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Introduction & Key Contacts
Introduction

Congratulations and welcome to the CareMore Health family! We look forward to working with you to meet high quality of care standards and provide, and manage cost-effective health care for our members.

This New Provider Orientation provides you and your office staff with important information concerning CareMore Health resources.
## CareMore Health Contact Information

12900 Park Plaza Drive, # 150 Cerritos, CA 90703  
Monday - Friday: 8 a.m. – 5 p.m.

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Phone/Fax</th>
<th>Hours of Operation</th>
</tr>
</thead>
</table>
| CareMore Health Operator               | 1-888-291-1358, Option 0                       | Oct 1 - March 31:  
                                                | Mon - Sun: 8:00 a.m. – 8:00 p.m.  
                                                | April 1 - Sept 30:  
                                                | Mon - Fri: 8:00 a.m. – 8:00 p.m. |
| Case Management After Hours Case Manager | Ph.: 1-888-291-1358 (Options 1-3-1)  
                                               | Ph.: 1-888-295-7814                                      | 24 hours a day, 7 days a week |
| Extensivist                            | Ph.: 1-800-613-9374 (Options 1-1)              | 24 hours a day, 7 days a week |
| Utilization Management                 | Ph.: 1-888-291-1358 (Options 1-3-2-1)          | Mon - Fri: 5:00 a.m. – 5:00 p.m. |
| Prior Authorization Faxes:             |                                                 |                                      |
| AZ/NV: (562) 622-2927                   |                                                 |                                      |
| CA San Bernardino/Orange Counties: (562) 622-2996 |                                                 |                                      |
| CA Los Angeles/Santa Clara/Stanislaus/San Benito Counties: (562) 622-3066 |                                                 |                                      |
| VA: (562) 677-2538                      |                                                 |                                      |
| Tertiary Facilities:                   |                                                 |                                      |
| (562) 622-2898                          |                                                 |                                      |
| Expedited Fax:                         |                                                 |                                      |
| (562) 622-3094*                        |                                                 |                                      |
| *To be used only if applying the standard timeframe for making a determination could seriously jeopardize the member’s life, health, or ability to regain maximum function. |                                      |                                      |
| Inpatient Utilization Management Fax Number: | All regions:  
                                               | Fax (855) 295-7817                                      |                                      |
| Electronic Claims Submission           | Ph.: 1-800-282-4548                             | 8:00 a.m. – 8:00 p.m. EST, M-F  
                                               | www.availity.com  
                                               | CareMore Health Payor ID:  
                                               | CARMO                                      |
| Fraud Hotline                          | Ph.: 1-866-847-8247                             | 24 hours a day, 7 days a week |
| Provider Customer Service - Member Eligibility Claims Inquiry | Ph.: 1-888-291-1358 (Option 1, Option 1)  
                                               | Fax: 1-562-741-4412                                      | Mon - Fri: 8:00 a.m. – 5:00 p.m. PST |
| Provider Relations                     | Ph.: 1-888-291-1358 (Option 1, Option 5)       | Mon - Fri: 8:00 a.m. – 5:00 p.m. PST |
| Pharmacy Department                    | Ph.: 1-800-965-1235                             | Mon - Fri: 8:00 a.m. – 5:00 p.m. PST |
| CareMore Health Anytime                | Ph.: 1-800-589-3148                             | 24 hours a day, 7 days a week |
CareMore Health

CareMore Health is a company who was originally founded by physicians in 1993. The name “CareMore” was chosen because it embodies a philosophy that inspires proactive care and a caring touch—qualities that continue to drive our success. Throughout its history, CareMore has led the industry in clinical and quality outcomes, and aims to carry that legacy forward for many years to come.

CareMore Health believes it is important to meet patients where they need us. CareMore patients can enjoy peace of mind knowing they don’t have to face disease or conditions alone. Instead, they’re supported by a team whose priority is providing top-quality care.

Model of Care

CareMore is committed to expanding access to high quality care and providing new options for more timely, convenient and accessible care to meet the needs of our patients. In addition to our face to face patient programs and services, our model of care has evolved to deliver virtual and mobile care to accommodate the needs of our patients and ensure that they receive the right care at the right place and at the right time. Our newly enhanced model of care includes:

- Virtual care including telephonic and video visits, with an option to use interpreter services, allows CareMore to expand patient access beyond the in-person setting, which can be accessed from a patient’s home, a skilled nursing facility, or from a CareMore Care Center
- 24/7 access to clinical support from our CareMore Anytime phone line
- Care visits to patients’ homes, allowing our team to deliver a range of services, from Healthy Start assessments to subacute patient needs, including many ancillary testing and laboratory tests

Our enhanced model of care will continue to be an extension of the primary care you provide to CareMore patients. Your patients will be supported by an interdisciplinary team who will provide care and assist with care coordination to make sure that patients receive the necessary care to properly manage their health.
CareMore Care Centers

CareMore Care Centers serve as our patient’s medical home where they can access an array of programs and services to support their physical, behavioral, and medical needs. Patients can continue to access in-person care when necessary at our care centers, or they may opt to receive virtual services to accommodate their needs.

Services available to patients at the Care Centers include:

- Care and support from an interdisciplinary care team (Nurse Practitioners, social workers, pharmacist, and behavioral health specialists)
- Access to a variety of clinical and health education programs
- Advanced patient care from a CareMore Extensivist during and after any new critical event such as a hospitalization or emergency room (ER) visit
- Preventive services to support chronic illnesses such as Flu shots

Patients can access services at the Care Centers as often as necessary to help them manage their condition and for assistance in coordination of care. *Note not all programs and services are offered at all of our CareMore Care Centers.*
Healthy Start Program

Every new CareMore Health patient is encouraged to complete a Healthy Start visit at their local CareMore Care Center. The Healthy Start visit is a comprehensive assessment intended to help CareMore Health gain more insight into the patient’s medical, social, and behavioral needs and to appropriately triage them to other CareMore clinical programs. The assessment is conducted at the local CareMore Care Center, or virtually, to accommodate patients who do not feel comfortable going out due to the COVID-19 pandemic. The Staying Healthy Assessment is conducted by a specially trained clinician team. The interdisciplinary team is composed of Providers, Nurse Practitioners, Pharmacists, Social Workers, and Behavioral Health Specialist. As part of the Healthy Start appointment the clinical team will make specific recommendations that are tailored to the patient’s needs and will review all available programs and services offered at the CareMore Care Center.

After the assessment is complete, the patient will receive a care plan that includes a summary of their health, medical and social needs, and recommendations for follow-up care. The care plan and outcomes of the visit are shared with the patient’s Primary Care Physician.

Healthy Journey

All existing CareMore Health patients are encouraged to complete an annual assessment called Healthy Journey. The Healthy Journey appointment is an opportunity for CareMore Health to continue to monitor the patient’s health and capture any changes in their status. Any new health concern captured at this visit is immediately addressed by the clinical team, and enrollment into additional programs are initiated, as appropriate. As part of the visit, the clinical team updates the patient’s existing care plan with new findings and recommended follow-up care. The updated care plan is shared with the patient’s Primary Care Physician (PCP) to support the on-going care provided at their practice.

Clinical Care Programs

Primary care providers play a key role in CareMore Health’s model of care. However, we recognize that some patients have complex needs and require a high degree of coordinated services that may not be easy to provide in the primary care setting. Our goal is to support the services you provide to your patients by providing wraparound services to keep patients feeling their best. Our programs are designed to address every aspect of physical and mental health, with the support of an interdisciplinary care team consisting of physicians, advanced practice clinicians, case managers, social workers, community health workers, pharmacists, behavioral health specialists, podiatrists, and other professionals to make sure the most complex patient needs are met.

Patients can access our programs virtually, at our care centers, or in their homes, allowing them to access care that meets them where they are in their healthcare journey. Our programs and services are designed to make care conveniently accessible, without complicated processes or delays, while at the same time carefully monitoring and managing unnecessary utilization of health care services that can lead to unnecessary costs for the patient.
Below is a list of clinical programs available to CareMore Health patients categorized by different levels of support:

**Easy and accessible care 24/7**

- **CareMore Anytime:**
  This program provides patients access to a live clinician 24-hours a day, seven days a week. These clinicians have access to the patient’s medical record and can assist patients by answering clinical questions, prescribing or initiating referrals, providing education, and connecting them with appropriate resources within and outside CareMore Health. This program allows patients to have access to afterhours care without relying on emergency services alone.

- **Touch Management Program:**
  The Touch Management Program provides care to CareMore Health patients in skilled nursing facilities or who require the same level of care as someone living in a skilled nursing facility, but lives in a program-approved community living facility such as an assisted living facility, board and care home, group home, and adult care home. Patients who qualify receive regular onsite visits with an Advanced Practice Clinician such as a Nurse Practitioner or Physician’s Assistant and can expect an exceptional level of coordination of care that includes: a comprehensive initial and annual health assessment, quarterly Primary Care Provider visits, medication management, routine lab tests, x-rays, wound care management, supplies, and the clinical management of chronic diseases and conditions.

**Transition of Care**

- **Home-Based Care Program:**
  CareMore Health’s Transitional Care Program is a comprehensive program that provides palliative care, advanced wound care, and comprehensive chronic disease management to patients living with serious and advanced illness and to those individuals that are confined to their homes. The program’s mission is to provide expert symptom management and engage patients and their families in complex goals of care conversations so that patients can live as well as possible for as long as possible while also ensuring that the care delivered matches the care they desire. The program works collaboratively with primary care providers and consultants. It provides these services across multiple sites of care including skilled nursing facilities, the CareMore Care Centers and in the home.

- **Extensivist Program**
  CareMore Health has an Extensivist Program that serves as the admitting and attending physicians for CareMore Health patients. Our Extensivist are on-call 24 hours a day, seven days a week. They will manage any CareMore patient admitted to our contracted hospitals until discharged. If you need to reach an Extensivist, call the CareMore Care Center and ask for the Extensivist on-call for the specific hospital. Please discuss any potential hospital admission with the Regional Medical Officer for the market prior to that admission, if the clinical situation allows. If the clinical situation is emergent, send the patient to the Emergency Room (ER) by the appropriate means and, when time permits, call the Regional Medical Officer to inform him or her of the admission. If a hospital ER contacts you regarding a CareMore Health patient, please ask the ER staff to notify the CareMore Health Extensivist directly.
**Chronic Disease Management**

- **Congestive Heart Failure (CHF) Care Program:**
  The CHF program is designed for patients who have been diagnosed with congestive heart failure (CHF). CareMore Health helps these patients manage their CHF through evidence-based medications, weight tracking, dietary guidance, and physical activity. In partnership with the patient’s cardiologist, the care team provides more intensive monitoring of the patient, titration of their medications, more intensive teaching, and referral to cardiac rehabilitation through the Nifty After Fifty program, where indicated. Patients who require close monitoring may be enrolled into a wireless monitoring program with a scale and cellular pod to transmit their weight to a web-based program, which is monitored by an Advanced Practice Clinician 7 days a week.

- **Chronic Obstructive Pulmonary Disease (COPD) Program:**
  The COPD program provides support for those living with lung diseases such as chronic bronchitis and emphysema. The program collaborates with the patient’s pulmonologist to provide a comprehensive care plan including cost-effective, evidence-based medications and referral to pulmonary rehabilitation through our partnership with the Nifty After Fifty program. We also teach patients action planning and introduce them to resources in case of a severe exacerbation to prevent avoidable admissions for COPD. Where needed, the program can also engage the patient with our behavioral health team for smoking cessation counseling.

- **Diabetes Management and Prevention Program (DMPP):**
  This program effectively manages patients with diabetes and promotes well-being, prevents complications of the disease through education, self-management, clinical management, medication dosing, and titration. Some patients are eligible for continuous glucose monitoring devices free of cost!

- **Anti-Coagulation Center:**
  The Anti-Coagulation Center provides on-site testing with immediate reporting and counseling regarding proper anticoagulant medication dosing. The program promotes self-care by providing health education about the safe use of anticoagulant therapy.

- **Renal Disease Program:**
  CareMore Health's comprehensive End-Stage Renal Disease Program includes an individualized health evaluation and health risk assessment designed to support the complex, specialized needs of those with end-stage renal disease (ESRD). In this program, CareMore Health works collaboratively with the patient’s nephrologist to ensure better health outcomes.

- **Foot Care Program:**
  The Foot Care program provides evaluation, treatment and support for acute, and chronic foot conditions through podiatric medical care and routine podiatry (e.g. nail clipping and callous removal) to CareMore Health patients. These programs provide diabetic foot management, gait evaluation, and education for foot pathology to keep patients ambulatory in the communities in which they reside. These programs are critical for patients with vascular and diabetic complications.
• **Hypertension Program:**
  This program manages patients with uncontrolled hypertension through education, meditation titration, and on-site point of care laboratory monitoring. Patients who receive close monitoring may be enrolled into a wireless monitoring program with a blood pressure machine and cellular pod to transmit their readings to a web-based program monitored by an Advanced Practice Clinician.

• **Wound Care Center:**
  The Wound Care Program seeks to effectively manage acute and chronic wounds using a multidisciplinary approach. By providing upstream care and education, factors that affect wound healing are addressed early on to optimize healing rates and decrease risk of amputation. Workflows are integrated and optimized for treatment in a variety of settings, ranging from the home to a CareMore Care Center.

**Wellness Program**

• **Exercise and Strength-Training Program:**
  In collaboration with our Nifty After Fifty partners, we have developed a comprehensive strength and fitness program to support our patients and encourage wellness and physical activity. We feel that wellness and exercise can go much further than traditional physical therapy, and our approach emphasizes this philosophy. In addition to physical therapy, we offer tailored fitness plans, group classes, wellness discussions, and celebration activities. Our exercise and strength training program now includes virtual and online exercise programs to improve patient utilization by expanding how we deliver fitness coaching and support.

  Customized programs for patients recently discharged from the hospital and patients needing special attention for COPD and CHF management are also unique offerings. Especially during the COVID19 pandemic, these programs are highly effective for helping patients suffering from isolation and loneliness.

**Telemedicine**

Telemedicine services are available to patients of all product lines (clinic, mobile, and Touch). Telemedicine is the delivery of healthcare services or medical consultations through a virtual medium when the healthcare provider and patient are not physically in the same location. Virtual typically signifies a video call-type of interaction; however, if the patient is not tech-enabled, this can mean a telephonic interaction. Telemedicine services expand both the access and the reach of network providers while also increasing access for patients, especially those in rural and underserved areas. Telemedicine services are provided with a goal to increase service coordination and care continuity and address gaps in care through the use of innovative technologies.
Remote Health Monitoring

Remote health monitoring is the remote monitoring of a patient’s vital signs, biometrics, or other data through innovative technology to transmit this clinical data to a clinician for analysis, storage, and when necessary, a timely intervention. This technology also provides the ability for video calls and automated notifications. Through the Remote Health Monitoring Program, patients with chronic or high-risk conditions such as congestive heart failure, hypertension, or diabetes receive patient-centric in-home health management support focused on early intervention, self-management, and adherence to a prescribed plan of care.

Video Remote Interpreting (VRI)

We continue to enhance the suite of language services available to CareMore Health patients. Video Remote Interpreting (VRI) allows us to provide on-demand language services to patients receiving care at the CareMore Care Centers. Within 60 seconds, patients and clinicians are virtually connected face-to-face with live certified interpreters via iPads mounted onto telepresence stands.

VRI is now available at the CareMore Care Centers located in California, Arizona, Nevada, and Virginia. Video interpretation is offered for the most common 36 languages, including Spanish and American Sign Language. By offering VRI, we break down language barriers and enable increased access for patients with limited English proficiency and persons with disabilities.
# CareMore Care Center Locations

## Arizona

<table>
<thead>
<tr>
<th>Location Name</th>
<th>City</th>
<th>Street Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speedway</td>
<td>Tucson</td>
<td>7091 E. Speedway Blvd.</td>
<td>1-520-721-5777</td>
</tr>
<tr>
<td>Landing</td>
<td>Tucson</td>
<td>4705 S Landing Way</td>
<td>1-520-294-1740</td>
</tr>
<tr>
<td>Green Valley</td>
<td>Green Valley</td>
<td>191 W. Esperanza Blvd.</td>
<td>1-520-791-7300</td>
</tr>
<tr>
<td>West Tucson - Stone</td>
<td>Tucson</td>
<td>4821 N. Stone Ave.</td>
<td>1-520-314-3300</td>
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## Southern California

<table>
<thead>
<tr>
<th>Location Name</th>
<th>City</th>
<th>Street Address</th>
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<tbody>
<tr>
<td>Fullerton</td>
<td>Fullerton</td>
<td>1521 S. Harbor Blvd</td>
<td>714-399-9222</td>
</tr>
<tr>
<td>Santa Ana</td>
<td>Santa Ana</td>
<td>1945 E. 17th St., Suite 101</td>
<td>714-888-8900</td>
</tr>
<tr>
<td>Downey</td>
<td>Downey</td>
<td>10000 Lakewood Blvd.</td>
<td>562-862-3684</td>
</tr>
<tr>
<td>Lawndale</td>
<td>Lawndale</td>
<td>15230 Hawthorne Blvd.</td>
<td>424-269-3600</td>
</tr>
<tr>
<td>Long Beach</td>
<td>Long Beach</td>
<td>4540 E. 7th St.</td>
<td>562-344-1150</td>
</tr>
<tr>
<td>La Mirada</td>
<td>La Mirada</td>
<td>15034 Imperial Hwy.</td>
<td>562-902-4929</td>
</tr>
<tr>
<td>Whittier</td>
<td>Whittier</td>
<td>9209 Colima Rd., #1000</td>
<td>562-696-1104</td>
</tr>
<tr>
<td>East LA</td>
<td>Los Angeles</td>
<td>3513 E. 1st St.</td>
<td>323-859-2660</td>
</tr>
<tr>
<td>Glendale</td>
<td>Glendale</td>
<td>406 E. Colorado St.</td>
<td>818-844-2778</td>
</tr>
<tr>
<td>Downtown LA</td>
<td>Los Angeles</td>
<td>303 S Union Ave.</td>
<td>213-355-2600</td>
</tr>
<tr>
<td>Montebello</td>
<td>Montebello</td>
<td>2444 W. Beverly Blvd.</td>
<td>323-201-4130</td>
</tr>
<tr>
<td>West Covina</td>
<td>West Covina</td>
<td>301 N. Azusa Ave.</td>
<td>626-214-2600</td>
</tr>
<tr>
<td>Baldwin Hills/ West LA</td>
<td>Los Angeles</td>
<td>3711 S. La Brea Ave.</td>
<td>323-596-4800</td>
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## San Bernardino California

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<tr>
<td>Apple Valley</td>
<td>Apple Valley</td>
<td>19059 Bear Valley Rd.</td>
<td>760-515-5000</td>
</tr>
<tr>
<td>Upland</td>
<td>Upland</td>
<td>141 W. Foothill Blvd</td>
<td>909-296-8800</td>
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## Northern California

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<tr>
<td>White</td>
<td>San Jose</td>
<td>255 N White Rd., #200</td>
<td>408-503-7600</td>
</tr>
<tr>
<td>Atherton</td>
<td>San Jose</td>
<td>4855 Atherton Ave., #101</td>
<td>408-963-2400</td>
</tr>
<tr>
<td>Hollister</td>
<td>Hollister</td>
<td>321 San Felipe Rd., Suite 12</td>
<td>408-665-4400</td>
</tr>
<tr>
<td>Modesto</td>
<td>Modesto</td>
<td>1801 H. St. Ste. C-1</td>
<td>209-544-2554</td>
</tr>
<tr>
<td>Turlock</td>
<td>Turlock</td>
<td>1000 Delbon Ave., Ste.2</td>
<td>209-664-7700</td>
</tr>
<tr>
<td>Oakdale</td>
<td>Oakdale</td>
<td>205 S. Oak Ave Suite A3</td>
<td>209-544-2554</td>
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## Nevada

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<tbody>
<tr>
<td>Flamingo</td>
<td>Las Vegas</td>
<td>3041 E. Flamingo Rd., #A</td>
<td>702-436-0835</td>
</tr>
<tr>
<td>Henderson</td>
<td>Las Vegas</td>
<td>100 N. Green Valley Pkwy., #235</td>
<td>702-754-2200</td>
</tr>
<tr>
<td>Tenaya</td>
<td>Las Vegas</td>
<td>3150 N. Tenaya Way, Suite 100</td>
<td>702-233-4950</td>
</tr>
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</table>

## Virginia

<table>
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<th>Location Name</th>
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</thead>
<tbody>
<tr>
<td>Brook</td>
<td>Richmond</td>
<td>5620 Brook Rd.</td>
<td>804-767-8400</td>
</tr>
<tr>
<td>Robious</td>
<td>Richmond</td>
<td>10030 Robious Rd.</td>
<td>804-212-3450</td>
</tr>
<tr>
<td>Jahnke</td>
<td>Richmond</td>
<td>6315A Jahnke Rd.</td>
<td>804-767-8500</td>
</tr>
<tr>
<td>Watkins Center CLC</td>
<td>Richmond</td>
<td>2891 Anderson Hwy.</td>
<td>804-212-3450</td>
</tr>
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</table>
Section 3

Getting Started with CareMore Health
Provider Portal

The provider portal is the quickest way to get answers to questions you need. You can access real-time patient information, process and check claims status, enter and view authorizations, and much more. It is conveniently available 24/7 so that you can find what you need, when you need it, in order to take care of your patients.

To Request Access to Provider Portal for your Office

Contracted providers can request access to our Provider Portal by completing the online Provider Portal Access form located on www.CareMore.com in the Providers tab located at the top of the page. Once we receive your request, it will be processed within five business days. Each user will receive an email directly from Provider Relations with instructions on how to complete their registration. The registration link you receive expires 24 hours after being sent... so please complete this step right away.

How to Access Information and Forms on the Provider Portal Website

There are two ways to view the Provider Portal User Manual:

1. Visit our website at www.CareMore.com
   a. Select Providers
   b. Select Provider Training
   c. View options under Provider Portal Training

2. Log into Provider Portal at www.providerportal.caremore.com
   a. Select Documents
   b. Select Portal Training Material
   c. Select Provider Portal Training Videos or User Manuals

There is a wide array of valuable tools, information, and forms that can help you quickly process your request through this secure Provider Portal.

Below is a list of some of the tools and information you can find in the Provider Portal:

- Quickly view the patient’s eligibility and claims
- Submit prior authorization requests and view status
- View diagnosis and procedure codes
- Access to Patient Quick View (PQV)
- View quality measures
- Receive timely notification about your patient’s care at CareMore Care Centers
- Communicate securely with CareMore Health staff
- Manage access and permissions for your own office
- Access CareMore Health’s General Reference and Provider Communication tool which includes the Provider Manual, provider communications, and a variety of health related materials
- New Online PAHAFs
Referral and Authorizations

Referral Process

CareMore Health has two methods for referring patients to specialists and ancillary facilities:

- Self-Referral
- Service Request

Self-Referral Services

Patients do not need prior authorization and may self-refer for the following services provided by qualified, in-network Providers:

- CareMore Care Center services, including:
- Disease Management Programs
- Diabetes Management and Prevention Program
- Behavioral Health
- Brain Health Program
- Smoking Cessation Program
- Healthy Start Visits (new patients)
- Healthy Journey Visits (existing patients)
- Nifty after Fifty Exercise and Strength Training Programs
- Screening Mammography Services
- Influenza Vaccines
- Initial Gynecological Care
- High-resolution chest computed tomography for lung cancer screening

Service Requests

Service Request and Service Request Form

Providers are responsible for verifying eligibility and for ensuring that our Utilization Management (UM) Department has conducted pre-service reviews for elective non-emergency and scheduled services before rendering those services. Prior Authorization ensures that services are based on medical necessity, are a covered benefit, and are rendered by the appropriate providers.

CareMore Health encourages providers to submit service requests online via the Provider Portal. To register, please contact Provider Relations. If that is not an option for technical reasons (e.g., lack of internet access), Providers may submit a Service Request Form to CareMore Health when requesting a pre-service review. This form is located in the CareMore Health Provider Portal under the Reference Tools of the main menu.

Once our UM team has received your request, it will be approved, denied, or pended for additional medical information by the CareMore Health Utilization Management staff. If the request is pended, the CareMore Health Utilization Management staff will contact you by telephone, fax, or via email through the Provider Portal with a request for the information reasonably needed to determine medical necessity.
Services that Do Not Require Pre-Service Review

Providers no longer need to submit a service request to obtain a referral/authorization for plain film x-rays or mammograms as long as the service is prescribed/ordered by a treating physician and the service is directed to one of the preferred CareMore Health contracted providers.

Please ensure you provide the patient with a signed order and that the following information is included: patient name, DOB, requested procedure, providers printed name, and submit to the preferred provider. For a listing of the approved x-ray codes, radiology and mammography codes, and CareMore Health contracted preferred provider for your region, please contact Provider Relations. Service Requests are not required for:

- Lab tests (other than above) when performed by the contracted laboratory; and
- Services that fall under the Self-Referral policy (see above).

Services requiring pre-service approval that may be immediately approved without further review:

- Service requests are required for the services listed below. If the submitted request meets pre-determined criteria, it may be immediately approved without further review:
  - Screening colonoscopy
  - Consultation and follow up visits to the following specialists:
    - Endocrinology for non-diabetes conditions
    - Hematology/Oncology
    - Elective procedures or surgeries
    - All admissions, elective or emergent
    - Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)
    - Certain radiological procedures including:
      - Computed tomography (CT) without contrast, e.g., magnetic resonance imaging (MRI), and positron emission tomography (PET) scan

Service Request Function

Providers will no longer need to submit a service request for additional services rendered at the time of a pre-approved office visit/procedure for retrospective review, as long as the CPT code is listed on our Incidental approval lists for your specialty. For a listing of the approved Incidental codes, please refer to our provider portal at providers.caremore.com, or you may contact Provider Relations.

Service Requests, even when automatic approval is granted, support the following functions:

- Provide authorization for claims payment
- Support progressive care history when additional or more complex care or service is requested
- Support continuity and coordination of care
**Turn-Around-Time**

CareMore Health follows the following CMS rules for the timing of authorization decisions for services.

**Standard:** within 14 calendar days from receipt of the request  
**Expedited:** within 72 hours from receipt of the request

The average turn-around-time of service requests is approximately 4 business days. However, as per the Centers for Medicaid and Medicare Services (CMS) guidelines, the health plan may take up to 14 calendar days to make a decision.

**Expedited Referrals**

The Expedited Referral Request may be used for cases involving an imminent and serious threat to the patient’s health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. Expedited requests must meet the definition of “Expedited” as listed above and are reviewed and completed within 72 hours of receipt. If the request is urgent, and you need to speak to CareMore Health Utilization Management to discuss the request, please contact our CareMore Health Utilization Management. However, if the physician’s medical opinion is that 72 hours is an adequate amount of time to receive a response from UM, there is no need to call. Simply mark the request “Expedited” and also indicate that the request is “Expedited” in the Special Instructions section of the Service Request form.

**Provider is Notified of Determination**

Upon review of the request, the UM authorization system will fax a response to the requesting provider and specialist or facility. Copies of all authorization determinations are faxed to the patient’s PCP to ensure that the provider is apprised of the services the patient is receiving from other providers. Auto-approval of many services is done instantly and, when the request is submitted electronically, the ordering provider receives an immediate approval notice to give to the patient.
Patient’s Rights and Responsibilities

The following section details the information provided to members regarding their rights and responsibilities as a patient of CareMore Health. Providers are encouraged to assist members with their grievances, and no disciplinary action will be taken against a provider who supports a member through the appeals process.

Patient Rights

Patients have the right to:

- Receive care with respect regardless of race, religion, education, sex, cultural background, physical or mental disability, or financial status
- Receive appropriate accessible culturally sensitive health services
- Choose a Primary Care Physician in our network who has the responsibility to provide, coordinate and supervise care
- Be seen for appointments within a reasonable period of time
- Participate with providers in making health care decisions, including the right to refuse treatment, to the extent permitted by law
- Formulate advanced directives
- Confidentiality concerning medical care
- Access personal medical record
- Receive information in a way that they can easily understand and find help when they need it
- Receive emergency services when they need them from any provider without CareMore Health’s approval
- Talk with providers in confidence and to have their health care information and records kept confidential
- Ask for a second opinion
- File a grievance if they disagree with CareMore Health’s decision that a service is not medically necessary for them
- File a complaint if they are unhappy about the care or treatment they have received

Patient Responsibilities

Member responsibilities include, but are not limited to:

- Provide complete and accurate information about past and present medical illnesses, including medications, and other related matters
- Follow the treatment plan and instructions agreed upon with health care providers
- Ask questions regarding condition and treatment plans until clearly understood
- Keep scheduled appointments or call in advance to cancel their appointment
- Call in advance for prescription refills
- Be courteous and cooperative to health care providers and staff who provide health care services
• Actively participate in their health
• Understand their health problems and participate in developing mutually agreed-upon treatment goals to the best degree possible
• Provide information (to the extent possible) that the organization and its practitioners and providers need in order to provide care

**Termination of Physician-Patient Relationship**

It is our desire to have the best applicable care for all our patient’s healthcare needs and keep the provider/patient relationship trustworthy and respectful.

If, however, the physician or his/her designee identifies a patient with whom the physician-patient relationship has been affected negatively or is no longer therapeutic, consideration of termination may be prompted.

A physician’s improper termination of the physician-patient relationship may put the physician at risk for a claim of abandonment. Following these guidelines may mitigate that risk.

**Termination circumstances:**
The types of circumstances that can result in termination include, but are not limited to, the following:

• Repeated noncompliance with therapies or treatments essential to the patient’s safety as deemed medically necessary by the physician or other attending healthcare provider
• Failure to meet financial obligations to regarding care provided or to cooperate with payment processes consistent with payment policies
• Consistent or repeated failure to keep appointments without good cause and/or without notice of intent to cancel appointments
• Threatening, violent, abusive or patterns or repetitive rude or offensive behavior directed at a Provider, staff, or other patients or visitors
• Attempts by the patient to use the relationship to illegally or improperly obtain controlled substances for non-therapeutic purposes, abuse of controlled substances or otherwise refusing to obtain treatment for controlled substance abuse or addiction, seeking multiple prescriptions from different physicians or diverting controlled substances
Consideration:
When identifying situations that may prompt termination, consideration should be given to the following:

- Evaluate whether all options have been exercised to salvage the relationship. Don't act hastily in making a decision.
- For "patient noncompliance", facilitate a face-to-face conversation with the patient to clearly communicate expectations. Allow the patient to voice their understanding and expectations. Clarify any misunderstanding or misperceptions. Facilitate a mutual agreement to a plan. Provide the patient with a copy of the written agreement.
- Review the documentation in the patient record to determine if the documentation supports the decision to terminate the relationship.
- If the patient is in a protected class or disabled, consult CareMore or an attorney to determine if the termination is prohibited.

Termination should not be pursued if:

- The same type of medical care cannot be found within a reasonable geographic area.
- The patient has an urgent or emergent condition or is being treated for an acute condition requiring continuous care. The patient must be treated until the acute phase has stabilized.

Process:
When proceeding with a physician initiated patient’s dismissal:

- Notify CareMore Provider Relations @ 888-291-1358 option 1, then option 5; or contact directly your assigned Network Consultant/Network Support Manager to report the termination issue.
- When appropriate, discuss termination with the patient prior to processing a dismissal to foster acceptance and an understanding of the reasons for ending the relationship.
- Document a full account of the termination process in the patient's record. Inform your staff that the patient has been sent a termination letter. Advise staff not to schedule the patient after the effective termination date.
CareMore will facilitate:

- Authoring a termination letter to the patient that contains the following:
  - Notification that the physician patient relationship is being terminated. In a group practice, specify if the terminated relationship is with one physician or all physicians in the practice.
  - The effective date for end of coverage, from the date of the termination letter. Thirty days is a general guideline, but longer may be necessary based on patient’s circumstances. Threats of violence, actual violence or criminal acts (stealing prescription pads) may necessitate verbal and immediate termination. Follow up verbal dismissal with a termination letter to the patient and a copy to CareMore Provider Services.
  - Clarification that the physician is available to provide care during the transfer period.
  - Send the written termination letter via certified mail, with a return receipt requested.
  - The proof of receipt will serve as proper notice.
  - The letter may also be hand delivered during a visit.
- Resources to assist in locating another physician of the same specialty.
- The need for ongoing care and the consequences of forgoing continued care and treatment (as appropriate).
- An authorization for release of records and a statement that the office will facilitate a transfer of records at the patient's request. It is not advisable to charge the patient for copying the records. Stating the reason for termination in the letter is not necessary. If a reason is stated, it should be clear, concise, and objective.

Clinical Pharmacist... it’s a New Concept!

Our Pharmacy Department believes that good health goes beyond a lack of illness. As Pharmacists and Practitioners, we put forth our best efforts to optimize health for our patients by practicing evidence-based medicine, individualized education, and patient advocacy. We confer with all clinical care team members on a patient’s treatment plan to ensure our patients attain their best physical, mental, and emotional health at an affordable cost.

Ambulatory Care Pharmacist

Core Duties of Ambulatory Care Pharmacists

- Pharmacy collaboration with providers to increase evidence-based medicine by
  - Drug regimen review for CareMore Health patients at home and in skilled nursing facilities
  - Providing drug and disease state education to health care providers and patients
  - Optimizing patient care through virtual health visits and digital therapeutics
• Implementation of clinical strategies and best in class patient care to positively drive clinical outcomes
  o Uncontrolled disease state management
  o Medication regimen review
  o Medication adherence
  o Medication therapy management
  o Medication Reconciliation Post Hospital Discharge
  o Polypharmacy
  o Cost containment
  o High-risk patients as stratified through population analytics and high-risk huddles

• Pharmacist-Managed Patient Care Programs:
  o Anticoagulation
  o Diabetes management
  o Congestive Heart Failure
  o Hypertension

What Can/Can’t Pharmacy Do?

• Pharmacy can refill test strips and insulin syringes
• Pharmacy can’t adjust Warfarin
• Pharmacy can’t prescribe narcotics

Pharmacy Department
Phone: 800-965-1235
Fax: 800-589-3149

Claims

Having a fast and accurate system for processing claims allows Providers to manage their practices, and our Patients’ care, more efficiently. With that in mind, CareMore Health has made claims processing as streamlined as possible. The following guidelines should be shared with your office staff, billing service and electronic data processing agents if you use them.

• Submit “clean” claims, making sure that the right information is on the right form
• Submit claims as soon as possible after providing service
• Submit claims within the contract filing time limit

All claims information must be accurate, complete, and truthful based upon the Provider’s best knowledge, information, and belief.
Electronic Claims Submission

Availity is a full service clearinghouse offering a web-based service to providers for free. You are able to enter your CMS 1500 electronically, using your existing software, in a few simple steps. CareMore’s electronic payer ID is **CARMO** in Loop 1000B NM109 of the 837. There are instructions on how to set up Availity in the resource section.

You can access Availity’s Welcome Application at [https://apps.availity.com/web/welcome/#/](https://apps.availity.com/web/welcome/#/)

All Providers must submit claims within the timeframes listed in their agreement or contract with CareMore Health. The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

Claim Payment Options Offered Through Change Healthcare

**Change Healthcare:** 1-866-506-2830
[www.changehealthcare.com](http://www.changehealthcare.com) CareMore Health Payor ID: CM001

CareMore Health offers several payment options through our EFT vendor, Change Healthcare, to include the following:

- **Electronic Remittance Advice:** CareMore Health offers secure electronic delivery of remittance advices, which explain claims in their final status
- **Electronic Funds Transfer:** CareMore Health allows Electronic Funds Transfer (EFT) for claims payment transactions. This means that claims payments can be deposited directly into a previously selected bank account
- **Direct Pay:** Change Healthcare uses Elavon’s network to disburse payment and is similar to the EFT option. Payments are direct deposited to the provider’s account, and the remittance advice is available through Payment Manager
- **Virtual Credit Card:** Payment is electronically routed using credit card networks. Provider enters the transaction into the existing Point of Service terminal and the funds are deposited to the provider’s existing merchant account. Remittance advices are securely faxed to providers
Fraud Waste and Abuse Detection

We are committed to protecting the integrity of our health care programs and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud** - intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.

- **Waste** - includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but rather occurs when resources are misused.

- **Abuse** - when health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

Investigation Process

We investigate reports of FWA for all types of services provided under the contract, including those subcontracted to outside entities. We may take corrective action with a provider (either professional or a facility), which may include, but is not limited to:

- **Written warning and/or education** - We send letters to the provider advising the provider of the issues and the need for improvement. Letters may include education or requests for repayment or may advise of further action.

- **Medical record audit** - We review medical records to investigate allegations or validate claims submissions.

- **Special claims review** - A certified professional coder or investigator evaluates claims and places payment or system edits in the system. This type of review prevents automatic claim payment in specific situations.

- **Recoveries** - We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment for future claims, termination from our network, or legal action.
**Acting on Investigative Findings**

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a patient or provider to the appropriate regulatory and/or law enforcement agencies.

**Prepayment Review**

One method CareMore Health uses to detect FWA is through prepayment claim review. Through a variety of means, certain providers or facilities, or certain claims submitted by providers or facilities, may come to CareMore Health’s attention for behavior that might be identified as unusual, or for coding or billing or claims activity that indicates the provider or facility is an outlier compared to his/her/its peers.

Once a claim, or a provider or facility, is identified as an outlier, further investigation is conducted by the Special Investigation Unit (SIU) to determine the reason(s) for the outlier status or any appropriate explanation for an unusual coding and/or billing practice. If the investigation results in a determination that the provider’s or facility’s actions may involve FWA, the provider or facility is notified and given an opportunity to respond.

If despite the provider’s or facility’s response, CareMore Health continues to believe the provider’s or facility’s actions involve FWA or some other inappropriate activity, the provider or facility will be notified of placement on prepayment review. This means that the provider or facility will be required to submit medical records with each claim so CareMore Health can review the appropriateness of the services being billed. Failure to submit medical records to CareMore Health in accordance with this requirement will result in a rejection of the claim under review. The providers or facilities will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, CareMore Health may review coding and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of claims submitted by the provider or facility, even if those guidelines are not used for all providers or facilities delivering services to Plan’s Covered Individuals.

The provider or facility will remain subject to the prepayment review process until CareMore Health is satisfied that all inappropriate billing activity has been corrected. If the inappropriate activity is not corrected, the provider or facility could face corrective measures, up to and including termination from our network.

Finally, providers and facilities are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the prepayment review process, whether due to FWA any other coding or billing issue, or for failure to submit medical records as set forth above. Providers or facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their contract/agreement and state law. Providers or facilities also may appeal such determination in accordance with applicable grievance and appeal procedures.
Recoupment/Offset/Adjustment for Overpayments

CareMore Health shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by CareMore Health to provider against any payments due and payable by CareMore to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous claim payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by CareMore Health that any recoupment, improper payment, or overpayment is due from provider, provider must refund the amount to CareMore Health within thirty (30) days of when CareMore Health notifies provider. If such reimbursement is not received by CareMore Health within the thirty (30) days following the date of such notice, CareMore Health shall be entitled to offset such overpayment against other Claims payments due and payable by CareMore Health to provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, provider agrees that all future Claim payments applied to satisfy provider’s repayment obligation shall be deemed to have been paid in full for all purposes. CareMore Health reserves the right to employ a third-party collection agency in the event of non-payment.

Allegations of FWA can be submitted by calling Provider Services. To report anonymously, individuals may call 1-866-847-8247.

Next-Generation Clinical Communications

CareMore Health’s innovative approach to delivering accessible patient care is the driving force to implementing high-tech solutions that support you in your practice. We’re using powerful applications to help CareMore Health clinicians, and contracted clinicians collaborate better by staying connected through secure and intuitive platforms. Here are just a few of the new services available to you:

TigerConnect

TigerConnect is the new compliant standard for real-time communications for providers. It is a mobile or desktop app that is easy for providers to download and use for care coordination and collaboration. Here are just a few of the many benefits to using the TigerConnect for patient care:

- Securely text CareMore Health about your patients and get quick real-time updates
- Save time by texting CareMore Health instead of waiting on hold
- Decrease the number of emails to your inbox
- Send a group text for easier coordination of care
- Instantly audio or video call any colleague from the app

This service is available to all our contracted providers.
Section 4

Provider Responsibilities
Provider Responsibilities

This section outlines general provider responsibilities for our Primary Care Physicians and Specialists. Contracted providers are obligated to adhere to and comply with all terms of CareMore Health’s programs, Provider Agreement, and requirements outlined in this Manual.

Primary Care Providers (PCPs)

A Primary Care Provider (PCP) is a physician who manages the primary and preventive care of CareMore Health patients and acts as a coordinator for specialty referrals and inpatient care. CareMore Health’s model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services provided by other physicians or providers to meet the needs of the patient.

The primary role and responsibilities of PCPs include, but are not be limited to:

- Providing primary and preventive care that includes, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable
- Providing or arranging for urgent covered services as defined in your contract
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services, and maintaining continuity of patient care
- Acting as the patient’s advocate
- Maintaining the patient’s medical record
- Conducting office visits during regular office hours
- Responding to phone calls within a reasonable time and on an on-call basis 24 hours per day, 7-days per week (refer to the Medical appointment standards outlined in this section)

PCPs, in their care coordination role, serve as the referral agent for specialty and referral treatment and services provided to patients assigned to them and attempt to verify that coordinated, quality care is efficient and cost-effective.

Coordination responsibilities include, but are not limited to:

- Referring patients to CareMore Care Center clinical programs, behavioral health providers, specialty providers, or hospitals within our network, as appropriate, and if necessary, referring patients to out-of-network specialty providers who needed
- Coordinating with our Utilization Management Department regarding prior authorizations for patients
- Conducting follow-up (including maintaining records of services provided) for referral services rendered to their assigned patients by other providers, specialty providers, or hospitals
- Coordinating medical care for the programs the patient is assigned to, including at a minimum:
  - Oversight of drug regimens to prevent negative interactive effects
  - Assurance that care rendered by specialty providers is appropriate and consistent with each patient’s health care needs
Capitation

Capitation is a payment arrangement for health care service providers. A set amount is paid to the capitated provider/group for each enrolled person assigned to them, per period of time, whether or not that person seeks care. *Capitation is generated on or around the 10th of each month and mailed with payment by the 27th of each month.* All payments made reflect the current month and six months’ retroactivity.

Encounter Data

PCPs who receive monthly capitation reports for patients are required to submit encounter data on a monthly basis. All encounter data submitted to CareMore Health must be accurate, complete, and truthful based upon the provider’s best knowledge, information and belief. This data should be submitted through Availity and include:

- Patient name
- Patient ID number
- Date of birth
- Date of service
- Place of service
- CPT code number
- ICD-10 code number
- Charge

Specialist Providers

A provider specialist is a Medical Physician who specializes in a branch of medicine or surgery, such as cardiology or neurosurgery. When additional specialty providers are needed, the PCP refers the patient to the appropriate service or specialist.

Specialty providers are responsible for providing services in accordance with the accepted standards of care and practices. Specialists provide services to patients upon receipt of an approved written referral form from CareMore Health or from the patient’s PCP in some cases.

Specialists can coordinate referrals to other contracted specialists. The specialist is responsible for verifying patient’s eligibility prior to providing services. When a specialist refers a patient to a different specialist or provider, the original specialist must share the patient’s medical records, upon request, with the referred-to provider or specialist.

Written Report to PCP

After treating the patient, the specialist MUST submit a written report to the patient’s PCP regarding the results of all care provided and the proposed treatment plan. This report must include any plans for hospitalization or surgery and should be submitted to the PCP within 14 days of treatment or earlier if the medical condition of the patient is of a more urgent nature. This information should also be included on the Service Request Form that is submitted to the UM Department.
Current Procedure Terminology (CPT) Codes

The CPT code for a follow-up visit is 99213. Please note: If the services provided exceed a 99213, the specialist must include notes and supporting documentation when submitting the claim for reimbursement. CareMore Health reviews all requests for CPT codes 99214 and 99215 using the E & M guidelines to determine appropriate and accurate coding before making payment.

Telehealth

CareMore Health follows all applicable Federal and State laws in the use of Telemedicine services to provide consultation, access, and quality of care to patients. CareMore Health is providing the following guidance on providing health care services by Telehealth:

- Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or other settings
- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment
- The patient has provided verbal or written consent, and it is documented in the medical record
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient’s right to the patient’s own medical information
- The patient is not prohibited from receiving in-person health care services after agreeing to receive telehealth services. CareMore Health providers must use the appropriate modifiers and CPT-4 or HCPCS codes when billing for services delivered via telehealth and document the Place of Service code on the claim

PAHAF, HEDIS, and STARS

Are utilized for monitoring the performance of PCPs and for determining a health plan’s HEDIS and STARs ratings. HEDIS and STARs ratings are important indicators of quality and performance that consumers may use to compare health plans.

- Patient Annual Health Assessment Form (PAHAFs)
- STAR Ratings
  - HEDIS – Healthcare Effectiveness Data and Information Set
  - HOS – Health Outcomes Survey
  - CAHPS – Consumer Assessment of Healthcare Providers and Systems
  - Part D Data - Part D assesses patient safety and drug pricing
Medical Appointment Standards

This section summarizes the access to care standards for contracted providers, including Participating Physician Groups and their affiliated provider network.

- When medically necessary, enrollees have access to acute, emergent care 24 hours a day, seven 7-days a week.
- During office hours, practitioner’s office staff will answer at least 90 percent of telephone calls within 45 seconds and 100 percent within two minutes.
- The maximum waiting time for the following services with the exception of LTSS (including behavioral health, when applicable) should be:

<table>
<thead>
<tr>
<th>Medical Appointment Wait Time Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Exam:</strong> Serious condition requiring immediate intervention-no authorization needed</td>
</tr>
<tr>
<td><strong>Urgent (PCP or specialist):</strong> Services for a non-life-threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.</td>
</tr>
<tr>
<td><strong>Non-Urgent (PCP)</strong></td>
</tr>
<tr>
<td><strong>Adult Health Assessment:</strong> Unless a more prompt exam is warranted that is termed “urgent”</td>
</tr>
<tr>
<td><strong>Non-Urgent Consult/Specialist Referral</strong></td>
</tr>
<tr>
<td><strong>Waiting time in practitioner’s office excludes walk-in/same-day appointments</strong></td>
</tr>
<tr>
<td><strong>After-hours access</strong></td>
</tr>
<tr>
<td><strong>Behavioral Health non-life-threatening emergency</strong></td>
</tr>
<tr>
<td><strong>Behavioral urgent care</strong></td>
</tr>
<tr>
<td><strong>Behavioral Health routine office visit</strong></td>
</tr>
</tbody>
</table>
Ethics and Compliance Training

New CareMore Health providers are required to complete compliance trainings within (90) days of the effective date of their agreement with CareMore and annually thereafter. These trainings will include CMS as well as CareMore developed trainings. The trainings can be found on CareMore’s website at www.CareMore.com.

Annual Provider Training

CareMore Health providers are required to complete annual trainings on a variety of required CMS topics including Fraud, Waste and Abuse, Model of Care, Cultural Competency, CareMore Health services, among others.

You can find the annual provider training materials online by visiting https://www.caremore.com/Providers/Current-Provider/Provider-Training.aspx. You will be asked to complete a registration and attestation before viewing the training materials.

The registration and attestation will grant you access to all training materials for the next 365 days. After that time period is up, you’ll be required to complete another registration.

How to Update any Demographic Changes

This includes things such as adding, deleting, or replacing an office location, changing remit address, opening or closing your PCP panel, and changing your fax or phone number. Please email all the appropriate information to providerrelations@caremore.com – don’t forget to include an effective date of the requested change.

Have you added or removed a physician or mid-level provider from your office?

If a provider is leaving your office or has left, please send the termination letter to providerrelations@caremore.com. Don’t forget to include the effective date of the termination. If you have a new provider joining your office, please submit a participation request online with as much advanced notice as possible. The online participation request form is located at: CareMore Health Participating Provider Request (PPR)

New providers should not see CareMore Health patients until they have passed credentialing and been notified.
WHAT IS TIGERCONNECT? TigerConnect is a secure HIPAA Compliant Messaging application designed for clinical communications and collaboration. Used in over 5,000 facilities, TigerConnect is the leader in secure messaging for healthcare and facilitates real-time communication of Patient Health Information.

WITH TIGERCONNECT, YOU CAN:

- Get real-time updates from CareMore on admits / discharges
- Cut down on disruptive phone calls and respond at your convenience
- Reach out to CareMore extensivists easily with questions on patient care

TIGERCONNECT BENEFITS:

- HIPAA-compliant communication method
- Non-intrusive and privacy sensitive
- Direct clinician-to-clinician communication

EMAIL: tigerconnect@caremore.com
With Your Work Email Address to Request an Invitation Now.
CareMore Anytime

Provides CareMore members with 24/7 access to a clinician, who can:

- Answer their clinical questions,
- Provide education, and
- Connect them with appropriate resources within and outside CareMore

CareMore Anytime
24/7 access to trusted care

1-800-589-3148

Call this number to:

- Understand your symptoms and receive advice on appropriate care options
- Decide whether to visit your provider, CareMore Care Center or urgent care
- Get answers to urgent health questions in the comfort of your home

For health plan benefit questions, call the phone number on the back of your Member ID card.

If you are in need of emergency care, call 911 immediately.
Availity Letter

Dear Provider Partner:

Effective 1/1/2020, Availity will serve as CareMore’s new Electronic Data Interchange (EDI) partner for your organization’s electronic claim submissions.

There are several ways you can exchange EDI transmission with Availity:

1. **Continue to exchange your EDI transmissions with Office Ally or another vendor or clearinghouse setup to submit claims directly to Availity.**
   - You can continue to use your existing vendor for CareMore claim submissions. However, effective 1/1/2020, all CareMore claims must be sent directly to the Availity EDI Gateway, so ensure your clearinghouse is ready for the transition.
   - It’s imperative that you work with your existing vendor to ensure connectivity to the Availity EDI Gateway for your CareMore claim submissions after 1/1/2020. Please provide your vendor with the instructions outlined below.

2. **Submit your own claims - become a direct Trading Partner with Availity.**
   - You can choose to submit your CareMore claims directly to the Availity EDI Gateway. The Availity Welcome Application is your guide to setting up your business for exchanging EDI transactions with Availity.
   - You can access Availity’s Welcome Application at https://apps.availity.com/web/welcome/#/

The following instructions and guides will assist you through the transition:

- The EDI Connectivity Services Startup Guide provides information on the different ways claims can be submitted. The guide can be accessed at:
- Availity’s EDI Companion Guide provides details on ISA and GS values required for direct submission of claims to Availity and other important information. The guide can be accessed at:
- You can exchange the following 837 transactions through the Availity EDI Gateway:
  - ASC X12N 837 version 005010X223A2 Institutional Claims
  - ASC X12N 837 version 005010X222A1 Professional Claims

**Claims Payer ID**

Use **CARMO** in Loop 1000B NM109 of the 837 when sending claims to Availity.

**Contacting Availity**

If you have any questions, please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548); Monday through Friday 8:00 a.m. - 7:30 p.m. EST.
Dear Provider:

CareMore Health Plan has partnered with Change Healthcare (formerly Emdeon) & ECHO Health, Inc. to provide new electronic methods. Many of our providers already work with Change Healthcare and ECHO today.

Below we have outlined the payment options and any action items needed by your office:

1. **EFT/ACH** - EFT/ACH allows your office to receive payment via electronic funds transfer. You may choose to enroll for EFT/ACH payments by providing your banking account information, and once your enrollment is verified you will begin receiving payment via electronic funds transfer (EFT). Setting up EFT is a fast and reliable method to receive payment. If you wish, you can elect to receive an email notification each time a payment is made to you. To enroll for EFT/ACH, please visit:
   
   https://view.echohealthinc.com/EFTERADirect/CareMore/index.html
   
   An enrollment code will be required for enrollment. Your enrollment code is CM001.

3. **Virtual Card Services** - Going forward, if we don’t have a documented choice of payment for you, the default method of payment will now be virtual card rather than a paper check. Virtual cards allow your office to process our payments as credit card transactions. Virtual card payments are generally received 7-10 days earlier than paper checks since there are no print and mail delays. Your office will receive fax notifications, each containing a virtual card with a number unique to that payment transaction. Once the number is received, you simply enter the code into your office’s credit card terminal to process payment as a regular card transaction. If the card is not processed within 30 days, the virtual transaction will be voided and a paper check will automatically be sent to your office. To avoid delay please process the card or notify us of your preference from the other options below. Normal transaction fees apply based on your merchant acquirer relationship.

4. **Paper Check** - If there are concerns with electronic payments, you must elect to opt out of Virtual Care Services to receive paper checks and paper explanation of payments.

In addition, you may register at [www.providerpayments.com](http://www.providerpayments.com) to access a detailed explanation of payment for each transaction and to set up email notifications for electronic and/or paper payments.

If you have additional questions regarding your payment method, please contact the ECHO Provider Relations Department at 844-586-7463.

We appreciate your support as we roll out these new payment options, and we look forward to continuing to work with you to deliver a positive experience for your CareMore patients.
EFT Enrollment FAQ

The following collection of questions pertain to Enrollment for Electronic Funds Transfer (EFT)

Q: Why am I getting a Virtual Credit Card Payment and how do I Opt Out?
A: The Virtual Credit Card Payment is payer driven, to Opt Out, please call the number listed on the Virtual Credit Card Payment. A generic number is 855-886-2830, however the payment may indicate a unique number for the payer, please call the number listed.

Q: Where do I go to Enroll for EFT Services through Change Healthcare?
A: Follow the link to begin your initial enrollment, you’ll need to complete the EPayment Enrollment Authorization Form and submit the required Validation Paperwork with your Enrollment Form:
https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms

Q: What is a “Trading Partner ID” and where do I obtain it?
A: This is a payer assigned value – also called a Provider ID/Legacy

Q: What is the turnaround time for an EFT Enrollment?
A: For an initial EFT Enrollment it is approximately 15 business days, an email with instructions will be sent to the email listed on the enrollment form. Please be aware that until the test deposit is confirmed the enrollment is not complete.

Q: How can I view my EOB/ERA’s?
A: EOB/ERA’s can be viewed by logging into the Payment Manager Portal, it is suggested after logging in for the first time that the Admin go into Production Documentation – Training – Payment Manager to review the Training Information available: https://cda.changehealthcare.com/

Q: How do I Add/Change or Delete payers?
A: Follow the link and complete the EFT Payer Add/Change/Delete Authorization Form: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms
Q: How do I change/update my banking information?
A: Follow the link and complete the EPayment Enrollment Authorization Form and provide the required Validation Paperwork with your Enrollment Form: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms

Q: How can I still get ERA’s through my current Clearinghouse?
A: Follow the link and complete the Enrollment ERA Provider Setup Form, you can indicate where you would like to have your ERA’s delivered, or contact your current Clearinghouse for assistance: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-era-enrollment-forms

Q: Who do I notify if I’m missing an EFT payment or EOB/ERA?
A: Contact the EFT Support Helpdesk at 866-506-2830 OR email eftenrollment@changehealthcare.com the following information is required:
• Tax ID
• Payer Name/Payer ID
• Check Number/EFT Payment Number
• Payment Date
• Payment Amount

Q: Which payers can I receive EFT Payments through Change Healthcare?
A: Follow the link to view the current listing of all Change Healthcare EFT Participating Payers: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms/eft-participating-payers

Q: The test deposit isn’t visible in my bank account, how can I verify the account information?
A: A test deposit takes on average 1-2 business days to be deposited into your bank account from the day that your form is processed. If more than 3 business days have passed since the receipt of the Test Deposit Verification email, please follow the link and complete the EFT Test Transaction Resubmission Form: https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms

Q: I’ve lost a Virtual Credit Card Payment, how can I have my payment reissued?
A: You would need to reach directly out to the payer to request that they send another copy of the Virtual Credit Card Payment and EOB.