDD, as well as the rights of individuals and their families. Examples of rights for people with IDD

³ Alan R. Factor, Ph.D., “Growing Older with a Developmental Disability: Physical and Cognitive Changes and Their Implications,” Institute on Disability and Human Development, University of Illinois at Chicago (1997). http://depts.washington.edu/aedd/growing_older_dd_Factor.html

include the right to prompt medical care and treatment; freedom from harm, unnecessary physical restraint or isolation; freedom from excessive medication, abuse and neglect; and freedom from hazardous procedures.

Skills

- **Communication and Interviewing Skills:** This skill includes strategies to gain a history, screen, and evaluate an individual with IDD, particularly when he or she may be nonverbal. Communication skills also include the ability to effectively obtain and share information with families or caregivers.
- **Observation Skills:** Observation skills are critical when working with people with IDD, especially to identify behaviors that may be affecting or may be resulting from the individual's health condition. This skill includes the ability to observe subtle changes in a person's behavior as these changes may in some cases require medical attention. Observing subtle changes, as well as gathering the information about such changes and being alert to caregiver reports about such changes, requires additional time and openness on the part of the provider.
- **Physical Examination Skills:** Physical examination skills specific to working with persons with IDD include providing assistance with the positioning of the physical exam as well as patience in working with individuals who may need extra time to be coaxed and talked through the exam procedure. This also includes the ability to engage in preplanning and diagnostics in order to assist the participant immediately and effectively.
- **Ability to Identify, Coordinate, and Communicate with Members of the Participant's Interdisciplinary Team:** This skill encompasses the recognition that a multi-disciplinary team is required in order to adequately care for a person with IDD. Members of the participant's IDT include those who conduct the assessment and develop and implement the care plan, including care managers and coordinators, service providers, specialists, and caregivers. In addition to understanding the various roles of the team members, this skill also includes the ability to effectively coordinate the services for the participant.

Attitudes

- **Compassion and Sensitivity:** Sensitivity to the needs and experiences of people with IDD includes having compassion, good listening skills, and flexibility, as well as an understanding of the context in which individuals live and how that may influence treatment compliance. This also encompasses recognition of the challenges that people with IDD face on a daily basis and the types of accommodations they may need.
- **Participant- and Family-Centered Attitude:** Health care providers should strive to tailor their care according to what the participant wants. This encompasses extending respect to the participant by using appropriate terminology, interacting directly with the participant, and including him or her in the conversation. In addition, this attitude includes being respectful towards families and providing support when needed. Strong relationships with persons with IDD and their families are necessary in order for participants to trust and have confidence in their providers.
- **Cultural Sensitivity:** Cultural appropriateness reflects the ability for providers to be sensitive to

differences. In this context, culture encompasses not only race/ethnicity and language, but also the disability culture. Cultural sensitivity includes using respectful terminology (e.g., people-first language), providing language assistance when necessary in order to communicate with participants, and providing care in a manner that takes into consideration the participant's background and culture.

- **Recognition of the Additional Time Necessary to Serve Persons with IDD:** In order to adequately serve and meet the needs of people with IDD, providers must be prepared to spend additional time with them, as they often experience more complex problems compared to the general population.

About the FIDA Program for People with IDD

PHP's specialized FIDA-IDD program integrates OPWDD waiver services such as habilitation and residential services with medical, behavioral, dental, vision, and other health-related services to provide the full continuum of Medicare- and Medicaid-covered services and supports to adults with IDD. This program is designed to:

- Link primary, specialty, and community-based services for some of New York's most vulnerable residents
- Break down service delivery silos
- Reduce or eliminate duplicative and/or unnecessary services and supports
- Promote timely and effective communications among the various stakeholders involved in a participant's care
- Improve outcomes
- Enhance participant and family satisfaction

PHP's goals are lofty, but so too are the expectations of the people we serve. As a contracted provider with PHP, we thank you for your willingness to assist our team toward the achievement of these ambitious goals.

About this Provider Manual

This Manual is designed to enable providers to easily access information on the majority of issues that may affect working with Partners Health Plan. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Relations staff at 1-855-747-5483 or email us at providerrelations@phpcares.org.

Partners Health Plan will update the Provider Manual at least annually and distribute bulletins as needed to alert you about any changes. Please check our website regularly at www.phpcares.org for the most up-to-

date version of the Provider Manual.

The Partners Health Plan Provider Manual is available in hard copy form or on CD-ROM at no charge by contacting our Provider Relations Department at or 1-855-747-5483 or by emailing us at www.providerrelations@phpcares.org.

How PHP Works with Providers and Participants

Provider Relations

PHP's Provider Relations staff is dedicated to fostering durable, long-term partnerships with all contracted providers and practitioners. Working directly with your regional Account Field Managers, the relationship begins with an initial orientation and continues with ongoing training, education, and support on policies, procedures, and issues that concern service delivery within PHP's guidelines and requirements.

Care Management

PHP's Care Management staff, including Care Coordination, Quality Management, and Utilization Management, evaluates the quality and appropriateness of the services provided to PHP's participants. Our Care Managers can provide assistance to you and your staff with service authorizations, care management and coordination, and referrals as well as with participants that are proving challenging to treat owing to communication difficulties or who resist being touched or examined. In most cases the participant's caregiver will accompany the participant to the appointment, but if this is not possible or if other types of assistance are required, our trained and experienced Care Managers will gladly provide any needed help.

Care Management staff is available to provide any needed assistance — including assistance with service authorizations. Each participant will have a dedicated Care Manager whose name and phone number can be on the front of the Participant's ID card.

Participant Services

The Participant Services Call Center is available 24 hours a day, 7 days a week at 1-855-747- 5483. A live person is available on all business days from 8:00 a.m. to 8:00 p.m. to assist participants and their caregivers and to respond to any questions or concerns regarding their coverage. This includes information regarding eligibility and enrollment, covered benefits, choosing, or changing a primary care provider, orienting participants to PHP, and participant rights and responsibilities, among other topics. At all other times, the Call Center employs an interactive voice response system to record voice messages. All voicemail messages will be promptly responded to on the next business day.

Importantly, Call Center staff never provides health-related advice to participants or their families/caregivers. Calls of this nature are instead “soft-transferred” without losing contact with the caller (during business hours) to an appropriate care manager or clinician who is trained to assist with participants' health care needs. At all other times, the IVR system phone tree will automatically transfer

calls of a clinical nature to a clinically licensed care manager that is trained to provide general health-related information as well as assistance in accessing services outside of normal business hours.

Translation services are available at no charge for participants and/or families/caregivers with limited English proficiency (LEP), and NY Relay and other accommodations are available in accordance with participants' individual needs. Participant Services staff also solicits feedback from participants and their caregivers regarding their satisfaction with the services and supports provided by PHP. It is always our goal to address concerns or complaints quickly and efficiently.

Claims

PHP's claims processing staff adjudicates and pays claims for covered services and supports in accordance with the provider contract and PHP's policies and procedures. The claims department also collects encounter data for services and supports.

Contact Information - Important Phone Numbers

Name of Department or Organization	Phone Number	Email Address and /or Fax Number	Hours of Operation
Partners Health Plan	1-646-844-4020		Mon.-Fri. 8:00 a.m. – 5:00 p.m.
PHP Administration	1-646-455-1598	Tracy Corrado Vice President Analytics and Informatics Tcorraro@phpcares.org	Mon.-Fri. 8:00 a.m. – 5:00 p.m.
Participant Services	1-855-747-5483	1-855-619-4678	Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours – secure voicemail box)
Nurse Hotline	1-855-769-2507		24/7, 365 days a year
Grievances & Appeals	1-855-747-5483	1-855-619-4678	Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours - secure voicemail box)

Fraud and Abuse Hotline	1-855-747-0013		Available 24/7, 365 days per year via voicemail
Name of Department or Organization	Phone Number	Email Address and /or Fax Number	Hours of Operation
Provider Relations	1-844-871-2355	Email phpproviders@healthsmart.com	Mon.-Fri. 8:00 am – 5:00 pm
NY Relay	7-1-1 1-800-662-1220 for out-of-state		24/7, 365 days per year
Pharmacy Services (MedImpact)	1-888-648-6759 (Pharmacy) 1-888-648-6759 (Participant Services)		24/7, 365 days per year
Member Relations & Advocacy	1-855-747-5483 TTY 711	Email: MemberFeedback@phpcares.org	24/7, 365 days per year
Transportation (Modivcare)	1-855-369-3721		Reservations Mon.-Fri. 8:00 a.m. – 5:00 p.m.
Vision Services (NVA)	1-877-865-7925		24/7, 365 days per year
Dental Services 2016 – 2021 (BeneCare)	1-800-903-3335		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)
Dental Services Dates of Service 2022 (DentaQuest)	Member Services: 833-493-0576 Provider Services: 888-308-2508	nyproviderengagement@dentaquest.com	Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)

Name of Department or Organization	Phone Number	Email Address and /or Fax Number	Hours of Operation
Audiology/ Hearing Services	Call Participant Services at 1-855-747-5483		Mon.-Fri. 8:00 a.m. – 8:00 p.m. (after hours voicemail)
Medicare	1-800- MEDICARE or 1-800-633-4227 TTY: 1-877-486- 2048	www.medicare.gov	24/7, 365 days per year
NY Health Insurance Information, Counseling, and Assistance Program (HIICAP)	1-800-701-0501	www.aging.ny.gov	
NY Quality Improvement Organization (Livanta)	1-866-815-5440 TTY: 1-866-868-2289	1-844-420-6671 (main fax) 1-855-236-2423 (appeals) www.livanta.com	Mon.-Fri. 8:30 am – 4:30 pm
Social Security	1-800-772-1213	www.ssa.gov	Mon.-Fri. 7:00 am – 7:00 pm

To Report a Complaint

Organization Name	Phone Number	Email Address and/or Fax Number	Hours of Operation
<p><u>Adult Care and Assisted Living Complaints</u></p> <p>http://www.health.state.ny.us/facilities/assisted_living/</p> <p>Mail Complaints to:</p> <p>NYS Department of Health Division of Long-Term Care Bureau of Certification & Finance 875 Central Avenue Albany, NY 12206</p>	1-866-893-6772		<p>Mon.-Fri.</p> <p>8:30 am - 4:30pm (after hours voicemail)</p>
<p><u>Complaints About Home Care Agencies</u></p> <p>The New York State Department of Health, Division of Home and Community-Based Care</p> <p>https://profiles.health.ny.gov/home_care/pages/complaints</p> <p>Mail Complaints to:</p> <p>Division of Home & Community-Based Services 875 Central Avenue Albany, NY 12206</p>	1-800-628-5972	1-518-408-5309	<p>Mon.-Fri.</p> <p>10:00 a.m. –4:00 p.m.</p>
<p><u>Managed Care Complaints</u></p> <p>managedcarecomplaint@health.state.ny.us</p> <p>Mail Complaints to:</p> <p>NYS Department of Health Bureau of Managed Care Certification and Surveillance Complaint Unit Room 2019 Corning Tower ESP Albany, NY 12237</p>	1-800-206-8125		

Organization Name	Phone Number	Email Address and/or Fax Number	Hours of Operation
<u>Nursing Home Complaints</u> The New York State Department of Health, Division of Residential Services (DRS) http://www.health.state.ny.us/facilities/nursing/complaints.html Mail Complaint Forms to: NYSDOH DRS/SNHCP Mailstop: CA/LTC Empire State Plaza Albany, NY 12237	1-888-201-4563	1-518-408-1157	24/7, 365 days per year
Office of the Medicaid Inspector General Fraud Hotline	1-877-873-7283		24/7, 365 days per year
NYS Office of Advocate for Persons with Disabilities http://cqc.ny.gov/	1-800-624-4143		Online 24/7
NYS FIDA Program Ombudsman (Independent Consumer Advocacy Network)	1-844-614-8800		

Important Addresses

PHP Main Office	Partners Health Plan 2500 Halsey Street Bronx, NY 10461
Provider Correspondence	Partners Health Plan P.O. Box 16309 Lubbock, TX 79490
Provider Claims Disputes	Partners Health Plan Attn: Provider Relations Manager P.O. Box 16309 Lubbock, TX 79490
PHP Claims Submission and Resubmission (including paper claims)	Partners Health Plan Claims Department P.O. Box 16309 Lubbock, TX 79490
Provider Correspondence/Claim appeals	Partners Health Plan P.O. Box 16309 Lubbock, TX 79490
Provider Grievances	Partners Health Plan P.O. Box 16309 Lubbock, TX 79490

SECTION 2: PHP'S MODEL OF CARE FOR ADULTS WITH IDD

The individuals that Partners Health Plan (PHP) serves are markedly different from the elderly and physically disabled populations typically enrolled in fully integrated plans for the dually eligible, and their care and services must reflect these differences. The most significant contrast is that intellectual and other developmental disabilities (IDD) are life-long, and as our participants grow older, they require differing levels of support based not only on their assessed needs and abilities, but also on the strengths and abilities of their caregivers and extended circles of support. Parents and other family members often remain close and most have very definitive ideas about their loved ones' care and treatment. Consent for treatment is complex, based on the abilities of the person, his or her legal status, and the level of family involvement. Adding a further layer of complexity, the individual may not be able to communicate wishes or even pain or discomfort, thus requiring ongoing monitoring by a person who knows the individual well.

Finally, as their parents age and are no longer able to provide support, other services must be added such as respite, enhanced day services, and, ultimately, residential placement.

To meet this challenge, PHP must not only manage and coordinate the participant's health-related care and services, but habilitation and care and service plan (i.e., "Life Plan") supports as well, and all of these services and supports must be integrated. Our goal is to provide a seamless array of services and supports that keeps each of our participants as healthy, happy, and independent as possible while simultaneously assisting them in pursuing their "valued outcomes" and dreams.

Care Management Teams

Upon initial enrollment in PHP, each participant is assigned a two-person care management team that includes a QIDP Care Manager (note: QIDP is an acronym for "Qualified Intellectual and Developmental Disabilities Professional"),⁴ and a clinically licensed professional (e.g., RN, social worker, or psychologist), who serves as the Clinical Team Leader. The care management team is in turn responsible for assembling the participant's Interdisciplinary Team (IDT) based upon the needs and personal preferences identified during the initial assessment process. A participant's IDT will be comprised of professionals with the necessary experience and qualifications to have an impact on the health, personal desires, and well-being of the participant, depending on his or her medical history, assessed needs, and personal preferences.

Please see below for a more detailed description of the IDT's role and responsibilities.

A participant's individual characteristics and living environment will also help to determine the intensity of care management and IDT involvement he or she receives. Intellectual and other developmental disabilities are life-long, and all of our participants require permanent care and services tailored to their

cognitive and functional abilities, behavioral challenges, medical conditions, and ability to communicate.

This approach is different from the Primary Care Provider (PCP) gatekeeper model. Our care management teams and IDTs are responsible for identifying participant needs in collaboration with their treating providers and circles of support and assisting our participants in accessing needed supports and services in a timely manner. This includes making appointments; arranging transportation; accompanying participants to the appointment, if needed (e.g., participant's caregiver is not available); and documenting the results of all provider encounters in PHP's electronic care management application.

Moreover, since most of our participants attend day habilitation or are involved in supported employment programs most weekdays and are transported to and from their daytime activities in IDD Agency-operated vehicles (and a large percentage of them reside in Agency-operated residences) they have significant "eyes on" supervision from trained personnel who are sensitive to their needs and understand their capabilities, normal behavior patterns, and personal desires. If Agency staff should identify any changes in a participant's behavior or health condition, they are trained to document the issue and immediately report it to the participant's care management team for follow-up.

Our care management teams thus represent the key element in our model of service delivery for three reasons: 1) they have direct access to the participant and his or her family and caregivers and are the most familiar with the participant's needs, abilities, preferences, and goals; 2) they provide the interface/connection between the participant, his or her medical and long-term services and supports providers, and community-based habilitation programs; and 3) as the participant's advocate, they assure that authorized services meet availability, accessibility, and quality standards.

Under our person-centered model, care management teams have five primary roles:

- Overseeing the often-confusing array of services necessary to help the participant navigate the complex medical and long-term care system and to efficiently make the services and supports the participant needs available with the required frequency
- Empowering participants by directly involving the participant and his or her circle of support in the assessment and care planning process
- Breaking down barriers to care through participant advocacy within the plan, the provider network, and other related entities and systems
- Coordinating and making appropriate referrals for covered, clinically necessary medical, behavioral, dental, and long-term care services and supports (this includes facilitating appointments and transportation)
- Crisis management to address events or issues that may cause the participant to lose independence and/or move to a more restrictive residential placement

SECTION 3: PARTICIPANT RIGHTS AND RESPONSIBILITIES

Participant Rights

PHP's participants are guaranteed the right:

- To receive medically necessary items and services as needed to meet the participant's needs, in a manner that is sensitive to the participant's language and culture, and that is provided in an appropriate care setting, including the home and community
- To receive timely access to care and services
- To request and receive written and oral information about PHP, its network providers, its benefits and services, and the participant's rights and responsibilities in a manner that the participant and/or the participant's representative understands
- To receive materials and/or assistance in a foreign language and in alternative formats, if necessary
- To be provided qualified interpreters, free of charge, if a participant and/or a participant's representative needs interpreters during appointments with providers and when talking to PHP
- To be treated with consideration, respect, and full recognition of his or her dignity, privacy, and individuality
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Not to be neglected, intimidated, physically or verbally abused, mistreated, or exploited
- Not to be discriminated against on the basis of and to receive care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, marital status, or religion
- To be told where, when, and how to get the services the participant needs, including how to get covered benefits from out-of-network providers if they are not available in PHP's network
- To complain to NYSDOH or the Local Department of Social Services, and to use the New York State Fair Hearing System and/or a New York State External Appeal, if appropriate
- To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies
- To appoint someone to speak on the participant's behalf about the care he or she needs
- To be informed of all rights, and the right to exercise such rights, in writing prior to the new participant's Effective Date of Enrollment
- To participate in his or her Life Planning and participate in any discussions regarding changes to the Life Plan, if or when they are warranted

- To recommend changes in policies and services to agency personnel, NYSDOH, or any outside representative of the participant's choice
- To have telephone access to a nursing hotline and on-call network providers 24/7 in order to obtain any needed emergency or urgent care or assistance
- To access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access for participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act
- To receive reasonable accommodations in accessing care, in interacting with PHP and its providers, and in receiving information about one's care and coverage
- To see a specialist and request to have a specialist serve as Primary Care Provider
- To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the participant or his or her representative understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment
- To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication
- To receive a written explanation if covered items or services were denied, without having to request a written explanation
- To have privacy in care, conversations with providers, and medical records such that:
 - Medical and other records and discussions with providers will be kept private and confidential
 - Participant or his or her representative gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law
 - Participant may request that any communication that contains Protected Health Information from PHP be sent by alternative means or to an alternative address
 - Participant is provided a copy of PHP's Privacy Practices, without having to request the same
 - Participant may request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, if the privacy rule, as set forth in 45 CFR 160 and 164, A and E, applies
 - Participant may request information on how his or her health and other personal information has been released by PHP
- To seek and receive information and assistance from the independent, conflict free Participant Ombudsman
- To make decisions about providers and coverage, which includes the right to choose and change providers within PHP's network and to choose and change coverage (including how one receives his or her Medicare and/or Medicaid coverage – whether by changing to another type of managed care plan,

returning to Original Medicare, or making other changes in coverage)

- To be informed at the time of enrollment and during Life Plan updates or revision meetings of what an Advance Directive is and the right to make an Advance Directive – giving instructions about what is to be done if the participant is not able to make his or her own medical decisions, and to have PHP and its network providers honor it
- To access information about PHP, its provider network, and covered items and services including:
 - Information about PHP’s financial condition, its performance rating, how it compares to other plans, and the number of appeals made by participants
 - Information about the qualifications of network providers and how they are paid
 - Information about the rules and restrictions on covered items and services
- The right to have all plan options, rules, and benefits fully explained, including through the use of a qualified interpreter if needed
- The right to have access to an adequate network of primary and specialty providers who are capable of meeting the participant’s needs with respect to physical access, and communication and scheduling needs
- The right to have a voice in the governance and operation of PHP’s system, provider, or health plan, as detailed in this Contract
- The right to participate in all aspects of care and to exercise all rights of appeal. Participants have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, participants must:
 - Receive an in-person Comprehensive Assessment upon enrollment in PHP and participate in the development and implementation of a Life Plan. Participants, or their designated representative, also have the right to request a Comprehensive Reassessment by PHP, and to be fully involved in any such Comprehensive Reassessment
 - Receive complete and accurate information on his or her health and functional status by the Interdisciplinary Team (IDT)
 - Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration the participant’s condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
 - ◇ Before enrollment
 - ◇ At enrollment
 - ◇ At the time an eligible individual’s or participant’s needs necessitate the disclosure and delivery of such information in order to allow the eligible individual or participant and/or his or representative to make an informed choice
 - ◇ Be encouraged to involve caregivers or family members in treatment discussions and decisions

- ◇ Be afforded the opportunity to file an Appeal if items or services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review
- The right to freely exercise his or her rights with the assurance that the exercise of those rights will not adversely affect the way PHP and its providers or the state agency or CMS provide, or arrange for the provision of, supports and services to the participant
- The right to receive timely information about PHP changes. This includes the right to request and obtain the information listed in the Marketing, Outreach, and Participant Communications materials at least once per year, and the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change
- The right to be protected from liability for payment of any fees that are the obligation of PHP, including the right not to be balanced billed by a provider for the cost of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part
- The right not to be charged any cost sharing for Medicare Parts A and B services and/or Medicaid supports and services

In the event PHP is made aware of a participant being denied any of the rights identified above, PHP will initiate an investigation into the matter and report the findings to the Chief Compliance Officer and the Quality Oversight Committee. Any PHP staff member or network provider who violates this policy will be appropriately disciplined, up to and including termination of employment/contract.

PHP participants and their authorized representatives will not be penalized or suffer any negative consequences for exercising their rights.

Participant/Caregiver Responsibilities

PHP participants and/or their authorized representatives have the responsibility:

- 1) To try to understand Covered Items and Services and the rules around getting Covered Items and Services
- 2) To tell providers that they are enrolled in PHP and show their PHP ID card
- 3) To treat providers and PHP staff with respect
- 4) To communicate problems immediately to PHP
- 5) To keep appointments or notify the participant's care management team/IDT if an appointment cannot be kept
- 6) To supply accurate and complete information to PHP's staff
- 7) To actively participate in Life Plan development and implementation

- 8) To notify the state and the FIDA-IDD Plan of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets
- 9) To ask questions and request further information regarding anything not understood
- 10) To use PHP's network providers for services included in PHP's benefit package
- 11) To notify PHP of any change in address or lengthy absence from the area
- 12) To comply with all PHP policies as noted in the Participant Handbook
- 13) If sick or injured, to call their doctors or care coordinators for direction right away
- 14) In case of emergency, to call 911
- 15) If emergency services are required out of the service area, to notify PHP as soon as possible

In the event PHP is made aware of a participant not complying with the responsibilities outlined above, PHP will make a good faith effort to address the issue with the participant and his or her authorized representative, educate the participant and his or her authorized representative about their responsibilities, and document the interaction in PHP's MediSked care management system.

Interdisciplinary Teams (IDTs)

Definition

An IDT represents a group of health care professionals and other individuals from diverse fields appropriate to meeting the participant's needs and preferences (e.g., treating providers, personal/home care support staff, designated individuals in the participant's circle of support, etc.) who work in a coordinated fashion toward a common goal for the participant. Each IDT member will be appropriately licensed/certified/credentialed in his or her area of practice, experienced in working with persons with IDD, and qualified to meet the participant's needs and preferences.

IDT Composition Tailored to Participant Needs

PHP's Interdisciplinary Teams (IDT) are comprised of professionals with the necessary experience and qualifications to have an impact on the health, personal choices, and well-being of PHP participants based on their medical history, assessed needs, and individual preferences. As applicable, PHP's provider credentialing or HR staff will appropriately review each IDT member's licensure and background to ensure they are operating within their professional scope of practice and qualified to meet the participant's needs. The IDT is responsible for providing consultation and clinical expertise in the development and implementation of each participant's Life Plan and carrying out its duties with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.

The composition of the IDT will vary depending on the specific needs and preferences of each participant. Each participant's care manager will serve as the leader of the IDT, and will ensure that the composition of the IDT includes, at minimum:

- The participant and/or his or her caregiver/guardian or designee
- Primary providers of OPWDD services, who have knowledge of the participant's desired outcomes and service needs. PHP will additionally ensure that the composition of the team may include the following participants, as appropriate and preferred by the participant and /or his or her representative:
- The participant's Primary Care Provider or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the participant
- Psychologist/behavioral health specialists, if needed, or a designee with clinical experience from the BH professional's practice who has knowledge of the needs of the participant
- Participant's home care aide(s) or a designee with clinical experience from the home care agency who has knowledge of the needs of the participant, if the participant is receiving home care and the participant and/or the participant's authorized representative approves the home care aide/designee's involvement with the IDT
- Participant's nursing facility or ICF representative who is a clinical professional, if receiving nursing facility or ICF care
- Registered nurse (note: this may be the same RN who completed the participant's assessment, if approved by the participant and/or his or her authorized representative)
- Other providers either as requested by the participant or his or her authorized representative or as recommended by the IDT members as needed for adequate care planning and approved by the participant and/or his or her designee. These may include, but are not limited to, the following:
 - Treating specialty physicians (e.g., neurologist, cardiologist, endocrinologist)
 - Dentist
 - Speech pathologist
 - Physical and occupational therapists
 - Social worker
 - Pharmacist
 - Habilitation specialists
 - Nutritionist

Again, participants and/or their authorized representatives may request the inclusion or exclusion of any specific clinician or other member of the IDT. Once added, any member of the IDT may be excused from further involvement by the care management team, unless objected to by the participant. IDT members may also be added or dropped based on the participant's needs.

IDT Role and Responsibilities

PHP has designed the IDT process to be participant-centered and to ensure the delivery of needed services to each participant with transparency, individualization, accessibility, linguistic and cultural competence, and dignity. In addition to assessment and Life Planning activities, the ongoing care management functions of the IDT include:

- Assisting with the development and implementation of the participant's individualized, person-centered Life Plan, which also serves as the authorization vehicle for the participant's covered services and supports
- Ensuring that participants and/or their families/caregivers are able to provide input in the development of the Life Plan and any subsequent modifications or updates
- Convening on a routine basis (i.e., at least every six months) at which time the IDT may make coverage determinations and authorize and/or modify the participant's Life Plan services
- Convening unscheduled meetings of the IDT or a sub-group of IDT participants when needed (e.g., as a result of a triggering event such as an ER visit or inpatient admission or as requested by the participant and/or his or her family/caregiver)
- Facilitating and/or delivering timely access to appropriate services included in the participant's Life Plan and monitoring the participant's health and wellness on an ongoing basis in collaboration with the participant's care management team and circle of support
- Arranging for necessary specialty care, community-based and facility-based LTSS, and behavioral health services
- Assisting participants in accessing authorized Life Plan and other needed services
- Utilizing PHP's MediSked automated care planning and tracking system to manage communications and information flow regarding referrals, transitions, and services provided across the continuum of medical, behavioral, dental, and LTSS in conjunction with the participant and his or her authorized representative, the participant's care management team, and providers.
- Documenting changes in a participant's condition in the IDT member's own medical record, consistent with PHP's policies and procedures

IDT Meeting Protocols

All current IDT members must play an active role in the Life Planning and care management processes. In particular, when meeting for the purpose of developing or revising a participant's Life Plan, care managers are responsible for scheduling the IDT meeting at a time convenient to all members with current goals and objectives relating to the participant along with any proposed changes to the Life Plan. IDT members must attend the meeting in person, or via means of real-time, two-way communication (e.g., telephone or videoconference).

The frequency of IDT meetings will be based on the individual needs of each participant, but no less often than every 180 days; more frequent meetings will take place for participants with more complex physical

and behavioral health needs, especially if the participant also lives in a private residence. The participant's care management team will notify IDT members of team meetings via telephone or secure email.

Care and Service Planning (Life Planning)

PHP's approach to care management and coordination reflects our commitment to treating participants respectfully and to placing an individual participant's needs and preferences at the center of the care and service planning process, which culminates in the development of the individual's "Life Plan." The initial assessment process enables the participant's care management team and IDT to integrate relevant information and develop a mutually agreed upon plan of care and service with the participant, his or her circle of support, and other stakeholders involved in the participant's care. As needed, the care management team and IDT may also consult with the Medical Director, the Chief of Care Coordination, as well as with the participant's PCP, specialist providers, and other relevant professionals.

Under this fully integrated model of care, participant Life Plans will include all services necessary to support participants' valued outcomes and health and safety needs. These may include long-term services and supports (LTSS), as well as medical, dental, and behavioral health services, community-based supportive service programs, habilitation and employment programs, transportation assistance, and other services, as needed and appropriate. For services which require authorization, these will be included directly on the participant's Life Plan. The relationship between care management staff, the IDT, and the participant and his or her formal and informal supports is collaborative in nature, and options are presented accordingly.

Person-Centered Planning Process

- The participant and/or the participant's authorized representative leads the person-centered planning process where possible.
- The planning process includes people chosen by the participant.
- The process includes necessary information and support, including scheduling at times and locations convenient to the participant, to ensure that the participant directs the process to the extent possible and can make informed choices and decisions.
- Providers of home- and community-based services (HCBS) for the participant, or those who have an interest in or are employed by a provider of HCBS for the participant, must not provide care management or develop the person-centered service plan.

Life Plan Features

- The plan must reflect the services and supports that are required for the participant to meet needs identified through an assessment of functional need.
- The plan must indicate that the setting in which the participant resides is chosen by the participant and/or his or her authorized representative.

- The plan must reflect the participant's strengths and preferences and include individually identified goals and desired outcomes.
- The plan must:
 - Include services and supports, both paid and unpaid
 - Reflect risk factors and strategies to minimize them
 - Identify the person or entity responsible for monitoring the plan
 - Identify any self-directed services
 - Be distributed to the participant and all others involved in implementing the plan
 - Prevent the provision of unnecessary or inappropriate services and supports
- The plan must have the written informed consent of the participant and/or his or her authorized representative.

Life Plan Monitoring

- The plan must be reviewed and revised, based upon a functional assessment, as follows:
 - At least every 12 months
 - When the participant's needs or circumstances change significantly
 - At the request of the individual or his or her authorized representative

CQL Personal Outcome Measures

The Council on Quality and Leadership (CQL) is an international not-for-profit organization that is dedicated to the definition, measurement, and improvement of the quality of life for people with intellectual and other developmental disabilities that are receiving community-based supports and services. CQL's focus is on identifying and measuring the factors that "really matter" to people so that service providers can develop and provide individually tailored services and supports. Personal Outcomes Measures are embedded within the comprehensive assessment completed for all PHP participants upon initial enrollment and at least annually thereafter. PHP care managers and IDTs use the results of this comprehensive assessment to develop the person-centered Life Plan. PHP expects its LTSS providers to support and encourage participants as they work toward achieving their chosen outcomes.

Principles of the Personal Outcome Measures

- No standard definition of any outcome applies to a group of people.
- It is unlikely that any two people will define an outcome in the same manner.
- People define their own outcomes based on their own experiences.
- Personal outcomes are defined from the person's perspective.

- Personal outcomes reinforce “differentness” and diversity.

CQL’s Personal Outcome Measures (POMS)

POMS are divided into three primary categories, as follows:

- **My Self**
 - People are connected to natural support networks.
 - People have intimate relationships.
 - People are safe.
 - People have the best possible health.
 - People exercise rights.
 - People are treated fairly.
 - People are free from abuse and neglect.
 - People experience continuity and security.
 - People decide when to share personal information.
- **My World**
 - People choose where and with whom they live.
 - People choose where they work.
 - People use their environments.
 - People live in integrated environments.
 - People interact with other members of the community.
 - People perform different social roles.
 - People choose services.
- **My Dreams**
 - People choose personal goals.
 - People realize personal goals.
 - People participate in the life of the community.
 - People have friends.
 - People are respected.

Service Authorization

Once completed, the participant's approved Life Plan will be reviewed with the participant and his or her family/caregiver and copies will be provided to his or her treating providers (including the PCP and any additional specialists or other professionals engaged in the participant's care). Authorized users can also access participant Life Plans through MediSked Connect. The participant’s providers will also be notified about the participant’s authorized services and they will be entered into the claims system to ensure timely payment.

SECTION 4: COVERED SERVICES AND SUPPORTS

Please see the Service Authorization section of this Manual for a detailed description of PHP's prior authorization process and requirements.

Covered services and supports are benefits that Partners Health Plan (PHP) will pay for on behalf of its participants. These services should be provided by a Network Provider. However even if a service or support is not covered, PHP would still like to assist participants in making appointments, arranging transportation, and communicating with their providers about any treatments, services, or medications they may be receiving. Keeping informed about all of our participants' health-related needs helps us to do our job better and to keep our participants as healthy and independent as possible.

The specific supports and service(s) provided to each participant based on their medical condition(s); assessed health, habilitation, and social needs; abilities; and personal preferences and valued outcomes. Participants will continue to receive covered services as long as they are determined necessary to prevent, diagnose, correct, or cure conditions that may cause acute suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity, or threaten some significant handicap.

The Life Plan that participants develop with their care management and Interdisciplinary Teams (see Model of Care Section above) helps PHP to make sure that each participant receives what he or she needs. Also, depending on where a participant lives (for example, an OPWDD-certified residence or ICF), he or she may not be eligible for certain services that are already made available within the residence or facility. Providers should consult with the participant's care management team/IDT if they have questions about service coverage.

The following table lists the categories of covered services we may pay for participants to receive if they are determined to be necessary and appropriate.

Table of Covered Services and Supports

Covered Benefit	Description/Remarks	Benefit Limitations
Abdominal Aortic Aneurysm Screening	Covered only if referred as a result of a “Welcome to Medicare” preventive visit.	A one-time abdominal aortic aneurism ultrasound for someone at risk because he/she has a family history of abdominal aortic aneurysms or he is a man age 65 to 75 and has smoked at least 100 cigarettes in his lifetime.
Adult Day Health Care	Care and services provided in a residential health care facility or approved extension site under the medical direction of a physician.	
AIDS Adult Day Health Care	Targets services to high need individuals with HIV and co-morbidities such as substance abuse and mental illness, and those who may need assistance with managing other chronic condition such as diabetes and hypertension.	
Ambulance Services	See transportation.	
Ambulatory Surgical Centers	Facility services furnished in connection with covered surgical procedures provided in an ambulatory surgical center.	
Article 16 Clinic Services	OPWDD-certified treatment facilities that provide rehabilitation/habilitation services (e.g., physical therapy, occupational therapy, psychology, speech and language pathology, social work); medical/dental services; and health care services (e.g., nursing, dietetics and nutrition, audiology, podiatry).	

Covered Benefit	Description/Remarks	Benefit Limitations
Assertive Community Treatment (ACT)	A mobile, team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management, and support services to individuals in their natural living setting.	For participants in their own home. All ACT referrals are received through the local single point of access process (SPOA).
Assistive Technology – Adaptive Devices	Aids, controls, appliances, or supplies which are necessary to enable a person with IDD to increase or maintain his or her ability to live at home and in the community with independence and safety. Assistive Technology includes, but is not limited to: augmentative communication aids and devices, adaptive aids and devices, and vehicle modifications.	Not to exceed \$35,000 per participant in any consecutive two-year period.
Bone Mass Measurement	Procedures to identify bone mass, detect bone loss, or determine bone quality in persons determined to be at risk of losing bone mass, including a physician's interpretation of the results.	Covered every 24 months or more frequently, if medically necessary; for these services.
Breast Cancer Screening (Mammograms)	Baseline mammograms, screenings and clinical breast exam as appropriate.	One baseline mammogram between the ages of 35 and 39; one screening mammogram every 12 months for women age 40 and older; and clinical breast exams once every 24 months.
Cardiac Rehabilitation Services	Comprehensive programs that include exercise, education, and counseling for participants who meet certain conditions with a doctor's order.	36 visits per year, (2-3 per week) over 12-18 weeks but can be renewed.

Covered Benefit	Description/Remarks	Benefit Limitations
Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)	Visit to help lower the participant's risk for cardiovascular disease.	One PCP visit per year
Cardiovascular Disease Screening and Testing	Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	Covered once every five years.
Care Management	A key element in the Interdisciplinary Team approach to assessment, care planning, and care coordination. Provides primary assistance to the participant in gaining access to needed services.	
Cervical and Vaginal Cancer Screening	Screening tests as indicated.	<p>As part of the exam, Part B also covers a clinical breast exam to check for breast cancer.</p> <p>Once every 24 months for all women, once every 12 months if the participant is at high risk for cervical or vaginal cancer, or if the participant is of childbearing age and has had an abnormal Pap test in the past 36 months.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
Chemotherapy	For cancer patients who are hospital inpatients or outpatients as well as patients in a doctor's office or freestanding clinic.	
Chiropractic	Manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers.	
Colorectal Screening	Testing frequency varies depending on the participant's level of risk and may include barium enema, flexible sigmoidoscopy or colonoscopy, and fecal occult blood tests.	<p>For people age 50 and older to help find precancerous growths or find cancer early, when treatment is most effective.</p> <p>Other screenings may include: Barium enema – once every 48 months for 50 or over and, once every 24 months for high-risk patients, when this test is used instead of a flexible sigmoidoscopy or colonoscopy.</p> <p>Colonoscopy – every 24 months for high-risk participants. If low risk, then once every 120 months (but not within 4 years of a flexible sigmoidoscopy). Cologuard/at-home multi-target stool DNA lab test - once every 3 years if low risk and over 50 years old. Fecal occult blood tests once every 12 months for 50 years or older.</p> <p>Flexible sigmoidoscopies once every 48 months for most people 50 or older or once every 120 months (10years) after a colonoscopy if low risk and 50 and older.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
Community Habilitation	Community Habilitation services for persons with IDD can be delivered at any non- certified location, including the individual's home. Supports include adaptive skill development, assistance with activities of daily living (hands-on), community inclusion and relationship building, training, and support for independence in travel, transportation, adult educational supports, development of social skills, leisure skills, self-advocacy and informed choice skills, and appropriate behavior development to help the individual access the community.	
Community Habilitation for people who live in a certified setting		Only reimbursed if delivered on weekdays with a start time prior to 3 PM.
Community Transitional Services	Individually designed services intended to assist a participant to transition from living in a nursing home or ICF to living in the community. The services may include the cost of moving furniture and other belongings; the purchase of certain essential items such as linen and dishes; security deposits (including broker's fees); purchasing essential furnishings; set-up fees or deposits for utility or service access; and health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy.	Once in a lifetime with \$3000 limit. Cannot be used for monthly rental or mortgage expenses, food, regular utility charges, cable/internet access charges, diversional or recreational items.

Covered Benefit	Description/Remarks	Benefit Limitations
Consumer Directed Personal Assistance Services	Services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Included are, services by personal care aide (home attendant), home health aide, or nurse. Recipients have flexibility and freedom in choosing their caregivers and assume full responsibility of hiring, training, supervising, and terminating employed staff.	
Continuing Day Treatment	Services designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management.	
Day Habilitation- Group	Habilitation services provided within a group setting.	
Day Treatment	A combination of OPWDD-certified diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of a clinic treatment program as well as social training, task and skill training, and socialization activities. Services are expected to be of six (6) months duration.	Limit 6 months of treatment.

Covered Benefit	Description/Remarks	Benefit Limitations
Defibrillator (implantable automatic)	Defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.	
Dental (preventive and comprehensive)	<p>Dental services include necessary preventive, prophylactic, and other dental care, services, supplies, routine exams, prophylaxis, oral surgery, and dental prosthetics and orthotic appliances required to alleviate a serious health condition including one which affects employability.</p> <p>Certain ambulatory dental services are subject to prior authorization.</p>	<p>Oral exams, cleanings and x-rays are once every six months.</p> <p>No authorization required for Dental Services provided through Article 28 Clinics Operated by Academic Dental Centers.</p>
Depression Screening	Screening conducted in a primary care setting (like a doctor's office) that can provide follow-up treatment and/or referrals.	One screening per year.
Diabetes Monitoring (Self- Management Training)	<p>Diabetes self-monitoring, management training and supplies, including coverage for glucose monitors, test strips, and lancets.</p> <p>OTC diabetic supplies such as 2x2 gauze pads, alcohol swabs/pads, insulin syringes and needles are covered by Part D.</p>	
Diabetes Screening	Tests to check for diabetes (including fasting glucose tests) if any of the following risk factors are present: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose).	Two screenings every 12 months based on these test results if 2 or more apply: age 65 or older, overweight, family history of diabetes or a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds.

Covered Benefit	Description/Remarks	Benefit Limitations
Diabetes Services and Supplies	<p>Supplies include blood sugar (glucose) test strips, blood sugar testing monitors, lancet devices and lancets, glucose control solutions, and therapeutic shoes or inserts.</p> <p>Services include diabetes self-management training, yearly eye exam, foot exam, glaucoma tests, and nutrition therapy services (medical).</p>	
Diabetic Therapeutic Shoes or Inserts	<p>Inserts are for participants with severe diabetic foot disease.</p>	<p>One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year; or one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes). It also includes fitting the therapeutic custom-molded shoes or depth shoes and training to help participants manage their diabetes.</p>
Diagnostic Testing (laboratory and radiology)	<p>Includes medically necessary clinical diagnostic laboratory services and radiology services to help a doctor diagnose or rule out a suspected illness or condition.</p>	<p>Cancer screenings do not require prior authorization however other services must be authorized in accordance with the IDT Policy.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
Durable Medical Equipment (DME)	All Medicaid-covered and Medicare-covered DME.	
Emergency Care	Covered inpatient and outpatient services that are needed to evaluate or stabilize an Emergency Medical Condition.	
Environmental Modifications	<p>Internal and external physical adaptations to the home necessary to assure the health, welfare, and safety of the participant.</p> <p>Includes modifications that address the participant's sensory deficits, such as Braille identification systems, strobe light smoke detectors, and alarm devices as well as modifications that promote a safer environment for individuals with challenging behaviors, including window protection, reinforcement of walls, open-door signal devices, and durable wall finishes.</p>	Not to exceed \$60,000 per participant in any consecutive five-year period.
Family Care Residential Habilitation (includes certified setting)	Services provided to HCBS waiver enrolled as well as non-waiver enrolled participants. Services include - community-based residential housing in certified private homes for individuals with developmental disabilities. By providing the support, guidance and companionship of a family, the Family Care program fosters a caring and stable home environment for children, adolescents, and adults.	

Covered Benefit	Description/Remarks	Benefit Limitations
Family Education and Training	Education and training to participants' families/caregivers to enhance their knowledge, skills, and decision-making capacity.	
Family Planning Services	Includes all types of contraception, emergency contraception, pregnancy tests, sterilization procedures, STD testing, HIV testing, and related diagnostic procedures.	
Freestanding Birth Center Services	These services are now covered by Medicare OR Medicaid fee-for-service. PHP and IDT will be responsible for coordinating, arranging, and ensuring receipt of these services by the Participant from the Medicare and Medicaid FFS programs when called for in a Participant's Life Plan.	EXCLUDED from PHP's covered benefits.
Health/Wellness Education	Includes the provision of, 1) classes, support groups, and workshops, 2) educational materials and resources, and 3) website, email, or mobile application communications, at no cost to the participant. This benefit also includes annual preventive care reminders and caregiver resources.	
Hearing Services (Hearing Exams and Hearing Aids)	Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing.	Three replacement hearing aids (due to damage or loss) allowed over 24-month period. Hearing Aids require prior authorization by an audiologist. Required from prescriber (<i>Medicaid guidelines</i>) - If hearing aid is over 5 years old, indicate why the request is for repair rather than replacement - If hearing aid is less than 5 years old, indicate why the request is for replacement rather than repair.

Covered Benefit	Description/Remarks	Benefit Limitations
HIV Screening	For people who ask for an HIV screening test, who are pregnant, or who are at increased risk for HIV infection.	One screening exam every 12 months or up to three screening exams during a pregnancy.
Home Health Services	Medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services.	
Home Infusion Bundled Services	The Part D covered infusion drug should be billed to Part D for payment and the cost of the administration of the drug and the cost of the supplies needed to administer the drug should be covered by the FIDA-IDD Plan as a medical benefit.	
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs	Home infusion involves the intravenous administration of drugs to a participant at home. The components needed to perform a home infusion include the drug (e.g., antibiotics, immune globulin), equipment (e.g., a pump or a pole), and supplies (e.g., tubing and catheters). Visiting nurses may play a role in home infusion. For antibiotics, nurses typically train the patient or caregiver to administer the drug independently and visit periodically to provide catheter care. Some drugs require more nursing time.	
Home Visits by Medical Personnel	Individually designed services to provide diagnosis, treatment, and wellness monitoring in order to preserve the participant's functional capacity to remain in the community. Services are expected to decrease the likelihood of exacerbation of chronic medical conditions and unnecessary and costly emergency room visits, hospitalizations, and nursing facility placement.	

Covered Benefit	Description/Remarks	Benefit Limitations
Immunizations	Flu, hepatitis B vaccine for people who are at risk, and pneumonia vaccine.	One flu shot per flu season in the fall or winter
Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	All medically necessary inpatient hospital acute care services, including substance abuse and rehabilitation services.	Up to 365 days per year (366 days for leap year).
Inpatient Mental Health Care	All medically necessary inpatient mental health services, including voluntary or involuntary admissions for mental health services and including days in excess of the Medicare 190-day lifetime maximum.	
Inpatient Services during a Non-covered Inpatient Stay	If a participant has exhausted his or her inpatient benefits or if the inpatient stay is not Medically Necessary such that the FIDA-IDD Plan will not cover the inpatient stay, in some cases a FIDA-IDD Plan will cover certain services received while in the hospital or the skilled nursing facility (SNF) stay (e.g., physician services, diagnostic tests, prosthetics, etc.).	

Covered Benefit	Description/Remarks	Benefit Limitations
Intensive Behavioral Services Hourly	Short-term (6 month) outcome-oriented services that focus on developing effective behavior management strategies for individuals with IDD who have challenging behavioral issues that put the individual at risk of placement in a more restrictive residential setting. While not a crisis intervention program, this program does teach the individual, families, and other caregivers how to respond to and deal with those challenging behaviors that might otherwise result in admission to a hospital or psychiatric center.	Limit: 25 hours in a 6-month period for individuals in uncertified settings, their own home, or in certified family care homes.
Intensive Behavioral Services Plan Development	Covers the functional behavioral assessment and the development of the participant's behavioral management plan.	One Plan per Participant every three years
Intensive Psychiatric Rehabilitation Treatment Programs	A time limited active psychiatric rehabilitation program designed to assist a participant in forming and achieving mutually agreed upon goals in living, learning, working, and social interactions to intervene with psychiatric rehabilitative technologies to overcome functional disabilities	
Intermediate Care Facility for Individuals with Intellectual and Other Developmental Disabilities (ICF/IID)	ICF/IIDs provide "intermediate developmental disability care," defined as "the provision of nursing care services, health-related services, and social services for persons with intellectual and other developmental disabilities (IDD). These residential facilities provide room and board, a planned program of care, supervision on a continuous 24 hour-a-day basis, and active treatment for residents of the facility.	
Kidney Disease and Conditions (ESRD)	Covered services include disease-related education, outpatient and inpatient dialysis, treatments, self-dialysis training, home dialysis equipment and supplies, certain home support services, and dialysis medications.	For Participants with stage IV chronic kidney disease when referred by their doctor, - covers up to six sessions of kidney disease education services per lifetime.

Covered Benefit	Description/Remarks	Benefit Limitations
Mammograms	See breast cancer screening.	
Medicaid Pharmacy Benefits as Allowed by State Law	Coverage for certain drugs excluded from the Medicare Part D benefit such as some prescription vitamins and some non-prescription drugs as identified on the State Specific ADD File.	OTC drugs are not covered for residents of OPWDD-supervised residences.
Medical Nutrition Therapy	This benefit is for participants with diabetes, kidney disease (but not on dialysis), or after a transplant when referred or ordered by a doctor. It covers three hours of one-on-one counseling services during the first year that a participant receives medical nutrition therapy services under Medicare and two hours of one-on-one counseling services each year after that, as needed. If condition, treatment, or diagnosis changes, a participant may be able to receive more hours of treatment with a physician's order.	Covered only for individuals diagnosed with diabetes, renal disease, or individuals who have had a kidney transplant within the past three years. Coverage limited to three hours of counseling per year.
Medical Social Services	Includes the assessment of a participant's psychosocial and environmental circumstances relating to an illness. Services are provided and arranged for by the provider and may include services such as: home visits to the individual or family (or both); visit(s) preparatory to the participant's transfer home; individual and family counseling; and consultation regarding the participant's specific social problems.	These services must be provided by a clinical social worker.
Medical/Surgical Supplies	Items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment, or orthopedic footwear which treat a specific medical condition, and which are usually consumable, non-reusable, disposable, for a specific purpose, and generally have no salvageable value. Includes supplies such as enteral/parenteral nutritional formula, incontinence products,	Note: disposable gloves, diapers, and under pads are not covered for residents of ICF/IIDs and OPWDD-supervised residences. Coverage of enteral formula and

	<p>catheters, ostomy, wound dressings, diabetic test strips, glucometers, and hearing aid batteries.</p>	<p>nutritional supplements is subject to regulatory benefit limits.</p> <p>Enteral nutritional therapy is not covered as a convenient food substitute.</p>
<p>Medicare Part B Prescription Drugs</p>	<p>The following drugs are covered under Part B:</p> <ul style="list-style-type: none"> • Drugs injected or infused while getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs taken using DME (such as nebulizers) that were authorized by the plan • Clotting factors given by self-injection for participants with hemophilia • Immunosuppressive drugs, if a participant was enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for participants who are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themselves. • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents • IV immune globulin for the home treatment of primary immune deficiency diseases 	

Covered Benefit	Description/Remarks	Benefit Limitations
Medicare Part D Prescription Drug Benefit as Approved by CMS	Drugs defined in 42 C.F.R. § 423.100. See the Partners Health Plan formulary for a detailed listing of covered medications.	
Medication Therapy Management (MTM)	<p>Medical care provided by pharmacists to optimize drug therapy and improve therapeutic outcomes in accordance with Subpart D of 42 CFR 423. Includes a broad range of professional activities including, but not limited to, performing patient assessment and/or a comprehensive medication review, formulating a medication treatment plan, monitoring the efficacy and safety of medication therapy, enhancing medication adherence through patient empowerment and education, and documenting and</p> <p>communicating MTM services to prescribers in order to maintain comprehensive patient care.</p>	
Mobile Mental Health Treatment	Individual therapy that is provided in the home. This service is available to a participant who has a medical condition or disability that limits his or her ability to come into an office for regular outpatient therapy sessions.	
Non-Emergency Transportation	See Transportation.	Note: This benefit is not covered by the FIDA plan for residents of ICF/IIDs or OPWDD-supervised “Individual Residential Alternatives” (IRAs) or “Community Residences” (CRs) since this service is provided by the ICF or residential provider.

Covered Benefit	Description/Remarks	Benefit Limitations
Nursing Hotline	A toll-free phone service which participants and their families/caregivers can call 24/7 for answers by an RN to general and immediate health-related questions.	
Nutritional Services	Includes the assessment of nutritional needs and food patterns, or dietary planning appropriate for the participant's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.	Nutrition services are covered when prescribed by a physician. These services must be provided by a qualified nutritionist. Includes Nutritional Counseling and Educational Services. Note: this benefit is not covered for residents of ICF/IIDs.
Obesity Screening and intensive behavioral therapy to Keep Weight Down	Intensive counseling to assist with weight loss for a participant with a body mass index of 30 or more.	Counseling covered annually for participants with a BMI of 30 or more.
Opioid Treatment Services – Substance Abuse	Opioid treatment is a medical service designed to manage heroin addiction. Methadone treatment is delivered on an ambulatory basis, with most programs located in either a community or hospital setting. Services include primary medical care, counseling, and support services.	
Organ Transplants	Refers to the moving of an organ from one body to another or from a donor site to another location on the person's own body, to replace the recipient's damaged or absent organ. Organs that can be transplanted include the heart, kidneys, liver, lungs, pancreas, intestine, and thymus. Tissues include bones, tendons (both referred to as musculoskeletal grafts), cornea, skin, heart valves, nerves and veins. Depending on local	

	<p>circumstances, PHP can elect to have the procedure performed at a distant, out-of-network location. If PHP elects this option, PHP will also provide reasonable transportation and living accommodations for the participant and a companion.</p>	
<p>Other Supportive Services the IDT Determines Necessary</p>	<p>This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but are necessary and appropriate for the participant. One example would be purchasing a blender to puree foods for a participant who has difficulty chewing and swallowing solid food.</p>	
<p>Outpatient Blood Services</p>	<p>Storing and administering blood that a participant needs.</p>	
<p>Outpatient Hospital Services</p>	<p>Medically necessary services that a participant receives in the outpatient department of a hospital for the diagnosis or treatment of an illness or injury. Covered services include:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that the participant cannot self-administer 	

Covered Benefit	Description/Remarks	Benefit Limitations
Outpatient- Medically Supervised Withdrawal – Substance Abuse	Medical supervision of persons undergoing mild to moderate withdrawal or who are at risk of mild to moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence. Services must be provided under the supervision and direction of a licensed physician.	Following services must be provided: medical supervision of intoxication and withdrawal conditions; evaluation; discharge and recovery care plan; pharmacological services shall be provided as a means of reasonably controlling, or preventing, active withdrawal symptoms and/or averting a life-threatening medical crisis or major suffering and/or disability; family educational services must be provided based upon the identified needs of the Participant/family. The service Provider must provide or make available a twenty-four (24) hour telephone crisis line to help facilitate the provision of this information; and referral and linkages to other appropriate and necessary services as required by the Participant in support of recovery.
Outpatient Mental Health	Individual and group therapy visits.	Participants must be able to directly access one assessment from a network provider in a twelve (12) month period without requiring prior authorization.

Covered Benefit	Description/Remarks	Benefit Limitations
Outpatient Rehabilitation	Medicaid OT, PT, and ST	Note: This benefit is not covered for residents of ICF/IIDs. Limited to twenty (20) visits per therapy per calendar year except for persons with IDD, traumatic brain injury, and individuals under age 21.
Outpatient Substance Abuse	Includes both individual and group visits.	Participants must be able to directly access one assessment from a network provider in a twelve (12) month period without requiring prior authorization.
Outpatient Surgery	Medically necessary visits to an ambulatory surgery center or outpatient hospital facility.	
Palliative Care	Health care treatment, including interdisciplinary end-of-life care, and consultation with Participant and family members, to prevent or relieve pain and suffering and to enhance the Participant's quality of life.	Coverage includes: Family Palliative Care Education, Pain and Symptom Management, Bereavement Services, Massage Therapy, and Expressive Therapies.
Pap Smear and Pelvic Exams	See cervical and vaginal cancer screening.	

Covered Benefit	Description/Remarks	Benefit Limitations
Partial Hospitalization (Medicaid)	A structured program of outpatient psychiatric services provided as an alternative to inpatient psychiatric care. This treatment is provided during the day and does not require an overnight stay. Services include assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention.	
Partial Hospitalization (Medicare)	A structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in Participant's doctor's or therapist's office and, is an alternative to inpatient hospitalization.	
Pathway to Employment	A person-centered, comprehensive employment planning and support service that engages individuals with IDD in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above the minimum wage.	Limit: 12 months or 278 hours; lifetime limit 556 hours
PCP Office Visits	Includes all regularly scheduled and "as needed" visits to the participant's assigned Primary Care Provider (PCP).	

Covered Benefit	Description/Remarks	Benefit Limitations
Personal Care Services	Includes limited or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (e.g., meal preparation and housekeeping). Personal care must be medically necessary, ordered by the participant's physician and provided by a qualified person in accordance with a Life Plan (Plan of Care).	Note: This benefit is not covered for residents of ICF/IIDs and OPWDD-Supervised IRAs/CRs. Participants receiving Day Habilitation or Day Treatment services may not concurrently receive personal care services during the hours when they are receiving these services.
Personal Emergency Response Services (PERS)	PERS is an electronic device which enables certain high-risk participants to secure help in the event of a physical, emotional, or environmental emergency.	
Personalized Recovery- Oriented Services (PROS)	Designed to assist participants in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. Specific components of PROS include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation, and Support and Clinical Treatment.	
Plan of Care (Life Plan)	The Plan of Care (also known as the Life Plan) is an individualized person-centered care and service plan that is collaboratively developed with the Participant, his or her family/Representative and/or Designee, and other IDT members to address the full continuum of covered and non-covered physical, behavioral, and Long-Term Service and Supports (LTSS).	The FIDA-IDD Plan shall develop and implement a LP in accordance with the timelines and requirements outlined in the IDT Policy.

Covered Benefit	Description/Remarks	Benefit Limitations
Podiatry	Medically necessary foot care, including diagnosis and medical or surgical treatment of injuries and diseases of the lower limbs and/or feet (such as hammer toe or heel spurs) and routine foot care for participants with conditions affecting the legs, such as diabetes.	
Positive Behavioral Interventions and Support	Individually designed and provided to participants who have significant behavioral difficulties that jeopardize their ability to remain in their community of choice due to inappropriate responses to events in their environment.	
Preventive Services	Medicare and Medicaid preventive services including those specified in this Table and any others that Medicare and Medicaid cover or may begin to cover during the FIDA-IDD Demonstration.	
Prevocational Services	Prevocational services address the individual's vocational interests. They assist individuals who are interested in joining "the world of work" but whose skills are such that they may not expect to obtain competitive employment within the next year. The individual may or may not perform work for which he or she is paid while receiving prevocational services. Prevocational services include support and training related to the ability to obtain and retain employment, excluding training on job tasks	Limit on a given weekday: one unit of site-based prevoc or a combination of one-half unit of group day hab, or 4 hours of community prevoc and one-half unit of site-based prevoc. For individuals in IRAs/CR/Family Care Homes: one half unit of group day hab or 4 hours of community hab or community prevoc services or a combination and one-half unit of site-based prevoc services.

Covered Benefit	Description/Remarks	Benefit Limitations
Private Duty Nursing	Private duty nursing services are covered for continuous or intermittent skilled nursing services which are beyond the scope of care available from a certified home health agency and are provided in the participant's home when ordered by the IDT or by a qualified practitioner but approved by the IDT or FIDA Plan and incorporated into the participant's Life Plan.	
Prostate Cancer Screening	Prostate Cancer Screening exams	Once every 12 months for men age 50 and older.
Prosthetics	Prosthetics, including orthotic appliances and orthopedic footwear, must be ordered by a qualified practitioner. The product dispensed must be medically necessary to prevent, diagnose, correct, or cure a condition which causes acute suffering; endangers life; results in illness or infirmity; interferes with the capacity for normal activity; or threatens to cause a significant handicap and is the least costly alternative to meet the medical need.	If a Participant exceeds the limit on an item, prior authorization must be requested with supporting medical documentation.
Pulmonary Rehabilitation Services	Comprehensive programs of pulmonary rehabilitation are covered for participants who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	

Covered Benefit	Description/Remarks	Benefit Limitations
Respiratory Care Services	Includes Respiratory Therapy, which is an individually designed service, specifically provided in the home, intended to provide preventive, maintenance, and rehabilitative airway-related techniques and procedures.	
Respite	<p>An individually designed service intended to provide scheduled, short-term relief to non- paid/informal caregivers. The service may be provided in the participant's home or another appropriate venue in a 24-hour block of time as required.</p> <p>Respite free-standing services are services provided to the participant with IDD in a free-standing facility while receiving support from trained and caring staff. This benefit allows the participant's family/caregiver an opportunity to take a break or address other responsibilities for a few hours or even several days, as needed.</p> <p>Respite – hourly – provides temporary relief to the caregiver that is responsible for the primary care and support of a person with IDD. The service can be provided in or out of the home, during the day, evening, or overnight.</p>	<p>Participants in self-direction can have Family- Reimbursed Respite (FRR) in their budgets paid for with 100 percent State funds capped at \$3,000 annually.</p> <p>Free-standing Respite sites (certified IRAs with temporary use beds) have a limit of no more than 30 consecutive days and no more than 42 days in a calendar year.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
Routine Physical Exam	Routine physical exam is an annual wellness visit to develop or update a personalized prevention plan based on current health and risk factors.	One routine physical per year.
Sexually Transmitted Infections (STI) Screening and Counseling	STI screening tests must be ordered by a primary care doctor or other primary care practitioner. Also covers up to two individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs, which must be provided by a primary care doctor or other primary care practitioner and take place in a primary care doctor's office or primary care clinic.	Once every 12 months or at certain times during pregnancy for persons determined to be at risk.
Skilled Nursing Facility	Medically necessary Medicare and Medicaid care provided in a skilled nursing facility. No prior hospital stay is required.	
Smoking and Tobacco Cessation Counseling	Medicaid coverage of comprehensive counseling and pharmacotherapy for cessation of tobacco use by all Medicaid eligible recipients, including pregnant women.	Maximum of two quit attempts per 12 months; includes a maximum of four face-to-face counseling sessions per quit attempt.
Specialist Office Visit	Visits to a medical specialist. With certain exceptions, visits to participating network specialists do not require prior authorization or a referral.	
Substance Abuse Program	Services provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant which, if not effectively dealt with, will interfere with his or her ability to remain in the community. The program is cost-effective and necessary to avoid institutionalization. Services are provided in an outpatient, congregate setting.	Program differs from State Plan service in that these services will integrate non-residential services with Participant specific interventions in the community to reinforce the training in a real- life situation.

Covered Benefit	Description/Remarks	Benefit Limitations
Supervised IRA Residential Habilitation	Residential Habilitation for people living in a Supervised IRA is designed to address both the residential and day habilitation needs of the person with IDD. It is based primarily at a person's certified residence with some scheduled community activities, i.e., activities that are external to the residence and determined according to the person's needs and personal interests. The benefit is appropriate for people who have valid needs or interests that justify a reduced frequency of community activity during the week. Normally staff is onsite or proximately available when the persons are present.	
Supported Employment (SEMP) - Intensive	Provides the supports individuals with IDD need to obtain and maintain paid competitive jobs in the community. The program typically supports those that require limited job coaching to successfully maintain their employment.	Limit: 365 days from date of employment OR 250 hours whichever comes first
Supported Employment (SEMP) - Extended	Supported Employment Extended must be directed toward obtaining or maintaining competitive employment or self-employment in an integrated setting at or above the minimum wage. Participant must have competitive employment or self-employment as a GOAL in their Life Plan.	Extended - limited to 200 hours of service across 365 days. Can be individual or group (2 to 8 individuals).
Supportive IRA Residential Habilitation	Habilitation services provided to persons with IDD that are residing in a "Supportive Individualized Residential Alternative" that provides practice in independent living under variable amounts of oversight, (e.g., 2 days per week) in accordance with his/her needs for supervision; with staff not typically onsite or proximately available at all times.	

Covered Benefit	Description/Remarks	Benefit Limitations
Supports for Participant Direction: Fiscal Intermediary (FI)	<p>Participants and/or their authorized representatives who choose to exercise budgetary authority over their supports and services are assigned a fiscal intermediary that is responsible for implementing the participant's budget, disbursing funds, withholding taxes, filing reports, and performing general financial oversight over the program. That said, the participant/representative can choose the degree of FI involvement and can elect to purchase "traditional" services directly from provider agencies without FI involvement. Consequently, payments to the FI are no longer based on the participant's total budget amount.</p>	
Supports for Participant Direction: Individual Directed Goods and Services (IDGS)	<p>Allows participants/representatives who choose to self-direct their own budgets to purchase the goods and services they need to achieve their goals. Examples include transportation, small kitchen appliances, laundry services, assistance with chores, massage therapy, gym memberships, recreational activities, and creative arts. Participants must be living in non-certified residences.</p>	<p>Service Eligibility Criteria:</p> <ul style="list-style-type: none"> - Available for individuals who are self-directing services.
Supports for Participant Direction: Live-In Caregiver (LIC)	<p>The LIC is an unrelated care provider. The person must be unrelated to the participant by blood or marriage to any degree that provides supports needed to address the participant's physical, social, or emotional requirements.</p>	<p>LIC resides in the same household as the waiver participant.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
<p>Supports for Participant Direction: Support Brokerage</p>	<p>A 1915(c) HCBS Waiver approved service available for participants who may self-direct some or all of their services.</p> <p>A support broker is selected by participants/caregivers to assist them in self-directing/managing services, such as providing support or training on ongoing self-directed decisions and tasks. Support brokers may be specialists hired on a limited basis to achieve a specific goal or provide ongoing assistance. The extent of help and the hourly rate are determined by the participant/caregiver and specified in a written agreement between the two parties.</p>	<p>(HCBS) Waiver Support Brokerage services are not available to people who reside in the following settings that are non-HCBS</p> <p>Waiver eligible: Intermediate Care Facilities (ICFs), Nursing Homes, Residential Schools, and Developmental Centers. For individuals seeking to transition out of these settings and into self-directed services within the community, Start-Up Brokerage services up to \$2400 can be funded with 100% State funds.</p>
<p>Telehealth, Telemonitoring, and Web-Phone-Based Technology</p>	<p>Coverage of home telehealth, telemonitoring and web-phone based technology services may be provided for participants with *conditions or clinical circumstances associated with the need for frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services where telehealth technology can appropriately reduce the need for on-site or in-office visits or acute long-term care facility admissions.</p>	<p>*Conditions or clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.</p>

Covered Benefit	Description/Remarks	Benefit Limitations
Transportation (Non-emergency / routine)	<p>Transportation essential for a participant to obtain necessary medical care and services under the FIDA-IDD Plan or Medicaid Fee for Service. Includes transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the participant's medical condition. Also includes a transportation attendant to accompany the participant, if necessary. For participants with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.</p> <p>Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets to obtain services and goods.</p>	<p>Note: This benefit is not paid for by the FIDA- IDD plan for residents of ICF/IIDs or OPWDD-supervised "Individual Residential Alternatives" (IRAs) or "Community Residences" (CRs) since these providers are responsible for providing the transportation.</p>
Urgent Care	<p>Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an emergency condition.</p>	

Covered Benefit	Description/Remarks	Benefit Limitations
Vision Services/Eye Exams and Eye Wear	Services of optometrists, ophthalmologists, and ophthalmic dispensers including eyeglasses, medically necessary contact lenses, and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids, and low vision services. Coverage also includes the repair or replacement of parts as well as examinations for diagnosis and treatment for visual defects and/or eye disease.	Examinations for refraction are limited to once every two years unless otherwise justified as medically necessary, one glaucoma screening each year, eyeglasses/contacts once every two years. For replacement of eyeglasses, consult with Chief of Care Coordination or Chief Medical Officer.
“Welcome to Medicare” Preventive Visit	The “Welcome to Medicare” Preventive Visit is a one-time visit that includes a review of the participant’s health, education, and counseling about the preventive services the participant needs (including screenings and shots), and referrals for other care if needed.	Covered within 12 months of initial enrollment with MEDICARE.
Wellness Counseling	Wellness Counseling is an individually designed service intended to assist the medically stable participant in maintaining optimal health status. An RN assists the participant to identify his or her health-related needs and provides guidance to minimize, or in some cases prevent, acute episodes of disease and utilize health care resources efficiently and effectively.	

If you have questions about any of these covered supports and services, please contact our Care Management staff at 1-855-769-2507.

Prescription Drug Coverage

Medicare Part D prescription drugs are only available by prescription, are used or sold in the United States, and must be used for medically accepted indications. Part D prescription drugs covered by Partners Health Plan are listed in the Medicare three-tier formulary, which includes all generic drugs covered under the Part D program as well as many brand-name drugs, non-preferred brands, and specialty drugs. In addition, NYS Medicaid provides coverage for certain drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, some prescription vitamins, and a number of non-prescription drugs. A complete copy of the formulary is included on the PHP website at www.phpcares.org. Some of these drugs have prior authorization or step-therapy requirements or quantity limits. Participants should obtain covered drugs from a network pharmacy pursuant to a physician's prescription.

MedImpact

Pharmacy claims are processed by MedImpact, PHP's Pharmacy Benefit Manager (PBM). MedImpact services also include home infusion, long-term care pharmacy, specialty pharmacy, and mail-order pharmacy. MedImpact contact information and applicable forms are available on the PHP website. For pharmacy inquiries, including authorization requests, please dial the MedImpact phone number included on the PHP Participant ID Card (1-888-648-6759).

Required Characteristics of HCBS Settings

CMS mandates that settings in which HCBS are provided to persons with IDD must have all of the following qualities **unless the participant has an assessed need that contraindicates one or more of them**:

- The setting is integrated in and supports full access of participants to the community, including opportunities to:
 - Seek employment and work in competitive integrated settings
 - Engage in community life
 - Control personal resources
 - Receive services in the community to the same degree of access as people not receiving Medicaid-funded HCBS
- The setting is chosen by the participant from among available options, including settings not specifically for people with disabilities and an option for a private unit in a residential setting.
- The setting ensures an individual's right of privacy, dignity, respect, and freedom from coercion and restraint.
- The residential setting optimizes individual initiative, autonomy, and independence in making life choices.

- If the participant resides in a provider-owned or controlled residence, he or she must be able to occupy it under a legally enforceable agreement that at a minimum has the same protections from eviction that tenants have under applicable landlord/tenant laws.
- The residential setting must afford each participant:
 - Privacy in his or her sleeping/living unit
 - Doors which can be locked by the person
 - Choice of roommates
 - The freedom to furnish and decorate sleeping or living units
 - Freedom to control their schedules
 - Access to food at any time
 - The ability to have visitors at any time of the participant's choosing and physical accessibility

Any modification of the above requirements must, among other requirements, be supported by a specific assessed need, be proportionate to the assessed need, have the informed consent of the participant and/or the participant's authorized representative, be periodically reviewed and revised as indicated, and be documented in the participant's Life Plan.

Non-Covered Services

Before rendering non-covered services, providers should always inform participants and/or their authorized representatives that the cost of services not covered by PHP will be charged to the participant.

A provider who chooses to provide a non-covered service(s):

- Recognizes that PHP only reimburses for services that are medically necessary
- Understands that he or she may not bill or take recourse against a participant for denied or reduced claims for services within the amount, duration, and scope of benefits of the FIDA- IDD program

Obtains the participant's or the participant's authorized representative's signature on the Client Acknowledgement Statement (see below) specifying that the participant will be held responsible for payment of non-covered services prior to rendering services

SECTION 5: ELIGIBILITY AND ENROLLMENT

FIDA-IDD Eligibility

Partners Health Plan (PHP) exclusively serves adults aged 21 and older who are eligible for the Office of People with Developmental Disabilities (OPWDD) waiver program, dually eligible for Medicare and Medicaid, and reside in PHP's service area. The program is voluntary, and participants may enroll and disenroll on a month-to-month basis.

If a potential applicant and/or his or her authorized representative expresses a desire to enroll in PHP, Participant Services staff will confirm the applicant's:

- Age
- Area of residence
- Eligibility for Medicaid (if the applicant is not enrolled in Medicaid but appears eligible, Partners Health Plan will provide information regarding Medicaid application process)
- Eligibility for IDD services (if the applicant is not currently receiving IDD services but appears eligible, Partners Health Plan will refer him or her to a local OPWDD regional office for an eligibility assessment, (OPWDD Front Door process)). Eligibility for Medicare (if the applicant is eligible for Medicare but not enrolled, e.g., eligible through the SSDI "Child's Benefit," PHP will provide assistance)

Enrollment

All voluntary enrollments must be processed through a New York State Enrollment Broker (i.e., NY Medicaid Choice) consistent with the FIDA-IDD program's Enrollment Effective Date requirements. If a potential applicant and/or his or her authorized representative directly contacts PHP and expresses a desire to enroll in PHP Care Complete FIDA-IDD, Participant Services staff will arrange a 3-way call with NY Medicaid Choice and connect the applicant for enrollment counseling and assistance with enrollment.

New Enrollees

After the enrollment has been completed and the state has confirmed the Enrollment Effective Date (if the enrollment is processed by the 20th of the month, the effective date will be the 1st of next month. If the enrollment is processed after the 20th of the month, the effective date will be the first of the following month), the new participant will be scheduled for an initial assessment and evaluation at his or her residence or other agreed-upon venue within the first 30 days of enrollment. PHP will also notify the LDSS/HRA and OPWDD of the applicant's enrollment, if needed, and notify the state about the existence of any third-party liability. Participant Services staff will further ensure that new participants have been provided with a Welcome Packet within the first 10 business days following receipt of CMS confirmation of

Enrollment or by the last calendar day of the month prior to the Effective Date. The Welcome Packet will include:

- A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products
- A combined Provider and Pharmacy Directory
- A single ID Card
- A Participant Handbook/Evidence of Coverage

Applicants who fail to meet the eligibility criteria will be provided with a full explanation of the reasons why he or she is not eligible for the program and offered referrals to other available resources in the community.

Disenrollment Procedures

PHP will not, either orally or in writing, request or encourage a participant to disenroll nor will PHP attempt to discourage participants from disenrolling if they indicate a desire to do so. PHP will contact disenrolling participants to determine the reason behind the decision and explain how Medicaid and Medicare coverage will be provided going forward, but PHP staff will make no effort to convince the participant and/or the participant's authorized representative to remain enrolled. All disenrollments will be effective the first day of the following month unless the request is submitted after the state's "pull-down" date (usually around the 20th of the month).

If a participant and/or the participant's authorized representative requests to disenroll, PHP will instruct the participant how to submit the request. All disenrollment-related transactions will be performed by NY Medicaid Choice, the state's Enrollment Broker. Disenrollment requests submitted to NY Medicaid Choice or CMS by the last calendar day of the month will be effective on the first calendar day of the following month (e.g., a participant that requests disenrollment at the end of May will have a Disenrollment Effective Date of July 1st).

A participant may request to disenroll from PHP at any time and for any reason. To the extent permitted under New York's Memorandum of Understanding (MOU) with CMS for the FIDA- IDD program, participants and/or their authorized representatives may disenroll by:

- Enrolling in another Medicare health or Part D plan, including PACE (if eligible)
- Enrolling in another FIDA plan, if persons with IDD are permitted to do so under New York State's primary FIDA program
- Giving or faxing a signed written disenrollment notice to the state or PHP
- Calling 1-800-MEDICARE

- Calling the state's enrollment broker (i.e., NY Medicaid Choice)
- Other New York-specific resources, if applicable

Providers are thus strongly encouraged to verify a patient's enrollment in PHP each time he or she presents for services. PHP also encourages participants who choose to disenroll to inform us of their decision as soon as possible so that we can assist with the transition.

Disenrollment Denials

The state may deny a voluntary request for disenrollment only if:

- The request was made by someone other than the participant and that individual is not the participant's authorized representative.
- The request was incomplete, and the required information is not provided within the required time frame.

Cancellation of Voluntary Disenrollment

A participant's voluntary disenrollment request can be cancelled only if the request to do so is made prior to the effective date of the disenrollment, unless otherwise directed jointly by the state and CMS. If PHP receives a request to cancel a disenrollment, PHP will notify the participant that he or she must contact NY Medicaid Choice to remain enrolled without disruption.

Required Involuntary Disenrollment

New York State must disenroll a participant from PHP under the following circumstances:

- A change in residence (includes incarceration) makes the participant ineligible to remain enrolled in PHP (i.e., participant permanently moves out of PHP's authorized service area, or a temporary absence exceeds six months)
- The participant loses entitlement to either Medicare Part A or Part B
- The participant loses Medicaid eligibility or additional state-specific eligibility requirements (e.g., loses eligibility for OPWDD services)
- Upon participant's death, PHP's contract with CMS is terminated, or PHP reduces its service area to exclude the area where the participant resides
- The participant materially misrepresents information to PHP regarding reimbursement for third-party coverage (requires CMS approval)
- PHP will continue to offer the full continuum of covered services and supports to affected participants through the end of the calendar month in which the state notifies PHP of the loss of Medicaid eligibility or loss of other state-specific eligibility requirements included in the FIDA- IDD MOU.

Discretionary Involuntary Disenrollment

PHP must never seek to terminate enrollment because of:

- An adverse change in a participant's health status
- Because of the participant's utilization of covered services and supports
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from the participant's special needs (except to the extent the participant's continued enrollment seriously impairs PHP's ability to furnish covered services and supports to that participant or other participants)
- A participant who attempts to exercise, or is exercising, his or her appeal or grievance rights

That said, PHP may submit a written request accompanied by supporting documentation to the FIDA program Contract Management Team (CMT, which serves as the agent for CMS and SDOH) to disenroll a participant for one of the following causes:

- **Disruptive Behavior:** The participant engages in disruptive behavior to the extent that his or her continued enrollment substantially impairs PHP's ability to arrange for or provide services to either that particular participant or other participants. However, PHP and the state (if appropriate) must make a serious effort to resolve the issue prior to submitting a disenrollment request, including providing reasonable accommodations for participants with mental illness and/or IDD. The participant/representative must also be informed of his or her right to exercise grievance procedures. This process requires three verbal and written notices to the participant/representative, as follows:
 - 1) Advance notice to inform the participant that the consequence of continued disruptive behavior may be disenrollment (if the disruptive behavior ceases after this notice has been received and then later resumes, PHP must repeat the disenrollment request, including sending another advance notice).
 - 2) Notice of PHP's intent to request that the CMT disenroll the participant, which must include information on grievance procedures and contact information for the CMT. PHP must also provide prior written notice to the CMT of its intent to request disenrollment.
 - 3) A planned action notice advising the participant/representative that the CMT has approved the disenrollment request.
- **Fraud and Abuse:** The participant provides fraudulent information on an enrollment request form or other enrollment mechanism that materially affects the eligibility determination. PHP may also request to disenroll a participant that intentionally permits others to use his or her ID card to obtain services or supplies. PHP will further notify the state and CMS immediately so the HHS (Health and Human Services) Office of the Inspector General may initiate an investigation of the alleged fraud

and/or abuse.

- **Failure to Pay:** The participant/representative fails to pay or make satisfactory arrangements to pay the amount, as determined by the LDSS (Local Department of Social Services), owed to PHP as spend-down/surplus or Net Available Monthly Income (NAMI) within 30 days after such amount first becomes due, provided that during that 30-day period PHP first made a reasonable effort to collect the amount owed, including making a written demand for payment, and advised the participant and/or the participant's authorized representative in writing of his or her prospective disenrollment.
- **Failure to Consent to Release Information:** The new participant/representative knowingly fails to complete and submit any necessary consent or release allowing PHP and/or its network providers to access necessary health information for the purpose of implementing PHP's Model of Care.

For the CMT to process a discretionary request for disenrollment, PHP must submit all required documentation of the steps we have taken to locate and engage the participant/representative as well as the results of these efforts or responses we have received. If the CMT elects to grant the involuntary disenrollment request for cause, it will notify PHP of its decision and instruct us to send the participant/representative a CMT-developed Involuntary Disenrollment Form, with additional copies to the CMT and the Enrollment Broker. The Effective Date of Disenrollment will be 11:59 p.m. on the last day of the month following the month the disenrollment is processed.

Continuation of Services Pending an Appeal

Under no circumstances will PHP cease to provide previously authorized services to a participant until SDOH or CMS or the Enrollment Broker informs PHP that the services may be terminated because the participant has received appropriate notice and waived or exhausted all Appeal rights. The termination will take effect on the effective date indicated by SDOH, CMS, or Maximus.

If you or your staff should have any questions about eligibility and enrollment in PHP, please do not hesitate to contact our Participant Services Department during any business day at 1-855- PHP-LIVE (1-855-747-5483).

Client Acknowledgement Statement: A provider may bill a PHP participant for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are met:

- The participant and/or the participant's authorized representative requests the specific item or service

- The provider obtains a written acknowledgement statement signed by the participant or by the participant's authorized representative and the provider stating:

I understand that, in the opinion of (provider's name), the services or items I have requested to be provided to me on (dates of service) may not be covered under Partners Health Plan as being reasonable and medically necessary for my care or are not a covered benefit. I understand Partners Health Plan has established the medical necessity standards for the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Partners Health Plan medical necessity standards for my care or are not a covered benefit.

Signature: _____

Hospice Services

Hospice care is a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill, or seriously ill patient's pain and symptoms while attending to his or her emotional and spiritual needs. The modern concept of hospice includes palliative care for the incurably ill given in such institutions as hospitals or nursing homes, but also care provided to those who would rather spend their last months and days of life in their own homes.

Although hospice services are not a covered benefit under the FIDA-IDD demonstration, PHP participants may elect to receive hospice services under the Medicare Fee-for-Service program. If a participant/representative chooses to exercise this option, he or she can continue to receive all non-hospice services and supports covered under Medicare Part D and Medicaid through Partners Health Plan.

If a Participant in the FIDA-IDD Plan becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access the FIDA-IDD Plan's Benefit Package while Hospice costs are paid for by Medicare fee-for-service.

PHP will be responsible for coordinating the participant's care with the hospice provider and ensuring that all needed supports and services are provided in a seamless manner.

Balance Billing

PHP participants must NOT be balance billed for the difference between the amount paid by PHP and the billed amount for covered services.

In addition, providers may not bill a participant if any of the following occurs:

- Failure to submit a claim in a timely manner, including claims not received by PHP
- Failure to submit a claim to PHP for initial processing within the 90-day filing deadline
- Failure to submit a corrected claim within the 90-day filing resubmission period

- Failure to appeal a claim within the 60-day administrative appeal period
- Failure to appeal a utilization review determination within 60 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission, or the appeal process

Provider Network

PHP's global criteria for provider network participation include:

- Providers' past experience and current capacity to serve individuals with IDD, including those with co-morbid chronic medical conditions (e.g., diabetes, heart disease, dementia)
- Providers' compliance with state and federal licensure and qualifications, including credentialing criteria and state regulatory requirements
- Providers' ability and commitment to maintain and improve participant health status and promote greater independence and service options
- Providers' commitment to collaborate with PHP, its participants/families/caregivers, other providers, and SDOH/OPWDD to improve service availability, quality, and participants' satisfaction with their care

Many of PHP's network providers have specific experience and expertise in serving individuals with IDD, which is of vital importance for individuals with moderate to severe cognitive impairments, many of whom are non-verbal. They also have experience in desensitization, which has proven to be very effective when delivering certain types of services to persons with IDD without the use of anesthesia or sedatives (e.g., dental cleanings, gynecological exams). The most common barriers to effective care for individuals with IDD include:

- May not be able to communicate history or symptoms
- May be unable to tolerate waiting room stay
- May be threatened by aspects of the office or hospital environment such as needles, physical examinations of private areas, unfamiliar clinicians
- May resist or fight when confronted with an examination

- May require ancillary or family help for even the smallest procedures

Should you wish to learn more about treating individuals with IDD or you have questions or concerns, please feel free to contact our Care Management staff at 1-855-769-2507. The UM fax number is 1-855-769-2509.

SECTION 6: PROVIDER ROLES AND RESPONSIBILITIES

Contracted providers and practitioners with Partners Health Plan (PHP) are obligated to comply with the following rules, regulations, and guidelines:

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community as well as applicable OPWDD standards. These 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 providers and practitioners seek advice or guidance or to which they are subject for licensing and oversight.
- Providers must immediately notify PHP's Medical Director, in writing, of any of the following circumstances:
 - If their ability to carry out their professional responsibilities is restricted or impaired in any way
 - If their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor, or is limited in any way
 - If any adverse action is taken
 - If an investigation is initiated by any authorized local, state, or federal agency
 - If there are any new or pending malpractice actions
 - If there is any reduction, restriction, or denial of clinical privileges at any affiliated hospital
- Providers shall comply with all PHP administrative, participant referral, quality assurance, utilization management, reporting, and reimbursement protocols and procedures.
- Providers shall not differentiate or discriminate in the treatment of participants on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, source of payment, or any other category protected by law.
- Providers shall observe, protect, and promote the rights of participants.

- Providers shall cooperate and participate in all PHP peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by PHP.
- Providers shall comply with all final determinations rendered by PHP peer review programs or external arbitrators for grievance procedures consistent with the terms and conditions of the provider's agreement with Partners Health Plan.
- Providers shall notify PHP 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 PHP at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with PHP or as required by the provider's agreement with Partners Health Plan.
- Providers shall not under any circumstances, including non-payment by or insolvency of PHP, bill, seek, or accept payment from PHP participants for covered services or benefits.
- Providers agree to maintain standards for the confidentiality of and documentation of participant medical/service records.
- Providers agree to retain medical/service records for 10 years after the last date of service or the length of time required by applicable law.
- Providers shall maintain appointment availability in accordance with federal and state requirements.
- Primary Care Providers shall maintain 24-hour access in accordance with federal and state standards. PCPs shall notify PHP of any extended coverage arrangements for sick leave, vacation, etc.
- Providers agree to continue care in progress during and after termination of a participant's enrollment in PHP for up to 60 days (so long as they maintain coverage under Medicare and/or Medicaid), or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the participant to another network provider.
- Providers must establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act (ADA).

Informed Consent

The provider must adhere to all federal and state requirements, including applicable OPWDD requirements, for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent. Providers must additionally provide participants/representatives with complete information concerning their diagnosis, evaluation, treatment, and prognosis and grant them the opportunity to take part in decisions involving their health care.

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR § 164.501), related to services provided to participants 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/Service records of all PHP participants shall be confidential and only be disclosed to and by the provider's staff in accordance with applicable laws and regulations.

You Can Help Protect Patient Confidentiality

Protecting 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.
- 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 patients (e.g., taking body weight, lab draws)
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.
- Ask your patients and/or their authorized representatives to sign an Authorization to Release Information prior to releasing medical records to anyone.
- Have a protocol for sending confidential information via fax.

Participant Complaints and Grievance Procedures

All PHP providers and practitioners must respect Participant Rights as outlined in this Provider Manual. In addition, providers should participate in, and are obligated to cooperate with, the resolution of any participant complaint or grievance that may arise relating to the services they provided to a PHP participant. Any concerns identified by participants and/or their caregivers with PHP, a provider, or any of a provider's staff with respect to the provision of services will be handled in accordance with PHP's complaint and grievance procedures as described in this Manual.

New York State Confidentiality Law and HIV

Public Health Law (Article 27-F) requires AIDS and HIV-related information to be kept strictly confidential. This law requires anyone receiving a voluntary HIV test to first sign a consent form. When disclosure of HIV-related information is authorized by a signed release, the person who has been given the information must also 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 an understanding of what the test is for, what the results mean, and options for care and treatment.
- No HIV-related test can be done without signed, written consent from the person (or the person's legal representative) that is being tested. At the time informed consent is given, a copy of the informed consent form approved by the State Health Commissioner must be offered to the person being tested and/or the person's legal representative.
- Any time an HIV-related test is done, the healthcare provider giving the test must provide counseling before the test and at the time the test results are received.
- 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 or the patient's legal representative authorizing the release of the HIV-related information.
- HIV-related information may be disclosed without a specific HIV release signed by the participant when (1) the medical professionals treating the participant 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 (as applicable); (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 (please note that this provision is not applicable to PHP participants as no one under age 21 is eligible to enroll); (8) a court orders disclosure; (9) the information is being provided to supervisory or medical staff if he or she is in jail, prison, or on parole.

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

New York State Department of Health HIV Confidentiality Hot Line: 1-800 962-5065

Or write:

Special Investigation Unit

HIV and Developmental Disabilities

Consistent with OPWDD guidance, all PHP participants should be offered the opportunity to be tested for HIV. Participants and the surrogates who provide consent on their behalf should be educated and encouraged to consent to an HIV test. OPWDD regulations at 14 NYCRR 633.11 must be followed when seeking informed consent from individuals receiving services or from their surrogates.

- **Individuals who are self-consenting:** Individuals who are capable of providing consent to HIV testing must be given the opportunity to consent or decline testing. If an individual refuses to consent to an HIV test, providers should document the refusal in the individual's record and continue to educate the individual regarding the benefit of knowing his or her HIV status.
- **Individuals with an authorized surrogate:** For those individuals who are not capable of providing consent to HIV testing, but who have a guardian or an actively involved family member who acts as a surrogate pursuant to 14 NYCRR 633.11, consent must be sought from such surrogate.

Use of the DOH model forms (Informed Consent to Perform HIV Testing), or its equivalent is required unless the physician's office has provided its own HIV consent form. The model form can be found at <http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm>

DOH requires that individuals receive seven (7) points of information about HIV before consenting. A description of these points can be found at:

http://www.health.ny.gov/diseases/aids/forms/docs/key_facts_before_testing.pdf

Advance Directives

During the initial orientation, all new PHP participants and their authorized representatives are informed of their right to specify oral or written advance instructions regarding health care treatment. The PCP is responsible to ask participants and their representatives if they have executed any advance directives. All participating providers are required to comply with all NYS rules and regulations—including OPWDD regulations—relating to advance directives and must provide care and treatment according to the wishes of the participant/representative. For

The New York State Office for People with Developmental Disabilities (OPWDD) has approved the use of the revised [NYS DOH-5003 Medical Orders for Life-Sustaining Treatment \(MOLST\) form](#) for individuals with IDD. However, the MOLST form must be accompanied by the [MOLST Legal Requirements Checklist For People With Developmental Disabilities](#).

Use of this checklist is required for individuals with IDD who lack the capacity to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life-sustaining treatment (LST) must comply with the process set forth in the Health Care Decisions Act for persons with IDD. Effective June 1, 2010, this included the issuance of DNR orders.

The advantage of the MOLST form is that it is transferable to other, non-hospital settings. Accordingly, a DNR issued on a MOLST form is effective not only in hospitals and nursing homes but in community settings as well. The MOLST includes medical orders and instructions for intubation and mechanical ventilation, future hospitalization/transfer, etc.

Call PHP or visit the [OPWDD website](#) for more information.

Health Care Proxy

A health care proxy is a document which names another person as the participant's Health Care Agent with the authority to make health care decisions if and when the participant is determined to be incapable of making personal medical care decisions.

A health care agent has the authority to make any and all health care decisions on the participant's behalf that the participant could make if he or she had the capacity. This authority can be limited by adding express limitations to the health care proxy.

A proxy may include the participant's health care wishes regarding, but not limited to, the following:

- Artificial nutrition and hydration
- Blood transfusions
- Artificial respiration
- Antipsychotic medication
- Surgical procedures
- Dialysis

Importantly, if a participant does not make his or her wishes known regarding artificial nutrition and hydration, a health care agent does not have the authority to accept or refuse nutrition and hydration on the participant's behalf.

And finally, even if a participant has appointed an agent to make health care decisions on his or her behalf, the participant retains the right to object to a health care decision made by an agent. If this should occur, the participant's objection or decision shall prevail unless the participant is determined by a court to lack capacity.

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

Family Health Care Decisions Act

New York's Family [Health Care Decisions Act \(HCDA\)](#) establishes the authority of a participant's family member or close friend to make health care decisions for the participant in cases where the participant lacks decisional capacity and did not leave prior instructions or appoint a health care agent. Under HCDA, the surrogate decision-maker is empowered to make all health care

decisions that the participant could make if he or she had the capacity, including the withdrawal or withholding of life-sustaining treatment when standards and procedures set forth in the statute are met.

The current list of authorized surrogates, in the order of precedence, is as follows:

- 1) Article 17-A Guardian (i.e., a court-appointed guardian)
- 2) An actively involved spouse
- 3) An actively involved parent
- 4) An actively involved adult child
- 5) An actively involved adult sibling
- 6) An actively involved adult family member
- 7) The Consumer Advisory Board for the Willowbrook Class
- 8) A court-appointed surrogate

The surrogate is required to base all advocacy and health care decision-making solely and exclusively on the best interests of the participant and, when reasonably known or ascertainable with reasonable diligence, on the wishes of the participant, including moral and religious beliefs.

An assessment of the best interests of the participant must include a consideration of five factors:

- 9) The dignity and uniqueness of every person
- 10) The preservation, improvement, or restoration of the health of the person
- 11) The relief of the suffering of the person by means of palliative care (care to reduce the person's suffering) and pain management
- 12) The unique nature of artificially provided nutrition or hydration, and the effect it may have on the person
- 13) The entire medical condition of the person

In addition, a surrogate's health care decisions may not be influenced by a presumption that the participant is not entitled to the full and equal rights, equal protection, respect, medical care, and dignity afforded to other persons, nor by financial considerations of the surrogate.

Decisions Regarding Life Sustaining Treatment (LST)

Life-sustaining treatment means medical treatment including cardiopulmonary resuscitation and nutrition

and hydration without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life sustaining treatment without the necessity of a medical judgment by an attending physician.

If a surrogate makes a decision to withdraw or withhold life-sustaining treatment (including "do not resuscitate" or DNR) from a participant, the attending physician must confirm that the person lacks capacity to make health care decisions. The attending physician who makes the confirmation is required to consult with another physician or licensed psychologist to further confirm the person's lack of capacity. Either the attending physician or the consulting physician or psychologist must possess specialized training or have experience in providing services to people with mental retardation or developmental disabilities.

The surrogate may express a decision to withdraw or withhold life-sustaining treatment either orally or in writing. If done orally, it must be stated to two persons 18 years of age or older, at least one of whom is the participant's attending physician. If done in writing, it must be dated and signed in the presence of one witness 18 years of age or older who must also sign the decision, and presented to the attending physician.

The attending physician must then either issue an order in accordance with the surrogate's decision and advise the responsible staff members, or promptly object to the surrogate's decision. Other persons may also legally object to the surrogate's decision, including the participant, an actively involved parent or adult sibling, another treating practitioner, or an authorized representative from OPWDD.

An objection by any of these individuals will result in the suspension of the surrogate's decision, pending judicial review, except if the suspension would be likely to result in the death of the participant. If the surrogate's decision is suspended following an objection, the objecting party is required to notify the surrogate and the other parties who could have objected to such decision.

Surrogates cannot be subjected to criminal or civil liability as long as they make a health care decision reasonably and in good faith pursuant to the law.

If you or your staff should have any questions or concerns about this policy, please do not hesitate to contact PHP at 1-855-747-5483 or OPWDD at 1-866-946-9733.

Participant Access to Care - Appointment Availability/Waiting Time

All PHP providers must have an appointment system that meets the following standards for appointment availability:

Circumstance	Required Timeframe
Emergency Care	Immediately upon presentation at a licensed service delivery site

Urgent medical or behavioral problems	Within 24 hours of request
Non-urgent “sick” visits	Within 48-72 hours of request, as clinically indicated
Routine, non-urgent, or preventive care	Within four (4) weeks of request
Specialist appointments (non-urgent)	Within four (4) weeks of request
Pursuant to an ER visit or hospital discharge, mental health or substance abuse follow-up visits with a network provider (as included in PHP’s benefit package)	Within five (5) business days of request, or sooner if clinically indicated
Non-urgent mental health or substance abuse visits with a network provider (as included in PHP’s benefit package)	Within two (2) weeks of request
Visits to a network provider to conduct health, mental health, or substance abuse assessments for the purpose of making recommendations regarding a participant’s ability to perform work	Within 10 business days of request

Mental Health Clinics

Mental health clinics must provide a clinical assessment within five (5) business days of request for participants in the following designated groups that are not currently receiving treatment:

- Participants in receipt of services from a mobile crisis team
- Participants in domestic violence shelter programs
- Homeless participants and those present at homeless shelters
- Participants aging out of foster care
- Participants who have been discharged from an inpatient psychiatric facility within the last 60 calendar days
- Participants referred by rape crisis centers
- Participants referred by the state court system

Community-Based Long-Term Services and Supports (LTSS)

- **New-to-Service Participants (i.e., those not already receiving community-based LTSS):** Service delivery must commence within 30 calendar days of enrollment in PHP.
- **Transitioning Participants:** For participants transitioning into PHP that have already been receiving community based LTSS, PHP must allow the participant to continue receiving all previously authorized services until the completion of the comprehensive assessment and Life Planning

process.

In addition, PHP must contract with an adequate number of community-based LTSS providers to offer participants a choice of at least two (2) providers of each covered service within a 15-mile radius or 30 minutes from the participant's residential ZIP code.

Facility-Based LTSS

- **New to Service Participants:** PHP must enter into contracts or make payment arrangements with nursing facilities/ICFs consistent with the minimum access standards outlined for all providers in this policy. PHP's network must include eight (8) nursing facilities/ICFs per county for participants that are new to service.
- **Transitioning Participants:** PHP must either enter into contracts or make other payment arrangements with all nursing facilities in our authorized service area to ensure participants' residency/placement and access to services are not interrupted.

Primary Care Services

PHP must provide participants with access to PCPs and OB/GYNs on a 24/7 basis and educate participants and their families/caregivers on the process for obtaining services during non- business hours and on weekends and holidays.

Office Wait Times

PHP's participants with a previously scheduled appointment must not be made to wait longer than fifteen (15) minutes on a routine basis.

Missed Appointments

Participants and/or their caregivers may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. PHP encourages practitioners/providers to attempt to contact participants/representatives who have not shown up for or canceled an appointment without rescheduling. If you or your staff experience difficulty in contacting the participant/representative or if a participant has a pattern of missed or canceled appointments, please contact Participant Services or the participant's care manager/coordinator for follow-up.

Second Medical or Surgical Opinion

Participants and/or their representatives may request a second opinion if they:

- Dispute the reasonableness of a decision
- Dispute the necessity of a procedure decision
- Do not respond to medical treatment after a reasonable amount of time

Participants must obtain a second opinion from a network provider unless a network provider with the necessary qualifications and experience is unavailable within a reasonable timeframe. Participants may not visit out-of-network providers without prior authorization.

Laws Relating to Federal Funds

The payments that providers receive for furnishing services to PHP participants are derived in whole or in part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds including, but not limited to:

- Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84
- The Age Discrimination Act of 1975 as implemented by 45 CFR Part 91
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act

Cultural Competency

Cultural Competency is a process of developing and exercising proficiency in effectively communicating in a cross-cultural context. The word “culture” is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. The word “competence” is used because it implies having the capacity to function effectively. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery to meet patients’ social, cultural, and linguistic needs.

The term “culturally competent”, as defined by the Developmental Disabilities Bill of Rights and Assistance Act of 2000 (DD Act), "means services, supports, or other assistance that is conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving the services, supports, or other assistance, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program involved."

Cultural competency assists providers and participants to:

- Acknowledge the importance of culture and language

- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include, but are not limited to:

- The perception that illness and disease and their causes vary by culture.
- The understanding that belief systems relating to health, healing, and wellness are very diverse.
- The recognition that an individual's cultural background influences help-seeking behaviors and attitudes toward health care providers.
- An acknowledgement that individual preferences affect traditional and non-traditional approaches to health care.

PHP strongly encourages providers to recognize cultural factors that shape personal and professional behavior and to accept that their own world views and those of the participant and/or his or her caregiver may differ while avoiding stereotyping and misapplication of scientific knowledge.

PHP staff will gladly assist providers who may have questions or require help in accessing needed resources such as language translation services or other available community-based resources for adults with IDD. In addition, PHP provides detailed information about the provision of culturally competent care for adults with IDD on our website at www.phpcares.org.

Americans with Disabilities Act Requirements

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination against individuals with disabilities in programs or activities that receive federal financial assistance, including Medicare and Medicaid. This legislation requires that medical providers offer individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable accommodations to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the essential nature of the services

PHP's policies and procedures are designed to promote compliance with the ADA. Providers are strongly

encouraged to take actions to remove an existing barrier and/or to accommodate the needs of PHP participants, many of whom have some degree of physical disability. This action plan includes the following:

- Providing reasonable accommodations to individuals with hearing, vision, cognitive, and psychiatric disabilities
- Utilizing waiting room and exam room furniture that meets the needs of all participants, including those with physical and non-physical disabilities
- Utilizing clear signage and wayfinding throughout facilities
- Clearly marking handicap parking unless there is street-side parking
- Providing street-level access to provider offices
- Providing elevators or accessible ramps into facilities
- Providing wheelchair accessible entrances and restrooms
- Providing access to an examination room that accommodates a wheelchair
- Offering first and last appointment availability to accommodate special needs visits

All providers are strongly encouraged to complete the NYSDOH ADA Attestation form that is included as Attachment A to this Provider Manual. If you should have further questions about ADA provisions and provider responsibilities, please contact our Provider Relations staff at 1-844-871-2355 or email us at www.providerrelations@phpcare.org

SECTION 7: PRIMARY CARE SERVICES

Primary Care Provider Responsibilities

At the time of initial enrollment, each Partners Health Plan (PHP) participant will select or be assigned a primary care provider (PCP) that will serve as the participant's "medical home." PCPs are typically family practitioners, internists, or OB/GYNs, although nurse practitioners and physician assistants may also fulfill this role. Under certain circumstances, a specialist physician may serve as a participant's PCP (e.g., participant has a chronic and/or complex health condition that requires regular consultation with a specialist), but the specialist must agree to the designation and fulfill all the obligations of a PCP as described in this section.

PCPs are responsible for:

- **Primary Care:** Providing primary and preventive care services including, but not limited to:
 - Providing health counseling and advice
 - Conducting baseline and periodic health examinations
 - Diagnosing and treating conditions that do not require the services of a specialist
 - Consulting with specialists and laboratory and radiological services, as needed
 - Working collaboratively with behavioral health providers, as applicable
- **24/7 Availability:** Ensuring the availability of primary care services to participants 24/7, including arranging for on-call and after-hours care with other network PCPs
- **Referrals:** Serving as the participant's referral source for most medically necessary specialist services and long-term services and supports, including inpatient care
- **IDT Participation:** It is highly recommended that the PCP be a member of the participant's Interdisciplinary Team (IDT)
- **Care Plans:** Assisting in the development of participant care and service plans (i.e., Life Plans)
- **Coordination of Care:** Collaborating in the coordination of the participant's care with PHP's care management team/IDT and other stakeholders involved in the participants' care
- **Medical Records:** Maintaining participants' medical records in accordance with all state and federal rules and regulations and contractual requirements
- **Stakeholder Communications:** Communicating participants' medical records, reports, treatment summaries, and related documents to PHP and other providers, upon request and as appropriate
- **Care Transitions:** Ensuring the continuity of care of participants during enrollment/disenrollment, inpatient admissions/discharges, change of PCP, and other transitions in collaboration with the participant's care management team/IDT

- **Claims and Encounters:** Submitting claim forms and encounters within ninety (90) days of the date of service using appropriate procedure and diagnostic codes
- **Medical License & Insurance:** Maintaining professional credentials and liability insurance in accordance with PHP credentialing standards
- **UM Compliance:** Complying with all utilization management protocols as outlined in this Provider Manual
- **Clinical Practice Guidelines:** Adhering as appropriate to generally accepted clinical practice guidelines and protocols, including guidelines and protocols specific to adults with intellectual and other developmental disabilities (IDD)
- **Grievances:** Working closely with PHP to resolve any problems, complaints, and disputes that may arise involving participants, caregivers, providers, and PHP
- **Participant Rights:** Treating participants and their caregivers with courtesy and respect and honoring their right to fully understand the participant's diagnosis, prognosis, and anticipated outcomes of recommended medical or surgical procedures
- **Cultural Competency:** Interacting with participants and their caregivers in a culturally competent manner and not differentiating or discriminating in the treatment of participants on the basis of race, gender, ethnicity, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, or any other basis prohibited by applicable federal, state, or local rules and regulations

Choice of Network PCP

At the time of initial enrollment, each participant/representative will be given a list consisting of no fewer than three network PCPs located within the FIDA-IDD program's time/distance standards from which they can make a selection (note: if the participant's existing PCP already contracts with PHP, the participant's care management team will encourage the participant to maintain the relationship). If the participant has a relationship with a Medicare-certified PCP that is not in PHP's network, Provider Relations staff will make a reasonable effort to recruit the practitioner into PHP's network.

If the participant/representative fails to express a preference on a timely basis, PHP will send the participant/representative a written notification regarding the issue and make other reasonable efforts to encourage an affirmative selection. If the participant/representative still does make a selection, PHP will assign a network PCP based on the participant's geographic location, medical history, cultural and linguistic background, level of disability/PCP accessibility and experience with persons with IDD, and other relevant factors (if known).

If the participant selects or is assigned to a multi-provider clinic in PHP's network (e.g., Article 28 Clinic), the participant must choose or be assigned to a specific provider or provider team within the facility to serve as his or her PCP. This "lead" provider will then be accountable for carrying out PCP requirements (e.g., serving on the participant's IDT).

Participant Access to Primary Care Services

Office Hours

New York State Department of Health guidelines require FIDA-IDD program PCPs to practice at least 16 hours per week at a primary care site and be available at least four (4) hours on two separate days of the week. If you cannot comply with these criteria, please contact PHP's Provider Relations staff by email at providerrelations@phpcares.org or the Medical Director.

Wait times within a primary care site should comply with the following standards:

- Within one (1) hour for scheduled appointments on a routine basis
- Non-urgent walk-in participants should be seen within two (2) hours or scheduled for an appointment consistent with the timeframes listed above under “Participant Access to Care.”
- Urgent walk-ins should be seen within one (1) hour

24/7 Telephonic Access

PCPs are responsible for arranging on-call and after-hours coverage to ensure 24/7 telephone access to participants and their caregivers (please note that participants can also access a PHP care manager and/or Nurse Hotline 24/7).

All PHP primary care providers are required to maintain 24-hour, 7-day-a-week telephone access for their participants. The standard for returning a participant 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., caller alert system, call forwarding, etc.). An automated message must direct the participant to a live voice.

PCPs are required to notify PHP, in writing, at least 30 calendar days in advance of any change in their office address, telephone number, or office hours.

Changing PCPs

Participant-Initiated Change

Participants/Representatives may request a change in PCP at any time and for any reason. Care managers will provide any assistance the participant/representative may need in selecting a new PCP and ensuring a smooth transition. After receiving a request to change PCP, PHP will process the request and inform the participant/representative of the effective date of the change, which must take place within five (5) business days of the request.

Relinquishing practitioners are responsible for making participants' medical record available to receiving practitioners upon request and in compliance with the confidentiality requirements of PHP and HIPAA/HITECH. At a minimum, practitioners are requested to transmit medical records related to current diagnostic tests and determinations, current treatment services, immunizations, recent hospitalizations (within the past year) with concurrent review data and discharge summaries (if data and summaries available), current medications list, recent specialist referrals, and emergency care.

PHP will facilitate the transfer of pertinent medical records (as needed) and will transfer other requested records that exceed the requirements of the policy if so directed or required.

Provider-Initiated Change

In the event that a PCP determines that he or she is unable to continue providing services to a participant, the PCP must send a written notification to PHP's Medical Management Department stating the specific problem. PHP will not simply remove a participant from a PCP's roster without good cause. Depending upon the circumstances, the participant's care management team may contact the PCP to discuss the issue and attempt to resolve it (e.g., communication issues, lack of compliance with treatment recommendations, etc.). Some examples of good cause include:

- Fraudulent acts in obtaining services
- Consistent verbal or physical abuse to the PCP or to his or her staff and/or harm to other patients
- Habitual lack of compliance with treatment recommendations
- Chronic no-show for appointments

Participant disenrollment may not be initiated for refusal to accept a specific treatment or for behavior related to an underlying medical condition, alcohol or substance abuse, mental illness, or intellectual or other developmental disability.

PHP recognizes the importance of the participant (patient)-PCP relationship and will make every effort to preserve and nurture it. To this end, PHP encourages network PCPs to contact the participant's care management team to communicate any issues of concern.

If a PCP-initiated change is approved, the relinquishing PCP is responsible for transferring participant medical records in the same manner as a participant-initiated change (see above).

Closed Panel

A PCP's panel may be closed upon request or upon reaching the maximum number of participants permitted under New York State standards based on a 40-hour, full-time employment/work status. If the PCP believes that he or she is unable to provide care for additional participants, the practitioner has the option of closing his or her panel. In that case, the practitioner should email PHP's Provider Relations Department at providerrelations@phpcares.org and PHP will close the panel to future participants until

further notice. The Provider Directory will reflect this change by indicating that the provider's panel is only open to current participants.

When closing a practice to additional PHP participants, PCPs are required to:

- Provide PHP with 60 days prior written notice that the practice will be closing to additional participants as of a specified date
- Keep the practice open to PHP participants who were patients before the panel closed
- Give PHP prior written notice of the re-opening of the panel, including a specified effective date

PCP Leaves PHP's Network

If a participant's PCP leaves PHP's network of providers or is terminated for reasons other than imminent harm to participants, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, PHP will permit the practitioner's assigned participants to continue an ongoing course of treatment during the transitional period at the previously agreed upon reimbursement rate.

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

PHP will authorize the care for the transitional period only if the provider agrees:

- To accept reimbursement as payment in full at the Medicare or Medicaid rates applicable prior to the start of the transitional period
- To adhere to PHP's utilization management and quality assurance requirements
- To communicate medical information related to such care
- To adhere to all other applicable policies and procedures

SECTION 8: SPECIALIST PROVIDER SERVICES

PHP's network specialists are encouraged to work in partnership with participants' PCPs, Interdisciplinary Teams (IDTs), and care managers to promote the delivery of appropriate, high- quality medical and behavioral health care services to PHP's participants. Similarly, network PCPs are encouraged to communicate with participants' care management teams/IDTs when making referrals to specialists for specific services. Specialists play a critical role by providing care within their area of expertise and within the scope of the referral.

Although PHP strongly encourages participants and their families/caregivers to discuss any issues or concerns relating to their medical or behavioral condition(s) with their PCP and care management team before seeing a specialist, with few exceptions' participants are permitted to visit in-network specialists without a referral.

For a detailed description of PHP's specialist referral policies and protocols, please see Section 14 below.

Responsibilities

PHP's network specialists are responsible for:

- Coordinating care with the participant's PCP, IDT, and care management teams, except in an emergency
- Providing services normally performed in the practice specialty and provide care that conforms to accepted medical and surgical practice standards in the community
- Reporting findings and recommendations to the referring PCP/IDT by telephone and in writing
- Admitting and referring participants to hospitals that participate in PHP's network, except in emergencies
- Maintaining medical records that meet the medical record standards described in this Manual
- Sending copies of participant medical records, reports, treatment summaries, and other related documents to PHP and, upon request, to other participating providers
- Submitting claim forms for services within ninety (90) calendar days of the date of service with the appropriate treatment and diagnostic codes
- For covered services, seeking reimbursement only from PHP (network providers may not seek payment from PHP participants under any circumstances)
- Maintaining professional credentials and liability insurance consistent with PHP's credentialing standards

- Complying with all utilization management protocols as outlined in this Provider Manual
- Adhering as appropriate to generally accepted clinical practice guidelines and protocols, including guidelines and protocols specific to adults with intellectual and other developmental disabilities (IDD)
- Working closely with PHP to resolve any problems, complaints, and disputes that may arise involving participants, participants' caregivers, providers, and PHP
- Treating participants and their families/caregivers with courtesy and respect and honoring their right to fully understand the participant's diagnosis, prognosis, and anticipated outcomes of recommended medical or surgical procedures
- Interacting with participants and their caregivers in a culturally competent manner and not differentiating or discriminating in the treatment of these individuals on the basis of race, gender, ethnicity, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, income level, or any other basis prohibited by applicable federal, state, or local laws, rules, and regulations
- Accepting peer review of professional services provided to PHP participants
- Abiding by agreements made with PHP as a result of participant complaints, peer review, quality assurance, and utilization review
- Immediately notifying PHP's Medical Director, 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
 - If any new or pending malpractice actions occur
 - If any reduction, restriction, or denial of clinical privileges at any affiliated hospital is initiated
- Immediately notifying PHP's Provider Relations Department by email at providerrelations@phpcares.org about any changes in information included on the Provider Application (e.g., changes in address or office hours, on-call arrangements, etc.)

Appointment System

Participating specialists must abide by the applicable appointment availability standards as defined in Section 3 of this Manual.

Verification of Participant Eligibility

Prior to providing services, the provider's office must verify the participant's current eligibility either by accessing PHP's secure provider portal at www.phpcares.org or by calling Participant Services at 1-855-747-5483. **Failure to verify eligibility may result in denial of payment for services rendered.**

Authorized Services

Appropriate evaluation and treatment of a participant may require a provider to order certain diagnostic tests. PHP does not require prior authorization for diagnostic tests that are considered part of a routine examination and consistent with the provider's practice (e.g., an EKG or a CBC). However, PHP reserves the right to deny reimbursement if, in the opinion of the Medical Director, the test being performed was not medically necessary nor part of a routine exam.

Providers are encouraged to call PHP's UM Department at 1-855-769-2508 if they have any questions regarding a particular test. Additionally, providers are encouraged to contact the participant's care manager/coordinator if there are any questions regarding tests that may have already been ordered and conducted by other providers to prevent duplicative testing. The UM fax number is 1-855-769-2509

Coordination of Care

Specialists are required to provide any relevant documentation with all treatment information to the participant's PCP/IDT in order to ensure effective care 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/IDT in a prompt and efficient manner.

SECTION 9: EMERGENT, URGENT, AND INPATIENT SERVICES

Emergency Services

Definition

An emergency medical condition manifests itself by acute symptoms of severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Emergency services are defined as covered inpatient and outpatient services that are furnished by a provider/practitioner that is qualified to furnish such services and such services are needed to stabilize an emergency medical condition.

Emergency and Post-Stabilization Care

PHP complies with all federal and state requirements as it relates to the provision and coverage of emergency and post-stabilization care services. This means that PHP:

- Does not require prior authorization for emergency services
- Does not deny payment for treatment if a participant had an emergency medical condition or if PHP staff instructed the participant to seek emergency services
- Does not limit what is considered to be an emergency medical condition on the basis of a list of diagnoses or symptoms
- Does not refuse to cover emergency services based on the provider not notifying the participant's PCP or PHP of the participant's screening and treatment within 10 calendar days of presentation for emergency services
- Does not allow a participant to be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the participant
- Does not require prior authorization for post-stabilization care services, regardless of whether the participant obtains the services within or outside of PHP's provider network if:
 - PHP pre-approved the services.
 - The services were not pre-approved by PHP because either PHP did not respond to the

provider's request within one hour or PHP could not be reached by the provider to request pre-approval.

- PHP and the treating physician could not reach an agreement concerning the participant's care and PHP's Medical Director, Chief of Care Coordination, or Director of UM was not available for consultation. (PHP also assures that the attending emergency physician or the treating provider is responsible for a binding determination of participant stabilization for transfer or discharge based upon the general rule for coverage and payment.)

Emergency Behavioral Health Services

Participants who need behavioral health services on an urgent or emergent basis may present directly to psychiatric facilities, hospital emergency departments, or other providers including out-of-network providers. In instances when inpatient care is appropriate, the hospital must arrange to transfer the participant to a network psychiatric facility. The participant's care management team will contact the recommended facility to determine bed availability and assist with the transition, as needed and appropriate.

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

- Stabilizing and otherwise securing the participant's health and safety
- Verifying the participant's PHP eligibility
- Contacting PHP's Medical Management staff as soon as possible

For assistance with behavioral health issues, please contact PHP's Behavioral Health Coordinator at 1-855-769-2507.

Urgent Care Services

Definition

An urgent medical condition is defined as a medical or behavioral condition other than an emergency condition, manifesting itself by acute symptoms requiring prompt (within 24 hours) medical or behavioral health services in order to prevent impairment of health and are the result of an unforeseen illness, injury, or condition. Urgent care is appropriately provided in a clinic, urgent care center, practitioner's office, or in a hospital emergency room if a clinic/urgent care center or practitioner's office is not accessible. Urgent care does not include primary care services or services to treat an emergency condition.

Urgent Care Policy

PHP will not deny payment for urgent care services if the needed services are obtained from a network provider. However, if the circumstances are unusual and/or a network provider is unavailable or if the

participant is temporarily away from PHP's service area, PHP will cover urgently needed care from an out-of-network provider.

Inpatient Services

Authorization is required for all inpatient admissions, including unscheduled medical and surgical hospital admissions following stabilization. PHP requires notification of the participant's hospital admission as soon as feasible but no longer than two business days following stabilization. This also 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. To request authorization or access additional information, please contact PHP's UM staff at 1-855- 769-2508. The UM fax number is 1-855-769-2509.

Transfer to another Hospital

Prior authorization is required to transfer a participant from one hospital to another. PHP will not authorize transfers unless:

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

If the participant is transferring to an alternative inpatient facility, PHP will assist in ensuring a seamless transition by facilitating communication between the two facilities and other treating providers, facilitate the transfer of all pertinent records, and ensure all needed supports are in place prior to transferring the participant. PHP can also assist in arranging for transportation for pre-authorized transfers if necessary.

Transfer to a non-participating facility requires approval from PHP's Medical Director or Director of UM 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 promptly communicate clinical information to PHP so that concurrent review and discharge planning can take place.

Concurrent Review and Discharge Planning

PHP will conduct concurrent review and discharge planning (CR/DP) activities on behalf of participants who are hospitalized or in a nursing facility or ICF/IID for a short-term stay.

Whenever possible, PHP's CR/DP staff will collaborate with facility staff and other stakeholders involved in

the participant's care to ensure that a comprehensive discharge plan is in place prior to the participant's discharge from the facility. The CR/DP process enables PHP to:

- Ensure the level of service being provided is consistent with the need for continued hospitalization
- Collaborate with inpatient facility (i.e., hospital, nursing facility, ICF/IID) staff to reduce preventable injuries to participants within the facility
- Identify potential clinical issues and refer them to the Medical Director or the applicable Regional Director of Care Management for discussion with the participant's treating physician
- Monitor the participant's status and well-being prior to discharge to ensure that progress is being achieved toward targeted milestones in his or her recovery and ability to successfully transition to a home- and community-based setting
- Evaluate and assess the post-discharge needs of the participant and ensure any needed prior authorizations are in place within 48 hours of discharge
- Identify alternative care settings post-discharge and:
 - Explain the options to the participant and his or her authorized representative
 - Make recommendations to the discharge planner or treating physician in accordance with the participant's needs and preferences
 - Ensure that Medicare's standard provision that requires a 3-day hospital stay prior to covering a skilled nursing facility stay is not imposed with FIDA-IDD participants

SECTION 10: WOMEN'S HEALTH PROVIDERS

Responsibilities

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

As required by New York State law, each female enrolled in PHP is allowed unrestricted access to an annual well-woman exam for primary and preventive OB/GYN services from a qualified provider/practitioner of her choice in the PHP network. The participant 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 gynecological condition or disorder.

In addition, the participant is allowed unrestricted access to a qualified provider of OB/GYN services in the PHP network for any care related to pregnancy. Consistent with this policy, a referral from the participant's Primary Care Physician (PCP) is not required for these services. The specialist must, however, discuss the services and treatment plan with the participant's care managers/IDT.

Participants must further have after-hours access to a network OB/GYN physician or practitioner for emergency consultation and care.

SECTION 11: PARTICIPANT TRANSITIONS IN CARE

Partners Health Plan's (PHP) participant transition process is designed to ensure that participants' care continues without interruption or delay when transitioning into or out of PHP or from one provider/practitioner to another. The objective is to maintain the continuity and quality of participants' care and services during enrollment, disenrollment, or when changing providers/practitioners. To accomplish this, PHP:

- Tracks participants who are leaving or joining the health plan or changing from one service provider to another
- Identifies transitioning participants who need special assistance or care during the process
- Notifies applicable stakeholders (e.g., the receiving health plan, participants' practitioners and/or providers, facilities, advocates) regarding the transition
- Monitors the continuity and quality of care and services throughout the process and conducts appropriate interventions, as needed

- Carries out transition activities efficiently and within federal and state-mandated timeframes
- Maintains the confidentiality of information during the transition process

Transition Coordinator

If PHP's Medical Director, Medical Management staff, or Care Management Team/IDT determines that a participant is at risk for transferring, a licensed Care Manager with the appropriate education and experience will be assigned to coordinate the transition functions (this will typically be the participant's assigned care manager). The primary duties of the Care Manager during the transition process are to:

- Coordinate transition activities within PHP and with the receiving or relinquishing health plan, as applicable
- Lead the transition team and confirm that transition activities are carried out in accordance with established policies and procedures and participant needs
- Act as an advocate for transitioning participants
- Coordinate transition activities between the participant's providers/practitioners and the inpatient facility (as applicable) to minimize unnecessary complications relating to care setting transitions and hospital readmissions, including making sure that hospitals and nursing homes are not imposing a requirement for a three-day hospital stay prior to covering a skilled nursing facility stay
- Coordinate with the participant's Interdisciplinary Team to ensure that any needed authorizations are in place within 48 hours of readiness for discharge from an inpatient facility to the community or to a skilled nursing facility/ICF
- Communicate with network practitioners and other providers to ensure that all community supports, including housing, are in place prior to discharge
- Educate applicable network practitioners and providers to ensure they are knowledgeable and prepared to support the transitioning participant effectively, and assist them in coordinating care (including both clinical services and HCBS) for the participant following discharge
- Communicate and work with applicable departments and staff to identify transitioning participants and notify practitioners/providers of services to be monitored during the care setting transition or hospital readmission
- Ensure the transitioning participant has an adequate supply of prescribed medications (i.e., at least a 30-day supply in outpatient settings and 91-day supply in LTC settings), including non-formulary drugs (during the first 90 days of coverage)
- Conduct outreach with a newly enrolled participant and his or her authorized representative if he or she has been receiving either a non-covered service or a covered service from a non-participating provider to discuss potential alternatives
- Ensure there is a home visit within the required timeframes when the participant is transitioning from a hospital or institutional setting to a home or community-based setting

Provider/Practitioner Responsibilities

Providers/Practitioners participating in PHP's network are responsible for:

- Transmitting medical records as requested to a participant's receiving provider/practitioner at the new health plan or within the fee-for-service (FFS) system
- Obtaining prior authorization from a receiving health plan (i.e., the new health plan) before continuing care or services for a participant who is disenrolling from PHP (e.g., maternity care, surgical follow-up). Out-of-network providers may be requested to submit supporting documentation as a condition for reimbursement from the receiving health plan
- Complying with Partners Health Plan's contractual requirements relating to transitioning participants

Continuity of Care Requirements

Parties involved in a participant's transition are required to facilitate the transfer of the following care and services as described below.

Continued Access to Providers/Practitioners

If a provider's/practitioner's contract is discontinued, PHP will allow affected participants continued access to the provider/practitioner, as follows:

- Continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for participants undergoing active treatment for a chronic or acute medical condition
- Continuation of care through the postpartum period for participants in their second or third trimester of pregnancy

Continued access to providers/practitioners applies only if the provider/practitioner agrees to the following:

- To share information regarding the treatment plan with PHP
- To continue to follow PHP's Utilization Management policies and procedures
- To accept payment based on the current Medicare or Medicaid fee schedule, as applicable

Exceptions

- When a participant requires only routine monitoring for a chronic condition (e.g., if a participant sees a physician for monitoring chronic asthma but is not in an acute phase of the condition)

- When PHP has discontinued a contract based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 11101 et seq.)
- When a provider/practitioner is unwilling to continue to treat the participant or accept PHP's payment or other terms
- If no provider/practitioner contracts have been discontinued

Transfer of Medical/Service Records

Providers/Practitioners are responsible for making participant records available to health plans to which participants are transferring and/or to other providers/practitioners, upon request, and in compliance with PHP's internal confidentiality requirements as well as HIPAA/HITECH. At a minimum, providers are requested to transmit medical/service records related to current diagnostic tests and determinations, current treatment services, immunizations, recent hospitalizations (within the past year) with concurrent review data and discharge summaries (if data and summaries available), current medications list, recent specialist referrals, and emergency care.

PHP will facilitate the transfer of pertinent medical/service records (as needed) and will transfer other requested records that exceed the requirements of the policy if so directed or required.

Receiving providers/practitioners may request records directly from the relinquishing provider/practitioner.

Medical Equipment and Supplies

Participants transitioning into PHP and receiving treatment for chronic or acute medical conditions may continue care with the out-of-network treating practitioner or provider(s) through the lesser of:

- The current cycle or phase of active treatment
- Up to 90 calendar days for participants undergoing active treatment for a chronic or acute condition
- Up to two years for the active treatment of a behavioral health condition or until treatment is complete

Upon completion of treatment, the participant's care manager will help the participant choose a network practitioner/provider for future care.

SECTION 11A: DENTAL SERVICES

Dental Benefit Manager (DBM) Change Effective 01/01/2022

- From 04/01/2016 to 12/31/2021, PHP utilized BeneCare as our dental vendor.
 - Please continue to submit claims to BeneCare for dates of service in 2021 and earlier.
- Beginning 01/01/2022, PHP will be partnering with DentaQuest to provide dental services to our members.
 - Please submit claims to DentaQuest for all dates of service in 2022.

Required Documentation for Claim Submission

Please visit DentaQuest's Provider Portal at <https://govservices.dentaquest.com/> for the most up to date information, including an Office Reference Manual.

Providers must submit on a 2006 or newer ADA claim form.

The following information is required on all claims:

- The subscriber's PHP member ID;
- The patient's name, date of birth and relationship to the subscriber;
- The billing dentist or practice name, tax identification, billing national practitioner identification number (NPI);
- The treating dentist's name and national practitioner identification number (NPI);
- The American Dental Association Current Dental Terminology procedure code number ("CDT code"), the completed treatment date, tooth number, tooth surface(s), the dentist's usual and customary fee and a narrative or description of services as appropriate;
- The member's signature for release of information and/or assignment of benefits;
- The dentist's signature. However, signature on file is acceptable if prior claims have been submitted with the dentist's actual signature.

The documentation listed on the following page should always be included with the initial submission for pre-determination or claim processing in order to minimize any delay caused by the need to request additional information.

As part of the claim adjudication process, submitted documentation is reviewed to determine what services the program should appropriately benefit, consistent with accepted standards of dental practice and the exclusions

and limitations that apply to a specific patient's coverage.

Procedure	Documentation
SINGLE CROWNS, INLAYS AND ONLAYS	PRETREATMENT PERIAPICAL X-RAY(S) OR FINAL FILM FROM COMPLETED ENDO
ENDODONTIC THERAPY	PRETREATMENT PERIAPICAL X-RAY AND A FILM OF THE COMPLETED FINAL FILL
PERIODONTAL THERAPY, INCLUDING SCALING AND ROOT PLANNING	A COMPLETE MOUNTED PERIAPICAL X-RAY SERIES, CHARTING
PARTIAL DENTURES	A MOUNTED PERIAPICAL X-RAY SERIES OR PANOGRAM OF THE ARCH BEING RESTORED ALONG WITH A TREATMENT PLAN ADDRESSING THE PROPOSED THERAPY FOR ANY EXISTING CARIES, PERIODONTAL, ENDODONTIC, OR OTHER PATHOLOGY
FIXED BRIDGEWORK	A MOUNTED PERIAPICAL X-RAY SERIES OR PANOGRAM OF THE ARCH BEING RESTORED ALONG WITH A TREATMENT PLAN ADDRESSING THE PROPOSED THERAPY FOR ANY EXISTING CARIES, PERIODONTAL, ENDODONTIC, OR OTHER PATHOLOGY
IMPLANTS	COMPLETE TREATMENT PLAN ADDRESSING ALL PHASES OF CARE. MAY NEED FULL MOUTH RADIOGRAPHS OR A DIAGNOSTIC PANOREX INCLUDING PERIAPICALS OF SITE REQUESTING DENTAL IMPLANTS

Predetermination

As previously noted, pre-determination is not required but is strongly recommended in order to protect both the patient and the office from any unexpected denial of service or denial of payment by the plan. A predetermination certification is valid for one year from the completion of review. Should the patient select treatment from a provider other than the one listed on the original form, and the treatment plan remains the same, a new pre-determination can be requested without a review from the consultants. However, if the treatment plan changes, a subsequent review is required.

It is important to note that a pre-determination is not a guarantee of payment, it is only an estimate based upon eligibility and plan usage at the time of processing. Interim treatment by your office or another practitioner and /or changes in the patient's eligibility will modify the available benefit at the time that treatment is actually provided.

Please note: if one of your members requires more than two cleanings per year, documentation must be provided on the claim to BeneCare or DentaQuest to prevent the claim from denying. There are no frequency limitations on periodontal maintenance procedures.

Prior Authorization

The following services will require prior authorization from DentaQuest.

- Dental Implants (Procedure Codes D6000 – D6199).
- Orthodontist Services (Procedure Codes in D8000 range.)

Authorization requests should be sent to:

DentaQuest IPA of New York, LLC- Authorizations
PO BOX 2906
Milwaukee, WI 53201

Electronic Claims

DATES OF SERVICE 04/01/2016 – 12/31/2021: BeneCare Dental Plans accepts claims, coordination of benefits, and predetermination submissions through claims clearinghouses. BeneCare's clearinghouse Payer ID exclusively for the Partners Health Plan dental programs is **23213**. Contact your practice management software vendor for a software update if you are unable to use PHP's Dental Payer ID number.

DATES OF SERVICE 01/01/2022 AND ONWARD: DentaQuest offers multiple options for claims submission.

Electronic Claims should be sent to:

Direct entry on the web – www.dentaquest.com

OR

Via Clearinghouse – Payer ID: CX014

Include address on electronic claims –

DentaQuest, LLC

PO BOX 2906

Milwaukee, WI 53201

Paper Claims should be sent to:

DentaQuest IPA of New York, LLC- Claims

PO BOX 2906

Milwaukee, WI 53201

Coordination of Benefits (“COB”)

The following narrative describes DentaQuest’s general order of benefit determination. The office should first submit a claim(s) to the primary plan for adjudication.

If PHP is the secondary plan, the office should submit the original claim(s), and all necessary documentation, to DentaQuest along with the Explanation of Benefits from the primary plan. DentaQuest will process the claim(s) subject to accepted standards of care, patient eligibility, exclusions and limitations in order to coordinate the benefits that the patient is eligible to receive.

The Partners Health Plan dental programs are always secondary to “commercial” dental plan coverage.

Standard Exclusions and Limitations Plan payments will not be made for:

- Experimental procedures
- Appliances, restorations, and procedures to alter vertical dimension; including, but not limited to, occlusal guards and periodontal splinting
- Space maintainers for dependent children age 10 or older.
- Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance

- Restorations which are not of any dental health benefit, but purely cosmetic in nature, including, but not limited to laminate veneers and posterior composites. Payment of the applicable percentage of the plan allowance for the alternate service will be made toward such treatment and the balance of the cost remains the responsibility of the patient.
- Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a removable partial denture would restore the arch. Payment of the applicable percentage of the plan allowance for the alternate service will be made toward such treatment and the balance of the cost remains the responsibility of the patient.
- General anesthesia, except for the following reasons:
 - Removal of one or more impacted teeth.
 - Removal of four or more erupted teeth.
 - Treatment of a physically or developmentally disabled person.
 - Treatment of a child under age 11.
 - Treatment of a person who has a medical problem, when the attending physician requests in writing that the treating dentist administer general anesthesia. This request must accompany the dental claim form.
- Expenses incurred for a temporary denture
- Duplicate charges
- Services incurred prior to the effective date of coverage.
- Services incurred after cancellation of coverage, or loss of eligibility.
- Services incurred in excess of the benefit year maximum, unless documentation is provided
- Reconstruction(s)
- Services that are incomplete.
- Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six (36) months or a service provided outside of ages five through fourteen.
- Services such as treatment for traumatic injuries which are customarily provided under Medical-Surgical coverage.
- More than one oral examination in any continuous six-month period.
- More than one prophylaxis in any continuous six-month period.
- More than one full mouth x-ray series in any period of thirty-six consecutive months
- More than three bitewing x-ray series in any twelve-month period.
- Adjustments or repairs to dentures performed within six months of the date of the initial insertion of the denture.
- Services or supplies in connection with periodontal splinting.
- Expenses incurred for replacement of an existing denture which is or can be made satisfactory.

- Expenses incurred for the replacement of a denture, for which benefits were previously paid, if such replacement occurs within eight years from the date the expense was originally benefited.
- Expenses incurred for the replacement of a crown, for which benefits were previously paid, if such replacement occurs within five years from the date the expense was originally benefited.
- Expenses incurred for the replacement of a bridge for which benefits were previously paid, if such replacement occurs within five years from the date the expense was originally benefited.
- Training in plaque control or oral hygiene, or for dietary instructions.
- Completion of reporting forms.
- Charges made by the attending dentist for the patient's failure to appear as scheduled for an appointment.
- Charges for services and supplies which are deemed not necessary for treatment of the injury or disease or are not recommended and approved by the attending dentist, or charges which are not reasonable.
- Scaling and root planning, which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy scaling and root planning will be considered a prophylaxis and subject to the limitations of that procedure.
- Services for any condition covered by Workmen's Compensation law or by any other similar legislation
- Claims submitted more than six months (180 days) following the date of service.
- Services or supplies that are not necessary according to accepted standards of dental practice.

Radiographs

The submission of fourteen or more radiographs at one appointment will be considered a Full Mouth X-ray Series, coded accordingly for processing and subject to the standard frequency limitation of once in any consecutive thirty-six (36) months.

Debridement Procedure

Debridement is not a covered benefit. However, in order to permit the practitioner to tailor the patient's treatment in the most suitable manner the practitioner may choose to submit the service as one of a series of prophylaxes. The benefit will be subject to the patient's plan's frequency limitations, but DentaQuest will benefit prophylaxes completed on successive appointments, there is no need for a six-month interval.

In order to avoid future disputes, the practitioner should clearly inform the patient in advance of their financial responsibilities if the number of prophylaxis exceeds the patient's benefit.

Apicoectomy and Retrograde Restoration

DentaQuest consider retrograde restorations and the other ancillary services listed in the CDT codes to be an inherent component of the apicoectomy procedure and therefore not benefited as a separate procedure.

Palliative Treatment

Palliative Treatment should be submitted with a procedure code that specifically identifies what procedure has been performed or with a narrative of the treatment and services rendered. Claims submitted using the palliative code will then be reviewed and approved or denied on an individual basis. This is allowed two times per 12 months without any additional documentation.

Occlusal and Athletic Guards

Plan payments will be made for occlusal guard--hard appliance full arch, occlusal guard--soft appliance full arch, and occlusal guard--hard appliance, partial arch once per year per arch.

Athletic guards are not regarded as a dental treatment procedure and therefore are not a covered dental benefit.

Consultations

A consultation is defined as a diagnostic service provided by a dentist other than the treating dentists for the sole purpose of providing a second opinion. Accordingly, this service should not be submitted as a substitute for another examination procedure.

Implant Services

Dental Implants will be covered when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's physician and dentist. A letter from the patient's physician must explain how implants will alleviate the patient's medical condition. A letter from the patient's dentist must explain why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants.

Procedure Codes D6000 – D6199.

- General Guidelines: A complete treatment plan addressing all phases of care is required and should include the following:
 - Accurate pretreatment charting;

- Complete treatment plan addressing all areas of pathology;
- Interarch distance;
- Number, type, and location of implants to be placed;
- Design and type of planned restoration(s)/prosthetics;
- Sufficient number of current, diagnostic radiographs allowing for the evaluation of the entire dentition
- If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed
- Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
- Treatment on an existing implant / implant prosthetic will be evaluated on a case-by-case basis.
- Implant and implant related codes not listed will be considered on a case-by-case basis and should be billed as a By Report using code D6199
- Physician's documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current accepted practices.

Dental Services under the Partners Health Plans FIDA-DD programs are considered Medicaid dental services and are subject to the New York Department of Health Medicaid Dental regulations and coverage guidelines. The follow chart reflects the NY Medicaid coverage guidelines and PHP's enhancements to NY Medicaid dental coverage for its FIDA-DD dental program.

Procedure Code	Procedure Name	UM Review Required?	Auth Required?	Narrative	Teeth Covered	Period Description	Documentation Required	Referral Required
D0120	periodic oral evaluation - established patient	N	N	May not be billed on the same date of service as D9310 or D9430.		One of (D0120) per 6 Month(s) Per patient.	Not Applicable	N
D0140	limited oral evaluation- problem focused	N	N				Not Applicable	N
D0150	comprehensive oral evaluation - new or established patient	N	N	May not be billed on the same date of service as D9310 or D9430.		One of (D0150) per 1 Lifetime Per Provider OR Location.	Not Applicable	N
D0160	detailed and extensive oral eval- problem focused, by report	N	N	May not be billed on the same date of service as D9310 or D9430. May not be billed within 90 days of D0120, D0140, or D0150 with the same billing provider.		One of (D0160) per 90 Day(s) Per Provider OR Location.	Not Applicable	N
D0210	intraoral - complete series of radiographic images	N	N	Either a D0210 or D0330. (only exception is diagnosis of new condition (i.e. traumatic injury)). Minimum of 14 images. Must be billed after approval or denial of implant pre-authorization request.		One of (D0210, D0330) per 36 Month(s) Per patient.	Not Applicable	N
D0220	intraoral - periapical first radiographic image	N	N			Three of (D0220) per 6 Month(s) Per patient.	Not Applicable	N
D0230	intraoral - periapical each additional radiographic image	N	N			The total fee for additional intraoral films may not exceed the total fee allowed for a complete intraoral series.	Not Applicable	N

D0240	intraoral - occlusal radiographic image	N	N		Per Arch (01, 02, LA, UA)	One of (D0240) per 36 Month(s) Per patient, Same Arch.	Not Applicable	N
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	N	N	Not reimbursable for TMJ radiographs.		Two of (D0250) per 1 Week(s) Per patient.	Not Applicable	N
D0251	extra-oral posterior dental radiographic image	N	N	Image is limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image. Not to be used as TMJ radiographs.		Two of (D0251) per 1 Week(s) Per patient.	Not Applicable	N
D0270	bitewing - single radiographic image	N	N			Three of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	Not Applicable	N
D0272	bitewings - two radiographic images	N	N			Three of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	Not Applicable	N
D0273	bitewings - three radiographic images	N	N			Three of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	Not Applicable	N
D0274	bitewings - four radiographic images	N	N			Three of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	Not Applicable	N
D0310	sialography	N	N			Two of (D0310) per 1	Not Applicable	N

						Week(s) Per patient.		
D0320	temporomandibular joint arthrogram, including injection	N	N			Two of (D0320) per 1 Lifetime Per patient.	Not Applicable	N
D0321	other temporomandibular joint films, by report	N	N			Two of (D0321) per 12 Month(s) Per patient.	Not Applicable	N
D0330	panoramic radiographic image	N	N	Molar endodontic treatment, retreatment or apical surgery is not approvable as a routine procedure. Prior approval requests will be considered for members under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those members age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis		One of (D0210, D0330) per 36 Month(s) Per patient.	Not Applicable	N

D0340	cephalometric radiographic image	N	N	Reimbursement is limited to orthodontists or oral surgeons for the purpose or treatment of physically handicapping malocclusion.		One of (D0340) per 36 Month(s) Per patient.	Not Applicable	N
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	N	N	Reimbursement is limited Orthodontic and implant cases (D8010-D8999 and D6010-D6199).		Two of (D0350) per 6 Month(s) Per patient.	Not Applicable	N
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	Y	N			Capture of Cone beam CT with interpretation of such-limited to less than whole jaw.	Narr. of Med. Necessity, Full Mouth Xrays	N
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	Y	N			Capture of Cone beam CT with interpretation of such-limited to mandibular arch.	Narr. of Med. Necessity, Full Mouth Xrays	N
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Y	N			Capture of Cone beam CT with interpretation of such-limited to maxillary arch (without cranium).	Narr. of Med. Necessity, Full Mouth Xrays	N
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	Y	N			A panoramic radiograph (D0330) or similar film, along with documentation of medical necessity, must be submitted with requests for prior approval. Approval is limited to	Narr. of Med. Necessity, Full Mouth Xrays	N

						those cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups and implants.		
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Y	N			Capture of Cone beam CT with interpretation of such-limited to TMJ series (2 or more exposures).	Narr. of Med. Necessity, Full Mouth Xrays	N
D0470	diagnostic casts	N	N	Reimbursement is limited to orthodontists or oral surgeons for the purpose or treatment of physically handicapping malocclusion.		One of (D0470) per 12 Month(s) Per patient.	Not Applicable	N
D0474	accession of tissue, gross and microscopic exam (surgical)	N	N			Reimbursement is limited to enrolled oral pathologist.	Not Applicable	N
D0485	consultation, including preparation of slides from biopsy material supplied by referring source	N	N			Reimbursement is limited to enrolled oral pathologist.	Not Applicable	N
D0502	other oral pathology procedures, by report	Y	N			Reimbursement is limited to enrolled oral pathologist.	Pathology report	N
D0999	unspecified diagnostic procedure, by report	Y	N				narr. of med. necessity, pre-op x-ray(s)	N

D1110	prophylaxis - adult	N	N	Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Prophylaxis is intended to control local irritation factors. Cannot be used in conjunction with periodontal maintenance (D4910). Once D4910 is used, then ONLY D4910 can be used. Cannot be used in conjunction with D4341 on the same date of service.		One of (D1110) per 6 Month(s) Per patient.	Not Applicable	N
D1206	topical application of fluoride varnish	N	N	For individuals 21 years of age and older D1206 is only approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.		One of (D1206, D1208) per 3 Month(s) Per patient. Four of (D1206) per 12 Month(s) Per patient.	Not Applicable	N

D1208	topical application of fluoride - excluding varnish	N	N	For individuals 21 years of age and older D1208 is only approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.		One of (D1208) per 6 Month(s) Per patient.	Not Applicable	N
D1320	tobacco counseling for control and prevention of oral disease	N	N				Not Applicable	N
D1354	interim caries arresting medicament application - per tooth	N	N	Covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service if D1354 is being used to treat caries and D1206 or D1208 is being used to prevent caries.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Two of (D1354) per 12 Month(s) Per patient, Same tooth. Four of (D1354) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D1999	Unspecified preventive procedure, by report	Y	N				narrative of medical necessity	N
D2140	Amalgam - one surface, primary or permanent	N	N		Teeth 1 - 32, A - T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335,	Not Applicable	N

						D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.		
D2150	Amalgam - two surfaces, primary or permanent	N	N		Teeth 1 - 32, A - T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2160	amalgam - three surfaces, primary or permanent	N	N		Teeth 1 - 32, A - T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2161	amalgam - four or more surfaces, primary or permanent	N	N		Teeth 1 - 32, A - T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392,	Not Applicable	N

						D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.		
D2330	resin-based composite - one surface, anterior	N	N		Teeth 6 - 11, 22 - 27, C - H, M - R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2331	resin-based composite - two surfaces, anterior	N	N		Teeth 6 - 11, 22 - 27, C - H, M - R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2332	resin-based composite - three surfaces, anterior	N	N		Teeth 6 - 11, 22 - 27, C - H, M - R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per	Not Applicable	N

						24 Month(s) Per patient, Same tooth/Same surface.		
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	N	N		Teeth 6 - 11, 22 - 27, C - H, M - R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2390	resin-based composite crown, anterior	N	N		Teeth 6 - 11, 22 - 27, C - H, M - R	One of (D2390) per 24 Month(s) Per patient, Same tooth.	Not Applicable	N
D2391	resin-based composite - one surface, posterior	N	N		Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2392	resin-based composite - two surfaces, posterior	N	N		Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391,	Not Applicable	N

						D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.		
D2393	resin-based composite - three surfaces, posterior	N	N		Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2394	resin-based composite - four or more surfaces, posterior	N	N		Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/Same surface.	Not Applicable	N
D2710	crown - resin- based composite (indirect)	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781,	pre- operative x- ray(s)	N

						D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.		
D2720	crown-resin with high noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2721	crown - resin with predominantly base metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2722	crown - resin with noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751,	pre- operative x- ray(s)	N

						D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.		
D2740	crown - porcelain/ceramic	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2750	crown - porcelain fused to high noble metal	Y	N	Crowns will not be routinely approved for a molar tooth in those beneficiaries age 21 and over which has been endodontically treated without prior approval from the Department of Health. The use of esthetic veneers is at the discretion of the provider as to when they are clinically indicated. Acrylic (processed) jacket crowns	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N

				may be approved as restorations for severely fractured anterior teeth. Crowns include any necessary core buildups.				
D2751	crown - porcelain fused to predominantly base metal	Y	N	Crowns will not be routinely approved for a molar tooth in those beneficiaries age 21 and over which has been endodontically treated without prior approval from the Department of Health. The use of esthetic veneers is at the discretion of the provider as to when they are clinically indicated. Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth. Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D2752	crown - porcelain fused to noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753,	pre-operative x-ray(s)	N

						D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.		
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	Y	N	Porcelain fused titanium crowns not dissimilar to any other PFM crowns.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2780	crown - $\frac{3}{4}$ cast high noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2781	crown - $\frac{3}{4}$ cast predominantly base metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740,	pre- operative x- ray(s)	N

						D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.		
D2782	crown - ¾ cast noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D2790	crown - full cast high noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N

D2791	crown - full cast predominantly base metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D2792	crown - full cast noble metal	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D2794	Crown- Titanium and Titanium Alloys	Y	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792,	pre-operative x-ray(s)	N

						D2794) per 60 Month(s) Per patient, Same tooth.		
D2920	re-cement or re-bond crown	N	N	Claims for recementation of a crown by the original provider within one year of placement, or claims for subsequent recementations of the same crown, will be pending for professional review. Documentation to justify the need and appropriateness of such recementations may be required as a condition for payment.	Teeth 1 - 32, A - T	One of (D2920) per 24 Month(s) Per patient, Same tooth.	Not Applicable	N
D2931	prefabricated stainless steel crown-permanent tooth	N	N	Crowns include any necessary core buildups.	Teeth 1 - 32	One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient, Same tooth.	Not Applicable	N
D2932	prefabricated resin crown	N	N	Crowns include any necessary core buildups.	Teeth 1 - 32, A - T	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.	Not Applicable	N
D2933	prefabricated stainless steel crown with resin window	N	N	Crowns include any necessary core buildups.	Teeth 1 - 32, A - T	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.	Not Applicable	N

D2951	pin retention - per tooth, in addition to restoration	N	N	Reimbursement is allowed once per tooth regardless of the number of pins placed.	Teeth 1 - 32	Two of (D2951) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D2952	cast post and core in addition to crown	N	N		Teeth 1 - 32	One of (D2952) per 60 Month(s) Per patient, Same tooth. One of (D2952, D2954) per Day(s) Per patient, Same tooth.	Not Applicable	N
D2954	prefabricated post and core in addition to crown	N	N	May not be billed in conjunction with endodontic therapy.	Teeth 1 - 32	One of (D2954) per 60 Month(s) Per patient, Same tooth. One of (D2952, D2954) per Day(s) Per patient, Same tooth.	Not Applicable	N
D2955	post removal (not in conjunction with endodontic therapy)	N	N		Teeth 1 - 32	One of (D2955) per 60 Month(s) Per patient, Same tooth.	Not Applicable	N
D2980	crown repair, by report	Y	N		Teeth 1 - 32	One of (D2980) per 60 Month(s) Per patient, Same tooth.	narrative of medical necessity	N
D2999	unspecified restorative procedure, by report	Y	N		Teeth 1 - 32, A - T		narr. of med. necessity, pre-op x-ray(s)	N
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	N	N	Not reimbursable if performed in conjunction with root canal therapy on the same date of service. This is not to be considered as the first stage of root canal therapy. This	Teeth 1 - 32, A - T	One of (D3220) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N

				procedure code may not be used when billing for an emergency pulpotomy which should be billed as palliative treatment (D9110).				
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Y	N		Teeth C - H, M - R	One of (D3230) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	Y	N		Teeth A, B, I - L, S, T	One of (D3240) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3310	endodontic therapy, anterior tooth (excluding final restoration)	Y	N	Includes primary teeth without succedaneous teeth and permanent teeth.	Teeth 6 - 11, 22 - 27	One of (D3310) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3320	endodontic therapy, premolar tooth (excluding final restoration)	Y	N		Teeth 4, 5, 12, 13, 20, 21, 28, 29	One of (D3320) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3330	endodontic therapy, molar tooth (excluding final restoration)	Y	N	Molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or; where there is a documented medical condition which	Teeth 1 - 3, 14 - 19, 30 - 32	One of (D3330) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N

				precludes extraction.				
D3346	retreatment of previous root canal therapy-anterior	Y	N		Teeth 6 - 11, 22 - 27	One of (D3346) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3347	retreatment of previous root canal therapy - premolar	Y	N		Teeth 4, 5, 12, 13, 20, 21, 28, 29	One of (D3347) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3348	retreatment of previous root canal therapy-molar	Y	N		Teeth 1 - 3, 14 - 19, 30 - 32	One of (D3348) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3410	apicoectomy - anterior	Y	N		Teeth 6 - 11, 22 - 27	One of (D3410) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3421	apicoectomy - premolar (first root)	Y	N		Teeth 4, 5, 12, 13, 20, 21, 28, 29	One of (D3421) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3425	apicoectomy - molar (first root)	Y	N		Teeth 1 - 3, 14 - 19, 30 - 32	One of (D3425) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3426	apicoectomy (each additional root)	Y	N		Teeth 1 - 5, 12 - 21, 28 - 32	One of (D3426) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3430	retrograde filling - per root	Y	N		Teeth 1 - 32	One of (D3430) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D3999	unspecified endodontic procedure, by report	Y	N		Teeth 1 - 32, A - T		narr. of med. necessity, pre-op x-ray(s)	N

D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Y	N	Reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. Documentation must be provided.	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4210, D4211) per 12 Month(s) Per patient, Same quadrant.	pre-op x-ray(s), perio charting	N
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Y	N	Reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. Documentation must be provided.	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4210, D4211) per 12 Month(s) Per patient, Same quadrant.	pre-op x-ray(s), perio charting	N
D4245	apically positioned flap	Y	N		Teeth 1 - 32	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Not Applicable	N
D4266	guided tissue regenerate-resorbable barrier, per site, per tooth	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4266, D4267) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D4267	guided tissue regeneration - nonresorbable barrier, per site, per tooth	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4266, D4267) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N

D4273	subepithelial connective tissue graft procedure	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4273, D4275) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D4275	soft tissue allograft	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4273, D4275) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	Y	N		Teeth 1 - 32	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Not Applicable	N
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4278) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4283, D4285) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth,	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D4283, D4285) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N

	implant or edentulous tooth position in same graft site							
D4341	periodontal scaling and root planing - four or more teeth per quadrant	Y	N	A minimum of four (4) teeth in the affected quadrant. Limit of four different quadrants within a 24 month period. Limit of 2 quadrants on the same date of service. Prophylaxis or periodontal maintenance (D1110, D1120 or D4910) will not be reimbursed on the same date of service. May be billed for those beneficiaries who have periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated.	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	pre-op x-ray(s), perio charting	N
D4342	periodontal scaling and root planing - one to three teeth per quadrant	N	N	A minimum of Three (3) teeth in the affected quadrant. Limit of four different quadrants within a 24 month period. Limit of 2 quadrants on the same date of service. Prophylaxis or periodontal maintenance (D1110, D1120 or D4910) will not be reimbursed on the same date of	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	Not Applicable	N

				service. May be billed for those beneficiaries who have periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated.				
D4910	periodontal maintenance procedures	N	N	Includes removal of bacterial plaque and calculus from subgingival and supragingival regions. Cannot be used in conjunction with, or billed within six (6) months of any other prophylaxis procedure (e.g. D1110).		One of (D4910) per 6 Month(s) Per patient.	Not Applicable	N
D4999	unspecified periodontal procedure, by report	Y	N				narrative of medical necessity	N
D5110	complete denture - maxillary	Y	N			One of (D5110, D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5120	complete denture - mandibular	Y	N			One of (D5120, D5212, D5214, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Y	N			One of (D5110, D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N

D5212	mandibular partial denture – resin base (including retentive /clasping materials, rests, and teeth)	Y	N			One of (D5120, D5212, D5214, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Y	N			One of (D5110, D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Y	N			One of (D5120, D5212, D5214, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5225	maxillary partial denture-flexible base	Y	N			One of (D5110, D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5226	mandibular partial denture-flexible base	Y	N			One of (D5120, D5212, D5214, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)	N
D5410	adjust complete denture - maxillary	N	N	Not covered within 6 months of placement.		Four of (D5410) per 12 Month(s) Per patient.	Not Applicable	N
D5411	adjust complete denture - mandibular	N	N	Not covered within 6 months of placement.		Four of (D5411) per 12 Month(s) Per patient.	Not Applicable	N
D5421	adjust partial denture-maxillary	N	N	Not covered within 6 months of placement.		Four of (D5421) per 12 Month(s) Per patient.	Not Applicable	N
D5422	adjust partial denture - mandibular	N	N	Not covered within 6 months of placement.		Four of (D5422) per 12 Month(s) Per patient.	Not Applicable	N

D5511	repair broken complete denture base, mandibular	N	N			Two of (D5511) per 12 Month(s) Per patient.	Not Applicable	N
D5512	repair broken complete denture base, maxillary	N	N			Two of (D5512) per 12 Month(s) Per patient.	Not Applicable	N
D5520	replace missing or broken teeth - complete denture (each tooth)	N	N		Teeth 1 - 32	One of (D5520) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D5611	repair resin partial denture base, mandibular	N	N			Two of (D5611) per 12 Month(s) Per patient.	Not Applicable	N
D5612	repair resin partial denture base, maxillary	N	N			Two of (D5612) per 12 Month(s) Per patient.	Not Applicable	N
D5621	repair cast partial framework, mandibular	N	N			One of (D5621) per 12 Month(s) Per patient.	Not Applicable	N
D5622	repair cast partial framework, maxillary	N	N			One of (D5622) per 12 Month(s) Per patient.	Not Applicable	N
D5630	repair or replace broken retentive/clasping materials per tooth	N	N		Teeth 1 - 32	Two of (D5630) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D5640	replace broken teeth-per tooth	N	N		Teeth 1 - 32	One of (D5640) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D5650	add tooth to existing partial denture	N	N		Teeth 1 - 32	One of (D5650) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D5660	add clasp to existing partial denture	N	N		Teeth 1 - 32	One of (D5660) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D5710	rebase complete maxillary denture	N	N	Not covered within 6 months of placement.		One of (D5710) per 60 Month(s) Per patient.	Not Applicable	N

D5711	rebase complete mandibular denture	N	N	Not covered within 6 months of placement.		One of (D5711) per 60 Month(s) Per patient.	Not Applicable	N
D5720	rebase maxillary partial denture	N	N	Not covered within 6 months of placement.		One of (D5720) per 60 Month(s) Per patient.	Not Applicable	N
D5721	rebase mandibular partial denture	N	N	Not covered within 6 months of placement.		One of (D5721) per 60 Month(s) Per patient.	Not Applicable	N
D5730	reline complete maxillary denture (chairside)	N	N	Not covered within 6 months of placement.		One of (D5730) per 12 Month(s) Per patient.	Not Applicable	N
D5731	reline complete mandibular denture (chairside)	N	N	Not covered within 6 months of placement.		One of (D5731) per 12 Month(s) Per patient.	Not Applicable	N
D5740	reline maxillary partial denture (chairside)	N	N	Not covered within 6 months of placement.		One of (D5740) per 12 Month(s) Per patient.	Not Applicable	N
D5741	reline mandibular partial denture (chairside)	N	N	Not covered within 6 months of placement.		One of (D5741) per 12 Month(s) Per patient.	Not Applicable	N
D5750	reline complete maxillary denture (laboratory)	N	N	Not covered within 6 months of placement.		One of (D5750) per 24 Month(s) Per patient.	Not Applicable	N
D5751	reline complete mandibular denture (laboratory)	N	N	Not covered within 6 months of placement.		One of (D5751) per 24 Month(s) Per patient.	Not Applicable	N
D5760	reline maxillary partial denture (laboratory)	N	N	Not covered within 6 months of placement.		One of (D5760) per 24 Month(s) Per patient.	Not Applicable	N
D5761	reline mandibular partial denture (laboratory)	N	N	Not covered within 6 months of placement.		One of (D5761) per 24 Month(s) Per patient.	Not Applicable	N
D5850	tissue conditioning, maxillary	N	N	Once per denture prior to reline, rebase, or impression for new denture. Payable within six (6) months prior to the delivery of a new prosthesis.		One of (D5850) per 60 Month(s) Per patient.	Not Applicable	N

D5851	tissue conditioning,mandibular	N	N	Once per denture prior to reline, rebase, or impression for new denture. Payable within six (6) months prior to the delivery of a new prosthesis.		One of (D5851) per 60 Month(s) Per patient.	Not Applicable	N
D5899	unspecified removable prosthodontic procedure, by report	Y	N				Narr. of med. necessity, pre and post-op x-ray(s)	N
D5911	facial moulage (sectional)	Y	N			One of (D5911) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5912	facial moulage (complete)	Y	N			One of (D5912) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5913	nasal prosthesis	Y	N			One of (D5913) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5914	auricular prosthesis	Y	N			One of (D5914) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5915	orbital prosthesis	Y	N			One of (D5915) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5916	ocular prosthesis	Y	N			One of (D5916) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5919	facial prosthesis	Y	N			Six of (D5919) per 2 Month(s) Per patient.	narrative of medical necessity	N
D5922	nasal septal prosthesis	Y	N			One of (D5922) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5923	ocular prosthesis, interim	Y	N			One of (D5923) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5924	cranial prosthesis	Y	N			One of (D5924) per	narrative of medical necessity	N

						12 Month(s) Per patient.		
D5925	facial augment implant prosthesis	Y	N			One of (D5925) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5926	nasal prosthesis, replacement	Y	N			One of (D5926) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5927	auricular prosthesis, replace	Y	N			One of (D5927) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5928	orbital prosthesis, replace	Y	N			One of (D5928) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5929	facial prosthesis, replacement	Y	N			One of (D5929) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5931	obturator prosthesis, surgical	Y	N			One of (D5931) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5932	obturator prosthesis, definitive	Y	N			One of (D5932) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5933	obturator prosthesis, modification	Y	N			One of (D5933) per 6 Month(s) Per patient.	narrative of medical necessity	N
D5934	mandibular resection prosthesis with guide flange	Y	N			One of (D5934) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5935	mandibular resection prosthesis without guide flange	Y	N			One of (D5935) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5936	obturator prosthesis, interim	Y	N			One of (D5936) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5937	trismus appliance (not for TMD treatment)	Y	N			One of (D5937) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5951	feeding aid	Y	N			One of (D5951) per 12 Month(s) Per patient.	narrative of medical necessity	N

D5952	speech aid prosthesis, pediatric	Y	N			One of (D5952) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5953	speech aid prosthesis, adult	Y	N			One of (D5953) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5954	palatal augment prosthesis	Y	N			One of (D5954) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5955	palatal lift prosthesis, definitive	Y	N			One of (D5955) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5958	palatal lift prosthesis, interim	Y	N			One of (D5958) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5959	palatal lift prosthesis, modification	Y	N			One of (D5959) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5960	speech aid prosthesis, modification	Y	N			One of (D5960) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5982	surgical stent	Y	N			One of (D5982) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5983	radiation carrier	Y	N			One of (D5983) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5984	radiation shield	Y	N			One of (D5984) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5985	radiation cone locator	Y	N			One of (D5985) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5986	fluoride gel carrier	Y	N		Per Arch (01, 02, LA, UA)	Two of (D5986) per 12 Month(s) Per patient, Same Arch.	narrative of medical necessity	N
D5987	commissure splint	Y	N			One of (D5987) per 12 Month(s) Per patient.	narrative of medical necessity	N

D5988	surgical splint	Y	N			One of (D5988) per 12 Month(s) Per patient.	narrative of medical necessity	N
D5999	unspecified maxillofacial prosthesis, by report	Y	N				narrative of medical necessity	N
D6010	surgical placement of implant body: endosteal implant	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6010, D6013) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D6013	surgical placement of mini implant	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6010, D6013) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D6055	connecting bar - implant supported or abutment supported	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Per Arch (01, 02, LA, UA)	One of (D6055) per 1 Lifetime Per patient, Same Arch.	Not Applicable	N

D6056	prefabricated abutment	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6056, D6057) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6057	custom abutment	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6056, D6057) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6058	abutment supported porcelain/ceramic crown	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6059	abutment supported porcelain fused to metal crown (high noble metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N

D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6061	abutment supported porcelain fused to metal crown (noble metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6062	abutment supported cast metal crown (high noble metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6063	abutment supported cast metal crown (predominantly base metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6064	abutment supported cast metal crown (noble metal)	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6058, D6059, D6060, D6061, D6062, D6063, D6064) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N

D6065	implant supported porcelain/ceramic crown	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6065, D6066, D6067) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6066	Implant Supported Crown- Porcelain Fused to High Noble Alloys	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6065, D6066, D6067) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6067	Implant Supported Crown- High Noble Alloys	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva.	Teeth 1 - 32	One of (D6065, D6066, D6067) per 96 Month(s) Per patient, Same tooth.	Not Applicable	N
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	Y	N	Cannot bill for same date of service as D1110 or D4910. Cannot bill for same date of service and same quadrant as D4241, D4342. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D6081) per 12 Month(s) Per patient, Same tooth.	Not Applicable	N
D6090	repair implant prosthesis	Y	N	Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6090) per 12 Month(s) Per patient.	narrative of medical necessity	N
D6091	replacement of attachment-implant/abutment prosthesis	Y	N	Please see detailed requirements in Implants section of ORM	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D6091) per 12 Month(s) Per patient, Same quadrant.	narrative of medical necessity	N

D6092	re-cement or re-bond implant/abutment supported crown	Y	N	Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6092) per 2 Year(s) Per patient, Same tooth.	narrative of medical necessity	N
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	Y	N	Please see detailed requirements in Implants section of ORM	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D6093) per 2 Year(s) Per patient, Same quadrant.	narrative of medical necessity	N
D6094	Abutment supported crown-titanium and titanium alloys	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D6094) per 8 Year(s) Per patient, Same tooth.	Not Applicable	N
D6095	repair implant abutment	Y	N	Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6095) per 12 Month(s) Per patient, Same tooth.	narrative of medical necessity	N
D6096	remove broken implant retaining screw	Y	N	Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6096) per 12 Month(s) Per patient, Same tooth.	narrative of medical necessity	N
D6100	implant removal, by report	Y	N		Teeth 1 - 32	Please see detailed requirements in Implants section of ORM	narrative of medical necessity	N
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	Y	N	Pre-operative x-ray(s), detailed narrative, intra-oral photo of defect area. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6101, D6102) per 2 Year(s) Per patient, Same tooth.	Not Applicable	N

D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Y	N	Pre-operative x-ray(s), detailed narrative, intra-oral photo of defect area. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6101, D6102) per 2 Year(s) Per patient, Same tooth.	Not Applicable	N
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	Y	N	Pre-operative x-ray(s), detailed narrative, intra-oral photo of defect area. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6103) per 2 Year(s) Per patient, Same tooth.	Not Applicable	N
D6104	Bone graft at time of implant placement	Y	N	Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6104) per 1 Lifetime Per patient, Same tooth.	narrative of medical necessity	N
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva. Please see detailed requirements in Implants section of ORM.	Per Arch (01, 02, LA, UA)	One of (D6110, D6112) per 96 Month(s) Per patient, Same Arch.	Not Applicable	N
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva. Please	Per Arch (01, 02, LA, UA)	One of (D6111, D6113) per 96 Month(s) Per patient, Same Arch.	Not Applicable	N

				see detailed requirements in Implants section of ORM.				
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva. Please see detailed requirements in Implants section of ORM.	Per Arch (01, 02, LA, UA)	One of (D6110, D6112) per 96 Month(s) Per patient, Same Arch.	Not Applicable	N
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Y	N	Periapical radiograph of integrated implant with abutment and intra-oral photo of healed abutment showing healthy gingiva. Please see detailed requirements in Implants section of ORM.	Per Arch (01, 02, LA, UA)	One of (D6111, D6113) per 96 Month(s) Per patient, Same Arch.	Not Applicable	N
D6190	radiographic/surgical implant index, by report	Y	N	Please see detailed requirements in Implants section of ORM	Per Arch (01, 02, LA, UA)	One of (D6190) per 12 Month(s) Per patient, Same Arch.	narrative of medical necessity	N
D6191	semi-precision abutment – placement	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6191) per 96 Month(s) Per patient, Same tooth.	Full mouth x-rays	N

D6192	semi-precision attachment – placement	Y	N	Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided. Please see detailed requirements in Implants section of ORM	Teeth 1 - 32	One of (D6192) per 96 Month(s) Per patient, Same tooth.	Full mouth x-rays	N
D6199	unspecified implant procedure	Y	N		Teeth 1 - 32	Please see detailed requirements in Implants section of ORM	narrative of medical necessity	N
D6210	pontic - cast high noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6211	pontic-cast base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N

D6212	pontic - cast noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6214	Pontic - titanium and titanium alloys	Y	N		Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6240	pontic-porcelain fused-high noble	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6241	pontic-porcelain fused to base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242,	pre-operative x-ray(s)	N

				services will only be approved in extreme situations.		D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.		
D6242	pontic-porcelain fused-noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6243	Pontic - Porcelain fused to titanium and titanium alloys	Y	N	Crowns utilized in fixed bridges alloyed to titanium replacing a missing tooth or teeth.	Teeth 2 - 15, 18 - 31	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6245	prosthodontics fixed, pontic - porcelain/ceramic	Y	N		Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N

D6250	pontic-resin with high noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6251	pontic-resin with base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6252	pontic-resin with noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 6 - 11, 22 - 27	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6545	retainer - cast metal fixed	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These	Teeth 5 - 12, 21 - 28	One of (D6545) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N

				services will only be approved in extreme situations.				
D6720	crown-resin with high noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6721	crown-resin with base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6722	crown-resin with noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753,	pre-operative x-ray(s)	N

				only be approved in extreme situations.		D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.		
D6740	retainer crown – porcelain/ceramic	Y	N		Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6750	crown-porcelain fused high noble	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N

D6751	crown-porcelain fused to base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6752	crown-porcelain fused noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6753	Retainer Crown-Porcelain fused to titanium and titanium alloys	Y	N	Crowns utilized in fixed bridges alloyed to titanium that support pontics.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784,	pre-operative x-ray(s)	N

						D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.		
D6780	crown-3/4 cst high noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D6781	prosthodontics fixed, crown $\frac{3}{4}$ cast predominantly based metal	Y	N		Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D6782	prosthodontics fixed, crown $\frac{3}{4}$ cast noble metal	Y	N		Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751,	pre- operative x- ray(s)	N

						D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.		
D6783	prosthodontics fixed, crown $\frac{3}{4}$ porcelain/ceramic	Y	N		Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	Y	N	Crowns utilized in fixed bridges alloyed to titanium that support pontics that are not full coverage.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N

D6790	crown-full cast high noble	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6791	crown - full cast base metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	N
D6792	crown - full cast noble metal	Y	N	Fixed Bridgework is considered beyond the scope of the New York State Medicaid program. These services will only be approved in extreme situations.	Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784,	pre-operative x-ray(s)	N

						D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.		
D6794	Retainer crown - titanium and titanium alloys	Y	N		Teeth 5 - 12, 21 - 28	One of (D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient, Same tooth.	pre- operative x- ray(s)	N
D6930	re-cement or re- bond fixed partial denture	N	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D6930) per 24 Month(s) Per patient, Same quadrant.	Not Applicable	N
D6980	fixed partial denture repair	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D6980) per 60 Month(s) Per patient, Same quadrant.	narrative of medical necessity	N
D6999	fixed prosthodontic procedure	Y	N		Teeth 1 - 32		narrative of medical necessity	N
D7111	extraction, coronal remnants - primary tooth	N	N		Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7111) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N

D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	N	N		Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7140) per 1 Lifetime Per patient, Same tooth.	Not Applicable	N
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Y	N		Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Includes cutting of gingiva and bone, removal of tooth structure and closure.	pre-operative x-ray(s)	N
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	N	N		Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Includes cutting of gingiva and bone, removal of tooth structure and closure.	Not Applicable	N
D7220	removal of impacted tooth-soft tissue	Y	N	Removal of asymptomatic tooth not covered.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7220) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D7230	removal of impacted tooth-partially bony	Y	N	Removal of asymptomatic tooth not covered.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7230) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D7240	removal of impacted tooth-completely bony	Y	N	Removal of asymptomatic tooth not covered.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7240) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N

					QS, RS, SS, TS			
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	Y	N	Removal of asymptomatic tooth not covered.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7241) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D7250	surgical removal of residual tooth roots (cutting procedure)	Y	N	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7250) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)	N
D7260	oroantral fistula closure	Y	N		Per Quadrant (UL, UR)	One of (D7260) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7261	primary closure of a sinus perforation	Y	N		Per Quadrant (UL, UR)	One of (D7261) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Y	N	Includes splinting and/or stabilization.	Teeth 1 - 32	One of (D7270) per 1 Lifetime Per patient, Same tooth.	narr. of med. necessity, pre-op x-ray(s)	N
D7272	tooth transplantation (includes reimplantation from one site to another)	Y	N	Includes splinting and/or stabilization.	Teeth 1 - 32	One of (D7272) per 1 Lifetime Per patient, Same tooth.	narr. of med. necessity, pre-op x-ray(s)	N
D7280	Surgical access of an unerupted tooth	Y	N		Teeth 1 - 32	One of (D7280) per 1 Lifetime Per patient, Same tooth.	narr. of med. necessity, pre-op x-ray(s)	N

D7283	placement of device to facilitate eruption of impacted tooth	Y	N		Teeth 1 - 32	One of (D7283) per 1 Lifetime Per patient, Same tooth.	narr. of med. necessity, pre-op x-ray(s)	N
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	Y	N			One of (D7285) per 12 Month(s) Per patient.	Pathology report	N
D7286	incisional biopsy of oral tissue-soft	Y	N			One of (D7286) per 12 Month(s) Per patient, Same quadrant.	Pathology report	N
D7290	surgical repositioning of teeth	Y	N		Teeth 1 - 32	One of (D7290) per 1 Lifetime Per patient, Same tooth.	narrative of medical necessity	N
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Y	N	For non-surgical extractions only.	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N

D7340	vestibuloplasty - ridge extension (secondary epithelialization)	Y	N	Only those cases in which a patient could not otherwise wear a denture successfully.	Per Arch (01, 02, LA, UA)	Two of (D7340) per 60 Month(s) Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	N
D7350	vestibuloplasty - ridge extension	Y	N	Only those cases in which a patient could not otherwise wear a denture successfully.	Per Arch (01, 02, LA, UA)	Two of (D7350) per 60 Month(s) Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	N
D7410	radical excision - lesion diameter up to 1.25cm	Y	N				Pathology report	N
D7411	excision of benign lesion greater than 1.25 cm	Y	N				Pathology report	N
D7412	excision of benign lesion, complicated	Y	N				Pathology report	N
D7413	excision of malignant lesion up to 1.25 cm	Y	N				Pathology report	N
D7414	excision of malignant lesion greater than 1.25 cm	Y	N				Pathology report	N
D7415	excision of malignant lesion, complicated	Y	N				Pathology report	N
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Pathology report	N
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Pathology report	N
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Pathology report	N
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Pathology report	N
D7460	removal of nonodontogenic cyst or tumor -	Y	N		Per Quadrant (10, 20, 30,		Pathology report	N

	lesion diameter up to 1.25cm				40, LL, LR, UL, UR)			
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Pathology report	N
D7465	destruction of lesion(s) by physical or chemical method, by report	Y	N				Pathology report	N
D7471	removal of exostosis - per site	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7471) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7472	removal of torus palatinus	Y	N				narr. of med. necessity, pre-op x-ray(s)	N
D7473	removal of torus mandibularis	Y	N		Per Quadrant (LL, LR)		narr. of med. necessity, pre-op x-ray(s)	N
D7485	surgical reduction of osseous tuberosity	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7485) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7490	radical resection of maxilla or mandible	Y	N		Per Arch (01, 02, LA, UA)		narrative of medical necessity	N
D7510	incision and drainage of abscess - intraoral soft tissue	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Includes insertion and removal of all drains.	narr. of med. necessity, pre-op x-ray(s)	N
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Includes insertion and removal of all drains.	narr. of med. necessity, pre-op x-ray(s)	N
D7520	incision and drainage of abscess - extraoral soft tissue	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Includes insertion and removal of all drains.	narr. of med. necessity, pre-op x-ray(s)	N

D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Includes insertion and removal of all drains.	narr. of med. necessity, pre-op x-ray(s)	N
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		narr. of med. necessity, pre-op x-ray(s)	N
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	May include but not limited to removal of splinters, pieces of wire, bone plates, screw, etc. from muscle and / or bone.	narr. of med. necessity, pre-op x-ray(s)	N
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		narr. of med. necessity, pre-op x-ray(s)	N
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	Y	N		Per Quadrant (UL, UR)		narr. of med. necessity, pre-op x-ray(s)	N
D7610	maxilla - open reduction	Y	N				narrative of medical necessity	N
D7620	maxilla - closed reduction	Y	N				narrative of medical necessity	N
D7630	mandible-open reduction	Y	N				narrative of medical necessity	N
D7640	mandible - closed reduction	Y	N				narrative of medical necessity	N
D7650	malar and/or zygomatic arch-open reduction	Y	N		Per Arch (01, 02, LA, UA)		narrative of medical necessity	N
D7660	malar and/or zygomatic arch-closed	Y	N		Per Arch (01, 02, LA, UA)		narrative of medical necessity	N

D7670	alveolus stabilization of teeth, closed reduction splinting	Y	N				narrative of medical necessity	N
D7671	alveolus - open reduction, may include stabilization of teeth	Y	N				narrative of medical necessity	N
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	Y	N				narrative of medical necessity	N
D7710	maxilla - open reduction	Y	N				narrative of medical necessity	N
D7720	maxilla - closed reduction	Y	N				narrative of medical necessity	N
D7730	mandible - open reduction	Y	N				narrative of medical necessity	N
D7740	mandible - closed reduction	Y	N				narrative of medical necessity	N
D7750	malar and/or zygomatic arch-open reduction	Y	N		Per Arch (01, 02, LA, UA)		narrative of medical necessity	N
D7760	malar and/or zygomatic arch-closed reduction	Y	N		Per Arch (01, 02, LA, UA)		narrative of medical necessity	N
D7770	alveolus-stabilization of teeth, open reduction splinting	Y	N				narrative of medical necessity	N
D7771	alveolus, closed reduction stabilization of teeth	Y	N				narrative of medical necessity	N
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	Y	N				narrative of medical necessity	N
D7810	open reduction of dislocation	Y	N				narrative of medical necessity	N
D7820	closed reduction dislocation	Y	N				narrative of medical necessity	N

D7830	manipulation under anesthesia	Y	N				narrative of medical necessity	N
D7840	condylectomy	Y	N				narrative of medical necessity	N
D7850	surgical discectomy, with/without implant	Y	N			Two of (D7850) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7852	disc repair	Y	N			Two of (D7852) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7854	synovectomy	Y	N			Two of (D7854) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7856	myotomy	Y	N			Two of (D7856) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7858	joint reconstruction	Y	N			Two of (D7858) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7860	arthrotomy	Y	N			Two of (D7860) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7865	arthroplasty	Y	N			Two of (D7865) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7870	arthrocentesis	Y	N			One of (D7870) per 6 Month(s) Per patient.	narrative of medical necessity	N
D7872	arthroscopy - diagnosis with or without biopsy	Y	N			Two of (D7872) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7873	arthroscopy-surgical: lavage and lysis of adhesions	Y	N			Two of (D7873) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7874	arthroscopy-surgical: disc repositioning and stabilization	Y	N			Two of (D7874) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7875	arthroscopy-surgical synovectomy	Y	N			Two of (D7875) per 1 Lifetime Per patient.	narrative of medical necessity	N

D7876	arthroscopy-surgery discectomy	Y	N			Two of (D7876) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7877	arthroscopy-surgical debridement	Y	N			Two of (D7877) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7880	occlusal orthotic device, by report	Y	N	Reimbursable only when performed in conjunction with a covered surgical procedure. Not used for night guards, occlusal guards, bruxism appliances, or other TMJ appliances.		One of (D7880) per 12 Month(s) Per patient.	narrative of medical necessity	N
D7899	unspecified TMD therapy, by report	Y	N				narrative of medical necessity	N
D7910	suture small wounds up to 5 cm	Y	N				narrative of medical necessity	N
D7911	complicated suture-up to 5 cm	Y	N				narrative of medical necessity	N
D7912	complex suture - greater than 5cm	Y	N				narrative of medical necessity	N
D7920	skin graft (identify defect covered, location and type of graft)	Y	N				narrative of medical necessity	N
D7940	osteoplasty- for orthognathic deformities	Y	N				narrative of medical necessity	N
D7941	osteotomy - madibular rami	Y	N				narrative of medical necessity	N
D7943	osteotomy-mandibular rami with bone graft; includes obtaining the graft	Y	N				narrative of medical necessity	N
D7944	osteotomy - segmented or subapical - per sextant or quadrant	Y	N				narrative of medical necessity	N

D7945	osteotomy - body of mandible	Y	N				narrative of medical necessity	N
D7946	LeFort I (maxilla - total)	Y	N				narrative of medical necessity	N
D7947	LeFort I (maxilla - segmented)	Y	N				narrative of medical necessity	N
D7948	LeFort II or LeFort III - without bone graft	Y	N				narrative of medical necessity	N
D7949	LeFort II or LeFort III - with bone graft	Y	N				narrative of medical necessity	N
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Y	N				narrative of medical necessity	N
D7951	sinus augmentation	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7951) per 1 Lifetime Per patient, Same quadrant.	narrative of medical necessity	N
D7952	Sinus augmentation via a vertical approach	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	The augmentation of the sinus to increase vertical height access through the ridge crest by raising the floor of the sinus and grafting as necessary through the use of bone or bone substitutes.	narrative of medical necessity	N
D7953	bone replacement graft for ridge preservation - per site	Y	N	Reimbursement is limited to implant cases only. Please see detailed requirements in Implants section of ORM.	Teeth 1 - 32	One of (D7953) per 1 Lifetime Per patient, Same tooth.	narrative of medical necessity	N

D7961	buccal / labial frenectomy (frenulectomy)	Y	N	For pre-prosthetic correction of ankyloglossia or in association with orthodontic treatment. Indication must be documented in patient record.	Per Arch (01, 02, LA, UA)	Three of (D7961) per 1 Lifetime Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	N
D7962	lingual frenectomy (frenulectomy)	Y	N	For pre-prosthetic correction of ankyloglossia or in association with orthodontic treatment. Indication must be documented in patient record.	Per Arch (01, 02, LA, UA)	Three of (D7962) per 1 Lifetime Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	N
D7970	excision of hyperplastic tissue - per arch	Y	N	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	Per Arch (01, 02, LA, UA)	Two of (D7970) per 1 Lifetime Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	N
D7971	excision of pericoronal gingiva	Y	N		Teeth 1 - 32	One of (D7971) per 24 Month(s) Per patient, Same tooth.	narr. of med. necessity, post-op x-ray(s)	N
D7972	surgical reduction of fibrous tuberosity	Y	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Two of (D7972) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)	N
D7980	surgical sialolithotomy	Y	N				narrative of medical necessity	N
D7981	excision of salivary gland, by report	Y	N				narrative of medical necessity	N
D7982	sialodochoplasty	Y	N				narrative of medical necessity	N

D7983	closure of salivary fistula	Y	N				narr. of med. necessity, pre-op x-ray(s)	N
D7990	emergency tracheotomy	Y	N				narrative of medical necessity	N
D7991	coronoidectomy	Y	N			One of (D7991) per 1 Lifetime Per patient.	narrative of medical necessity	N
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	Y	N		Per Arch (01, 02, LA, UA)	Not for removal of orthodontic appliances. Includes both arches, if necessary.	narrative of medical necessity	N
D7998	intraoral fixation device---non-fracture	Y	N				narrative of medical necessity	N
D7999	unspecified oral surgery procedure, by report	Y	N				narrative of medical necessity	N
D9110	palliative (emergency) treatment of dental pain - minor procedure	N	N	Not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with comprehensive or periodic oral examinations.		Two of (D9110) per 12 Month(s) Per patient.	Not Applicable	N
D9120	fixed partial denture sectioning	N	N		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Not Applicable	N
D9222	deep sedation/general anesthesia first 15 minutes	Y	N	Only reimbursable when provided by a qualified dental provider who has the appropriate level of certification in Dental Anesthesia.		Two of (D9222) per 1 Week(s) Per patient.	narrative of medical necessity	N

D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	Y	N			Only reimbursable when provided by a qualified dental provider who has the appropriate level of certification in Dental Anesthesia.	narrative of medical necessity	N
D9239	intravenous moderate (conscious) sedation/analgesia - first 15 minutes	Y	N	Only reimbursable when provided by a qualified dental provider who has the appropriate level of certification in Dental Anesthesia.		Two of (D9239) per 1 Week(s) Per patient.	narrative of medical necessity	N
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	Y	N			Only reimbursable when provided by a qualified dental provider who has the appropriate level of certification in Dental Anesthesia.	narrative of medical necessity	N
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	N	N	Will not be reimbursed if claimed by the same provider within 180 days of an examination (D0120, D0140, D0150, D0160, D9110) or an office visit for observation (D9430). An exception can be made if a subsequent consultation is held for a distinctly		One of (D9310) per 6 Month(s) Per patient.	Not Applicable	N

				different condition, supported by documentation				
D9410	house/extended care facility call	N	N	Applies to patients seen in homes (boarding, nursing, convalescent, proprietary for adults, private for the aged, for the blind, residence). Not paid for individuals in facilities where dental services are included in the facility rate. Reimbursement is per visit, regardless of number of beneficiaries seen.		One of (D9410) per Day(s) Per patient.	Not Applicable	N
D9420	hospital or ambulatory surgical center call	N	N	Professional visits for pre-operative or operative care. Payable only when provided in a facility where professional services are not included in the rate.		Three of (D9420) per 1 Week(s) Per patient.	Not Applicable	N
D9430	office visit for observation - no other services performed	N	N	Cannot be used with any treatment codes or behavior management (D9920) on the same date of service. Limited to specialists for non-referred patients. Used		Four of (D9430) per 12 Month(s) Per patient.	Not Applicable	N

				to monitor the status of a beneficiary following an authorized phase of surgical treatment that are required beyond the follow up period for that procedure listed in the fee schedule. Not be used for orthodontic retention follow-up visits.				
D9440	office visit - after regularly scheduled hours	Y	N	Office visit - after regularly scheduled hours (REPORT NEEDED) Cannot be billed in conjunction with an examination, observation or consultation. Please include a report or narrative describing the circumstances involved.		One of (D9440) per Day(s) Per patient.	narrative of medical necessity	N
D9610	therapeutic drug injection, by report	Y	N			Name of drug with claim.	narrative of medical necessity	N
D9944	occlusal guard--hard appliance, full arch	N	N		Per Arch (01, 02, LA, UA)	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	Not Applicable	N
D9945	occlusal guard--soft appliance full arch	N	N		Per Arch (01, 02, LA, UA)	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	Not Applicable	N
D9946	occlusal guard--hard appliance, partial arch	N	N		Per Arch (01, 02, LA, UA)	One of (D9944, D9945, D9946) per	Not Applicable	N

						12 Month(s) Per patient.		
D9990	certified translation or sign-language services per visit	N	N			Two of (D9990) per Day(s) Per patient.	Not Applicable	N
D9995	teledentistry – synchronous; real-time encounter	N	N				Not Applicable	N
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	N	N				Not Applicable	N
D9997	Dental case management - patients with special health care needs	Y	N			This code is not billable in conjunction with D9430. Not billable as a stand alone procedure or in combination with deep sedation/general anesthesia. Another billable clinical service must be provided on the same date of service.	narrative of medical necessity	N
D9999	unspecified adjunctive procedure, by report	Y	N				narrative of medical necessity	N

SECTION 12: MEDICAL/SERVICE RECORD DOCUMENTATION STANDARDS

Unlike typical health plans that primarily focus on the management of physical and behavioral health services, PHP's responsibilities also include the management of the full continuum of Medicaid-covered long-term services and supports, including OPWDD waiver services such as habilitation, supported employment, respite care, personal care, transportation, and other non-clinical supports and services. For this reason, this section refers to both "medical" as well as "service" record documentation standards.

Medical and Service Records, whether electronic or on paper, communicate the participant's treatment history, past and current health status, and future treatment plans, as applicable.

Effective documentation facilitates communication, coordination, and continuity of care, and promotes the efficiency and effectiveness of treatment.

Partners Health Plan's (PHP) standards require providers/practitioners to:

- Maintain medical/service records in a manner that is up to date, detailed, and organized.
- Maintain a separate, distinct medical/service record for each participant.
- Have an organized medical/service record-keeping system.

Medical/Service Record Reviews

Network providers/practitioners must grant PHP access to medical/service records, including confidential participant information, for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing UM functions.

For this specialized managed care program, medical/service record audits will typically involve a review of five (5) randomly selected medical/service records for each applicable provider. QM staff will randomly select provider locations so that each site is reviewed at least once every three years; however, if a site has a prior identified issue PHP will continuously re-audit that site until the matter is resolved.

QM or Provider Relations staff will use a standardized assessment tool to monitor compliance with medical/service record policies and procedures as well as with evidence-based clinical/LTSS guidelines and protocols. This includes reviewing the medical records of nursing facility and ICF/IID residents for completeness, legibility, and the presence of all information required by state and federal regulations and guidelines.

Content of the Medical/Service Record

Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the PCP, and all diagnostic and therapeutic services for which the participant was referred by the PCP (e.g., specialty physician reports, hospital discharge reports, physical therapy reports, etc.). Specific content standards are reflected in the following table:

Participant Information	Each participant record must contain appropriate biographical/personal data including age, gender, race/ethnicity, address, employer, home and work telephone numbers, emergency contact, marital status, name of participant's PCP, and PHP ID number. All participants must have their own chart (i.e., no family charts). A centralized medical record for the provision of prenatal care and all other services must be maintained.
Provider Information	<p>The service provider for face-to-face encounters must be appropriately identified on medical/service records via their signature and physician/professional specialty credentials (e.g., MD, DO, DPM, LCSW, LMHP, etc.). Examples of acceptable signatures include:</p> <ul style="list-style-type: none"> •Handwritten signature or initials •Electronic signature with authentication by the respective provider •Facsimiles of original written or electronic signatures <p>This means that the credentials for the service provider must be somewhere on the medical/service record, either next to the provider's signature or preprinted with the provider's name on the group practice's stationery. If the service provider is not listed on the stationery, then the credentials must be part of the signature for that provider.</p>
Date	All entries must be dated.
Legibility	All entries must be legible to someone other than the writer. The medical/service record should be complete and legible; illegible medical record entries can lead to misunderstanding and serious patient injury.
Medications	Evidence of prescribed medications, including dosages and dates of initial and refill prescriptions, must be present in the record. This list should be updated following each visit.
Medication Allergies and Adverse Reactions	The presence or absence of medication allergies and/or adverse reactions should be prominently noted as NKA (no known allergies) or NKDA (no known drug allergies).

Problem List	A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10 (as applicable) diagnosis code on the date of service. A problem list should be either a classical separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and should include health maintenance. A repetitive listing of problems within progress notes is acceptable.
Past Medical History	Past history including experiences with illnesses, operations, injuries, and treatments must be documented. Family history, including a review of medical events, diseases, and hereditary conditions that may place the patient at risk must also be documented.
History and Physical (H&P)	Past medical history including physical examinations, necessary treatments, and possible risk factors for the participant relevant to the particular treatment are noted.
Substance Abuse	For patients 14 and older, there should be an appropriate notation concerning the use of tobacco, alcohol, and substances as part of risk screening in support of preventive health.
Follow-up Care	Encounter forms or notes should include a notation regarding follow-up care, calls, or visits, when indicated. The specific time of return is noted in weeks, months, or as needed (i.e., PRN).
Immunization Record	An immunization record (for children) is up-to-date, or an appropriate history has been made in the medical record (for adults). Participant-reported data is acceptable.
Preventive Screenings and Services	There should be evidence that preventive screenings and services are offered in accordance with Partners Health Plan's practice guidelines. Preventive screenings specific to participant age/gender/illness (i.e., mammography, immunizations, HA1c, LDL, etc.) should be documented.

Advance Directives	Advance directives should be noted in a prominent place in the record and whether or not the advance directive has been executed in the chart for participants over 21 years of age.
Treatment Plan	The record should include documentation of clinical/professional findings and evaluation for each visit (presenting complaints, Diagnosis and Treatment Plan, prescription, referral authorization, studies, instructions).
Inappropriate Risk	The record should document that there is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure and that diagnostic and therapeutic procedures are appropriate for the patient's diagnosis and risk factors.
Referrals	If a consultation/referral is made to a specialist, there should be documentation of communication between the specialist and the PCP with a notation that the physician has seen it. There should also be documentation of discharge summaries from hospitals, ICFs, and SNFs, if applicable.

Medical/Service Records must be stored in a secure location not accessible to participants, with a unique medical/service record for each participant and a medical/service record identifier (either name or number) on each page. Records should also be organized and filed to ensure easy retrievability. PHP will share the results of record audits with the provider at the conclusion of the review to assist in improving adherence to service record documentation and CMS/SDOH/OPWDD guidelines. The results will also be submitted to PHP's Quality Oversight Committee for review.

Performance Goals

PHP's goal is for 85 percent of aggregate and individual provider medical/service records to comply with the selected assessment measures listed above. PHP utilizes the National Medical Record Audit Tool to monitor, assess, and improve medical/service record documentation for participating providers who do not meet the required goal.

Corrective Actions

Quality Management staff will send written notifications to audited provider offices communicating the results of their audit and requesting corrective actions for those scoring below the overall 85 percent goal, and an educational letter to those that score less than 100 percent on individual criteria measures, including recommendations for improvements, if warranted.

When a provider scores below performance standards, PHP will require the implementation of a corrective

action plan (CAP) and re-audit the provider in six (6) months to ensure that the CAP is progressing properly. QM staff will be responsible for documenting all such corrective actions and related activities, including their resolution, and entering them into providers' confidential QM files. QM staff will further report this information to the Medical Director and the Quality Medical Oversight Committee, and it may also be used in re-credentialing/certification evaluations of Certified Home Health Agencies (CHHAs), Licensed Home Care Service Agencies (LHCSAs), and nursing facilities, among others. The Medical Director or Director of Provider Relations is also responsible for overseeing the preparation and submission of summary reports to the Quality Medical Oversight Committee.

Medical/Service Record Retention Requirements

CMS requires contracted providers of Medicare managed care plans (including FIDA-IDD plans) to retain participant medical records for at least ten years.

Confidentiality

Access to medical/service records must only be permitted to authorized individuals providing services to the participant. Information included in the record may be provided to PHP only for purposes directly connected with the performance of PHP's obligations.

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

Access to Medical/Service Records

Copies of medical/service records must be made available, without charge (unless otherwise noted), to other participating providers, consultants, or practitioners involved with the participant's care and treatment. They must also be made available upon request, and without charge (unless otherwise noted),

to PHP (e.g., Medical Director, Chief of Care Coordination, QM staff) for quality assurance and utilization review activities. The handling of medical/service records must comply with all federal and state laws and regulations regarding the confidentiality of participant records.

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

If you have any questions or concerns about the handling of confidential participant information including medical/service records, please do not hesitate to contact PHP at 1-855-747-5483.

SECTION 13: EVIDENCE-BASED PRACTICE GUIDELINES

Introduction

Partners Health Plan (PHP) recognizes that providers/practitioners appreciate the value and importance of evidence-based practice guidelines as a guide towards appropriate and high quality of care for their patients. By developing and disseminating evidence-based practice guidelines to our network providers/practitioners, PHP hopes to reduce the amount of time they must allocate to literature review and independent research on current best practices. That said, PHP also appreciates that practice guidelines are not intended to dictate clinical practice and that each provider has his or her own approach to care and good professional judgment will at times supersede practice guidelines.

PHP purposely avoids focusing only on “clinical practice guidelines” (CPGs) inasmuch as the provision of long-term services and supports to persons with IDD is not centered solely on a medical model of care; and a large percentage of PHP’s contracted providers and practitioners provide services such as habilitation, supported employment, respite care, social supports, and transportation, etc. For this reason, we instead define practice guidelines to include a broader base of clinical and non-clinical providers and practitioners.

References

PHP adopts evidence-based practice guidelines, including Preventive Services Guidelines, from recognized sources that follow NCQA and other accreditation standards and meet the New York State Department of Health (SDOH) regulatory and legislative requirements. At a minimum, PHP adopts practice guidelines that meet the following requirements:

- Are based on valid and reliable evidence or a consensus of professionals in the particular field, including IDD professionals
- Consider the unique needs of our participants

- Are adopted in consultation with contracting providers and practitioners
- Are reviewed and updated periodically, as appropriate

PHP will maintain a comprehensive listing of current practice guidelines on its website at www.phpcares.org.

Process for Adopting and Updating Practice Guidelines

PHP's Chief Medical Officer and Chief of Care Coordination regularly monitor multiple sources to keep current on practice guidelines including, but not limited to, the following:

- American College of Physicians/Internal Medicine
- American Psychological Association
- CQL Personal Outcome Measures
- National Core Indicators
- University Centers of Excellence in IDD
- American Academy of Family Medicine
- National Institutes of Health/National Heart Lung and Blood Institute
- American Diabetes Association
- American Heart Association
- National Guideline Clearinghouse™
- Agency for Health Research and Quality
- Hayes Medical Technology Directory™
- Milliman Care Guidelines™

PHP also adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). When there is lack of sufficient evidence to recommend for or against a preventive service by these sources, or there is a conflicting interpretation of evidence, PHP may adopt recommendations from other nationally recognized sources.

PHP's adopted guidelines are intended to augment, not replace, sound professional judgment. We welcome our providers and practitioners' feedback and will consider all suggestions and recommendations during our next review cycle. Comments may be submitted to PHP's Provider Advisory Group, Chief Medical Officer, or to the Chief of Quality Initiatives.

Updating Practice Guidelines

The Chief Medical Officer, Chief of Care Coordination, and their staff are responsible for reviewing and updating all practice guidelines at least every two years and responding immediately to new developments. The review process includes:

- Monitoring internal and national health trend data as well as published research from the IDD community for developments of potential concern to PHP and its participants
- Reviewing medical and other professional literature
- Seeking and receiving input from providers, practitioners, local medical societies, and other relevant organizations

Prior to updating practice guidelines, PHP's Chief Medical Officer and Chief of Care Coordination will consult with the following individuals/organizations (non-inclusive):

- Network providers and practitioners in relevant specialties
- External consultants (if applicable)
- SDOH and OPWDD
- Professional associations
- PHP's Quality Oversight Committee for review and recommendation
- Internal Professional Guideline Committees (e.g., Quality Oversight Committee)

Clinical Practice Guidelines (CPGs) for Adults with IDD

Because of the unique characteristics of PHP's participants, our primary focus is on the adoption of nationally recognized practice guidelines for medical and behavioral health conditions that are prevalent among adults with intellectual and other developmental disabilities (IDD), especially such common diagnoses as hyperlipidemia, osteoporosis, seizure disorders, obesity, anxiety and psychoses. Moreover, medications commonly prescribed for persons with IDD often have certain side effects (e.g., hyperlipidemia) that make it difficult to manage these conditions. In those cases, our protocols and guidelines include alternative measures to better manage these side effects and mitigate their negative impact.

The following table lists a representative sampling of physical health considerations for adults with IDD and current recommendations for addressing them. Please contact our Medical Management staff with any questions or concerns relating to CPGs for adults with IDD.

Physical Health Guidelines for Adults with IDD	
Considerations	Recommendations
<p>Physical inactivity and obesity are prevalent among adults with IDD and associated with adverse outcomes, including cardiovascular disease, diabetes, osteoporosis, constipation, and early mortality. Being underweight, with its attendant health risks, is also common.</p>	<ul style="list-style-type: none"> • Monitor weight and height regularly and assess risk status using body mass index, waist circumference, or waist-hip ratio measurements.
<p>Vision and hearing impairments among adults with IDD are often under-diagnosed and can result in substantial changes in behavior and adaptive functioning.</p>	<ul style="list-style-type: none"> • Perform office-based screening of vision and hearing annually as recommended for average-risk adults, and when symptoms or signs of visual or hearing problems are noted, including changes in behavior and adaptive functioning • Refer for vision assessment to detect glaucoma and cataracts at least every 5 years after age 45 • Refer for hearing assessment if indicated by screening and for age-related hearing loss at least every 5 years after age 45 • Screen for and treat cerumen (i.e., ear wax) impaction every 6 months

<p>Dental disease is among the most common health problems in adults with IDD owing to their difficulties in maintaining oral hygiene routines and accessing dental care. Changes in behavior can be the result of discomfort from dental disease.</p>	<ul style="list-style-type: none"> • Promote regular oral hygiene practices and other preventive care (e.g., fluoride application) by a dental professional • Ensure patient has annual dental care
<p>Cardiac disorders are prevalent among adults with IDD. Risk factors for coronary artery disease include physical inactivity, obesity, smoking, and prolonged use of some psychotropic medications</p>	<ul style="list-style-type: none"> • When any risk factor is present, screen for cardiovascular disease earlier and more regularly than in the general population and promote prevention (e.g., increasing physical activity, reducing smoking). • Refer to a cardiologist or adult congenital heart disease clinic • Follow guidelines for antibiotic prophylaxis for those few patients who meet revised criteria
<p>Respiratory disorders (e.g., aspiration pneumonia) are among the most common causes of death for adults with IDD. Swallowing difficulties are prevalent in those patients with neuromuscular dysfunction or taking certain medications with anticholinergic side effects, and they might result in aspiration or asphyxiation</p>	<p>Screen at least annually for possible signs of swallowing difficulty and overt or silent aspiration (e.g., throat clearing after swallowing, coughing, choking, drooling, long mealtimes, aversion to food, weight loss, frequent chest infections). Refer as appropriate.</p>
<p>Gastrointestinal and feeding problems are common among adults with IDD. Presenting manifestations are often different than in the general population and might include changes in behavior or weight.</p>	<ul style="list-style-type: none"> • Screen annually for manifestations of GERD and manage accordingly. If introducing medications that can aggravate GERD, monitor more frequently for related symptoms. • If there are unexplained gastrointestinal findings or changes in behavior or weight, investigate for constipation, GERD, peptic ulcer disease, and pica.

<p>Sexuality is an important issue that is often not considered in the primary care of adolescents and adults with IDD.</p>	<ul style="list-style-type: none"> • Discuss the patient's or caregiver's concerns about sexuality (e.g. menstruation, masturbation, fertility and genetic risks, contraception, menopause) and screen for potentially harmful sexual practices or exploitation. • Offer education and counseling services adapted for those with IDD.
<p>Musculoskeletal disorders (e.g., scoliosis, contractures, and spasticity, which are possible sources of unrecognized pain) occur frequently among adults with IDD and result in reduced mobility and activity, with associated adverse health outcomes.</p>	<ul style="list-style-type: none"> • Promote mobility and regular physical activity • Consult a physical or occupational therapist regarding adaptations (e.g., wheelchair, modified seating, splints, orthotic devices) and safety
<p>Osteoporosis and osteoporotic fractures are more prevalent and tend to occur earlier in adults with IDD than in the general population. In addition to aging and menopause, risk factors include severity of IDD, low body weight, reduced mobility, increased risk of falls, smoking, hypogonadism, hyperprolactinemia, the presence of particular genetic syndromes (e.g., Down syndrome and Prader-Willi) and long-term use of certain drugs (e.g., glucocorticoids, anticonvulsants, injectable long-acting progesterone in women).</p> <p>Diagnosis and management of osteoporosis related to the side effects of current treatments can be challenging in adults with IDD.</p>	<ul style="list-style-type: none"> • Periodically assess risk of developing osteoporosis in all age groups of male and female patients with IDD. Those at high risk warrant regular screening starting in early adulthood. • Recommend early and adequate intake or supplementation of calcium and vitamin D unless contra-indicated.
<p>Epilepsy and other forms of seizures are prevalent among adults with IDD and increases with the severity of the IDD. It is often difficult to recognize, evaluate, and control, and has a pervasive effect on the lives of affected adults and their caregivers.</p>	<ul style="list-style-type: none"> • Refer to guidelines for management of epilepsy in adults with IDD • Review seizure medication regularly (e.g., every 3-6 months) • Consider specialist consultation regarding alternative medications when seizures persist, and possible discontinuation of medications for patients who become seizure-free

	<ul style="list-style-type: none"> Educate patients and caregivers about acute management of seizures and safety-related issues
<p>Endocrine disorders (e.g., thyroid disease, diabetes, and low testosterone) can be challenging to diagnose in adults with IDD. Adults with IDD have a higher incidence of thyroid disease compared with the general population.</p>	<ul style="list-style-type: none"> Monitor thyroid function regularly. Consider testing for thyroid disease in patients with symptoms (including changes in behavior and adaptive functioning) and at regular intervals (e.g., every 1-5 years) in patients with elevated risk of thyroid disease (e.g., Down syndrome). Establish a thyroid baseline and test annually for patients taking lithium or atypical or second-generation antipsychotic drugs.

PHP reviews and updates all practice guidelines at least every two years and responds immediately to new clinical developments.

Evaluating the Use of Practice Guidelines

On an annual basis, PHP will evaluate sample medical and pharmacy records, analyze claims and encounter data, review HEDIS/QARR results, and evaluate CQL Personal Outcome Measures to determine whether providers and practitioners are adhering to our guidelines and conduct follow-up to address any identified issues. Interventions may include conducting in-person visits to provider offices to discuss the issue, emphasize the importance of evidence-based guidelines, provide additional education or training, and/or implement a corrective action plan, as needed and appropriate. This would include specific education on the unique issues related to providing services and supports to individuals with IDD, including those who have co-morbid chronic health conditions that are linked to their underlying developmental disability (e.g., early onset dementia in patients with Down syndrome or dysphagia among persons with cerebral

SECTION 14: PRIOR AUTHORIZATION AND REFERRALS

Partners Health Plan's (PHP) prior authorization policy is designed to support our utilization management program and ensure compliance with NCQA requirements and CMS/SDOH/OPWDD regulations and standards. The policy is further designed to provide a system of managing care and services that offers timely access to necessary, appropriate, high- quality services for participants and that supports providers in delivering these services with minimal administrative barriers.

The objective is to assist each participant, provider, and the Interdisciplinary Team (IDT) in determining the appropriate utilization of covered services and supports, identify opportunities to optimize participants' health and well-being, improve the quality-of-service delivery, and manage costs. Our service authorization process serves as a vital tool for monitoring the use of covered services and supports prior to their being rendered to make certain:

- Participants are provided services at an appropriate level of care and setting and are consistent with the participant's assessed needs
- Participants receive services that are covered, necessary, appropriate, timely, and cost efficient
- Participants' needs for covered services and supports are coordinated in a manner designed to ensure that services are non-duplicative and appropriate for the participant's needs
- Information regarding a service authorization request is communicated in a timely manner to all applicable operational areas, as appropriate (e.g., care management, quality management)
- Authorized services are properly documented to facilitate accurate and timely reimbursement
- Medication errors, duplication of services, and inappropriate delivery of services are minimized or eliminated

Prior Authorization Protocols

PHP's specialized managed care program for adults with intellectual and other developmental disabilities (IDD) applies utilization review criteria for covered services and supports that are consistent with state and federal regulations and nationally recognized best practices. We use evidence-based clinical guidelines (e.g., InterQual® Criteria) to review and determine the appropriate utilization of acute care services. Prior to adopting practice guidelines, PHP ensures they are:

- Based on valid and reliable evidence or a consensus of appropriately qualified ~~profession~~ professionals
- Consistent with the needs of PHP's participants
- Adopted in consultation with network providers and practitioners, as appropriate
- Reviewed and updated on an annual basis or as needed

Service authorization is based upon the individual participant's service and support needs and preferences, as well as, state and federal regulations governing the provision of services, as applicable. Our participants are supported by an Interdisciplinary Team (IDT) during the assessment and Life Planning process with a focus on maintaining the participant in the least restrictive and most integrated setting consistent with the participant's needs, preferences, and safety. PHP's licensed care managers (i.e., RNs, Social Workers, and psychologists) along with other members of the IDT will work with the participant, family/caregiver, his or her primary care and specialist physicians, and other stakeholders (e.g., residential services providers) to identify services that will promote the optimal outcomes and goals for each participant throughout the continuum of care.

Prior Authorization (PA) Criteria

Some Medicare- and Medicaid-covered services and supports accessed through PHP may be subject to prior authorization. Under most circumstances a participant's approved Life Plan will serve as the authorization vehicle for all medically necessary covered services. However, if the participant's care management team receives a request for a covered service in between IDT meetings that is not already included in the participant's Life Plan, the care manager will consult with the Chief Medical Officer or the Chief of Care Coordination and/or the Director of UM for additional review and approval.

Services Requiring PA

The list of services and/or procedures that require PA includes, but is not limited to, the following:

- Inpatient admissions to a hospital, skilled nursing facility including making sure that hospitals and skilled nursing facilities are not imposing a three-day hospital stay requirement prior to allowing a nursing facility stay
- Ambulatory surgeries
- Certain radiological/imaging tests such as an MRI or PET scan
- Non-formulary medications
- A request to access a service or procedure from an out-of-network provider/practitioner
- A request for an expansion of an existing service(s) that exceeds a pre-determined threshold

If you have a question or are uncertain if a proposed treatment or service requires PA, please contact the participant's care manager or PHP's UM staff at 1-855-769-2508. The UM fax number is 1-855-769-2509.

Services That Do Not Require PA

The services that are categorically excluded from PHP's service authorization requirements include:

- Emergency and Post-Stabilization Services, including Emergency Behavioral Health Care
- Urgently needed care

- PCP visits
- Family Planning and Women's Health Specialist Services
- For any participant who is an Indian eligible to receive services from a participating Indian health care provider; or from the Indian Health Service (IHS); or from an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services
- Public Health Agency Facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; and Directly Observed Therapy (TB/DOT)
- Immunizations
- Other Preventive Services
- Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services
- Dental Services through Article 28 Clinics Operated by Academic Dental Centers
- Cardiac Rehabilitation, first course of treatment (a physician or RN authorization is required for subsequent courses of treatment)
- Supplemental Education, Wellness, and Health Management Services
- Prescription Drugs which a) are on PHP's formulary, or b) are not on PHP's formulary but a refill request has been made for an existing prescription within the new participant's 90-day transitional period
- Single Visits to Specialist Providers (PHP may require PA for multiple visits to a specialist through a standing authorization for an ongoing course of treatment or through pre-approval of a fixed number of visits)

Services Requiring Authorization by a Specialist Provider

The items and services listed below must be authorized by an appropriate specialist and cannot be authorized by the participant's IDT or PCP. These items and services do not need to be included in the participant's Life Plan.

- Preventive Dental X-Rays (requires authorization by a Dentist)
- Comprehensive Dental (requires authorization by a Dentist)
- Eye Wear (requires authorization by an Optometrist or Ophthalmologist)
- Hearing Aids (requires authorization by an Audiologist)

As needed, PHP's care management teams will assist participants in obtaining specialist authorizations.

Service Requests Prior to IDT Assembly

Following initial enrollment, PHP must assemble a new participant's IDT as soon as possible but no later than 30 days from the Effective Date of Enrollment. In the interim period between the Effective Date of Enrollment and the date upon which the IDT has been assembled, PHP is responsible for adjudicating a request for a new service through its standard UM process.

Prior Authorization Requests

PHP's trained and qualified Utilization Management (UM), Care Management, and Participant Services staff will accept requests for services from participants, their authorized representatives, treating providers/practitioners, and other appropriate stakeholders either in-person or via telephone, email, or fax. A trained and experienced clinician will be available 24/7 to ensure the timely authorization of medically necessary services and to coordinate the transfer of stabilized participants in an ER.

All service authorization requests will be reviewed and notification given to the participant, the participant's authorized representative and the applicable service provider by telephone and in writing within contractually-mandated timeframes by trained staff with the appropriate licensure and experience to conduct utilization review activities in compliance with state and federal laws governing confidentiality. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by the Chief Medical Office or a qualified designee. In the case of clinically related requests, the Chief Medical Officer and/or IDT will consult with the participant's requesting provider and/or other health care professional that has the appropriate expertise in treating the participant's medical condition, performing the procedure, or providing the treatment. The Chief Medical Officer is further responsible for ensuring the clinical accuracy of all Part D coverage determinations involving medical necessity. For non-clinical requests, the Chief Medical Officer or Regional Director of Care Management will make the determination in consultation with appropriately licensed and experienced IDD professionals.

A service authorization request must include the following:

- Participant identifying information, including name, DOB, gender, and participant ID number
- Name of treating provider/practitioner, including contact information
- Problem/diagnosis, including ICD-10 code, as applicable
- Reason for the service request
- Presentation of supporting information, such as clinical notes, treatment information, etc.

Service Authorization Process

PHP's service authorization policies and procedures are designed to facilitate the timely delivery of needed services to participants, including allowing clinical care managers and/or the IDT to authorize the delivery of certain services for participants. As needed, care managers and/or IDT members may also consult with the Chief Medical Officer, Chief of Care Coordination, UM staff, network providers, and other appropriate stakeholders to evaluate a service authorization request to ensure it meets evidence-based criteria for medical necessity and is in the participant's best interests.

Our service authorization process serves as a vital tool for monitoring the use of covered services and supports prior to their being rendered in order to make certain:

- Participants are provided services at an appropriate level of care and setting and are consistent with their assessed needs and preferences
- Participants receive services that are covered, necessary, appropriate, timely, and cost efficient
- Participants' needs for covered services and supports are coordinated in a manner designed to ensure that services are non-duplicative and appropriate for their needs
- Information regarding the service authorization request is communicated in a timely manner to all applicable operational areas, as appropriate (e.g., care management, quality management)
- Authorized services are properly documented to facilitate accurate and timely reimbursement
- Medication errors, duplication of services, and inappropriate delivery of services is minimized or eliminated
- PHP's UM staff will follow a well-defined process to research and analyze each service authorization request in order to:
 - Verify that the participant is eligible to receive services at the time of the request and on each date of service
 - Verify that the requested service is a covered benefit
 - Verify the service provider's qualifications and network participation
 - Evaluate and determine the necessity and appropriateness of each requested service and/or any need for additional supporting documentation
 - Determine and report whether a requested service is subject to coordination of benefits or third-party liability conditions (e.g., private health insurance coverage, TRICARE)
 - Research a participant's authorization history before approving services in order to avoid:
 - Duplicating services, the participant is already receiving
 - Authorizing services PHP is not responsible for providing
 - Duplicating authorizations already documented in the system.

PHP does not require prior authorization for emergency services in any setting.

Service Authorization Timeframes

PHP and/or participants' IDTs are responsible for processing service authorization requests and providing notification to the participant, the participant's authorized representative, and the requesting service provider by telephone and in writing in a timely manner in accordance with all applicable federal, state, and NCQA standards, as described in the following table.

Standard	Request for Service Process/Timeframes
<i>Services Requiring PA</i>	Decisions made and notice provided no later than three (3) business days following receipt of all necessary information.
<i>Standard Authorization Decisions</i>	<p>As expeditiously as the participant's health condition or other circumstances require and no later than three (3) calendar days following receipt of the request for service and receipt of all necessary information. Extensions for up to 14 additional calendar days may be allowed only if:</p> <ul style="list-style-type: none"> • The participant or the provider requests an extension • PHP can justify to the satisfaction of SDOH and CMS (if requested) that: • The extension is in the participant's interest • There is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to an approval of the request, if received • Such outstanding information is reasonably expected to be received within 14 calendar days
<i>Notice of Decision Timeframe Extension</i>	The participant, the participant's authorized representative, and the care management team will be notified verbally and in writing of the extension, including the right to appeal the extension.

<p><i>Notification of Decision Involving:</i></p> <ul style="list-style-type: none"> • Continued or extended health care services • Additional services for a participant undergoing a course of continued treatment • Home health services following an inpatient hospital admission 	<p>Notification of decision must be made to the participant, the participant's authorized representative, and/or the requesting provider by telephone and in writing within one (1) business day following receipt of all necessary information with the exception of home health services following an inpatient admission, in which case PHP must provide notice of its determination within 72 hours following receipt of all necessary information when the day subsequent to the request falls on a weekend or holiday.</p>
<p><i>Determination Regarding Services Already Delivered</i></p>	<p>PHP must provide notice of the determination within 14 days following receipt of the request for services.</p>
<p><i>Notice of Adverse Action</i></p>	<p>Notification of any decision to deny or authorize a service in an amount, duration, or scope that is less than requested will be provided in writing to the participant, the participant's authorized representative, the care management team and IDT, and applicable providers within the timeframes specified above and within at least 10 days before the date of action, as specified in federal regulation.</p>
<p><i>Termination, Suspension, or Reduction of Service Authorization</i></p>	<p>At least 10 calendar days before the date of the action.</p>

If PHP fails to make a determination within the specified timeframes, it is deemed a denial subject to appeal (see below). PHP does not base an adverse determination on a refusal to consent to observing any health care service or on a lack of reasonable access to a provider/practitioner's medical or treatment records without providing reasonable notice to the participant, the participant's authorized representative, or the requesting provider.

Service Authorization Approval Process

Following an initial assessment or reassessment of a participant and approval from the IDT, the participant's finalized Life Plan is reviewed with the participant and his or her family/caregiver and circle of support and they are asked to sign off on the plan indicating agreement with the services to be provided. The participant and his or her treating providers (including the PCP and any additional specialists or other professionals engaged in the participant's care) will be sent a copy of the approved Life Plan. Authorized users can also access participant Life Plans through the MediSked Connect Portal. Any services included in the Life Plan which require a UM review will be sent to the UM Department for review and determination. The participant's providers are notified about the participant's authorized services and they are entered into the claims system to ensure timely payment.

Service authorization requests may be submitted to PHP at any time and will be processed and verbal and written notifications provided in accordance with the timeframes listed in the table above. If all service authorization criteria are met, UM staff will approve the request and issue an authorization number for submission with claims for approved services. Generally, a service authorization number will remain valid until the participant's next scheduled Life Plan review or reassessment as long as the participant is enrolled and eligible on each date of service.

Service Authorization Denials

PHP will provide written notification (integrated coverage determination notice) to the participant and his or her authorized representative, the participant's care management team, IDT, and applicable providers of all adverse actions related to authorization decisions. This notice will:

- Specify the reason(s) for the denial
- Provide a reference to the benefit provision, guideline, and/or protocol on which the denial decision was based
- Explain that the participant and/or his or her authorized representative may obtain a copy of the provision or protocol
- Describe the participant's appeal rights and the appeals process, including:
 - The right to submit written comments, documents, or other information relevant to the appeal
 - Timeframes for deciding appeals
 - The participant's right to representation
- Describe the expedited appeals process (if the denial was for an urgent service request) and instruct the participant/designee on how to request an expedited appeal

PHP's service authorization staff will document all pertinent information relating to the decision in our care management application, including details about efforts to obtain all pertinent information and/or attempts to confer with the requesting provider before issuing a denial. Only the Chief Medical Officer or qualified designee can approve a denial of a service authorization request or a reduction in the amount, duration, or scope of a previously authorized service.

If Partners Health Plan issues a denial determination without first attempting to discuss the matter with the provider/practitioner who recommended the service, procedure, or treatment under review, the provider may request a reconsideration of the adverse determination. Except in cases of retrospective review, the reconsideration will take place within one (1) business day following receipt of the request and will be conducted by the participant's provider and the Chief Medical Officer or designated peer reviewer, as applicable. In the event the adverse determination is sustained following reconsideration, PHP will provide notice as required and the participant retains the right to initiate an appeal of the adverse determination.

Prior Authorization Appeals

A prior authorization request is a request by the participant (or the participant's family/caregiver or provider on behalf of the participant) for a new service or a request to change a service included in a participant's Life Plan for a new authorization period. A concurrent review request is a request by a participant or a provider (upon the participant's request) for additional services that are currently authorized in the participant's Life Plan (e.g., an increase in the number of hours of an authorized service).

A participant and/or his or her authorized representative may request an expedited review of a prior authorization or concurrent review request, although PHP will automatically expedite an appeal of a concurrent review action. If PHP denies a request for an expedited review of a prior authorization request, we will handle it as a standard review.

The timeframes for standard and expedited reviews of prior authorization and concurrent review requests are as follows:

- **Prior Authorization:**
 - **Expedited:** Three (3) business days from request of service.
 - **Standard:** Within three (3) business days of receipt of necessary information, but no more than 30 days after receiving the request.
- **Concurrent Review:**
 - **Expedited:** Within one (1) business day of receipt of necessary information, but no more than three (3) business days after receiving the request.
 - **Standard:** Within one (1) business day of receipt of necessary information, but no more than 30 days after receiving the request.

Participants (or others acting on a participant's behalf) may request an extension of up to 14 days either verbally or in writing. PHP may also initiate an extension if we can justify the need for additional information and the extension is in the participant's interest. In either case, we will fully document the circumstances behind the extension.

PHP's Notice of Decision will include the following information:

- Date and summary of the service request
- The reason for the determination and, in cases where the determination has a clinical basis, the clinical rationale for the determination
- Procedure for filing an internal appeal and an explanation that an expedited appeal can be requested if a longer timeframe would be injurious to the participant's health
- A description of what additional information, if any, PHP must obtain from any source in order to make an appeal decision if an internal appeal will be requested
- An explanation of the participant or the participant's authorized representative's right to file a Fair Hearing request after the internal appeal process is exhausted, as well as the option to file an External Appeal if the service denial is related to issues of medical necessity or an experimental or investigational nature of service
- An explanation that the participant or his or her authorized representative has the opportunity to present evidence and examine his or her case file during an appeal
- An explanation that the participant or his or her authorized representative can access the clinical review criteria relied upon in making the decision, if the action involved medical necessity or if the treatment or service was experimental or investigational
- An explanation that the participant or his or her authorized representative may request assistance (for language, hearing, or speech issues) if the participant decides to file an appeal as well as instructions for the accessing the assistance

If PHP decides against the participant's appeal of a prior authorization or concurrent review request, the participant or provider may appeal the decision under the standard appeal process (see Section 18 of this Manual).

Referrals

Specialist Visits

Although PHP strongly encourages participants and their families/caregivers to discuss any issues or concerns relating to their medical or behavioral condition(s) with their care management team and/or PCP before seeing a specialist, PHP's participants are permitted to visit in-network specialists without a referral for an initial visit/consultation; follow-up visits may be subject to PCP referral and/or prior authorization. If you should have any questions about this policy, please contact the participant's care management team or PHP's UM staff at 1-855-769- 2508. The UM fax number is 1-855-769-2509.

Self-Referrals

The following services do not require a referral or prior authorization:

- Routine women's health care, including breast exams, screening mammograms, Pap tests, and pelvic exams from a network provider
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations from a network provider
- Kidney dialysis services from a Medicare-certified facility when the participant is temporarily outside PHP's service area
- Preventive Health Screenings from in-network providers, including:
 - Prostate Screenings
 - Colorectal Screenings
 - Bone Mass Measurement
 - Vision Services
 - Routine Dental Care
 - Hearing Exams

Out-of-Network Services

With certain exceptions (see above), PHP requires prior authorization for all non-emergent and non-urgent out-of-network services. Authorization for out-of-network services is typically restricted to services that are not available on a timely basis from a network provider (with certain exceptions for transitional care services for new participants).

SECTION 15: CREDENTIALING AND RE-CREDENTIALING

This section describes Partners Health Plan's (PHP) process for reviewing, approving, and periodically recertifying the credentials of all network providers and practitioners licensed to provide covered physical and behavioral health services, long-term services and supports, and specialized services for persons with intellectual and other developmental disabilities (IDD), including habilitation services. The objective is to verify that contracted network practitioners and facilities meet state and federal requirements and possess all required licensing, certification, accreditation, or designation. The credentialing process also continuously ensures that network providers are not listed on the HHS Office of the Inspector General or the NYS Office of the Medicaid Inspector General List of Excluded Individuals/Entities or the General Services Administration System for Award Management (SAM) Excluded List.

General Policy Statement

PHP's credentialing process uses standards set forth by the SDOH and NCQA, URAC, CMS, and all other applicable state and federal regulations, including primary verification of training/experience, office site visits, etc. New York State regulatory requirements for providers of developmental and habilitation services are also incorporated into the credentialing process.

PHP only contracts with developmental and habilitation providers who meet OPWDD standards. Each provider is re-credentialed at least every three (3) years.

PHP uses the single, uniform provider credentialing application approved for use in the general FIDA program to credential all applicable providers.

Anti-Discrimination

When determining whether to contract with a provider/practitioner, PHP does not discriminate on the basis of race, ethnicity, age, color, gender, sexual orientation, national origin, disability, marital status, or religion. However, PHP may take the following actions:

- Refuse to grant participation because the provider's specialty is in excess of the number necessary to meet the needs of PHP's participants
- Use different reimbursement amounts for different specialties or for different practitioners in the same specialty
- Implement measures designed to maintain quality and control costs consistent with PHP's responsibilities to its participants

If PHP declines to include a given practitioner/provider or group of providers in its network, PHP will furnish written notice of the reason for the decision.

Credentialing and Performance Committee

PHP's credentialing activities are conducted in accordance with the standards set by its Credentialing and Performance Committee (CPC) and New York State requirements. This committee has oversight authority for all credentialing and re-credentialing activities, including individual providers/practitioners who deliver services to our participants. The committee is also

responsible for overseeing professional peer review activities for those providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of our participants and for reviewing and evaluating all credentialing and re-credentialing information and processes.

PHP's CPC advises the Medical Director on the credentialing and re-credentialing of network providers, including their selection, approval, or denial. Importantly, the Credentialing Committee has responsibility for reviewing the credentialing/background checks/fingerprinting reports of delegated providers (e.g., Home Health Agencies that employ direct-service workers). Anyone in an OPWDD-authorized program having regular and substantial contact with participants must be fingerprinted and successfully pass a criminal background check.

Required Credentials

Once PHP's credentialing staff receives a completed application, they are responsible for verifying the following credentials (as applicable):

- Valid License
- Board Certification
- Education and Training appropriate to the provider's specialty
- Past History, including work and licensure history, felony convictions, sanctions, malpractice history, etc.
- Clinical Privileges (if applicable)
- Medical Malpractice Insurance (if applicable)
- DEA/CDS Certificate
- National Practitioner Data Bank Information
- Valid National Provider Identifier (NPI) number (if applicable)
- Sanctions or Limitations on Licensure or Loss of Licensure
- Eligibility for Participation in Medicare/Medicaid (Excluded and Opt-Out)
- Quality of Care Issues, Grievances, etc. (usually during re-credentialing)

Secondary sources (i.e., copies of documents) are acceptable for many of the credentials, and in some cases provider attestation may be sufficient. Primary source verification (PSV) is required for the provider/practitioner's license, educational credentials, and board certification (if applicable). The most recent versions of these documents will be maintained in PHP's provider credentialing database and summary reports will be generated for the credentialing committee, as needed.

Independent Practitioners

At the time of initial application, PHP's credentialing staff conducts a review of each provider's service record and care planning practices to verify that they meet PHP's standards. In addition,

as needed, Provider Relations personnel conduct on-site, but in some situations may be virtual, to verify that the service sites of all initial applicants are in compliance with PHP's standards as well as state and federal regulations, including ADA and HIPAA requirements/recommendations. After completing the verification process, credentialing staff presents the application to the CPC for review and approval within 90 days of receiving a completed application and provider contract (practitioners with non-routine or unusual circumstances may require additional time). The information used in the review must be no more than six months old on the date of the determination.

Organizational Providers

For applications received from organizational providers, PHP's credentialing staff confirms that the organization is in good standing with state and federal regulatory bodies and, if applicable, verifies that an accrediting body has approved the entity. Each organizational provider (e.g., ICF/IIDs, Group Homes, Skilled Nursing Facilities, etc.) must have operating certificates as required by state or local regulations. PHP does not conduct site reviews of these providers if they are Medicaid-certified.

Organizational providers must further confirm that all ancillary staff are appropriately licensed, registered, or certified in their field and practice in accordance with all applicable laws and regulations. Providers must also provide appropriate supervision to ancillary staff and ensure that their responsibilities do not exceed those set forth in applicable state laws and regulations.

Laboratories

PHP requires all contracted laboratory testing sites to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.

Delegated Credentialing

- PHP delegates the credentialing process to external organizations such as the North Shore-LIJ Health System and Montefiore Health System), although PHP recognizes that delegation does not relinquish responsibility and PHP must continue to provide oversight. Once a decision to delegate has been reached, the next step is to create a mutually agreed-upon Delegated Credentialing Agreement that describes PHP's and the Delegate Specifies the delegated activities
- Describes the process by which PHP will evaluate the delegated entity's performance
- Describes how PHP will proceed if the delegated entity does not fulfill its obligations The Delegated Credentialing Agreement must further require the delegated entity to:
- Submit a complete list of providers to PHP on a quarterly basis in a format to be specified by PHP
- Maintain a file of all physician documentation, including primary source verification and compliance with the ADA

Even with delegation, PHP retains the right to approve or reject individual practitioners within the delegated entity based on quality-of-care issues. Finally, PHP must annually evaluate whether the delegated entity is conducting its activities according to agreed-upon standards to determine whether the contract will be renewed.

Credentialing Process

PHP's credentialing process consists of a series of steps designed to assist the CPC in determining whether to accept or reject an application to participate in PHP's provider network. At a minimum, the process consists of the following sequential activities:

- **Application:** Practitioners expressing an interest in participating in PHP's network and/or meet PHP's organizational needs and administrative requirements are invited to apply. Each applicant must complete a signed and dated application, including a signed release granting PHP access to key information, and an attestation of the correctness and completeness of the application. Each application is accompanied by a copy of the applicant's current professional license, current DEA registration (if applicable), and the face sheet of the current professional liability insurance policy. The application also includes a statement by the applicant regarding his or her:
 - Ability to perform the essential functions of the position
 - Illegal drug use
 - Loss of license or felony convictions
 - Loss or limitation of privileges or disciplinary activity
 - Correctness & completeness of the application

- **Initial Screening:** If the application is complete and meets the basic qualifications set out in a screening policy, it is forwarded to PHP's Medical Director, who reviews it to determine if a preliminary interview is warranted and if the full credentialing process is to be initiated (i.e., verification of credentials through primary sources and new provider site visit).
- **New Provider Site Visit:** The applicant is notified that a facility assessment and medical record keeping audit will take place, which is conducted during the time of primary verification of credentials, and prior to the presentation of the practitioner's file to the CPC. The site visit which in some situations may be done virtually, includes an assessment of a number of criteria, including:
 - Physical accessibility
 - Physical appearance
 - Adequacy of waiting and examining room space
 - Availability of appointments
 - Adequacy of medical record keeping
 - Quality of care (which is determined by randomly examining medical records against PHP's standards of care)
- **Primary Source Verification:** NCQA stipulates that seven criteria must be verified from the primary source because they identify the legal authority to practice as well as the relevant training and experience. PHP has the option to contract with an NCQA-accredited CVO (see Definitions) to complete this step. The criteria that require primary source verification include:
 - Valid license to practice
 - Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility
 - Valid DEA or CES certificate (if applicable)
 - Education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, as applicable
 - Board certification (if applicable)
 - Current adequate malpractice insurance
 - History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner
- **File Preparation: Immediately following the initial screening, QM staff prepares the file for presentation to the CPC, including:**
 - Completed credentialing form
 - Results from the on-site audit (facility assessment & medical record keeping process)
 - Primary source verification of key elements
 - Work history
 - Information from the National Practitioner Data Bank (NPDB), the NYS Board of Examiners, and sanction activity by Medicare and Medicaid
 - Any other data relevant to the credentialing of the applicant

- **Data Entry:** After all required data elements have been received, QM staff enters the credentialing file into the credentialing database that assists in tracking the application and ensuring appropriate review of time-sensitive material (e.g., license, DEA certificate, etc.)
- **The Decision:** The CPC is responsible for determining whether to accept or reject an application. The confidential minutes reflect the decisions of the Committee and any relevant discussion pertaining to the decisions. All applicants are notified of the Committee's decision and a description of the appeals process is included with all denials.
- **Re-credentialing:** A re-credentialing date is set for at least three (3) years after the initial credentialing decision (PCPs, OB/GYNs, and high-volume specialists should have site visits every two years). In considering whether to renew the practitioner's status, PHP reviews information from the following sources:
 - NPDB, State Board of Medical Examiners, and the Medicare and Medicaid Programs regarding sanction activity or practice limitations
 - Participant complaints and satisfaction survey results, as applicable
 - Quality Improvement and UM activity reports, as applicable
 - Provider Profiling reports
 - Medical record reviews and facility site visit results

PHP must also verify, in the same manner as under the initial credentialing process, the practitioner's admitting privileges, malpractice coverage, and DEA/CDS certification. In

addition, PHP requires practitioners to sign an attestation regarding their ability to carry out their responsibilities and another regarding the use of illegal drugs.

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.

Approval Process

PHP's Credentialing and Performance Committee (CPC) reviews provider files and makes appropriate recommendations. Prior to making any adverse decision regarding a provider, the Medical Director will appoint appropriately qualified providers to conduct a peer review (see Definitions) of the provider in question in order to evaluate whether accepted standards of care have been met. The QM department then compiles all appropriate information and presents it to the CPC as follows:

- Providers that meet credentialing criteria (“clean” files): The Medical Director reviews summary information and may recommend approval of a provider without reviewing the file or may request a full or partial review of the information.
- Providers with a deficiency/issue that does not meet all applicable criteria: Credentialing staff provides the committee with an analysis of the issue along with supporting documentation for review at the meeting.

After reviewing information on each provider, the CPC renders a decision to approve or deny the provider. A summary report of the activity of the CPC is submitted to the Quality Oversight Committee and the Quality Management Oversight Committee of the Board.

Notification to Providers

Once the process is complete, PHP's credentialing staff notifies the Provider Relations department of the final credentialing decisions and that department in turn notifies providers of the result in writing.

In the case of a denial or termination, it is PHP's policy to provide due process to providers/practitioners consistent with Section 4406-d of New York State Public Health Law. To this end, PHP has a hearing procedure in place to allow practitioners/providers, under certain circumstances, to appeal a proposed decision to deny an initial application or terminate an existing provider prior to the termination date of the contract. The hearing procedure is not available when the denial or termination involves:

- Imminent harm to participants
- A determination of fraud
- A final disciplinary action by the state licensing board or other governmental agency

Ongoing Monitoring of Provider Status

Following the initial recruitment, credentialing, and contracting process, PHP continuously reviews state and federal exclusion and/or debarment reports and state board sanction lists. Any provider with a license expiration, suspension, or revocation will be immediately terminated from the network. PHP also works with SDOH/OPWDD to establish protocols for receiving timely information regarding their onsite inspection findings related to ICF/IIDs and other certified settings. In addition, we review their quarterly report of nursing home violations for quality issues that need to be addressed.

Review and Verification for Re-credentialing

As applicable, PHP's CPC re-credentials providers at least every three years to verify that they continue to meet credentialing standards, and PHP employs a rigorous monitoring and oversight process to ensure that providers remain in compliance with credentialing requirements. If needed, PHP may initiate re-credentialing sooner if quality oversight and provider profiling activities have identified potential issues of concern.

As with initial credentialing, PHP conducts the primary source verification on all data elements that NCQA and state and federal agencies require. For organizational providers, PHP's credentialing staff will make positive confirmation that the entity is in good standing with the state and verify that an appropriate accrediting body has reviewed and approved the organization.

Council for Affordable Quality Healthcare (CAQH) Credentialing Application Process

CAQH is a not-for-profit collaborative alliance of the nation's leading health plans and networks. The mission of CAQH is the improvement of healthcare access and quality for patients and the reduction of the administrative requirements for physicians and other health care providers and their office staff members. The CAQH Provider Data source is designed to gather credentialing data in a single repository that may be accessed by participating health plans and other healthcare organizations. Its objective is to simplify the credentialing data gathering process and enable physicians and other health care providers to easily update their information.

PHP has adopted the CAQH credentialing application process for all provider types covered by the CAQH application and use the single, uniform FIDA Participating Provider Supplemental Information Form for providers applying through CAQH for obtaining additional information. PHP will also use the single, uniform FIDA Participating Provider Credentialing Application for providers that are not applying through CAQH for credentialing and re-credentialing of all providers within provider types not covered by the CAQH credentialing process.

SECTION 16: OUT-OF-NETWORK/NON-PAR PROVIDERS

In the unlikely event that a needed service or benefit is unavailable within PHP's provider network on a timely basis, PHP will authorize out-of-network services that are subject to utilization review (i.e., excludes emergency services, urgent care, etc.) from an appropriately licensed and qualified provider/practitioner that meets the following criteria:

- The provider is certified by Medicare and/or Medicaid to deliver services within his or her scope of practice.
- PHP would not otherwise exclude the provider from the network due to documented quality of care concerns.
- The provider is willing to accept payment based on the current Medicare/Medicaid fee schedule, as applicable, as payment in full, by entering into a Single Case Agreement (SCA) with PHP.
- The provider agrees to comply with PHP's practice guidelines and UM policies.
- The provider agrees to communicate as needed with the participant's care management team and IDT and share all records and documents relating to the participant's care.
- As appropriate, PHP's provider relations team will make reasonable efforts to recruit the provider into PHP's network to address any identified network gaps and/or enhance access to services for PHP's participants.

Provider Responsibilities

PHP's network PCPs and specialist physicians have the authority to refer participants to network providers for medically necessary services and should consult the Provider Directory and use participating practitioners, providers, and facilities. Authorization is only required for those services listed in Section 10 of this Manual. If you are unsure whether or not a service, treatment, or procedure requires prior authorization, please contact our UM staff at 1-855-769-2508. The UM fax number is 1-855-769-2509.

If a network provider believes a participant should receive care from an out-of-network provider or facility even though the recommended service is available in-network, he or she must request authorization from PHP and provide supporting clinical information. The Medical Director will review the request for medical necessity and discuss the request with the participant's PCP/referring provider, as applicable, and render a decision based on all available information as well as his or her own professional judgment. If the request is denied, the participant/representative and the participant's provider will receive oral and written notification along with instructions for filing an appeal.

SECTION 17: NON-CLINICAL PROVIDER APPEALS

Requests for Reconsideration of Administrative Denials or Paid Amount

On occasion, a provider may disagree with Partners Health Plan (PHP) over the amount payable for a claim or a group of claims or for the denial of a claim for administrative reasons such as the timeliness of the claim submission, existence of co-insurance, participant eligibility, lack of required prior authorization/precertification, or other errors in the claim. An administrative denial is not treated in the same manner as a clinical denial relating to the medical necessity of the treatment rendered or proposed, so the normal appeals process does not apply. However, the provider may seek reconsideration of an administrative denial or of claims the provider believes have been underpaid or otherwise incorrectly paid.

To request reconsideration, the provider should submit a written explanation within 60 days of the date of the administrative denial or alleged underpayment that clearly states the reason for the appeal and provides supporting documentation. PHP will render a decision within thirty (30) business days after receiving all information necessary to process the request for reconsideration. Providers have no further appeal rights if the administrative denial is upheld. In addition, if PHP does not receive a request for reconsideration of a claim within 60 calendar days of the date the claim was denied or underpaid, it shall be deemed final and without further recourse.

SECTION 18: PARTICIPANT COMPLAINTS/GRIEVANCES AND APPEALS

CMS and the State of New York have developed a fully integrated grievance and appeals process for the FIDA-IDD program in an effort to mitigate the complexity and confusion of having separate processes for Medicaid and Medicare. Note: the FIDA-IDD demonstration defines a “complaint” as being equivalent to a “grievance,” so to enhance clarity this section will employ the term grievance.

Participants and their authorized representatives (including the participant’s provider) may file grievances directly with any PHP staff member either orally or in writing within 60 calendar days of the incident or period of dissatisfaction (if there is more than one specific incident).

PHP staff will assist participants and/or their authorized representatives with completing forms and taking other procedural steps, if requested. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Participants and their representatives will also be informed about the availability of assistance from the state’s FIDA Participant Ombudsman program.

PHP will ensure that the personnel who make determinations on grievances were not involved in any previous level of review or decision-making. In addition, if the grievance relates to the denial of an

expedited resolution of an appeal or involves clinical issues, PHP will ensure that the persons making the determination are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the participant's condition or disease.

If a grievance determination overturns an initial denial, PHP will authorize or provide the disputed services promptly and as expeditiously as the participant's health condition requires.

PHP will not initiate disenrollment because of a participant's or a participant's authorized representative's attempt to exercise his or her rights under the grievance system. PHP will likewise not initiate punitive actions against a provider who files and/or supports a participant's grievance.

In keeping with regulatory requirements, PHP will cooperate with NYSDOH and/or CMS grievance investigations.

Grievance Process

All grievances must be filed within 60-calendar days of the incident or whenever the participant's unsatisfactory experience took place (if the grievance involves more than a single incident).

Same-day Grievance

To the extent possible, PHP's goal is to resolve grievances to the participant's satisfaction immediately (same day). Same-day grievances are acknowledged and resolved verbally and do not require a written response. All same-day grievances are documented for quality improvement purposes. Grievances that cannot be resolved the same day are referred to PHP's Grievances and Appeals (G&A) Coordinator for processing.

Standard Grievance

If a participant's oral or written standard grievance cannot be resolved immediately, PHP will resolve it as quickly as the participant's condition requires but no later than thirty (30) calendar days following receipt. The Business Analyst will send a written acknowledgment of the grievance within fifteen (15) calendar days following receipt unless a determination is reached beforehand, in which case no written acknowledgement will be sent.

The 30-day timeframe may be extended by up to 14-calendar days if the participant, the participant's authorized representative, or a provider acting on the participant's behalf requests an extension or if PHP justifies a need for additional information and can document that the delay is in the participant's interest. If PHP requests an extension, the participant and the participant's authorized representative and treating provider (if applicable) will be immediately notified in writing of the reason for the delay. Once a decision is reached, PHP will provide the participant/representative with written notification within three (3) business days, including instructions on how to file a grievance appeal.

Expedited Grievance

An expedited grievance is required when a standard decision would significantly increase the risk to a participant's health. Participants or their representatives must file an expedited grievance within 60 calendar days of the date of the coverage decision and must include a physician certificate of need. PHP will respond to an expedited grievance as quickly as the participant's condition requires, but no later than 24 hours following receipt of the grievance. PHP must immediately notify the participant/representative of the decision by phone and provide written notification within three (3) business days of the decision, including instructions on how to file a grievance appeal.

The resolution time period may be extended up to fourteen (14) calendar days if:

- The participant or the participant's authorized representative, or a provider acting on the participant's behalf requests the extension
- Partners Health Plan demonstrates that there is a need for additional information and provides documentation that the delay is in the participant's best interest

If PHP requests an extension, the participant will be immediately notified in writing of the reason for the delay. Once a decision is reached, PHP will provide the participant/representative with written notification within three (3) business days. The notification will include instructions on how to file an expedited grievance appeal if he or she disagrees with PHP's decision to grant an extension.

Grievance Acknowledgment

Partners Health Plan acknowledges all grievances types. Same-day grievances are acknowledged verbally, and all other grievances are acknowledged in writing within fifteen (15) business days

following receipt unless a determination is reached before the written acknowledgement is sent, in which case it will be acknowledged verbally. The written acknowledgment will include:

- The date that the grievance was received
- Participant's name and address
- Type of grievance
- Additional information requested
- Name of the staff member processing the grievance

If a participant/representative requests an expedited grievance and PHP decides not to expedite it, the acknowledgement will indicate that the grievance will be handled on a standard basis.

External Grievance

Participants and/or their authorized representatives may file an external grievance through 1-800- Medicare or online by submitting a completed electronic grievance form on the Medicare.gov website (PHP includes a link to this form on our main webpage). External grievances filed through 1-800-Medicare are automatically

entered into the CMS complaints tracking module, which PHP can access. External grievances filed with NYSDOH are forwarded to the FIDA Contract Management Team (CMT) and also entered into the CMS Complaints tracking module.

Appeals Processes

Other than Medicare Part D appeals, which remain unchanged (see below), the FIDA integrated appeals process includes the following features and processes:

Integrated Notice

PHP will provide participants and their authorized representatives with written notification of any adverse actions and all applicable Medicare and Medicaid appeal rights, including the availability of the FIDA Ombudsman to assist with appeals. The notice will specify:

- The action PHP has taken or intends to take
- The reasons for the action
- The regulatory citation that supports the action
- The participant's or the participant's authorized representative's or provider's right to file an appeal
- The procedures for the participant/representative to exercise his or her right to appeal
- The circumstances under which an expedited resolution is available and how to request it
- The participant's right to have benefits continue pending a resolution of the appeal, if applicable

Appeal Level One: Internal Appeal with PHP

- **Appeal Filing Deadline:** Participants, their representatives, or providers acting on their behalf must file a verbal or written appeal with PHP within the following timeframes:
 - 60 calendar days from the postmarked date of PHP's Notice of Action to file an appeal related to a denial, reduction, or termination of a covered benefit if there is no request to continue benefits while the appeal is pending.
 - 10 calendar days from the postmarked date of PHP's Notice of Action or by the intended effective date of the Action (whichever is later) if there is a request to continue benefits and the appeal involves the termination or modification of a previously authorized service. The participant will continue to receive benefits while the appeal decision is pending.
- **Acknowledgement of Appeal:** PHP will send the participant/representative a written acknowledgement of an appeal within fifteen (15) calendar days of receipt unless a decision is reached beforehand, in which case no written acknowledgement will be sent.
- **Appeal Timeframe:** PHP will decide an appeal and notify the participant, the participant's authorized

representative, and the provider (as applicable) of the decision as quickly as the participant's condition requires, but no later than:

- **Standard:** No later than thirty (30) calendar days from the date of the receipt (seven calendar days for Part D appeals). This may be a paper review unless the participant/representative requests an in-person review. Benefits will continue pending the appeal.
- **Expedited:** No later than seventy-two (72) hours following receipt of the appeal. This may be a paper review unless the participant/representative requests an in-person review. Expedited reviews will be granted if a standard decision would significantly increase the risk to a participant's health. Benefits will continue pending the expedited appeal.
- **Appeal Extension:** Appeal timeframes may be extended up to fourteen (14) calendar days if a participant, the participant's authorized representative, or a provider acting on the participant's behalf makes an oral or written request. PHP may also initiate an extension if it can justify the need for more information and the extension is in the participant's interest. If PHP initiates an extension, the participant/representative will be notified in writing of the reason for the delay, including the participant's right to file an expedited grievance if he or she disagrees with PHP's decision. All extensions must be well documented.
- **Notification of Appeal Decision:** The written notification will include the results and the date of the decision. In the case of adverse decisions (i.e., a decision that is not wholly in the participant's favor), the notification will also inform the participant and the participant's representative that the adverse decision will be automatically forwarded to the Integrated Administrative Hearing Office at the FIDA Administrative Hearing Unit at the New York State Office of Temporary and Disability Assistance (OTDA) and explain the process and timeframe for the hearing. As applicable, the notice will further inform the participant/representative that his or her benefits will continue pending the appeal and that even if PHP's action is upheld, the participant will not be liable for the cost of any continued benefits. The notice will additionally indicate that once OTDA receives the notice, it will contact the participant/representative regarding the date of the hearing and state that the participant and/or the participant's representative should contact OTDA in the event that he or she does not hear from OTDA within:
 - 24 hours for expedited appeals
 - Five (5) calendar days for Medicaid prescription drug appeals
 - 10 calendar days for all other appeals
- **Notification Timelines:**
 - **Standard Appeals:** PHP will provide written notice of its decision within two (2) calendar days.
 - **Expedited Appeals:** PHP will make a reasonable effort to provide prompt oral notice to the participant/representative for expedited appeals (these efforts must be documented) with a follow-up written notice within two (2) calendar days after providing oral notice of PHP's decision.
- **Continuation of Benefits Pending Appeal:** Continuation of benefits for all previously approved Medicare and Medicaid benefits will be provided throughout all four levels of the appeals process if the original appeal is submitted to PHP within ten (10) calendar days of the postmarked date of PHP's Notice of Action or by the intended effective date of the Action, whichever is later.

Appeal Level Two: Automatic Administrative Hearing

PHP's Business Analyst will automatically forward any adverse decision that PHP renders to the Integrated Administrative Hearing Officer at the Integrated Administrative Hearing Unit within the State Office of Temporary and Disability Assistance (OTDA) by secure email within two (2) business days of reaching a decision. A cover note will clearly indicate:

- PHP's identity
- The type of appeal (i.e., expedited, Medicaid prescription drug, or other)
- The name of the contact person at PHP that will participate in the Administrative Hearing
- The participant's name, address, phone number or other contact, social security number, and Medicaid or CIN number

Benefits will continue pending an appeal, as applicable. Within 14 calendar days of forwarding the administrative record, PHP will send the participant/representative an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status with a copy of the Integrated Administrative Hearing Office. If a decision is reached before the acknowledgement is sent, PHP will not send an acknowledgement.

The Integrated Administrative Hearing Office will provide the participant/representative and PHP with a Notice of Administrative Hearing at least 10 calendar days in advance of the hearing date. PHP is required to participate in the hearing (needless to say, the staff member designated to participate will be knowledgeable about the circumstances of the appeal), which will be conducted either by phone or in-person and a decision will be rendered as expeditiously as the participant's condition requires, but no later than seven (7) calendar days for Medicaid drug coverage matters and within 90 calendar days from the date the participant requested an appeal with PHP for all other matters.

In the case of expedited hearings, the Integrated Administrative Hearing Office will conduct the hearing and issue a notification of decision within 72 hours after PHP forwards its original appeal decision and review record. The notification will explain in plain language the rationale for the decision and specify the next steps in the Appeal process, including where to file the Appeal, the filing timeframes, and other information required by applicable federal and state requirements. PHP will be bound by the decision and may not seek further review and must implement the decision within one (1) business day.

Appeal Level Three: Medicare Appeals Council

If a participant/representative disagrees with the Integrated Administrative Hearing Officer's decision, he or she may appeal it to the Medicare Appeals Council within 60 calendar days by submitting a request to the Integrated Administrative Hearing Office, which will in turn forward the request to the FIDA Administrative Hearing Unit, which has responsibility for submitting the appeal request and all related documents to the Medicare Appeals Council. The Medicare Appeals Council will complete a paper review and issue a decision within 90-calendar days.

Benefits will continue pending an appeal.

Appeal Level Four: Federal District Court

An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which is the final level of appeal. Benefits will continue pending a decision.

If you have any questions or concerns about the FIDA integrated grievance and appeals process, please do not hesitate to contact Participant Services at 1-855-PHP-LIVE (1-855-747-5483).

Hospital Discharge Appeals

A hospitalized participant who wishes to appeal a discharge/non-coverage decision by PHP or the facility (if PHP has delegated the authority) will be provided with a “Notice of Discharge and Medicare Appeal Rights” (NODMAR) that includes the following information:

- The specific reason why inpatient hospital care is no longer needed or covered
- The effective date and time of the participant’s liability for continued inpatient care
- The participant’s appeal rights
- If applicable, the new lower level of care being covered in the hospital setting
- Any additional information specified by CMS

Before PHP can provide a participant and/or the participant’s authorized representative with a NODMAR, the participant’s treating physician must concur with the decision. PHP will deliver the NODMAR as soon as possible after learning of a participant’s dissatisfaction with the discharge decision, but no later than 6:00 p.m. of the day prior to discharge.

The NODMAR will inform the participant and/or the participant’s authorized representative of the right to request a review by a Quality Improvement Organization (QIO) responsible for reviewing participant grievances relating to quality-of-care issues. If the participant/representative opts for QIO review, he or she will not incur any additional financial liability if:

- The participant remains in the hospital as an inpatient
- The participant submits the request for immediate review to the QIO that has an agreement with the hospital
- The request is made either in writing, by telephone, or fax
- The request is received by noon of the first working day after the participant receives written notice of PHP’s determination that the hospital stay is no longer necessary

QIO Review Process

On the date that the QIO receives the participant’s request, the QIO must notify PHP that the participant has filed a request for immediate review and PHP and/or the hospital will supply any information that the QIO requires to conduct its review by the close of business of the first full working day. The QIO must also

solicit the views of the participant and/or the participant's authorized representative who requested the immediate QIO review.

The QIO must then make an official determination of whether continued hospitalization is medically necessary within one (1) business day after it receives all necessary information from the hospital, PHP, or both, and notify the participant/representative, the hospital, and PHP by the close of business. If the QIO upholds PHP's decision, PHP is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the participant/representative of its decision. If the QIO overturns PHP's decision, PHP is financially liable for the remainder of the hospital stay.

Expedited Internal Appeal

A participant and/or the participant's authorized representative who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with PHP. PHP will then expedite the request for an expedited reconsideration.

Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and then forwards that request to PHP, PHP will expedite the request. Thus, PHP will generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

Provider Appeals of a denial of a service

If you are a participating (in-network) provider, you can appeal an adverse decision only if you get an authorization of representative (CMS FORM 1696) from the participant. This form is available at www.phpcares.org.

If you are a non-participating provider, you can appeal the adverse decision if the waiver of liability is completed for the participant. This form is available at www.phpcares.org.

Part D Appeals

Please see the Part D Provider Manual for a description of the Part D Prescription Drug appeals process. Consistent with existing rules, all Part D appeals will be automatically forwarded to the CMS Medicare Part D independent review entity if PHP misses the applicable adjudication timeframe.

The NODMAR will inform the participant and/or the participant's authorized representative of the right to request a review by a Quality Improvement Organization (QIO) responsible for reviewing participant grievances relating to quality-of-care issues. If the participant/representative opts for QIO review, he or she will not incur any additional financial liability if:

- The participant remains in the hospital as an inpatient
- The participant submits the request for immediate review to the QIO that has an agreement with the hospital

- The request is made either in writing, by telephone, or fax
- The request is received by noon of the first working day after the participant receives written notice of PHP's determination that the hospital stay is no longer necessary

QIO Review Process

On the date that the QIO receives the participant's request, the QIO must notify PHP that the participant has filed a request for immediate review and PHP and/or the hospital will supply any information that the QIO requires to conduct its review by the close of business of the first full working day. The QIO must also solicit the views of the participant and/or the participant's authorized representative who requested the immediate QIO review.

The QIO must then make an official determination of whether continued hospitalization is medically necessary within one (1) business day after it receives all necessary information from the hospital, PHP, or both, and notify the participant/representative, the hospital, and PHP by the close of business. If the QIO upholds PHP's decision, PHP is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the participant/representative of its decision. If the QIO overturns PHP's decision, PHP is financially liable for the remainder of the hospital stay.

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If you are a non-participating provider, you can appeal the adverse decision if the waiver of liability is completed for the participant. This form is available at www.phpcares.org.

SECTION 19: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) GUIDELINES

Partners Health Plan (PHP) strives to ensure that contracted providers conduct business in a manner that safeguards protected patient/participant information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect to demonstrate compliance with the HIPAA privacy regulations.

- **Minimum Necessary Information:** PHP recognizes its responsibility under the HIPAA privacy regulations to only request the minimum necessary participant information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary participant information required to accomplish the intended purpose when contacting PHP. However, privacy regulations allow the transfer or sharing of participant information, which may be requested by PHP to conduct business and make decisions about care such as a participant's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment, or health care operations.
- **Fax Machines:** Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need participant information to perform their jobs. When faxing information to PHP, verify the receiving fax number is correct, notify the appropriate staff at PHP, and verify the fax was appropriately received.
- **Email:** e-mail should always be encrypted to transfer files containing participant information to PHP (e.g., Excel spreadsheets with claim information).
- **Standard Mail:** Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at PHP.
- **Voicemail:** PHP's voicemail system is secure, and password protected. When leaving messages for PHP staff, providers should only leave the minimum amount of participant information required to accomplish the intended purpose.

When contacting PHP, providers should be prepared to verify their name, address, and Tax Identification Number or National Provider Identifier number.

SECTION 20: MARKETING

Providers may not develop or use any materials that market (i.e., promote or encourage potential participants to enroll) Partners Health Plan without PHP's prior written approval. Under FIDA- IDD program regulations, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a FIDA-IDD plan unless the materials meet CMS marketing guidelines and are first submitted to CMS for review and approval.

Additionally, providers can have plan marketing materials in their office as long as marketing materials for all other FIDA plans the providers participate in are represented. In other words, providers are allowed to have posters or notifications that show they participate in PHP as long as the provider displays posters or notifications from all FIDA plans in which they participate.

General Requirements

PHP's network providers are permitted to assist prospective participants and their authorized representatives in objectively assessing their needs and potential options for meeting those needs, but must remain neutral when assisting with enrollment decisions. To this end, PHP's network providers must comply with the following "do's and don'ts":

Allowed	Not Allowed
<ul style="list-style-type: none"> • providing the names of health plans with which they contract and/or participate • Making available and/or distributing PHP marketing materials • Referring their patients to other sources of information, such as PHP's Outreach Associates, the State Medicaid Office, the FIDA-IDD Enrollment Broker, local Social Security Office, CMS's website, or 1-800-MEDICARE. • Sharing information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" or other documents that were written by or previously approved by CMS. 	<ul style="list-style-type: none"> • Offering sales/appointment forms • Accepting Medicare enrollment applications • Making phone calls or directing, urging, or attempting to persuade clients to enroll in a specific plan based on the financial or any other interests of the provider • Mailing promotional materials on behalf of PHP • Offering anything of value to induce PHP participants to select them as their provider • Offering inducements to persuade clients to enroll in a particular plan or organization • Conducting health screenings as a marketing activity • Accepting compensation directly or indirectly from PHP for prospective participant enrollment activities • Distributing materials/applications within an exam room setting

Provider Affiliation Information

PHP's network providers are permitted to publicize new or continuing affiliations with specific health plans such as PHP through general advertising (e.g., radio, websites, and mailings).

New Affiliations

New affiliation announcements apply to providers that have entered into a new contractual relationship with PHP. Newly contracted providers may make a one-time announcement that exclusively names PHP within the first 30 days of the agreement if it is conveyed through direct mail, email, or phone. If a provider wishes to use other mediums to make this announcement, the provider must disclose its relationships with other health plans as well.

Any affiliation communication materials that describe PHP in any way (e.g., benefits, formularies) must be pre-approved by CMS. Materials that only list PHP's name and/or contact information do not require CMS approval.

FIDA Affiliations

Because PHP is a specialty FIDA-IDD plan serving individual with intellectual and other developmental disabilities (IDD), network providers may feature PHP in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement by placing the PHP affiliation at the beginning of the announcement and may include specific information about PHP, including special plan features, the population PHP serves, or specific benefits. The announcement must list all other FIDA plans with which the provider is affiliated.

SECTION 21: FRAUD, WASTE, AND ABUSE (FWA)

Health care fraud costs taxpayers' tens of billions of dollars every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. There are several stages to addressing fraudulent acts, including detection, prevention, investigation, and reporting. In this section, PHP provides information on how to help prevent participant and provider fraud by identifying the different types.

Many types of fraud, waste, and abuse have been identified, including:

- **Provider Fraud, Waste, and Abuse:**
 - Billing for services not rendered
 - Billing for services that were not medically necessary
 - Double billing
 - Unbundling services
 - Upcoding services

Providers can prevent fraud, waste, and abuse by ensuring that services rendered are medically necessary, accurately documented in the medical records, and billed according to AMA/PHP guidelines.

- **Participant Fraud, Waste, and Abuse:**
 - Benefit sharing
 - Collusion
 - Drug trafficking
 - Forgery
 - Illicit drug seeking
 - Impersonation
 - Misinformation/misrepresentation
 - Subrogation/third-party liability fraud
 - Transportation fraud

One of the most important steps to help prevent participant fraud is as simple as reviewing the participant's ID card. PHP will not accept responsibility for the costs incurred by

providers rendering services to a patient who is not a current PHP participant, even if that patient presents a PHP participant ID card. Providers should take measures to ensure the cardholder is the person named on the card and his or her participation in PHP is up to date.

Additionally, providers can assist in encouraging participants and their caregivers to protect their cards as they would a credit card or cash, always carry their participant ID card, and report any lost or stolen cards to PHP as soon as possible.

PHP encourages its participants, participants' representatives, and providers to immediately report any suspected instance of fraud, waste, and abuse. No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and PHP will make every effort to maintain anonymity and confidentiality.

If you have any questions about identifying and/or reporting suspected instances of fraud, waste, and abuse, please contact PHP's Compliance hotline as soon as possible at 1-855-747-0013 (1-855-PHP-0013).

SECTION 22: PROVIDER PERFORMANCE & TERMINATION

Performance Standards and Compliance

Performance Standards

When evaluating a provider's performance and compliance, Partners Health Plan (PHP) reviews a number of clinical and administrative practice dimensions including, but not limited to, the following:

- **Quality of Care:** Measured by data related to the appropriateness of care and outcomes and adherence to evidence-based practice guidelines
- **Efficiency of Care:** Measured by clinical, non-clinical, and financial data related to the cost of care and services
- **Participant Satisfaction:** Measured by participant/caregiver survey results regarding accessibility, quality of care, participant/provider relations, and the comfort of the office setting
- **Administrative Requirements:** Measured by the provider's protocols for keeping records and transmitting information, ADA compliance, encounter reporting, completion of recommended training, participation on Interdisciplinary Teams, etc.

Compliance

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

- Unnecessary out-of-network referrals and utilization (which require prior authorization)
- Participant complaints and grievances filed against the provider
- Underutilization, overutilization, or inappropriate referrals
- Inappropriate prescribing patterns
- Inappropriate billing practices, such as balance billing of participants for monies that are not their responsibility
- Participant appointment and access to care issues
- Lack of adherence to evidence-based practice guidelines
- Non-supportive actions and/or attitude (e.g., refusal to participate on a participant's

IDT;lax reporting practices, etc.)

PHP tracks and trends provider compliance on a calendar year basis and takes corrective actions as appropriate to address identified issues.

Provider Termination and Appeals

If PHP denies, suspends, terminates, or opts not to renew a provider's contract, PHP will send a written notification of the reason(s) for the action (e.g., quality issues) including information about the provider's right to appeal the action to a hearing panel comprised of peers of the affected provider. As applicable, PHP will also notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Notification to Participants

PHP will make a good faith effort to provide affected participants and their caregivers with written notification of a provider's termination within at least 15 calendar days before the termination effective date, regardless of the reason for the termination. PHP may provide participant notification in less than 15 days as a result of a provider's death or exclusion from federal health programs.

When a termination involves a PCP, all participants who are patients of that PCP will be notified of the termination and the participant's care management team will assist in identifying a new PCP that will meet the participant's needs and preferences.

SECTION 23: CLAIMS PROCESSING AND ENCOUNTER REPORTING

General Payment Guidelines

When adjudicating claims, Partners Health Plan (PHP) applies all applicable federal and state statutes, regulations, and agency guidelines including, but not limited to, those payment rules set forth in Title 10 of the New York Code of Rules and Regulations.

PHP's providers are paid according to their contractual reimbursement arrangement with PHP. PHP's reimbursement for covered services provided to eligible participants is considered payment in full. Providers **MAY NOT** balance bill PHP's participants for the difference between the claims reimbursement and their charges.

Timeliness of Claims Submission

Claims must be submitted timely to PHP per the provider's contract. Some contracts indicate 90 days, other contracts may indicate 120 days. Claims submitted beyond the contractual timeframe will be denied for untimely filing.

PHP may pay claims that have initially been denied for untimely filing when it is documented that the claim could not be submitted within required timeframes as a result of an unusual circumstance. However, claims for dates of service beyond 365 days will not be considered for payment.

"Clean" Claims

PHP expects its contracted providers to submit "clean" claims, which is defined as a claim that can be processed without obtaining any additional information from the provider who rendered the service. Thus, clean claims have no defect, impropriety (including lack of substantiating documentation), or circumstances requiring special handling that might impact or prevent timely remittance of payment. Claim inquiries or appeals of claim denials must occur within 60 days of the original claim payment or appeal.

If using paper claims, providers should submit original claim forms. Submission of black and white copies delays claim processing time and may be returned as "unable to process."

Duplicate Claims

Submitting duplicate claims increases processing costs, processing times, and the potential for errors. PHP asks for your cooperation in checking claim status by any of these three methods before resubmitting a claim:

- Online via PHP's website portal at www.phpcares.org (available 24 hours a day, 7 days a week)
- Telephonically using the IVR phone system to check claim status at 1-844-871-2355 (available 24/7)

Telephonically by contacting PHP's Provider Services Department at 1-855-747-5483 (available M-F from 8 AM – 6 PM EST except for state holidays)

Additional Guidelines

- **National Provider Identifier (NPI):** Providers must include their National Provider Identifier (NPI) on each claim submission. If you have not obtained a NPI, you can apply through a web-based application process at <https://nppes.cms.hhs.gov>.
- **Atypical Services:** Atypical or nontraditional services are usually called “indirect healthcare-related services.” Atypical providers do not meet the HIPAA standard definitions of a health care provider and are not required to have a National Provider Identifier (NPI). Per the August 2008 Medicaid Update Newsletter; “atypical providers” can include:
 - ◇ Personal Care Services
 - ◇ Personal Emergency Response Services
 - ◇ Office of Mental Health (OMH) Rehabilitative Services
 - ◇ OPWDD Waiver Services
 - ◇ Non-Emergency Transportation Providers
- **Participant's ID Number:** Claims must include the participant's ID number and at least two nodes of the participant's DOB must match PHP's records (i.e., month, date, and year of birth).
- **Prior Authorization:** Claims for services that require authorization, or claims associated with denied authorizations, will be denied.
- **Change in Provider Information:** Network providers must inform PHP about any changes in Tax ID, corporate name, and/or addresses as soon as possible. Updates to provider records typically require 30 days. Email demographic/information updates to phpproviders@healthsmart.com

Billing and Claim Submission Guidelines

For more information pertaining to claim submission and payment methods please visit our website as follows: https://www.phpcares.org/wp-content/uploads/2021/12/Billing-Claims-Submission-Guidelines_V11.0.pdf

Electronic Claims Submission

PHP encourages providers to submit their claims electronically. PHP accepts claims from any clearinghouse that can submit to Change Healthcare (formerly known as Emdeon). The benefits of submitting claims electronically include:

- Claims submitted electronically process more quickly
- Reduced administrative costs for provider
- Reduced volume of paper for provider
- Reduced timely filing denials
- Optimization of reimbursement turnaround time

Change Healthcare (formerly known as Emdeon) currently accepts claims for PHP with Submitter ID #14966.

If you are not sure you are submitting the correct NPI number or you have any additional questions pertaining to electronic claims submission, please contact PHP Provider Services at 1- 855-747-5483

Providers that wish to submit electronic claims directly to HealthSmart's Clearinghouse can contact EDI Support Group at 1-888-744-6638.

An EDI enrollment packet will need to be completed and returned as indicated in the document located on the PHP website: <https://www.phpcares.org/wp-content/uploads/2018/06/PHP-Provider-EDI-Enrollment-Packet.pdf>

Paper Claims Submission

PHP utilizes Optical Character Recognition (OCR) technology to process CMS1500 and UB04 paper claim forms as expeditiously as possible. However, only legible, red-ink, current versions of these claim forms can be scanned into the OCR equipment.

Please follow these simple instructions to facilitate the processing of your claims:

- Submit original red-ink, current versions of CMS1500 and UB04 claim forms
- Avoid submitting black and white copies
- Report only six lines of service on a single CMS1500 claim form
- Avoid handwriting claims
- Print data within the allotted field size
- Include your National Provider Identifier (NPI)
- Company invoices and spreadsheets will not be processed.

Providers can obtain UB04 and CMS 1500 forms at <http://www.health-forms.com>.

REMEMBER: All paper claims and encounter forms must be submitted on a CMS1500 or UB04 form and mailed to the address below.

Partners Health Plan Claims Department
P.O. Box 16309
Lubbock, TX 79490

Claims Adjudication Processes

Auto Adjudication

PHP runs batch processes on a daily basis against a comprehensive set of edits that are individually configured based on contractual and regulatory requirements. This rules-based system allows for setting multiple edits to test claim validity and to determine if claims are paid or denied appropriately. These edits include, but are not limited to:

- Participant eligibility
- Covered/non-covered services
- Required documentation
- Services within the scope of the provider's practice
- Duplication of services
- Prior authorization
- Invalid procedure codes

Based on these and other system edits, claims are systematically processed to either a pay, deny, or pend status.

Corrected Claims

If a provider needs to make any adjustments to a previously submitted claim, such as adding a revenue code or changing a diagnosis/procedure code, you may resubmit your claim for payment as follows:

- On an Institutional UB-04 claim you should submit as a corrected claim, which is identified by utilizing the applicable Bill Type ending in '7' to designate as corrected (i.e., XX7, 137, 737, etc.)
- On a Professional CMS-1500 claim you should mark the claim as corrected and include the original claim number in Box 22 'Original Reference No.'

All resubmissions/corrected claims should include all original claim lines. Failure to do so may result in an inaccurate or denial of payment.

Claims Processing Timeframes

New York State Insurance Law has been amended to modify the timeframe for payment of claims based on electronic submission versus paper or facsimile submission. As of that date, affected health plans must pay:

- All clean claims submitted electronically within 30 days
- Clean paper or facsimile claims within 45 days

The 30-day timeframe for requesting additional information or for denying the claim was not changed.

Identification of Late and Interest Due Payments

PHP's claims processing system determines the timeliness of claims adjudication and uses the claim's receipt/clean date to calculate the submission window. Interest penalties are retrospectively calculated based on the receipt date of the claim. PHP is responsible to generate an interest payment calculating at \$2 or above.

The original claim will be adjusted, and a claim line will be added to reflect the additional interest payment.

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Coordination of Benefits

New York State Insurance Law has been amended to specify that the managed care organization cannot deny a claim, in whole or in part, on the basis that it is coordinating benefits and the participant has other insurance, unless the managed care organization has a "reasonable basis" to believe that the participant has other health insurance coverage that is primary for the claimed benefit. If the MCO requests information from the participant regarding other coverage and does not receive it within 45 days, the MCO must adjudicate the claim and it may not be denied on the basis of non-receipt of information about other coverage. This amended section of the law only addresses the denial of claims due to other insurance and leaves unchanged the plan's annual process for determining the existence of alternate insurance among its participants.

Claims submitted to Partners Health Plan as a secondary insurer must be submitted as a paper claim and include the primary insurer's Explanation of Benefits (EOB) for reimbursement consideration. PHP will deny claims for participants identified with other primary insurance if a paper claim, including a primary EOB, has not been submitted.

Overpayment

PHP periodically reviews payments made to providers to ensure the accuracy of claims payment pursuant to the terms of the provider's contract and/or to review claims activity in accordance with PHP's fraud and abuse prevention program.

In instances where PHP has identified overpayments, written notice will be sent to the provider requesting repayment within 60 days. The notice will include the participant's name, service dates, payment amounts, and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding and submit supporting evidence or remit payment. If a provider fails to respond to PHP's notice of overpayment, then PHP will initiate an overpayment recovery process that offsets the overpayment amount against current and future claim remittances until the full amount is recovered.

In the event that a provider identifies any overpayments, it is the provider's responsibility under Section 6402(a) of the ACA to report and refund the overpayment with a written explanation/reason within sixty (60) days following its initial identification.

For any Billing or Reimbursement questions, please call PHP's Provider Services Department at 1-855-747-5483

High-Cost Outliers

High-cost outliers are handled on appeal and require medical records for consideration.

Medical/Service Claim Review

PHP conducts ongoing reviews of medical/service claims to confirm consistency and accuracy in billing processes. Our goal has always been to be fair and equitable in this endeavor. PHP continues to utilize globally accepted guidelines, including CPT regulations as documented by the AMA, Correct Coding Initiatives (CCI), and Global Surgery Period Guidelines as outlined by the Center for Medicare and Medicaid Services (CMS). Several areas of review are based on the following globally accepted coding principles:

- **Global Surgical Principles:** CMS has defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure—furnished by the physician who performed the surgery—are to be included in the payment of the surgical procedure code. These procedure codes are evaluated based on major and minor service categories with differently defined global day allocations for each.

- **Add-On Principles:** Both CPT and CMS defined codes require the presence of a primary procedure code for appropriate coding. These rules follow the direction set forth in the CPT manual that describes “add-on codes” as “procedures/services that are always performed by the same physician” and “are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes.”
- **Assistant Surgeon Principles:** These represent CMS rules based on the need for an assistant surgeon, co-surgeons, and team surgeons for all surgical procedures, as CMS is the only governing body that continues to evaluate the need for this type of service.
- **National Correct Coding Initiative (CCI):** As defined by CMS:
 - Comprehensive: These procedure codes have been identified as the inappropriate unbundling of comprehensive procedure codes into its component parts (codes).
 - Mutually Exclusive: These procedures codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.
- **Duplicates:** These apply to the following areas: Radiology, Date Range Duplicates, Lifetime Duplicates, and E/M Service Range.
- **Unbundled Procedure Principles:** In addition to CCI, there are code pairs that are considered to be a component of another procedure code, filed on the same date of service by the same provider.
- **Evaluation and Management Crosswalk Principles:** These represent multiple submissions of E/M codes within the same category and/or two different categories by the same provider on the same date of service.
- **Incidental Procedures (IN):** The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status of B (bundled) or P (bundled/excluded) in the CMS National Physician Fee Schedule Relative Value File.
- **Medical Necessity (MN) Based on Appropriate ICD-10 Codes:** These are Regional and National Medical Necessity guidelines from CMS. Services reported must have the appropriate ICD-10 codes, as required, submitted on the claim that demonstrates medical necessity.

Anesthesia Billing: Frequently Asked Questions

Many anesthesia providers have asked us the following questions regarding the appropriate way to submit claims for the provision of anesthesia services.

- What interval is used to determine time units?
 - 15-minute intervals are used to determine an anesthesia time unit (i.e., 60 minutes = 4-time units).
 - Anesthesia time during which the anesthesiologist was in personal attendance will be considered for reimbursement.
- Do you reimburse base units in addition to time, and if so should the base units be identified on the claim submission?
 - Anesthesia procedures (CPT 00100-01999) are reimbursed as base plus time units.
 - Base units are maintained in the claims processing system and should not be included on your claim submission.
- Do you separately reimburse for CPT codes 99100 or 99140?
 - No. Procedure codes 99100 (special anesthesia service) and 99140 (emergency anesthesia) are not separately reimbursed.
- What calculation is used to reimburse general anesthesia services?
 - The total minutes billed are converted into time units and added to the base unit. This sum is then multiplied by the contracted conversion factor to determine the appropriate reimbursement. The calculation is as follows:
 - ◇ $\text{total time in minutes} \div 15\text{-minutes per time unit} = \text{time units sum}$
(rounded to the nearest whole value, e.g., 70 minutes \div 15 = 4.6 time units [rounded up to 5])
 - ◇ $(\text{time units sum} + \text{base units}) \times \text{per unit conversion factor}$
- What procedure codes should be utilized?
 - Bill general anesthesia services using the ASA/CPT codes (00100-01999).
 - DO NOT bill general anesthesia using surgical CPT codes with anesthesia modifiers. Claims submitted in this manner will be denied to resubmit using anesthesia CPT codes.
 - All other services (e.g., injections) should be billed with the appropriate CPT code.
- Should minutes or time units be billed?
 - Please bill the total time in minutes using qualifier MJ.
 - Do NOT utilize qualifier UN. Claims submitted using qualifier UN will be interpreted as total minutes and therefore underpaid.
 - Only the total minutes are to be reported as the days/units (i.e., box 24g of CMS-

1500) when billing general anesthesia services. For example, if anesthesia was administered between 9 a.m. and 10 a.m., box 24g should reflect 60 minutes; if anesthesia was administered between 12 noon and 2:12 p.m., box 24g should reflect 132 minutes.

- Where should the start and stop time be placed?
 - This information can be submitted but is not required for claims processing via EDI.
 - It is recommended that this information be included on paper claim submissions, but it is not required.
 - Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the physician is no longer in personal attendance.
 - Personal attendance, or time in attendance, is time spent face-to-face with the patient.
 - Documentation of time in attendance must always be recorded in the patient's record.

If you need additional assistance or have questions that are not covered in this section please contact PHP Provider Services at 1-855-747-5483.

Fraud and Abuse Monitoring

PHP adheres to all state and federal rules, regulations, and guidelines relating to the monitoring and identification of Fraud and Abuse and has implemented policies and procedures for the detection, investigation, and prevention of fraudulent activities.

- **Fraud:** For the purposes of this section, fraud is defined as any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by a managed care organization, contractor, subcontractor, provider, beneficiary, or enrollee or other person(s). A “provider” includes any individual or entity that receives funds in exchange for the provision, or arranging for the provision, of health care services to an enrollee of a health plan.
- **Abuse:** For the purposes of this section, abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the state or federal government or a managed care organization, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by a managed care organization, contractor, subcontractor, provider,

beneficiary or enrollee. It also includes enrollee practices that result in unnecessary cost to the state or federal government, managed care organization, contractor, subcontractor, or provider. For the purposes of this paragraph, a provider includes any individual or entity that receives funds in exchange for providing, or arranging for the provision, of health care services to an enrollee of a health plan.

PHP performs routine audits and edits of providers' claims to identify billing patterns that are aberrant.

Never Events

Health Plans throughout New York State are now required to have procedures in place to address inpatient claims that report a Never Event. Under current law, there are thirteen (13) Never Events, including:

- 1) Surgery performed on wrong body part
- 2) Surgery performed on wrong patient
- 3) Wrong surgical procedure done on patient
- 4) Retention of a foreign object in a patient after surgery or other procedure
- 5) Patient disability after medication error
- 6) Patient disability associated with a reaction to ABO incompatible blood or blood products provided by a healthcare facility
- 7) Patient disability associated with the use of contaminated drugs, devices, and biologics
- 8) Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- 9) Patient disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- 10) Patient disability associated with an electric shock while being cared for in a healthcare facility
- 11) Any incident in which a line designated for oxygen or other gas is contaminated with a toxic substance
- 12) Patient disability associated with a burn incurred from any source while being cared for in a healthcare facility
- 13) Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Source:

https://www.health.ny.gov/health_care/medicaid/quality/never_events/reimbursement_policy/update_2009-08-10.htm#:~:text=The%20State%20does%20not%20intend,be%20billed%20by%20that%20provider.

Never Events numbers 4 and 6 listed above will be monitored administratively in a manner similar to the procedure used by CMS. The remaining 11 Never Events will be monitored via chart review. There is no significant experience across the nation to serve as a template or guide in the development of policies and procedures for handling Never Events, although some data is available via NYPORTS. Hospitals must always submit the Present on Admission (POA) indicator on all claims.

The New York State Department of Health has developed three (3) rate codes that indicate whether a Never Event occurred, including:

Rate Code	Description
2590	Hospital will use this code to identify that a Never Event happened that was so severe that the hospital does not expect any payment on the claim.
2591	Never Event occurred and may have impacted DRG. Full or partial payment is expected. Claim requires MedReview.
2592	Never Event occurred and may have impacted Per Diem payment. Full or partial payment is expected. Claim requires MedReview.

Frequently Asked Questions and Answers:

- What is the effect on Prompt Payment Requirements?
 - Rate code 2590 would be denied with no payment as hospital would not expect to receive payment.
 - For rate codes 2591/2592, hospital will submit an original claim which will get paid, then hospital is expected to submit a second follow-up claim with one of these rate codes for the claim to be reviewed and adjusted. Since the original claim would be paid, there is no violation of the Prompt Payment Laws.
- How will the Hospitals be notified?
 - Hospitals will be notified via meetings with various Hospital Associations, direct communications to Hospitals, and Medicare/Medicaid Update Newsletters.

- Why would a Hospital ever use rate code 2590 and not expect payment on a claim?
 - Failure to identify these situations could position the facility for being sanctioned for fraud and abuse.
- How can the Events affect payment?
 - Event could change the DRG from a lower cost DRG to a higher-cost DRG
 - Event could add to a DRG by turning the DRG into a DRG with complications
 - Event could cause the DRG to become a high-cost outlier
- How will Never Events impact professional claims?
 - It is very possible that professional claims will be affected but this will be examined at a later date.
- Are any facilities excluded from the Never Events legislation?
 - Currently, nursing homes are the only facilities excluded both at a federal and New York State level. However, while excluded by the federal government, critical access hospitals and cancer hospitals are included for New York State.
- What should be done in cases where the Hospital will not release the medical record because there is litigation, and the Risk Management department of the facility will not release the data?
 - Hospitals have 30 days to submit the requested chart. Failure to do so will result in the claim being denied.

Claims Appeals

If a provider disagrees with an authorization-related denial or if the provider disagrees with the manner in which a claim was processed, the provider has the right to file an appeal with PHP within 60 days from the date of determination or denial unless contracted otherwise. Out-of-network providers must submit a waiver of liability (WoL) with their appeal. The WoL form can be found on our website (<https://www.phpcares.org/wp-content/uploads/2018/06/PHP-Waiver-of-Liability-Statement.pdf>). Appeals must include the following information:

- Claim number
- Authorization number (if applicable)
- Participant name and Partners Health Plan number
- Date(s) of service

- Service code(s) billed
- Unit(s) value billed
- Amount billed
- Reason for appeal
- Waiver of Liability (non-contracted providers only) Appeals must be submitted in writing and mailed to:

**Partners Health Plan
Attn: Appeals & Grievances
P.O. Box 16309
Lubbock, TX 79490**

Encounter Reporting

Definition

An encounter is defined as a professional face-to-face contact or transaction between a participant and a provider who delivers a procedure or service. Encounters for all incurred services in PHP's benefit package must be reported. In general, the participant must be physically present for an encounter to take place, with the exception of covered laboratory services. A provider consultation with another provider about a participant in the absence of the participant or making a referral to another network provider is not considered an encounter.

Encounters can be categorized into four separate types:

- Institutional
- Pharmacy
- Dental
- Professional

Encounter Reporting Policy

Partners Health Plan's (PHP) encounter data reporting policy and procedure is designed to ensure compliance with state and federal requirements governing the content, accuracy, format, and timeliness of encounter data reports. The objectives are to:

- Comply with regulatory requirements
- Accurately capture utilization and provider payment data for quality performance monitoring
- Identify potential opportunities for improvement
- State and federal regulatory agencies use the data to:
 - Describe the demographic and health status characteristics of the enrolled population
 - Report and monitor service utilization
 - Evaluate access and continuity of service issues
 - Monitor and develop quality and performance indicators
 - Calculate capitation rates
 - Perform cost effectiveness analysis
 - Evaluate various service models and environments

Fee-for-Service Providers

Providers and practitioners that PHP reimburses on a FFS basis (including institutional, pharmacy, dental, and professional providers, whether in-network or out-of-network) must submit valid claims to PHP in order to be paid. Each claim, whether paper or electronic, represents an encounter for reporting purposes.

Capitated Providers

If PHP enters into a capitated arrangement with a provider or practitioner, our contract will require the submission of all utilization and encounter data to PHP within three months of the month in which the service(s) were rendered. Providers who fail to meet the timeliness, validity, and adequacy requirements of their encounter reporting requirements will be

penalized in accordance with contract specifications.

In addition, PHP will require capitated or partially capitated providers/practitioners to adhere to the following encounter reporting guidelines:

- Reporting of services must be presented on a per participant, per visit basis
- Reporting of all services rendered by date must be submitted to PHP
- Encounter data must reflect all the same data elements required under a FFS arrangement
- All encounter data reporting must be in full compliance with HIPAA and all other state and federal reporting requirements

SECTION 24: QUALITY MANAGEMENT

This section describes Partners Health Plan's (PHP) process for communicating with network providers and enlisting their participation in the development of PHP's quality assurance and performance improvement program and other clinically related policies, procedures, and guidelines.

Provider Consultation

Professional Practice and UM Guidelines

PHP will implement a formal mechanism for consulting with network providers in the development and implementation of professional practice and utilization management guidelines that:

- Are based on reasonable evidence or a consensus of professionals in the particular field
- Consider the unique needs of PHP's participants
- Are reviewed and updated periodically

The guidelines will be communicated to all network providers and practitioners and, as appropriate, to PHP's participants, participants' families/caregivers, and other stakeholders.

Provider Participation on PHP Committees

To further ensure provider input in the development and implementation of PHP's provider- related policies, procedures, and guidelines, PHP encourages provider participation on the following committees:

- Participant Advisory Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Quality Oversight Committee
- Credentialing and Performance Committee
- Policy and Procedure Committee

If you are interested in participating on one or more of these committees or would like more information, including committee meeting schedules, please contact our Quality Management staff at 1-855-747-5483.

Policy of Non-Interference with Provider Advice to Participants

PHP will not prohibit or otherwise restrict providers from advising or advocating on behalf of participants about the following topics:

- The participant's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the participant and his or her authorized representative to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the participant and his or her authorized representative to refuse treatment and to express preferences about future treatment decisions

Provider Site Visits

PHP's protocols require Provider Relations staff to conduct regularly scheduled and ad hoc site visits to provider/practitioner offices to ensure that network providers maintain PHP's standards for accessibility, appearance, and adequacy of equipment as well as for medical/service record documentation and privacy in accordance with all state and federal rules and regulations, professional ethics, and accreditation standards.

PHP uses a standardized tool to evaluate provider/practitioner offices. If staff identifies a deficiency during an on-site visit, we will require the implementation of a corrective action plan (CAP) and re-visit the provider in six (6) months to ensure that the CAP is progressing properly. Quality staff will be responsible for documenting all such corrective actions and related activities, including their resolution, and entering them into providers' confidential provider files. Quality staff will further report this information to the Medical Director and the Quality Oversight Committee, and it may also be used in provider/practitioner re-credentialing/certification evaluations. The Chief Medical Officer or Chief of Quality Initiatives is also responsible for overseeing the preparation and submission of summary reports to the Quality Management Oversight Committee of the Board.

Potential Quality of Care Concerns (PQoC)

A "Potential Quality of Care Concern" is a concern raised by anyone internal or external to PHP that requires investigation as to whether the competence or professional conduct of an individual network practitioner, organizational provider, or vendor adversely affects, or could adversely affect, the health or welfare of a participant. A "Quality of Care Concern" is a determination that the competence or professional conduct of an individual practitioner, organizational provider, or vendor adversely affected or in the future could adversely affect the health or welfare of a participant.

Examples of PQoCs include, but are not limited to:

- Misdiagnosis or missed diagnosis with serious outcome or disability
- Major injury or unplanned removal of an organ during surgery/invasive procedure
- Complications from surgery, unplanned return to OR, complication with anesthesia, unexpected admission/readmission following surgery, etc.
- A delay in accessing care or service that has a negative effect on a health problem, worsened a condition, or required emergency treatment
- Alleged inadequate or improper examination

- Alleged failure to order diagnostic testing
- Abnormal diagnostic findings allegedly not addressed by practitioner
- Any other circumstances where a participant/representative alleges an adverse effect on his or her health or welfare
- An alleged breach of privacy by a participating provider/practitioner

PHP will investigate all PQoC concerns in accordance with all applicable state and federal rules and regulations. QM staff is responsible for documenting all PQoC concerns, investigations, and decisions in the PQoC database, regardless of the ultimate determination. If a PQoC issue is reviewed by the Credentialing and Performance Committee (CPC), documentation will be included in the committee minutes.

All PHP staff members are responsible and accountable for the identification and communication of PQoC concerns to the Chief Medical Officer. PHP's Chief Medical Officer and other appropriate staff members (e.g., Provider Relations, Chief Compliance Officer, Quality Staff, and Care Managers) are responsible for investigating and addressing PQoCs, as needed and appropriate.

Participant Satisfaction Surveys

On an annual basis, PHP will contract with a qualified, state-approved survey vendor to evaluate the level of satisfaction among our participants and their families/caregivers with PHP's program, services, and network providers. Senior management and PHP's quality oversight committees will closely evaluate the results consistent with PHP's dedication to continuous quality improvement and implement appropriate interventions to address any identified deficiencies or opportunities for improvement.

Quality Oversight Committees

PHP's Quality Oversight Committees are responsible for ensuring that PHP's program, services, and activities undergo multiple layers of review, analysis, and evaluation consistent with PHP's commitment to continuous quality improvement and all applicable state and federal rules and regulations, professional ethics, and accreditation standards. Committees include:

Board of Directors

The Board of Directors has ultimate accountability for PHP's corporate compliance and quality assurance and performance improvement (QAPI) program and related processes, activities, and systems and will monitor these activities through the Quality Management Oversight Committee (QMOC). This includes responsibility for monitoring and evaluating the care and services participants receive through PHP's contracted health delivery network.

PHP's Quality Management Oversight Committee (QMOC) is a standing advisory committee of the Board of Directors and has responsibility for the oversight of PHP's quality management systems and for reviewing all quality management activities and making recommendations for quality improvement to the Board.

Quality Oversight Committee (QOC)

The QOC's primary responsibility is to oversee PHP's quality strategy and make recommendations to the Medical Management, Care Management, Provider Relations, Quality Management and PHP Operation departments. QOC reports to QMOC, and the governing board. The QOC's specific responsibilities include, but are not limited to, the following:

- **Clinical/LTSS Guidelines and Review Criteria:** PHP's QOC promotes the recognition and use of nationally recognized practice guidelines and reviews services for appropriateness and medical necessity.
- **Quality of Care:** The QOC is responsible for addressing identified clinical, service, regulatory, and safety issues and resolving them according to approved clinical/LTSS/OPWDD guidelines and protocols. The resolution may include corrective action plans for providers or the initiation of a peer review monitoring process.
- **Adequate Staff and Resources:** The QOC continually assesses and evaluates the adequacy of staff and resources to assure that our participants receive timely and appropriate care. Committee recommendations to address inadequate resources may include hiring additional staff, contracting with additional network providers, or re-engineering operational processes.
- **Integration and Collaboration:** The QOC plays a key role in facilitating the integration of QM/UM/QI activities throughout the organization, including the provider network. The committee solicits input and information from internal sources (e.g., participant and provider grievances and appeals) as well as external sources (e.g., advocacy groups, community-based organizations, governmental agencies, accreditation organizations, etc.).

Pharmacy and Therapeutics Committee

The P&T Committee is chaired by the Medical Director and comprised of appropriate representatives from our network providers and health plan staff, including the Pharmacy Coordinator. The Committee's mission is to ensure that participants have access to a clinically sound and cost-effective formulary by providing constructive feedback to PHP regarding the structure, content, and utilization patterns of our drug benefit. The Committee also reviews potential quality of care issues related to drug prescribing patterns and makes recommendations for corrective actions.

Utilization Management Committee

The UM Committee is chaired by the Medical Director and responsible for monitoring all UM- related activities including prior authorization, concurrent review, discharge planning, retrospective review, and the under/over-utilization of services. The goal of the UM Committee is to assure timely participant access to high-quality care and services through the evaluation of the relevant aspects of service delivery, clinical and non-clinical practices, and service authorization processes.

Credentialing and Performance Committee

Credentialing activities are conducted on behalf of PHP in accordance with the standards set by the Credentialing and Performance Committee (CPC) and New York State requirements. The CPC has oversight authority for all credentialing and re-credentialing activities, including individual providers/practitioners who deliver services and supports to our participants. The committee is also responsible for overseeing professional peer review activities for those providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of our participants and reviewing and evaluating all credentialing and re-credentialing information and processes.

PHP's Credentialing and Performance Committee will advise the Chief Medical Officer on the credentialing and re-credentialing of network providers, including their selection, approval, or denial. Importantly, the Credentialing and Performance Committee has responsibility for reviewing credentialing/background checks/fingerprinting reports of delegated providers (e.g., Home Health Agencies that employ direct-service workers). Anyone in an OPWDD-authorized program having regular and substantial contact with participants must be fingerprinted and undergo a criminal background check.

Policies and Procedures

The Compliance Committee is responsible for reviewing and providing input on PHP's

P&Ps to maintain a salutary balance between FIDA-IDD program requirements and the needs of network providers, participants, contractors, PHP staff, and other stakeholders in accordance with all state and federal rules and regulations.

SECTION 25: PARTICIPANT RESOURCES

This section describes the general functions, operations, and responsibilities of Partners Health Plan's (PHP) Participant Services department. The Participant Services department's hours of operation are Monday through Friday, 8:00 a.m. to 8:00 p.m., with the exception of state and certain federal holidays, and the toll-free Call Center line at 1-855-747-5483 is staffed by a live representative from 8:00 a.m. to 8:00 p.m. on all normal business days. At all other times, the Call Center employs an interactive voice response system or similar technology to meet participants' needs. All secure voicemail inquiries will be promptly responded to on the next business day.

Participant Services Representatives

PHP's Participant Services Representatives responsibilities include, but are not limited to, the following:

- Responding to inquiries about PHP's operations, covered services, and responsibilities, including:
 - Eligibility, enrollment, and disenrollment
 - Care management and care coordination
 - Network providers, practitioners, and pharmacies
 - Covered services and how to access them
 - UM requirements, including prior authorization guidelines
 - Grievances and appeals
 - Cultural Competency
 - Participants rights and responsibilities
 - Privacy and confidentiality
 - Language translation services and other forms of communications assistance
- Explaining Partners Health Plan's processes for accessing services and assisting participants in making appointments and arranging transportation
- Explaining the role of the PCP and providing assistance in selecting one, if needed

- Connecting participants/caregivers with available internal and external resources, including community-based resources
- Providing translation services as needed, including the use of Language Line and NY Relay services
- Handling emergency crisis or urgent calls for assistance
- Adhering to protocols and restrictions regarding protected health information
- Clarifying information in the Participant and Family Handbook/EOC and PHP website
- Educating families/caregivers about their right to complain to CMS, the NYS Department of Health, and/or OPWDD at any time
- Advising participants and their families/caregivers about the grievance and appeals and the service authorization process
- Assisting care management staff with health promotion and wellness initiatives

Call Center/Nurse Hotline

PHP's dedicated toll-free Nurse Hotline Call Center is available 24 hours a day, seven days per week at 1-855-769-2507. At a minimum, the Call Center is staffed with a live person on each business day from 8:00 a.m. to 8:00 p.m. Eastern time; at all other times, the Center employs an interactive voice response system or similar technology to meet participants' needs. All voicemail inquiries will be promptly responded to on the next business day. Translation services are available for participants and/or families/caregivers with limited English proficiency (LEP) and NY Relay and other accommodations are available in accordance with participants' individual needs. Call Center staff is trained to respond completely and accurately to participant and prospective participant inquiries, issues, and problems regarding their services and have access to clinical staff when a participant has inquiries or issues that are clinical in nature.

The Call Center staff is trained and knowledgeable about eligibility, covered services, participant rights and responsibilities, and grievances and appeals, among other topics. They are also trained to provide information and assistance relating to provider services, community, and social service resources, and resolving complaints. Importantly, Call Center staff will not provide actual coverage determinations or decisions on grievances and appeals but will instead provide information on how the coverage determinations, grievances, and appeals processes work and assist callers to navigate these processes, if requested.

Call Center staff will promptly transfer any participant inquiry outside their scope of authority to the appropriate department within PHP, such as provider relations, medical management, claims, and participant complaints and grievances. Call Center staff never provides clinical advice or information as these inquiries are always responded to by appropriate clinical staff.

Access to After-Hours Clinical Advice

Call Center staff never provides health-related advice to participants or their families/caregivers. Calls of this nature are instead “soft-transferred” without losing contact with the caller (during business hours) to an appropriate care manager or clinician who is licensed and trained to understand and assist with participants’ health care needs. At all other times, the IVR system phone tree will provide the option to transfer calls of a clinical nature to a licensed nurse that is trained to provide general health-related information as well as assistance in accessing services, Care Managers, Interdisciplinary Team members, and service authorizations outside of normal business hours. This service is available at all times, 24/7, 365-days per year.

Language Translation Services

PHP makes oral interpretation services available free of charge in any language to all participants and their families/caregivers that need assistance in understanding oral communications or written materials. Professional interpreters will be used as needed to discuss technical, medical, or treatment information. PHP’s Participant Call Center will use Language Line Telephone number 1-800-523-1786 (Client ID# 730756) to access language translation services. As needed, the participant’s circle of support will also provide assistance in communicating about issues and preferences.

PHP utilizes the New York Relay service at 7-1-1 for communicating with participants and families/caregivers that are deaf or hearing impaired.

Participant Ombudsman

New York State has implemented a FIDA Participant Ombudsman program to assist participants/families/caregivers in accessing covered services, supporting individual

advocacy, and conducting oversight for the FIDA program. The Ombudsman's role is to ensure participants are able to access medically necessary services and supports in compliance with all state and federal rules and regulations. PHP's obligation is to respond accurately and on a timely basis (i.e., as expeditiously as possible or in compliance with required timeframes, if applicable) to all Ombudsman inquiries and work collaboratively to ensure a speedy resolution to any issues or concerns that the Ombudsman may have.

Participant and Family Education

PHP has implemented a robust process for educating participants and their families/caregivers about PHP's program, including covered services and benefits, participant rights and responsibilities, and other relevant information. The objectives are to:

- Encourage appropriate utilization of covered services and supports and compliance with Partners Health Plan requirements
- Promote optimal outcomes by providing information that facilitates access to care and the effective use of services
- Comply with all applicable state and federal rules and regulations governing communications with participants, prospective participants, and participants' families/caregivers

PHP uses a diverse set of communication tools and protocols to ensure that our participants and their families/caregivers have timely access to all relevant information consistent with state and federal regulations, HIPAA guidelines, and internal policies and procedures. Care managers and other staff communicate with participants and their families/caregivers through a variety of methods, including telephonically and via in-person visits, text messaging, email, standard mail, the PHP website, and through PHP's web-based care management application that allows authorized users to access participants' Life Plans, case notes, scheduled appointments, assessment results, and other information from any location with Internet access 24/7.

PHP makes all printed participant/family materials available in English, Spanish, as well as other languages spoken by at least five percent of our participants or as directed by the state and submits them to the state and CMS for review and approval prior to distribution. Upon request, participants can also receive materials in additional languages free-of-charge. In addition, participants can receive material in braille, large print, and audio.

SECTION 26: PROVIDER TRAINING AND EDUCATION

Partners Health Plan (PHP) strongly encourages network providers/practitioners to complete training on an array of topics and offers a variety of opportunities to complete the training, including:

- Orientation sessions
- Distribution of written materials through mailings and on the PHP website
- Regularly scheduled and ad hoc site visits
- Regularly scheduled provider training forums and meetings
- In-person training sessions at provider offices
- Webinars
- Online curriculum

New Provider Orientation

PHP requires all newly contracted providers/practitioners to participate in orientation sessions to promote an understanding of PHP's contractual requirements, covered services, UM processes, participant rights and responsibilities, and reimbursement protocols, etc., and to develop an appreciation for the unique needs and challenges of caring for adults with intellectual and other developmental disabilities (IDD).

To the extent possible, PHP schedules orientation sessions by provider type (e.g., PCPs, specialist physicians, therapists, dentists, HCBS providers, etc.) within one month after they join our network. Provider Relations staff may conduct orientation through group sessions, during visits to individual providers, through the use of the PHP website, or via written materials and cover such topics as:

- Model of Care
- Covered benefits
- Participant and provider responsibilities
- The special needs of persons with intellectual and other developmental disabilities, including but not limited to:
 - Specialized communications techniques and cultural sensitivities

- Evidence-based practices
- Common chronic conditions and treatment guidelines, including behavioral health conditions
- Types of services and supports available either through PHP or other community-based resources
- Types of barriers encountered
- Person-centered planning and self-determination
- Role of the Life Plan
- Utilization Management processes, including prior authorization requirements
- Cultural and linguistic competency
- Availability of language translation services, NY Relay (TTY/TDD), and other accommodations to assist participants in accordance with their individual needs
- Provider reference materials, such as the website, Newsletters, etc.
- Process for checking eligibility
- The role of the PCP/Medical Home, including:
 - The assessment and Person-Centered Life Planning process
 - Coordination of care and referrals, including referrals for behavioral health services and long-term services and supports
 - Medical record documentation requirements
 - Electronic health records and information sharing
- Appropriate use of the emergency department
- Provider responsibilities for compliance with the Americans with Disabilities Act and Olmstead requirements, including:
 - Waiting room and exam room furniture that is consistent with the needs of adults with IDD
 - Clear signage and directional finding (e.g., color and symbol signage) within provider facilities
 - Accessibility along public transportation routes and availability of parking
- Methods PHP uses to update providers on program and health plan changes
- The role of care management teams and related activities
- The role of Interdisciplinary Teams, including information relating to provider responsibilities for serving on IDTs
- Coordination of physical and behavioral health condition(s) and treatment(s)

- The importance of evidence-based practice guidelines
- Quality metrics tailored to persons with IDD
- Reporting requirements, including encounter data submission requirements
- PHP's medical/service record documentation requirements
- The provider complaint, grievance, and appeals process
- Medical management processes, including:
 - Referrals to specialists and out-of-network providers
 - Preferred drug list
- Evidence-based practice guidelines
- Appointment availability standards, including wait times and after-hours availability
- Pay-for-performance opportunities (as applicable) and supporting tools, such as provider profiles
- Participants' rights and responsibilities, including the right to file a grievance or appeal and how a provider can assist participants in this process
- Participant resources (e.g., Call Center, community resources, transportation services, etc.)
- Claims payment, including the use of electronic claims and availability of electronic funds transfer (EFT)
- Coordination of Benefits
- Strict prohibition against balance billing of PHP participants
- Provider responsibility for compliance with state and federal laws
- Procedures for reporting suspected cases of abuse and/or neglect
- Contact information for Provider Relations and other departments

PHP's provider relations staff uses an In-Service Checklist to guide discussions and verify that they address all topics. We also make this information available in this Provider Manual as well as on the PHP website.

Provider Site Visits

PHP Provider Relations and/or QM staff conduct provider/practitioner site visits, some which may be done virtually, at least bi-annually, with additional meetings held as necessary with providers with large panel sizes as well as those not meeting their contractual requirements/obligations. During these sessions, our staff will reinforce previously presented

information as well as communicate upcoming plan initiatives, new regulatory requirements, or new policies that may affect providers.

Additional Educational Forums

In addition to the initial orientation and site visits, PHP conducts additional forums for continued education, including:

- Individualized provider instruction on select topics focusing on those areas with a high rate of prevalence in our target population, such as hyperlipidemia, seizure disorder, obesity, and anxiety, among others
- Group Training Sessions on select topics (e.g., claims coding, participant benefits)
- Health Forums
- Provider Newsletters and Bulletins containing updates and reminders
- Frequently updated online web materials and presentations
- Instructional forums that focus on identifying opportunities for improvement based on the results of key quality measures.

Documentation of Provider Education

PHP's provider educational processes include strategies to encourage the completion of all required curricula. As indicated above, provider education can be completed via in-person sessions, a review of written materials, or web-based training. Each educational modality will utilize a specific means of documenting attendance (e.g., sign-in sheets, web-based confirmation records, provider attestations). PHP will maintain these records for a minimum of seven years.

Additional Provider Resources

PHP is committed to working in partnership with its network providers to ensure our participants are able to access high-quality services and supports on a timely basis in accordance with all federal and state rules and regulations, accreditation standards, and professional ethics. To this end, PHP encourages providers to contact our highly trained and dedicated staff immediately with any questions or concerns or to request any professional assistance that may be needed. At PHP, "continuous quality improvement" is much more than a slogan and we sincerely encourage and appreciate any and all comments, criticisms, and helpful advice you or your staff may wish to contribute.

SECTION 27: BEHAVIORAL HEALTH

Individuals with intellectual and other developmental disabilities (IDD) and co-occurring mental health and/or behavior disorders (i.e., persons with a "dual diagnosis"), along with their families and caregivers, often encounter significant obstacles to receiving needed services in New York and across the country. Research demonstrates the prevalence of behavioral health disorders among persons with IDD to range between 30 and 40 percent and they can exhibit the full range of psychiatric disorders present in the larger population such as depression, mood disorders, anxiety, and thought disorders in the form of verbal or physical aggression, self-injury, property destruction, impulsive behaviors, elopement, etc. Conversely, these unwanted, disturbing behaviors may also indicate the presence of interpersonal, physical, or environmental problems rather than a mental health disorder.

The causes of the increased vulnerability to behavioral health problems in persons with IDD are not well understood. Several factors have been suggested, including:

- Stress stemming from negative social conditions such as social rejection, stigmatization, and a general lack of acceptance.
- Limited coping skills associated with language difficulty, inadequate social supports, and a high frequency of central nervous system impairment.
- Behavioral phenotypes associated with certain genetic syndromes, many of which have characteristic behavioral and emotional patterns that may contribute to the increased rate of mental health problems among persons with IDD.

Although psychiatric disorders have been observed in persons with IDD for many years, there have been impediments to more widespread professional recognition of dual diagnosis. One obstacle is "Diagnostic Overshadowing" which occurs when a diagnostician overlooks or minimizes the signs of psychiatric disturbance because it is considered less debilitating than the underlying intellectual disability or because it is thought to be a result of intellectual deficits.

Professionals who are pressed to assign a "primary" diagnosis may focus on intellectual functioning, ignoring the psychiatric problem.

Basic Primary Behavioral Health Care Principles for Persons with IDD

Researchers in the field of dually diagnosed adults have developed a brief set of recommendations for primary behavioral health providers:

- Exclude medical causes before diagnosing behavioral problems
- Avoid medications when behavioral interventions control symptoms
- Use smaller doses of medications among persons who are frail or have severe cognitive impairments
- Beware of unrecognized side effects when prescribing psychotropic medications

Experts on the psychosocial treatment of dually diagnosed persons find that environmental management applied behavior analysis, and individual and family education (teaching about psychosocial problems and management) represent the most highly recommended forms of intervention across the complete range of intellectual disability and psychiatric or behavioral disturbances.

Perspectives on the use of psychotropic medications to treat persons with IDD are all but impossible to separate from their historical abuses within large institutional settings. That said, there are occasions when medication may represent the least intrusive and most positive treatment option, particularly for persons with intellectual disability and co-occurring psychotic, bipolar, or major depressive disorders.

Should you have any questions or concerns about behavioral health issues among persons with IDD, please do not hesitate to contact our Medical Management staff at 1-855-769-2507.