CenterLight Healthcare

Provider Manual

CenterLight®
Healthcare

CenterLight Healthcare is pleased to welcome you as a participating provider. CLHC is a not-for-profit managed care organization, affiliated with CenterLight Health System. We are certified under Article 44 of the New York State Public Health Law to operate in all five counties of NYC, and Westchester, Nassau and Suffolk.

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

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

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

This Provider Manual is a reference tool designed for you and your staff regarding CLHC policies and procedures. A copy of this manual is available upon request. Any updates and changes related to provider services will be communicated in writing to participating providers. It is important that you read the information and retain it with this manual, so changes can be incorporated into your practice. The CLHC website will be periodically updated to include new programs, policies, directories and new CLHC locations. If you have any questions about CLHC, please call our toll-free Provider Services number at 1-833-CL CARES.

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

Sincerely,

The CenterLight Team

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Chapter 1 | Overview of CenterLight Healthcare Programs: TeamCare (PACE) and Direct

1. Overview

CLHC offers a choice of Medicare and Medicaid managed care programs for frail adults who qualify for nursing home placement using the NYS assessment tool. They may reside in their home, assisted living facility, or a nursing home. The TeamCare (PACE) plan covers comprehensive long term home care, rehabilitation, transportation, vision, dental, and other services necessary to manage the member's care in a non-institutional setting for as long as possible. Additionally, the TeamCare (PACE) and Direct plans cover acute hospital, medical, surgical and behavioral health services and pharmacy. Please see below for a brief description of each program. A full list of Plan benefits is included in the Appendices.

CLHC Care Management Model

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

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

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

3. **Direct:** A Medicare Advantage plan and an Institutional Special Needs Plan for Medicare beneficiaries who are institutionally qualified and living in the community as well as members living in a contracted long term care facility. Direct covers hospital and medical services including vision, pharmacy and skilled intermittent nursing care at home. Members must choose a PCP from CLHC's provider network to coordinate their care. Residents in contracted nursing homes are also eligible for participation. These residents are followed by a Clinical Care Supervisor who is a nurse practitioner, is based at the facility and provides care in conjunction with the physician.

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

1. Dental Benefits

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

2. Optometry and Audiometry

Routine yearly visual exams, screening for glaucoma and hearing screening will be accessed by CLHC Members with assistance from CLHC Care Managers who will coordinate benefits according to the defined benefit structure. Vision care providers and audiology services are listed in the Provider Directory.

3. Hospital Services Inpatient Admissions

All non-emergency inpatient admissions require precertification from the CLHC Authorization Support Team.

4. Mental Health Services

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

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

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

5. Pharmacy

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

Some drugs have quantity limits or require pre-authorization or are subject to step therapy. The Navitus contacts and forms are available on our web site, www. CenterLightHealthcare.org. For PACE members, CLHC has a closed Formulary for prescription medications which can be accessed at www. CenterLightHealthcare.org via the "clinical pharmacy programs" link. The CLHC Formulary is also available on E-Prescribing systems. CLHC covers most Over-the-Counter (OTC) Medications. Under the CLHC "clinical pharmacy programs" link you can access the Over-the- Counter Exclusion List, for a list of alternatives to excluded OTC products.

6. Home Health Care, Transportation, DME

CLHC, through CenterLight Health System Long Term Home Health Care Program, contracts with a variety of providers to provide medically necessary services to members who reside in the community. If a member requires an authorization for any of these services refer to attachment 2. Authorization is required for non-emergency ambulette services and is provided for members with limited mobility. 24 hours notice is required for ambulette scheduling.

7. Member Eligibility and Verification of Coverage

Each CLHC member will receive a CLHC identification card containing the member's name, member number, PCP name, and information about their benefits. Members should present their cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage. Providers should refer to the member's ID card for the appropriate telephone number to verify eligibility in the CLHC Plan, deductibles, coinsurance amounts, copayments, and other benefit information (see Attachment 1 for card samples).

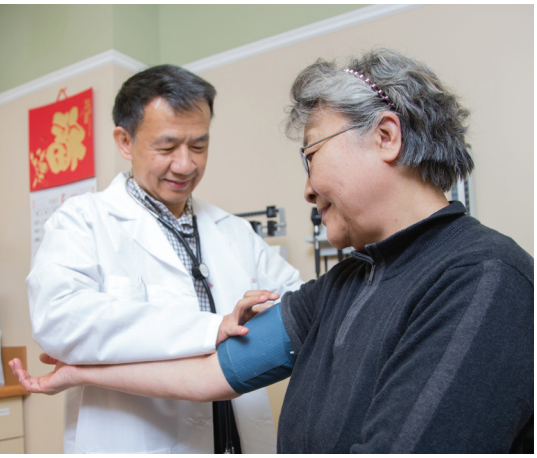
You may obtain information on CLHC member eligibility by calling the Provider Services telephone number listed in the Quick Reference Guide (Attachment 2) Monday through Friday from 8:00a.m.– 8:00p.m. Eastern Time.

8. Member Copayments

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

If you have questions about how to bill properly or how to determine the appropriate co-payment, co-insurance or deductible, please contact Provider Services at 1-833-252-2737.

Chapter 3 | Participating Provider Responsibilities – PACE/Direct



1. Role of PCPs

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

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

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

2. Role of Specialists

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

3. Access and Availability Standards

3.1 24-Hour Coverage

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

CLHC supports a 24-hour, 7 days a week nurse triage service that is also available to members and providers to provide health information and immediate advice. Please call 1-833-252-2737.

3.2 Emergency Care

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

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

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

3.3 Member Access to Services

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

- Routine physicals – within 3 months of enrollment
- Routine non-urgent, preventative care - As soon as possible, no longer than one month

- Emergency care – immediately upon presentation
- Urgently Needed Services - Within 24 hours
- Non-urgent "sick" visit - Within 48-72 hours of request, as clinically indicated
- Specialist referrals (non-urgent) – within 4-6 weeks of request
- Non urgent mental health or substance abuse visits – within 2 weeks of request
- Follow-up visits pursuant to an emergency of hospital discharge, mental health or substance abuse – within 5 days of the request, or as clinically indicated

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

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

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

4. Closing of Provider Panel

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

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

5. Provider Performance Standards and Compliance Obligations

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

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

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

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

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

6. Provider Compliance to Standards of Care

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

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

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

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

- Pre-authorization and notification requirements and timeframes;
- Participating provider credentialing requirements;
- Referral Policies;
- Care Management Program referrals;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of member medical record information to fulfill the business and clinical needs of CLHC;
- Cooperating with efforts to assure appropriate levels of care;
- Maintaining a collegial and professional relationship with CLHC personnel and fellow participating providers;

- Providing equal access and treatment to all CLHC members; and
- Using evidence based medicine to develop in-office protocols and treatment plans for common diagnoses.

6.1 Compliance Process

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

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

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

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

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

2. The risks, benefits, and consequences of treatment or non-treatment; and the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

6.2 Marketing

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

6.3 Laws Regarding Federal Funds

Payments that Participating Providers receive for furnishing services to CLHC Members are, in whole or part, from Federal funds. Therefore, Participating Providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities

receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

6.4 Sanctions under Federal Health Programs and State Law

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

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

7. Medical Records

7.1 Medical Record Review

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

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

7.2 Standards for Medical Records

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

7.3 Providers must comply with CLHC medical record guidelines.

Medical records must be readily accessible and available for review by CLHC personnel. A separate medical record must be maintained for each CLHC member. Medical records must

include entries that are current, legible, signed and dated by the person making the entry. The medical record must include relevant information concerning emergency room treatment, services rendered by specialists, and any hospitalizations.

PCP medical records must include, as appropriate:

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

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

Advance directives or MOLST which is the preferred advanced directive form, are written instructions, such as appointment of a health care proxy or durable powers of attorney for health care, recognized under the law of New York, and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

7.4 Confidentiality of Member Records

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

8. Informed Consent and HIPAA Compliance

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

- Conduct initial and annual in-service education of staff and contractors;
- Identify staff allowed access to confidential information and the limits of that access;

- Establish procedures to limit access to confidential information to trained staff (including contractors);
- Develop protocols for secure storage of confidential information (including electronic storage); and
- Develop procedures for handling requests for member information.

9. Provider Credentialing

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

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

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

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

Additional information regarding CLHC's Credentialing and Recredentialing policies is available upon request.

9.1 Initial Credentialing

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

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

9.2 Re-credentialing

Participating providers must be Re-credentialed every three years. The three year Re-credentialing cycle begins with the date of the initial Credentialing Committee decision.

Procedures for Re-credentialing include updating information obtained in initial credentialing and consideration of performance indicators. All providers must complete a Re-credentialing application including an attestation by the applicant to the correctness and completeness of the application.

Additional information regarding CLHC's Credentialing and re-credentialing policies is available upon request.

9.3 Site Visits

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

9.4 Confidentiality

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

9.5 Non-Discriminatory Credentialing

CLHC, its employees and anyone who may participate in the Recredentialing process, those who sit on the Credentialing Committee including CLHC managed care network participating practitioners are prohibited from solely basing any decision on an applicant's race, ethnic/ national identity, gender, age, sexual orientation, the types of procedures or types of patients the practitioner specializes in.

9.6 Monitoring and Off-Cycle recredentialing

CLHC monitors State License-Loss of license, State Sanctions, Exclusions, Medicare Opt-Out, restrictions and/or limitation of scope of practice as defined by the state licensing agent during initial Credentialing, Recredentialing and on a monthly basis. In addition, upon review of any quality issues or complaints receipt by the Provider Relations Department.

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

In the event that information is obtained by CLHC that may indicate a need for further inquiry, the Credentialing Committee retains the right to conduct an off-cycle review of a practitioner's credentialing status. The information will be made available to the Credentialing Committee for review and recommendation. Notwithstanding the above, practitioners who have had their licenses revoked or suspended, or who have been excluded from participation in the Medicare/ Medicaid programs will be terminated immediately. The Credentialing Committee will be notified of this action at the next meeting.

9.7 Terminations and Appeal Process

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

9.8 Formal Disciplinary Action

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

9.9 Appeal of Disciplinary Decisions

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

Chapter 4 | Medical Management

Participating providers must comply and cooperate with all CLHC Authorization Support policies, procedures and programs.

1. Specialist Referral Guidelines

PCPs should refer CLHC members to contracted network specialists. To ensure continuity of care, if a member desires to receive care from a different specialist, the PCP should try to coordinate specialty referrals within the list of contracted network specialists. When no additional physician within the required specialty is contracted in the network, PCP will contact Authorization Support to obtain prior authorization.

2. PCP Responsibilities

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

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

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

3. Specialist Responsibilities

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

4. Non-Participating Providers

All requests for services with a non-participating provider must be submitted to CLHC Authorization Support Department for authorization.

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

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

5. Direct Access Services

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

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

- Screening mammography's;
- Influenza vaccinations;
- Routine and preventive women's health services (s as pap smears); and in addition, members may no charged a copayment for influenza or pneumococ vaccinations.

6. Prior Authorization

Prior authorization is the process by which CLHC's Authorization Support Department reviews your request for a patient to receive inpatient or outpatient treatment at a hospital, ambulatory care facility, physician's office, or other healthcare setting for a range of procedures determined by CLHC to require prior authorization. A list of these services is provided in Chapter 7, Attachment 2 of this manual or on the provider portal at www.CenterLightHealthcare.org.

7. Process/Responsibility

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

Requests can be made by contacting the CLHC Authorization Support Department in the following ways:

- Telephone request should be called in to the telephone number for Medical Management located in Attachment 2.
- Faxed requests should be sent on a completed Prior Authorization Form to the toll free fax number for Authorization Support located in Attachment 2. A copy of this form is provided on our website at www.CenterLightHealthcare.org.
- Coverage determinations are based on Medicare coverage guidelines, nationally recognized evidence based guidelines, or by CLHC clinical coverage policies. A coverage determination requires the provision of information to CLHC regarding the clinical condition and treatment or services proposed for the member. There are three components to coverage determinations:
- Whether the patient is an eligible CLHC member,
- Whether the service is a covered service under CLHC, and
- Whether the service is medically necessary.

8. Notification Requirements

Timeframes for notification: You must notify CLHC's Authorization Support Department within the required timeframes.

8.1 Elective Services – 14 days prior to a scheduled service (both inpatient and outpatient)

8.2 Urgent / Emergent Services – Notify CLHC immediately. If circumstances do not allow for immediate notification, contact CLHC within one business day.

8.3 Inpatient Admission Notification

PCPs or the admitting hospital facilities must contact CLHC if they are admitting a CLHC member to a hospital or other inpatient facility.

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

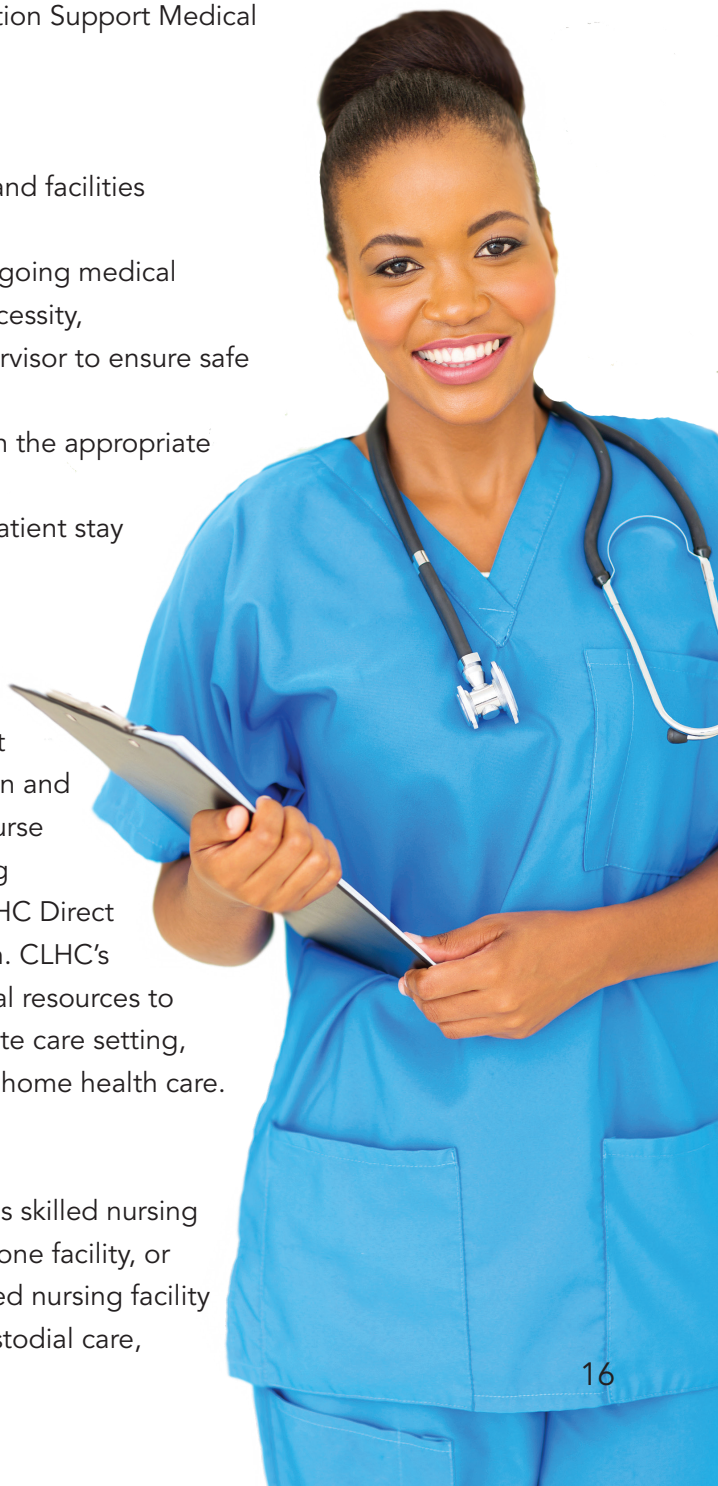
- Notifying PCP or hospital;
- Name of admitting PCP;
- Members' name, sex, and CLHC ID number;
- Admitting facility;
- Primary diagnosis; and
- Reason for admission.

9. Concurrent Hospital Review

CLHC Authorization Support Nurse will review all member hospitalizations within one business day for medical necessity, provided all clinical documentation has been received. If services do not meet the medical necessity criteria, the Authorization Support Medical Director will make the final determination.

The concurrent review process includes:

- Obtaining necessary information from providers and facilities concerning the care provided to the member,
- Assessing the member's clinical condition and ongoing medical services and treatments to determine medical necessity,
- Collaborating with PACE IDT / Clinical Care Supervisor to ensure safe discharge,
- Notifying providers of coverage determinations in the appropriate manner and within the appropriate time frame,
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting,



10. Discharge Planning

The CLHC Authorization Support Nurse will assist participating providers and hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, Authorization Support Nurse will discuss discharge planning with the participating provider, PACE IDT, Clinical Care Supervisor (for CLHC Direct members) and the hospital discharge planning team. CLHC's interdisciplinary approach provides additional clinical resources to coordinate the member's transition to the appropriate care setting, for example rehabilitation, skilled nursing facility, or home health care.

11. Skilled Nursing Facility Services

A skilled nursing facility is an institution that provides skilled nursing or skilled rehabilitation services. It can be a stand-alone facility, or part of a hospital or other health care facility. A skilled nursing facility does not include institutions that mainly provide custodial care, such as convalescent nursing homes or rest homes.

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

In the process of working with the healthcare team, particularly the PCP, hospital discharge planners and/or the CLHC Authorization Support Nurse may encourage the appropriate transfer of a member to a lower level of care at some point in the member's hospitalization. The Authorization Support Nurse will assist in the placement of members into participating skilled nursing facilities.

Requirements:
- The patient must need daily skilled nursing or skilled rehabilitation care, or both
- Prior authorization through the CLHC Authorization Support Department is required for all admissions into a Skilled Nursing Facility

12. Home Health Care

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

13. Durable Medical Equipment

The Authorization Support staff will review and authorize the use of durable medical equipment (DME). Refer to the Prior Authorization List for DME services that require authorization.

14. Second Medical or Surgical Opinion

A member may request a second opinion if the member:
- disputes reasonableness decision;
- disputes necessity of procedure decision; or
- does not respond to medical treatment after a reasonable amount of time.

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

15. Medical Criteria

Qualified professionals who are members of the CLHC Quality Improvement Committees and the Board of Directors will approve the medical criteria used to review medical practices and determine medical necessity. CLHC uses nationally recognized evidence based criteria, to guide the precertification, concurrent review and retrospective review processes. For more information or to receive a copy of these guidelines, please contact CLHC.

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

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

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

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

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

If you would like to propose a discussion topic to be considered for discussion by CLHC's Medical Management Committee, please contact the Authorization Support Department at 1-833-252-2737.

16. Pharmacy Benefit (Medicare Part D) for CLHC Direct Members

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

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

16.1 Medications Requiring Prior Authorization

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

To obtain authorization for medications, providers should:

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

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

16.2 Formulary Exceptions

In certain cases, a provider may determine that a member requires a non-covered prescription. When this occurs, the provider may request an exception from the formulary by completing an Exception Request Form or by calling Navitus. The formulary exception request form is available on our website, www.CenterLightHealthcare.org.

16.3 Specialty Pharmacy

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

CLHC providers shall prescribe, as usual, a Medicare Part B covered medication, adding a comment, if necessary, to highlight Medicare Part B coverage (e.g. "For treatment of ___-

cancer"). The provider will then contact Navitus to request the medication be sent to their office. Navitus will provide the necessary directions as to how to proceed with the request.

Select Part B medications will require prior authorization and will be administered by Navitus using CLHC criteria.

17. Timeframes

17.1 Prescription Drug Coverage Determinations
Standard coverage decisions will be rendered within 72 hours of being requested. Expedited coverage decisions will be rendered with 24 hours of being requested.

17.2 Medical Coverage Determinations
Standard decisions will generally be rendered within 14 days of being requested. CLHC is allowed a 14-day extension if the time is needed review additional documentation. Expedited coverage decisions will be rendered within 72 hours of being requested by a physician.

18. Clinical Trial Coverage

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

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

19. New Technologies

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

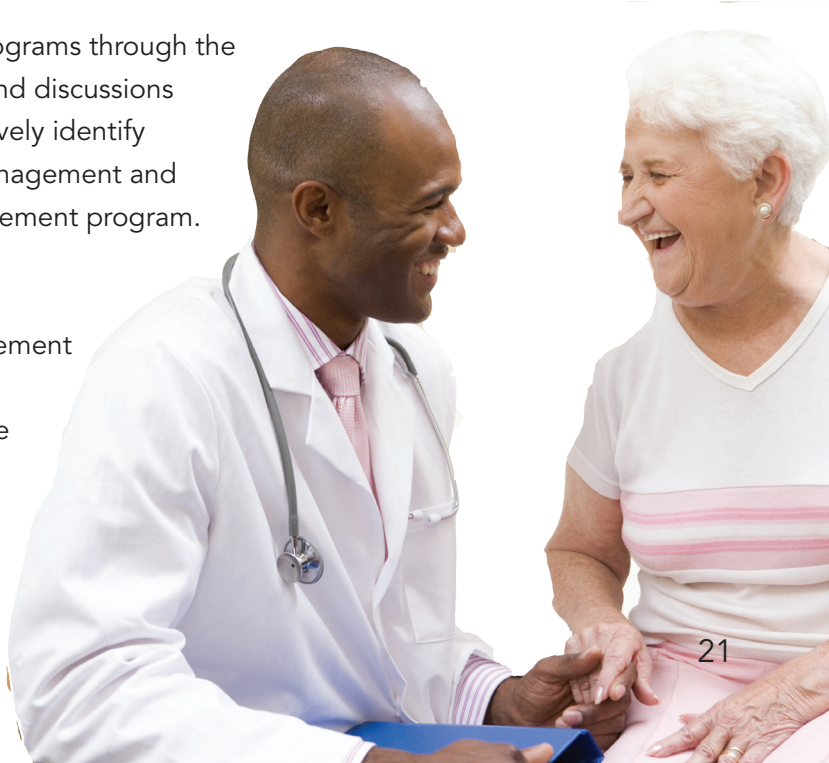
Additionally, there is a process for participating providers to submit new technology for coverage review. Please contact CLHC for more information.

20. Care Management

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

- Implement procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health;
- Make best efforts to conduct a health assessment of all new members within 90 days of the effective date enrollment;
- Identify members with complex health care needs who would benefit from medical care management interventions;
- Identify and recommend alternative care options and prevent hospitalization when feasible; and
- Monitor clinical services through close contact with physicians, ancillary service providers, CLHC care management team, and document the member's on-going care needs. The Care Management Program includes, but is not limited to: Defining and tracking quality and performance indicators;
- Implementing measures that contribute to improving quality of care and cost- effective management of targeted conditions;
- Encouraging preventive care strategies to keep members healthy;
- Promoting member education and behavioral modification that improve outcomes; and
- Monitoring outcomes and program effectiveness.

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



21. Physician Collaboration

The cornerstone of the CLHC Care Management program is effective collaboration with participating primary care physicians. These collaborative relationships will include: Identification of individuals appropriate for disease management, working with participating physicians and office staff;

Development and implementation of member-specific care plans, using evidence based treatment regimens that will be coordinated by the physician and care manager; Patient education, focused on supporting self-care management and monitoring; and Care manager feedback to physicians regarding patient status and clinical needs.

22. Pre-Authorization Reference Guide

Attachment 2

23. Services Requiring Prior Authorization

Attachment 4 and Attachment 5

Chapter 5 | Timely Filing and Prompt Payment of Claims

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

Please contact the CLHC Provider Service Line 1-833-CL CARES with any questions you may have on our claims process.

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

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

1. Prompt Payment of Claims Network providers will be paid according to the terms of their contract.

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

2. Claims Submission – Electronic

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

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

Providers may elect to submit claims through Claims Net. You can register to use this free service and get information by going online to www.claimsnet.com/ccm or phone 972-458-1701 ext. 121. The CLHC payer ID is CCMC1.

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

3. Coordination of Benefits

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

4. Balance Billing

You may not bill a Member for a non-covered service unless:
You have informed the Member in advance that the service is not covered – and –The Member has agreed in writing to pay for the non-covered service.

5. Claims Inquiries or Disputes

If you have questions regarding the status of a claim or other inquiries, contact the CLHC Provider Service Line at 1-833-CL CARES.

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

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

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

- Provider name,
- National Provider Identifier (NPI)
- Provider contact information,
- The CLHC member's identification number;
- The specific item in dispute;
- Clearly stated reason for contesting the determination and the justification as to why the service should be paid or approved; and
- Copies of all relevant information and supporting documentation required for review of the provider's concerns e.g. claims include claim number, medical records, authorizations, etc. The Provider must either fax the above information to the fax number indicated in Attachment 2, for Provider Services, or mail the information to the address designated for Provider Services in the Quick Reference Guide.

5.1 Dispute Review Process and Timeframes

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

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

5.2 Dispute Resolution

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

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

6. Member Appeals and Grievances

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

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

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

6.1 Resolving Grievances

If a CLHC member has a grievance about CLHC, a provider or any other issue, participating providers should instruct the member to contact Member Services at 1-833-252-2737. If an immediate resolution is not possible, CLHC will acknowledge the member's grievance in writing. CLHC will contact providers concerning grievances related to their practice and will request a response to the member complaint. Grievances will be decided within 30 days after filing and CLHC will send the member a written notice describing CLHC's actions to resolve the complaint, the reasons for our decision, and information about the appeal process as appropriate to the member's plan. Participating providers are expected to cooperate with CLHC on any grievance investigation related to the services provided to the member.

6.2 Adverse Determination

Adverse determinations are denials of coverage for proposed or actual medical services that, based on available information, do not meet accepted criteria for coverage. Only a physician may make an adverse determination. Providers are notified in writing of adverse determinations. The notice includes service/ treatment being denied, dates of service being denied, the reasons for the denial and instructions on how to initiate standard, expedited, and external appeals including time frames for filing/reviewing appeals.

6.3 Resolving appeals

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

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member's interest to extend

this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

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

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

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

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

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

6.4 Further Appeal Rights

If CLHC denies a Medicare Advantage member's appeal in whole or part, it will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of CLHC. This organization will review the appeal and, if the appeal involves

authorization for health care, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. CLHC will inform the member of all other rights if the IRE issues an adverse decision.

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

7. Fraud and Abuse Prevention

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

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

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

7.1 Anti-Kickback Statute

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

7.2 Beneficiary Inducement Law

Prohibits offering remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier; Creates liability of civil monetary penalties of up to $10,000 for each wrongful act.

8. Code of Conduct

CLHC adheres to a Code of Conduct which governs the conduct of employees and those independent contractors and others affiliated with the CenterLight Health System. (See attachment 3 for additional information)

Chapter 6 | Quality Improvement Program

CLHC is dedicated to providing appropriate, quality care and services in an efficient and cost-effective manner. We accomplish this by maintaining the focus of all levels of the organization on the assessment and improvement of all aspects of care. The overriding principle of CLHC's Quality Improvement Program (QIP) is to develop an integrated and comprehensive approach to continuously improving care and service to meet or exceed our participants' expectations. CLHC considers our participating providers essential to our efforts to deliver high quality, cost effective care to the participants. We encourage your participation in our quality improvement efforts and welcome your feedback on any aspect of the program.

The Board of Directors of CLHC has the authority and responsibility to establish, maintain and support the QIP on a continuing basis. The Quality Steering Committee (QIC) meets to ensure that the QIP is implemented and there are adequate resources to fulfill its mission. The Vice President of Qualityserves as the Chairperson of the QIC andreports activities of the QIC to the Board of Directors quarterly.

The CLHC Vice President of Quality is directly responsible for the management of all quality improvement and authorization support activities. In this capacity, the Vice President of Quality works closely with administrative and clinical personnel to address and resolve quality and utilization concerns.

1. Quality Improvement Committee

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

- Oversee CLHC's QI activities which include member rights and satisfaction, medical record audits, authorization support, medical management, contract oversight, credentialing, monitoring of access and availability and clinical studies
- Develop, prioritize, and evaluate an annual work plan
- Set and monitor performance standards and measurable clinical indicators for important aspects of care and services

- Set thresholds or factors that trigger further evaluation of care and service by analyzing data, trends and monitoring outcomes
- Assess the effectiveness of corrective actions and implement processes to sustain improvements
- Improve organizational communication through an integrated committee structure, formalized reporting, mechanisms for sharing information and engagement of staff, providers and participants in quality improvement activities

2. Members' Rights

CLHC members have the right to timely, high quality care, and treatment with dignity and respect.

Participating providers must respect the rights of all CLHC members. Specifically, CLHC members have been informed that they have the following rights:

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

Treatment with Dignity and Respect

- To be treated with dignity and respect and to have their right to privacy recognized
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care
- To confidential treatment of all communications and records pertaining to the member's care
- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care

- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision)
- To complete an Advance Directive, living will or other directive to the member's medical providers

Member Satisfaction

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

Services Provided in a Culturally Competent Manner

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

3. Advance Directives

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

4. Member Complaints/Grievances

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

Attachment 1: Sample Member ID Cards

Figure 1 | TeamCare Sample ID Card

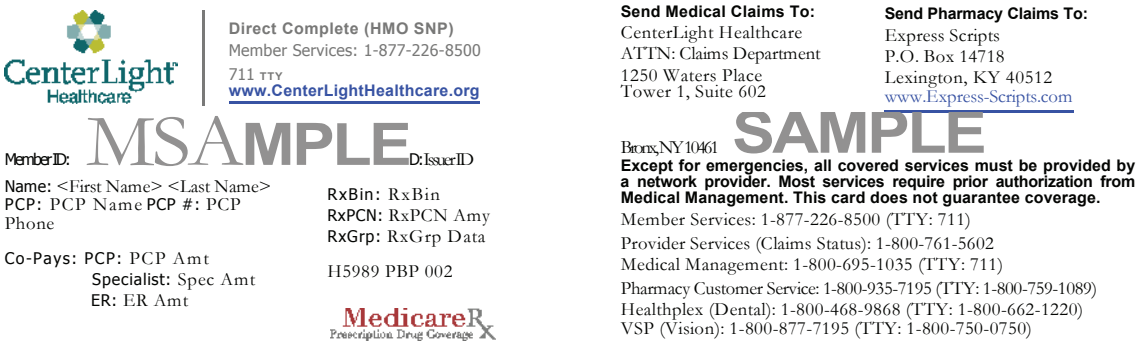
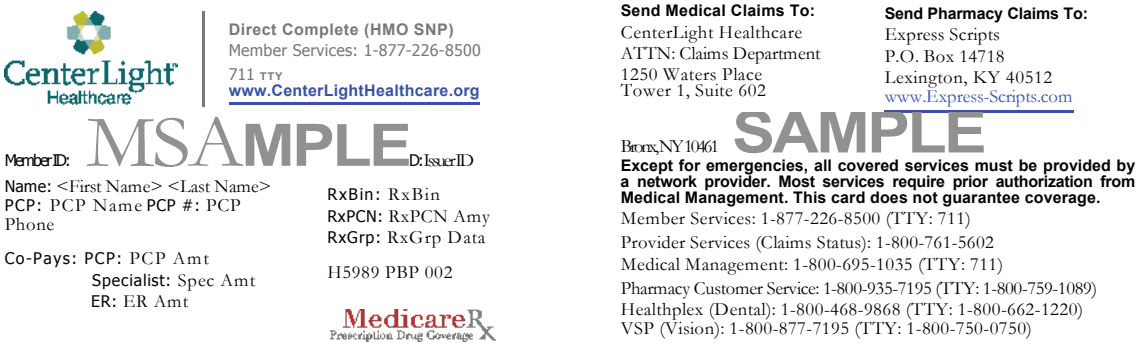


Figure 2 | DIRECT Sample ID Card



TeamCare™-PACE

A Medicare and Medicaid
Program of All-Inclusive Care for Adults 55+

SPONSORED BY CENTERLIGHT HEALTHCARE

Quick Reference Guide

	Contact Information	Hours of Operation	Description
Authorization Support	1-833-CL-CARES (1-833-252-2737)	Monday – Friday 8am to 8pm	TRANSPORTATION: If the member requires non-emergency transportation, please contact 1-833-CL-CARES (1-833-252-2737) at least 2 business days prior to the appointment. You will be transferred to the appropriate transportation team who will coordinate services.
Member Services	1-833-CL-CARES	Monday – Friday 8am to 8pm	Eligibility, benefits, general questions, referrals to CenterLight TeamCare
Provider Claims Line	1-833-CL-CARES (1-833-252-2737)	Monday – Friday 8am to 8pm	
Beacon Health Options	855-834-5652	24 hours, 7 days a week	Beacon Health Options manages the substance abuse and mental health benefits -PACE members only
Pharmacy	Navitus Customer Care 866-270-3877	24 hours a day, 7 days a week	Pharmacy related issues including prior authorization requests
Healthplex - Dental Services	1-800-468-9868	7 days a week 8am to 6pm	Healthplex administers all primary and medically necessary specialty dental care.

	Contact Information	Hours of Operation	Description
Vision	1-833-CL-CARES		
LabCorp	69 First Avenue Raritan, NJ 08869	P: 888-522-2677 F: 908-526-5188	Bronx, New York, Kings, Queens, Westchester, Nassau, Suffolk
Provider Services Call Center	833-252-2737 ProviderService@centerlight.org	Monday –Friday 8am to 8pm F: 718-944-1250	Claim status check information, EOP request
Provider Relations	ProviderRelationsRequest@centerlight.org		Provider network status, demographic updates, contract review, rates or other general questions.
Electronic claim submissions	Register online through our on-line registration sites at: **Emdeon / Change HealthCare** www.emdeon.com Payer ID is 13360 **MD On-Line** www.mdol.com/centerlight Payer ID 13360		Please submit claims within 90 days of the date of service to remain compliant with CenterLight Healthcare's timely filing process. An original CMS/HCFA 1500 or UB 04 should be utilized for paper claims submissions.
Provider Portal	Registration is quick and easy! Visit www.centerlighthealthcare.org (or use the direct link https://secure.healthx.com/centerlightprovider) 1. Click on the "For Providers" tab 2. Click on Provider Login link located on the homepage 3. On the right side of the web portal homepage, click Provider User Account Sign-Up and follow the step by step instructions to complete your one-time registration.		

Attachment 3: Code of Conduct

CenterLight Health System

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

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

To report any compliance concerns, please contact any of the following:

- Your Supervisor, Director or Administrator
- **Karen Eastmond**, Chief Compliance Officer, at **(347) 640-6103**
- **CenterLight Health System's Compliance Hotline** at **(855) 788-3937** or **https://centerlight.alertline.com**

All reports will be handled in accordance with CenterLight's confidentiality policy.

You can find a copy of this and other compliance policies by visiting the employee Intranet at **http://corporate-intranet** and clicking on "policies" on the left hand side of the home page.
You may also visit the Compliance Policies page directly at
http://intranet/Corporate%20Compliance%20Policies/Forms/AllItems.aspx

Attachment 4: Prior Authorization List – CLHC PACE

PRIOR AUTHORIZATION LIST
CENTER LIGHT TEAMCARE PACE

Services listed below require Prior Authorization from CenterLight Healthcare. Please allow 5 business days for approval of standard authorizations and 24- 48 hours for urgent requests.
Fax Prior Authorization requests to 718-944-1529.

You can contact Medical Management directly at 1-833-252-2737

Durable Medical Equipment
Custom Shoes / Orthotics
C-PAP Machines
Hospital Bed
Hoyer Lift
Insulin Pumps
Prosthetics- Major Limbs
Specialty mattresses
Wheelchairs (motorized, customized & scooters)
Wound Pumps

Inpatient Admissions
Acute Care Facilities, Skilled Nursing Facilities
Psychiatric Health Care Facilities
- Elective Admissions
- Urgent / Emergent Admissions *
Comprehensive Rehabilitation Facilities
*Does not require prior authorization but notify health plan within 24-48 hours of admission
Investigational / Experimental Treatment

Rehabilitation Services - Outpatient
Physical Therapy
Occupational Therapy
Speech Therapy
Pulmonary & Cardiac Rehabilitative Therapy

Radiology
CT, MRA, MRI, PET & SPECT

Transplant Evaluation & Services

Out-of-Network and Out-of-Area Services
Surgery/ Admissions/Testing at non-participating facility
Visits to non-participating Providers

All cosmetic procedures (if medically necessary-listed below)
- Abdominoplasty
- Blepharoplasty
- Keloid & Scar Revisions
- Mammoplasty, Reduction or Augmentation
- Surgical Treatment of Gynecomastia
- ENT Procedures (Rhinoplasty, Septoplasty, Uvoluplasty& LAUP)
- Mastopexy
- Otoplasty
- Varicose Veins Treatment and Ventral Hernias

Outpatient Services
Acupuncture
Ambulatory Surgeries
Chiropractic Services
Outpatient Behavioral Health
Outpatient Alcohol & Substance abuse
Podiatry

Other Services
Audiology Equipment
Hyperbaric O2 Therapy
Pain Management Therapy

Note: Some formulary medications may require prior authorization. The prescribing provider will be contacted by Express Scripts for clinical information and coverage determination.

Center Light Healthcare Participating Provider Network can be accessed at http://centerlight.org

Attachment 5: Prior Authorization List - Direct Members

PRIOR AUTHORIZATION LIST
CENTER LIGHT HEALTHCARE - DIRECT MEMBERS

Services listed below require Prior Authorization from CenterLight Healthcare. Please allow 5 business days for approval of standard authorizations and 24- 48 hours for urgent requests.
Fax Prior Authorization requests to 718-944-1529.
You can contact Medical Management directly @ 1-800-695-1035

Durable Medical Equipment
Custom Shoes / Orthotics
C-PAP Machines
Hospital Bed
Hoyer Lift
Insulin Pumps
Prosthetics- Major Limbs
Specialty mattresses
Wheelchairs (motorized, customized & scooters)
Wound Pumps

Inpatient Admissions
Acute Care Facilities, Skilled Nursing Facilities
Psychiatric Health Care Facilities
- Elective Admissions
- Urgent / Emergent Admissions *
Comprehensive Rehabilitation Facilities
*Does not require prior authorization but notify health plan within 24-48 hours of admission

Rehabilitation Services - Outpatient
Physical Therapy
Occupational Therapy
Speech Therapy
Pulmonary & Cardiac Rehabilitative Therapy

Radiology
CT, MRA, MRI, PET & SPECT

Transplant Evaluation & Services

Out-of-Network and Out-of-Area Services
Surgery/ Admissions/Testing at non-participating facility
Visits to non-participating Providers

Investigational / Experimental Treatment

All cosmetic procedures (if medically necessary-listed below)
- Abdominoplasty
- Blepharoplasty
- Keloid & Scar Revisions
- Mammoplasty, Reduction or Augmentation
- Surgical Treatment of Gynecomastia
- ENT Procedures (Rhinoplasty, Septoplasty, Uvoluplasty& LAUP)
- Mastopexy
- Otoplasty
- Varicose Veins Treatment and Ventral Hernias

Outpatient Services
Acupuncture
Ambulatory Surgeries
Chiropractic Services
Outpatient Behavioral Health
Outpatient Alcohol & Substance abuse
Podiatry

Other Services
Hyperbaric O2 Therapy
Pain Management Therapy

Note: Some formulary medications may require prior authorization. The prescribing provider will be contacted by Express Scripts for clinical information and coverage determination.