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SECTION I:
INTRODUCTION
MESSAGE FROM PRESIDENT AND CHIEF MEDICAL OFFICER

Welcome to CareMore Health!

Dear Physician Colleague:

CareMore Health’s goal is to partner with you in delivering unequaled care to your patients. We recognize that there are many forces making the practice of medicine more challenging for you. Our goal is to make your practice more rewarding for you by helping you achieve better patient outcomes, better practice economics, and greater ease and joy in caring for your patients.

We want you to be proud to have partnered with us. Over the last year CareMore Health has achieved national recognition from the New England Journal of Medicine, New York Times, Forbes, and the Harvard Business Review for our evolving, innovative model of care. We have a number of innovative disease management programs—such as our Togetherness program to address senior loneliness—that enhance clinical outcomes and improve the quality of life for your patients.

The hub for these CareMore Health programs are the neighborhood care centers where our teams of physicians, nurse practitioners, case managers, dieticians, and podiatrists partner to enhance the clinical care you deliver. Our Extensivists physicians care for your patients when they are admitted to the hospital and continue to follow them to nursing facilities or post-discharge clinics to ensure a smooth transition and recovery. We also partner with Nifty-After-Fifty fitness centers to deliver senior-focused physical training programs.

Please take some time to learn more about our programs and how they can help you support your patients. We also welcome you to come visit with us to see our model of care in action.

We are pleased to partner with you and appreciate your trust in us.

Thank you,

Sachin Jain, MD, MBA, FACP
President & CEO

Vivek Garg, MD, MBA
Chief Medical Officer
HOW TO USE THIS MANUAL

Overview

This Provider Manual (manual) serves as a guide to the policies and procedures governing the administration of CareMore Health and is an extension of and supplement to the Provider Agreement between CareMore Health and contracted providers delivering health care service(s) to our patients.

This manual is designed for CareMore Health contracted physicians, hospitals and ancillary providers who are participating with CareMore Health. We recognize that managing our patients’ health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of health care services and responsibilities. We want to help you navigate our managed health care to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our patients.

This manual is available to view or download on our provider portal. To access this manual through the provider portal please visit www.caremore.com. You may also contact our Provider Relations team to request that a printed copy be mailed to you.

This manual is updated annually. We retain the right to add, delete, and otherwise modify this manual at any time. Revisions to this manual reflect changes made to our policies and procedures updated at least annually.

DISCLOSURES

Disclaimer

The information provided in this manual is intended to be informative and to assist providers in navigating the various aspects of participation with CareMore Health programs. Unless otherwise specified in the provider contract, the information contained in this manual is not binding upon CareMore Health and is subject to change. CareMore Health will make reasonable efforts to notify providers of changes to the content of this manual.

This manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Agreement between you or your facility and CareMore Health, the Agreement shall govern.

In the event of a material change to the provider manual, CareMore Health will make all reasonable efforts to notify you in advance of such changes through fax communications and other mailings. In such cases, the most recently-published information shall supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all CareMore Health policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications. These communications include, but are not limited to, letters, bulletins and newsletters.
Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate only, and is not intended to be used or relied upon in any circumstance or instance.

This manual does not contain legal, tax or medical advice. Please consult other advisors for such advice.

**Third Party Websites**

The CareMore Health website and this manual may contain links and references to internet sites owned and maintained by third party entities. Neither CareMore Health nor its related affiliated companies operate or control, in any respect, any information, products or services on these third party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. CareMore Health disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. CareMore Health does not warrant or make any representations regarding the use or results of the use of third party materials in terms of their correctness, accuracy, timeliness, reliability or otherwise.

**Privacy and Security Statements**

CareMore Health’s latest privacy and security statements related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) can be found on the CareMore Health website at [www.caremore.com](https://www.caremore.com).

CareMore Health latest data collection and use practice for its website(s) can also be found on the CareMore Health website.

Please be aware that when you leave the CareMore Health website to another website, whether through links provided by CareMore Health or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such websites before providing any personal information.

**Collection of Personal and Clinical Information**

CareMore Health will collect, create, use, and disclose personal and clinical information related to patients in accordance with state and Federal laws, including HIPAA, court orders, and/or subpoenas. Release of records according to valid court orders or subpoenas are subject to the provisions of that court order or subpoena.

The person or entity that is seeking to obtain medical information must obtain a valid authorization from the patient, unless otherwise permitted by HIPAA and is to use that information only for the purpose it was requested and retain it only for the duration needed.

The individual physician or provider may not share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient, obtain reimbursement for such services, or for the physician’s or provider’s health care operations as defined by HIPAA.
Only the minimum necessary amount of information shall be collected and maintained. Reasons for collecting medical information may include but are not limited to:

- To review for medical necessity of care
- To perform quality management, utilization management and credentialing/re-credentialing functions
- To determine the appropriate payment under the benefit for covered services
- To analyze aggregate data for benefit rating, quality improvement, chronic disease management programs, and oversight activities, etc.
- To comply with statutory and regulatory requirements.

**Maintenance of Confidential Information**

CareMore Health maintains confidential information as follows:

- Clinical information received verbally may be documented in CareMore Health’s database. This database includes a secured system restricting access to only those with authorized entry. Computers are protected by a password known only to the computer user assigned to that computer. Computers with any computer screen displaying patient or Provider information shall not be left on and unattended.

- Electronic, facsimile, or written clinical information received is secured, with limited access to employees to facilitate appropriate patient care and reimbursement for such care. No confidential information or documents are left unattended (e.g., open carts, bins or trays at any time). Hard copies of all documents are not visible at any workstation during the employees’ breaks, lunch or time spent away from desks.

- Written clinical information is stamped “Confidential,” with a warning that its release is subject to State and Federal law.

- Confidential information is stored in a secure area with access limited to specified employees, and medical information is disposed of in a manner that maintains confidentiality (e.g., paper shredding and destroying of recycle bin materials).

- Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be “sanitized” (i.e., all identifying information blacked out), to prevent the disclosure of confidential medical information.

- Any records related to quality of care, unexpected incidence investigations, or other peer review matters may be privileged communications under state law. As such, these records are maintained as confidential. All such written information is stamped “Confidential”, with a warning that its release is subject to state and federal law. Information is maintained in locked files.

**Patient Authorization**

Patient authorization is not required for treatment, payment and healthcare operations. Direct treatment relationships (e.g., the provision and/or coordination of health care by providers) require patient consent.
When a patient is enrolled in more than one Managed Care Organization (MCO) (i.e., employer group and Medicare or Medicare and Medi-Cal) all such MCOs are not considered third parties for the purposes of sharing information. To ensure continuity and coordination of care, identifiable personal information pertaining to patient’s health and health care may be released, to the extent allowed under State and Federal law, without the prior consent of the beneficiary, to any other MCO.

**Patient Access to Medical Records**

Patient may access their medical records upon proper request. The patient may also provide a written request for amendment to their records if they believe that the records are incomplete or inaccurate.

No written request is required for information/documents to which a patient would normally have access, such as copies of claims, etc. CareMore Health substantiates the identity of the individual patient (e.g., subscriber number, date of service, etc.) before releasing any information.

A written request signed by a patient or the patient’s authorized representative is required to release medical records. An initial “consent to treat” may be signed at the point of entry into services prior to the provision of those services, but does not allow records to be released for any reasons other than those delineated in that original consent (e.g., payment and specialty referral authorization processes).

CareMore Health will assist the patient who has difficulty obtaining requested medical records.

**Disease Management Organizations**

CareMore Health and its contractors/vendors that administer disease management programs for conditions such as congestive heart failure, diabetes, chronic obstructive pulmonary disease and cardiovascular disease are prohibited from disclosing a patient’s medical information without physician authorization, except as expressly permitted by law. Disease management organizations are restrained from soliciting or offering for sale any products or services to a CareMore Health patient while providing disease management services unless, as specified, he or she elects to receive such information. CareMore Health staff may contact the patient as needed with information regarding the disease management program(s).

Release of confidential patient information to disease management organizations may be given for the purpose of providing disease management services, without the authorization of the treating physician, as long as the following is done:

- The disease management organization otherwise maintains the information as confidential as required by law.
- Notice of the disease management program (description of the disease management services) must be given to the treating physician for patients whom information will be provided to the disease management organization.

**Patients Consent to Medical Treatment**

Incompetent patients include:

- A patient/conservatee who has been declared incompetent to consent to treatment by a court.
A patient/conservatee who has not been declared incompetent to consent to treatment, but whom the treating physician determines lacks the capacity to consent.

A patient who is not capable of understanding the nature and effect of the proposed treatment.

CareMore Health will consult with legal counsel, as appropriate. The Durable Power of Attorney or Letters of Conservatorship may need to be reviewed by legal counsel to determine who may consent to the release of patient information.

**Release to Employers**

CareMore Health and its contracted/delegated medical groups/IPAs do not share patient-identifiable information with any employer without the patient’s written authorization. The patient must identify himself/herself by providing key information such as: subscriber number, provider name and date of service, etc.

Detailed claims reports will be encrypted or all individually identifiable information blanked out. Requests for reports for individual information may be forwarded to legal counsel for review to ensure employers protect the data from internal disclosure for any use that would affect the individual in compliance with state law.

**Release to Providers**

Provider requests may be honored if the request pertains to that provider’s services and the released is allowed by HIPAA, 45 CFR §164.506(c) (disclosures for treatment, payment or health care operations). All other requests require the patient’s or patient’s representative’s signed release for the information.

Electronic, facsimile, or written clinical information sent is secured with limited access to those employees who are facilitating appropriate patient care and reimbursement for such care.

**Release to Disease Management Organization**

Release of confidential patient information to disease management organizations may be given for the purpose of providing disease management services, without the authorization of the treating physician, as long as the following is done:

- The disease management organization maintains the information as confidential as required by law.
- The disease management organization does not attempt to sell its services to patients.
- Notice of the disease management program (description of the disease management services) is given to the treating physician for members whom information will be provided to the disease management organization.
- The disease management organization obtains the treating physician’s authorization prior to providing home health care services or prior to the dispensing, administering or prescribing of medication.

All other requests require the treating physician’s authorization for release of patient information to a disease management organization for provision of disease management services.
Electronic, facsimile, or written clinical information sent is secured with limited access to those employees who are facilitating appropriate Patient care and reimbursement for such care.

**Release of Outpatient Psychotherapy Records**

Anyone requesting patient’s outpatient psychotherapy records for any use or disclosure must obtain an authorization from the patient, except where specifically permitted by HIPAA (45 CFR §164.508(a)(2)).

The written authorization must be signed by the patient and must identify:

- What information is requested
- The purpose of the request
- The name or other specific identification of the person(s) or class of persons authorized to make the requested use or disclosure
- The name or other specific identification of the person(s) or class of persons to whom the provider may make the requested use or disclosure
- An expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure
- The signature of the patient and date
- A statement to place the patient on notice of their right to revoke the authorization in writing and either (a) the exceptions to the right to revoke and a description of how the patient may revoke the authorization or (b) to the extent that this information is included in the Notice of Privacy Practices (N OPP), a reference to the NOPP
- A statement to place the patient on notice of the ability or inability of the provider to condition treatment, payment, enrollment, or eligibility for benefits on the authorization by stating either (a) the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization or (b) the consequences to the individual of a refusal to sign the authorization when the provider can condition treatment, enrollment, or eligibility for benefits on failure to obtain an authorization.
- A statement adequate to place the patient on notice of the potential for information disclosed pursuant to authorization to be subject to re-disclosure by the recipient and no longer be protected

**Release of Records Pursuant to a Subpoena**

Patient information will only be released in compliance with a subpoena duces tecum by an authorized designee in Administration as follows:

- The subpoena is to be accepted, dated and timed, by the above person or designee.
- The subpoena should give CareMore Health at least 20 days from the date the subpoena is issued to allow a reasonable time for the Member to object to the subpoena and/or preparation and travel to the designated stated location.
• All subpoenas must be accompanied by either a written authorization for the release of medical records or a “proof of service” demonstrating the patient has been “served” with a copy of the subpoena.

• Alcohol or substance abuse records are protected by both Federal and State law and may not be released unless there is also a court order for release which complies with the specific requirements.

• Only the requested information will be submitted, (HIV and AIDS information is excluded). HIV and AIDS or AIDS related information require a specific subpoena per state law.

Should a notice contesting the subpoena be received prior to the required date, records will not be released without a court order requiring so. If no notice is received, records will be released at the end of the 20 day period.

The record will be sent through the US Postal Service by registered receipt or certified mail.

**Archived Files/Medical Records**

All medical records are retained by CareMore Health and/or the delegated/contracted medical groups as well as individual practitioner offices, according to the following criteria:

• Adult patient charts – 10 years
• X-Rays – 10 years

**Misrouted Protected Health Information**

Providers and facilities are required to review all patient information received from CareMore Health to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about patients that a Provider or facility is not treating. PHI can be misrouted to Providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately report any misrouted Patient information to the sender and then destroy or safeguard the PHI for as long as it is retained. In no event are Providers or facilities permitted to misuse or re-disclose misrouted PHI. If Providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Relations.
# CAREMORE HEALTH CONTACT INFORMATION

12900 Park Plaza Drive, # 150
Cerritos, CA 90703
Monday - Friday: 8 a.m. – 5 p.m.
Phone: 1-888-291-1358

## By Departments:

<table>
<thead>
<tr>
<th>Department Name</th>
<th>Phone/Fax</th>
<th>Hours of Operation and Website</th>
</tr>
</thead>
</table>
| Member Services                   | CA & NV: 1-800-499-2793  
AZ: 1-888-816-2790  
VA: 1-888-326-3584  
Cal MediConnect:  
LA: 1-888-350-3447  
SC: 1-855-817-5785 | Oct 1 - Feb 14:  
Mon - Sun: 8 a.m. - 8 p.m.  
Feb 15 - Sept 30:  
Mon - Fri: 8 a.m. - 8 p.m. |
| Case Management                   | Ph: 1-888-291-1358 (Option 3,  
Option 3, Option 1)  
Ph: 1-888-291-1384 | 24 hours a day, 7 days a week |
| After Hours Case Manager          | Ph: 1-800-613-9374 (Option 1,  
Option 1) | 24 hours a day, 7 days a week |
| Extensivist                       | Ph: 1-800-589-3148 | After hours line with a clinician  
Mon - Fri: 5 p.m. - 12 a.m.  
Sat - Sun: 8 a.m. - 5 p.m. |
| Disease Management Programs       | Ph: 1-888-291-1358 (Option 3,  
Option 3, Option 2) | Mon - Fri: 5 a.m. - 5 p.m. |
| Utilization Management            | Ph: 1-866-575-4120  
Fax: 1-360-896-2151 | 24 hours a day, 7 days a week  
[www.officeally.com](http://www.officeally.com)  
CareMore Payor ID: CARMO |
| Electronic Claims Submission      | Ph: 1-866-847-8247 | 24 hours a day, 7 days a week |
| Fraud Hotline                     | Ph: 1-888-291-1358 (Option 3,  
Option 1)  
Fax: 1-562-741-4412 | Mon - Fri: 8 a.m. - 5 p.m. |
| Provider Customer Service - Member Eligibility Claims Inquiry | Ph: 1-888-291-1358 (Option 3,  
Option 5) | Mon - Fri: 8 a.m. - 5 p.m. |
| Provider Relations                | Ph: 1-800-965-1235  
Fax: 1-800-589-3149 | Mon - Fri: 7 a.m. - 5 p.m. |
| Virtual Nurse Hotline             | Ph: 1-800-589-3148 | 24 hours a day, 7 days a week |
# CareMore Care Center Locations

## Arizona

<table>
<thead>
<tr>
<th>Location (Name)</th>
<th>City</th>
<th>Street Address</th>
<th>Phone Number</th>
<th>FO: X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speedway</td>
<td>Tucson</td>
<td>7091 E. Speedway Blvd.</td>
<td>520-721-5777</td>
<td>70132</td>
</tr>
<tr>
<td>Irvington</td>
<td>Tucson</td>
<td>315 W. Irvington Rd., #101</td>
<td>520-294-1740</td>
<td>70320</td>
</tr>
<tr>
<td>Green Valley</td>
<td>Green Valley</td>
<td>191 W. Esperanza Blvd.</td>
<td>520-791-7300</td>
<td>70504</td>
</tr>
<tr>
<td>West Tucson - Stone</td>
<td>Tucson</td>
<td>4821 N. Stone Ave.</td>
<td>520-314-3300</td>
<td>70903</td>
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</tbody>
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## Southern California

<table>
<thead>
<tr>
<th>City</th>
<th>Street Address</th>
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<tbody>
<tr>
<td>Anaheim</td>
<td>1182 N. Euclid St.</td>
<td>714-399-9222</td>
<td></td>
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<tr>
<td>Brea</td>
<td>380 W Central Ave.</td>
<td>714-529-3971</td>
<td>77335</td>
</tr>
<tr>
<td>Placentia</td>
<td>1325 N. Rose Dr., #102</td>
<td>714-203-1767</td>
<td>77320</td>
</tr>
<tr>
<td>Santa Ana</td>
<td>1945 E. 17th St., Suite 101</td>
<td>714-888-8900</td>
<td>78903</td>
</tr>
<tr>
<td>Downey</td>
<td>10000 Lakewood Blvd.</td>
<td>562-862-3684</td>
<td>77846</td>
</tr>
<tr>
<td>Lawndale</td>
<td>15230 Hawthorne Blvd.</td>
<td>424-269-3600</td>
<td>79101</td>
</tr>
<tr>
<td>South Street/Lakewood</td>
<td>3300 South St., Suite 203</td>
<td>562-232-1144</td>
<td></td>
</tr>
<tr>
<td>Long Beach</td>
<td>4540 E. 7th St.</td>
<td>562-344-1150</td>
<td>76201</td>
</tr>
<tr>
<td>La Mirada</td>
<td>15034 Imperial Hwy.</td>
<td>562-902-4929</td>
<td>78301</td>
</tr>
<tr>
<td>Pico Rivera</td>
<td>9330 Washington Blvd.</td>
<td>562-205-4200</td>
<td>79602</td>
</tr>
<tr>
<td>Whittier</td>
<td>9209 Colima Rd., #1000</td>
<td>562-696-1104</td>
<td></td>
</tr>
<tr>
<td>La Mirada</td>
<td>15627 Imperial Hwy.</td>
<td>562-501-1560</td>
<td></td>
</tr>
<tr>
<td>East LA</td>
<td>3513 E. 1st St.</td>
<td>323-859-2660</td>
<td></td>
</tr>
<tr>
<td>Glendale</td>
<td>406 E. Colorado St.</td>
<td>818-844-2778</td>
<td>79701</td>
</tr>
<tr>
<td>Downtown LA</td>
<td>303 S Union Ave.</td>
<td>213-355-2600</td>
<td>79401</td>
</tr>
<tr>
<td>Montebello</td>
<td>2444 W. Beverly Blvd.</td>
<td>323-201-4130</td>
<td>79301</td>
</tr>
<tr>
<td>West Covina</td>
<td>301 N. Azusa Ave.</td>
<td>626-214-2600</td>
<td>78801</td>
</tr>
<tr>
<td>Baldwin Hills/West LA</td>
<td>3711 S. La Brea Ave.</td>
<td>323-596-4800</td>
<td></td>
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## San Bernardino California

<table>
<thead>
<tr>
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<th>Street Address</th>
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<tbody>
<tr>
<td>Apple Valley</td>
<td>19059 Bear Valley Rd.</td>
<td>760-515-5000</td>
<td>77501</td>
</tr>
<tr>
<td>Hesperia</td>
<td>14466 Main St., #102</td>
<td>760-981-1284</td>
<td></td>
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<tr>
<td>Upland</td>
<td>141 W. Foothill Blvd</td>
<td>909-296-8800</td>
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### Northern California

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<th>Phone</th>
<th>Fax</th>
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<tr>
<td>White</td>
<td>San Jose</td>
<td>255 N White Rd., #200</td>
<td>95131</td>
<td>408-503-7600</td>
<td></td>
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<tr>
<td>Atherton</td>
<td>San Jose</td>
<td>4855 Atherton Ave., #101</td>
<td>95132</td>
<td>408-963-2400</td>
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</tr>
<tr>
<td>Gilroy</td>
<td>Gilroy</td>
<td>7888 Wren Avenue, Suite C-131</td>
<td>95020</td>
<td>408-665-4400</td>
<td>FO: X 79801</td>
</tr>
<tr>
<td>Modesto</td>
<td>Modesto</td>
<td>1801 H. St. Ste. C-1</td>
<td>95030</td>
<td>209-544-2554</td>
<td>FO: X 77026</td>
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<tr>
<td>Turlock</td>
<td>Turlock</td>
<td>1000 Delbon Ave., Ste.2</td>
<td>95080</td>
<td>209-664-7700</td>
<td>FO: X 78402</td>
</tr>
<tr>
<td>Patterson</td>
<td>Patterson</td>
<td>1700 Key Stone Pacific Pkwy, Suite A-2</td>
<td></td>
<td>209-664-7700</td>
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### Nevada

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<th>Address</th>
<th>Zip</th>
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<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>Flamingo</td>
<td>Las Vegas</td>
<td>3041 E. Flamingo Rd., #A</td>
<td>89117</td>
<td>702-436-0835</td>
<td>FO: X 74225</td>
</tr>
<tr>
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<td>100 N. Green Valley Pkwy., #235</td>
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SECTION III:
CLINICAL TECHNOLOGY AND INNOVATIONS
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, 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.

How to Access Information and Forms on the Provider Portal Website

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 portal:

- Submit prior authorization requests and view status
- View member’s eligibility and claims
- Access to Patient Quick View (PQV)
- Communicate with CareMore Health staff via Portal Email
- View CareMore Health’s Reference Tools which includes Provider Manual, and variety of health related materials

Throughout this manual, we will refer you to items located on the provider portal. If you have not yet registered to access the provider portal we encourage you to do so.

To access the Provider Portal, please visit: www.caremore.com

If you have questions about provider portal access or need training on how to navigate it, please contact the Provider Relations Department.

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 one of our most recent high-tech services that we’ve implemented to assist providers in accessing real-time information on patient care. TigerConnect is the new compliant standard for real-time communications. It is easy to access and use. Here are just a few of the many benefits to using the TigerConnect App for patient care:
- Get quick real-time updates from CareMore Health on your patients
- 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 call any colleague from the app

This service is available to all our contracted providers.

**TELEMEDICINE**

Telemedicine services are available to patients and may be provided as medically necessary. Telemedicine is the delivery of healthcare services or medical consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine services expand both the access and the reach of network providers, while increasing access for patients in rural and underserved areas as well. Telemedicine services are provided with a goal to increase service coordination and 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 a device that transmits this information to a clinician for analysis, storage, and when necessary, intervention. Through the Remote Health Monitoring Program, patients with chronic or high risk conditions such as congestive heart failure 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. 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.

Video Remote Interpreting (VRI) is now available at the CareMore Care Centers located in California, Arizona, Nevada, and Virginia. It will soon be available in all markets. 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.
SECTION IV:
CAREMORE HEALTH PROGRAM AND SERVICES
MODEL OF CARE OVERVIEW

Overview

Our Model of Care is designed to support PCPs by providing additional care to chronically ill patients that require on-going care and treatment. The services we provide to patients is an extension of the primary care you provide to them. CareMore Health uses clinical programs and services where all clinicians and non-clinicians are aligned and coordinated as a team. Your patients will be supported by this team who will provide care and assist with care coordinate to make sure that patients receive the necessary care to properly manage their conditions.

CareMore Care Centers

CareMore Care Centers are one-stop outpatient facilities designed to provide additional attention to chronic conditions, general health, and prevention. The services provided at these facilities are designed to support patients in managing every aspect of their condition.

Services available to your patients at the Care Centers include:

- Care and support from an interdisciplinary care team (Nurse Practitioners, registered dietitians, social workers, pharmacist and behavioral health specialists)
- Access to a variety of health education and clinical care programs
- Advanced patient care from a CareMore Health Extensivist during and after any new critical event such 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 coordinating their care.

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<th>CareMore Health Programs and Services</th>
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<tr>
<td>• Anti-coagulation Clinic</td>
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<td>• Back Pain Program</td>
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<td>• Cardiology</td>
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<td>• Cardiac Imaging Center</td>
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<td>• Congestive Health Failure Care Program</td>
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<td>• Chronic Kidney Disease Program</td>
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<td>• End Stage Renal Disease Program</td>
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<td>• Pre-Op Clinic</td>
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<td>• Pulmonology</td>
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<td>• Smoking Cessation</td>
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<td>• Togetherness Program</td>
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<td>• Transition of Care Program</td>
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<td>• Routine Podiatry</td>
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<td>• Wound Care</td>
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Programs and services offered at each CareMore Care Center vary by location. Please contact your local CareMore Care Center for a list of programs available at their location. You can also access this information on the provider portal.

**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 into our disease management programs and services to support their care. The assessment is conducted by a specially trained clinical team at the patient’s local CareMore Care Center. The interdisciplinary team is composed of doctors, Nurse Practitioners, Dietitians, 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 Centers.

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 PCP.

**Healthy Journey**

All existing CareMore Health patients are encouraged to complete an annual assessments 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 health status. Any new health concern captured at this visit is immediately address 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 PCP to support the on-going care provided at their practice.

**Extensivist Program**

CareMore Health has an Extensivist Program that serves as the admitting and attending physicians for CareMore Health patients. Extensivist are on-call 24 hours a day, seven days a week. They will manage any CareMore patient admitted to any of 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 Extensivist 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 Extensivist 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.
CASE MANAGEMENT

Our Case Management team is another level of support that you can count on to help you with patients who have complex medical needs. This team has trained health care professional with the skills, experience and compassion to help you and your patients in accessing necessary medical and mental health services.

In coordination with the PCP and local CareMore Health Clinical team, the case manager works with patients, families and caregivers to provide long-term, comprehensive care coordination to identified patients who are at risk of less than optimal outcomes in any setting. The Case Management Team does this by establishing and coordinating care plans, performing on-going evaluations, and providing education to patients, their families, and/or caregivers tailored to patient need(s). In doing so, the team is able to decrease fragmentation of care across the continuum, and ensure appropriate provision of cost-effective quality care. This is accomplished by ongoing communication to all involved clinicians, including the PCP, specialists, and Extensivist.

CareMore Health Case Management can be involved with patients for short term needs, such as identifying community resources or assistance with transportation needs or can be involved on a long–term basis to support patients with complex medical and psychological needs.

Program Components

There are several different components within the CareMore Health Case Management Program. Each component focuses on different aspects of patient care needs but all are focused on support and assistance to patients, families and caregivers to maintain patients at the optimal level of health and wellbeing. The CareMore Health Case Management components include, but are not limited to:

- Education and management of disease processes in the ambulatory setting
- Coordination of care across the care delivery, such as direct admits to acute inpatient or skilled nursing facilities if warranted, or arranging for home health services if indicated
- Support and management at the time of transition from an acute admission to another level of care, whether skilled or home
- Follow-up with Patients in the CareMore Care Centers at the time of their first post-discharge appointment after a hospital stay
- Outreach after an ER visit to support patient care in the PCP office or Care Center to prevent or reduce further ER visits
- Management of Patients admitted to non-contracted hospitals and coordination of care back within the CareMore Health network
- Establishing and coordinating care plans, performing on-going evaluation and assessments to meet the individual patient needs
- Improving continuity of care and appropriate benefit application, including but not limited to dialysis
End of life support to enhance comfort and improve the quality of patient’s life

CareMore Health has additional programs to help support the high risk population. In these programs, the Case Manager and providers (such as a Social Worker and Nurse Practitioner) work with the high risk physician to ensure patients at greatest risk are identified and managed through the end of care.

Role of Case Managers

CareMore Health case managers are responsible for long-term care planning and for developing and carrying out strategies to coordinate and integrate the delivery of medical and long-term care services. Our Case Management Department is dedicated to helping patients obtain needed services. Each patient is assigned to a Case Manager and care coordinator to assist them with every level of care needed to help them manage their condition(s).

Please contact the Case Manager team for changes in a patient’s status or questions regarding services, authorization for service or other issues pertaining to patient’s needs.

Case Management Interventions

Case management interventions can be performed by:

- Face-to-face encounters with the patient and/or family at our local CareMore Care Centers
- Telephonic follow-up with the Patient by a Case Manager
- Educational materials
- Communication with service Providers
- Coordination and integration of acute and long-term care services
- Communication within interdisciplinary care team meetings

CLINICAL CARE PROGRAMS

Primary care providers serve as the frontline player in our care model. We serve as your extension, supporting patients with extra health services to keep them healthy. Our clinical care programs offers your patient’s additional care by specially trained CareMore Health clinicians to foster an ongoing relationship between CareMore Health and the patient suffering from serious and chronic conditions. Our program are designed to address every aspect of their condition. The goal is to use high quality health care and practical solutions to improve patient’s health and keep them in their communities, with the resources necessary to maintain the highest possible functional status.

This collaborative and comprehensive care approach allow us to closely monitor their condition and provide the necessary intervention to prevent any unnecessary hospitalizations or ER visits. All patient’s encounter documentation from the Care Center Clinician will be shared with the PCP.

Patients may self-refer to any CareMore Health Program. Primary care provider and/or Extensivist are responsible for initiating or discontinuing treatment.
Clinical Care programs available to CareMore Health patients:

**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.

**Chronic Kidney Disease Program**

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

**Chronic Obstructive Pulmonary Disease (COPD) Program**

The COPD Program provides support for those living with lung disease such as asthma, chronic bronchitis, emphysema and COPD. The program provides patients with self-management techniques that can be applied immediately to their daily routine.

**Congestive Heart Failure (CHF) Care Program**

The CHF Care Program is designed for patients who have been diagnosed with congestive heart failure (CHF). CareMore Health helps these patients manage their CHF through medications, maintenance of appropriate weight levels, dietary guidance and physical activity. Patients receive education on how to manage their condition. The care team also works closely with the patient’s cardiologist. 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.

**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 dietary management.

**Exercise and Strength-Training Program**

The CareMore Health Exercise and Strength Training program, available through the Nifty After Fifty Fitness center, provides strength and balance training for those patients who would benefit from increased muscle strength. Both types of training aim to improve our Patients’ level and duration of independence.

**Togetherness Program**

This program is designed to support any patient dealing with loneliness due to lack of social or family support. The program connects patients with community resources and works with them...
to integrate them back in the community to decrease any social isolation.

**Fall Prevention Center**

This program targets patients who are predisposed to fall or who have fallen. It provides patient assessment, education and multi-systemic examination to determine reason for fall or predisposition to fall and works to reverse and/or reduce the risk of future falls.

**Foot Care Program**

CareMore Health’s Foot Care program provides medical podiatric care and routine podiatry (e.g. nail clipping and callous removal) to CareMore Health patients.

**Hypertension Program**

This program manages patients with uncontrolled hypertension through education and the monitoring of their blood pressure. 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.

**Transition of Care Program**

This program offers our patients a home visit or visits by a clinician following an inpatient stay in the hospital. Upon discharge, the attending extensivist identifies frail patients and the home visit(s) is arranged. The clinician’s visit includes assessing the patient’s condition at home, catching early signs of recurrent illness, and making sure the patient is taking medications properly.

**Pre-Op Clinic**

This is a clinical assessment of patients scheduled for surgery. A medical history is taken and a physical exam is performed to, as best as possible, identify potential medical complications. The goal of the clinicians in the Pre-Op Center is to, as best as possible, ensure the patient’s ability to undergo surgery without complications.

**Memory Care Program**

The Memory Care Program is designed to support patients diagnosed with Alzheimer’s or other memory loss condition. The program support patients and caregivers through the progression of their condition.

**Transitional 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 and
provides these services across multiple sites of care including skilled nursing facilities, the CareMore Care Centers and in the home.

**Touch Management Program**

The Touch Management Program provides care to CareMore Health patients 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 a contracted skilled nursing facility, assisted living facility, board and care home, group home, and adult care home. Patients who qualify receive regular onsite visits from a mid-level provider 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 and x-rays, wound care management and supplies, and the clinical management of chronic diseases and conditions.

**Wound Care Center**

Our Wound Care Center effectively manages acute and chronic wounds utilizing wound care products as well as addressing underlying medical issues that can impact healing. Patients are educated on self-care management techniques that includes foot checks, management of underlying medical problems, and signs/symptoms of when to call the CareMore Care Center by our Advanced Practice Clinicians at the wound clinic.

**HEALTH EDUCATION PROGRAMS**

**Health Education**

To support the care you provide to our patients and assist you in meeting their educational needs, CareMore Health offers a variety of Health Education Services and Programs, including health education materials. These programs are available at our CareMore Care Centers.

**Health Education Services**

Health education services include:

- Group Classes:
  - Diabetes
  - COPD
  - Heart Disease
  - Chronic Kidney Disease
- One-on-one counseling
- Medical Nutrition Therapy with a registered dietician

Process for referring a CareMore Health patient to Health Education Services:

- Obtain agreement for a referral to Health Education from the patient
- Stress compliance as part of the patient’s overall care plan
• Document the referral in the patient’s medical record
• Reinforce key concepts and compliance with patient at follow-up office visits

**Health Education Materials**

CareMore Health uses patient education materials that are culturally appropriate for various target populations in key subject areas. All materials are written at the sixth grade reading level or below to meet the literacy needs of patients with low health literacy. The most appropriate setting for a patient to receive written literature is from his or her Provider. To maximize the health message in health education handouts, we encourage you to have a brief discussion on the importance of this information.

Health education materials are available on a variety of topics including:

- Alcohol use
- Asthma
- Cholesterol
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart health
- Hypertension
- Injury prevention
- Flu and pneumonia vaccinations
- Medication safety
- Living well with mental health illness
- Nutrition
- Physical activity and fitness
- Weight management
- Preventive care

Materials are available in multiple languages and can be accessed through the provider portal.

**Newsletter**

A CareMore Health newsletter is sent to patients monthly containing a variety of required health education topics. A disclaimer is printed on the newsletter informing the patient that the content is for information only and does not take the place of Provider advice.

**Individual Health Education and Behavioral Assessment (IHEBA) (Cal MediConnect only)**

Primary Care Providers are responsible for administering the Individual Health Education Behavioral Assessment (also called “IHEBA” or “Staying Healthy”) for new patients within 120 days of enrollment as part of their initial health assessment for each Cal MediConnect patient. For existing patients, the assessment must also be completed at their next non-acute care visit and when entering into a new
age category. Patients should be encouraged, when appropriate, to complete the IHEBA on their own. PCPs are required to review the completed assessment with their patients and provide need-based counseling and health educations service referral.

Providers can access the age-appropriate IHEBA tools and educational tips ships in all threshold languages through the provider portal.

**Tobacco Prevention and Cessation Services (Cal MediConnect only)**

All providers are required to identify and track all tobacco use, both initially and annually. This must be performed by doing the following:

- Completing the Individual Health Assessment, which includes the IHEBA, for all new beneficiaries within 120 days of enrollment.
- Annually assess tobacco use status for every Cal MediConnect patient based on the IHEBA periodicity schedule.
- Ask tobacco users about their current tobacco use and document in their medical record at every visit.

If a CareMore Health patient has questions regarding our services and programs, please direct them to call Member Services.

**NON-EMERGENT TRANSPORTATION**

CareMore Health patients may have access to transportation services as part of their benefits. CareMore Health may coordinate these services for certain health plan members. We can work with the provider or the patient to coordinate transportation services. Please contact Member Services to find out if a patient has access to transportation services for their medical appointments.
PROVIDER RESPONSIBILITIES OVERVIEW

This section outlines general provider responsibilities, however, throughout the manual we cover additional responsibilities. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. 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)

Providers are responsible for providing appropriate primary and preventive care to CareMore Health patients and coordinate specialty referrals and inpatient care.

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, 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 members to out-of-network specialty providers
- 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

**Specialty Providers**

A specialty provider 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 specialist. 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.

**CONTINUITY OF CARE**

Continuity and coordination of care is ensured through the offering of a health care professional, (the Primary Care Physician) who is formally designated as having primary responsibility for coordinating the patient’s overall health care.

The Primary Care Physician (PCP) has the responsibility and authority to direct and coordinate the patient’s services.

The primary care medical record is designated to receive and contain documentation of all care and services rendered to the patient by the PCP, specialists, inpatient care and ancillary services.

- This includes any documentation of care/services provided regarding mental health and/or substance abuse, providing the patient has authorized the mental health/substance abuse provider to disclose that information.
- Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers.

The day-to-day activity of continuity of care is conducted by the health plan.

Each patient is ensured an ongoing source of primary care through this mechanism.

When a patient chooses a new PCP within the same network, the medical records are transferred to the new provider.

Patient information will be shared with any organization with which the patient may subsequently enroll, upon patient request.

New patient information provided by the health plan is assessed by the Case Management or Utilization Management Department for continuity of care.
Continuity of care issue may include but not be limited to:

- Ongoing DME in use in the patient’s home by the patient (e.g., wheelchair, hospital bed, oxygen, etc.)
- Open authorizations to specialty or diagnostic testing services (e.g., MRI, PT, Specialty consultation/follow-up visits, etc.)
- Specialty care being provided to the patient on an ongoing basis (e.g., patient with HIV under the care of Infectious Disease practitioner; ESRD patient undergoing dialysis, pregnant patient under an OB’s care, etc.)
- Other issues (e.g. patient out of area 3 months out of the year, patient resides in a custodial care facility, etc.)

Any issues identified are communicated to the appropriate entity:

- Primary Care Physician on record is notified via letter of the specific continuity of care issue and given suggested resolution, when indicated.
- Other issues are communicated to the appropriate individuals, as appropriate.

Medicare-Medicaid Plan (MMP) have additional continuity of care rights. Please refer to Cal MediConnect Addendum.

**Delivery of Primary Care**

After selecting their PCP, it is important that the Patient establish an ongoing relationship with their personal primary care provider.

The Patient will be encouraged to make an appointment with their new PCP in order to establish a care plan and address any existing health care needs. Primary care services will be available according to CareMore Health’s established access and availability standards. (See Primary Care Provider Access and Availability.)

When urgent services are not available from the patient’s PCP and the patient requires care while in the local area, the PCP will arrange/refer the patient to the appropriate source for care within the network.

If the patient is outside the service area, the PCP may recommend the appropriate level of care, but the final decision as to where to obtain services for the urgent care needs will reside with the Patient or a responsible caregiver.

Emergency services are available without prior authorization through the Emergency Medical Services system (911) or through an emergency room either within or outside the service area.

**Coordination of Services**

A health care professional, usually the PCP or designee, has the primary responsibility for evaluating the patient’s needs before recommending and arranging the services required by the patient. This PCP/designee is also responsible for facilitating communication and information exchange among the different Providers/practitioners treating the Patient.
The PCP/designee will ensure that all referrals contain sufficient clinical information for the specialist/diagnostician to make a decision regarding the treatment of the Patient.

The PCP/designee will ensure that all specialty consultation reports are received and filed promptly in the Patient’s medical record.

Providers will request information from other treating Providers as necessary to provide care.

Each practitioner participating in the patient’s care will give information on available treatment options (including the option of no treatment) or alternative courses of care and other information regarding treatment options in a language that the patient understands. This information should include:

- The patient’s condition
- Any proposed treatments or procedures and alternatives
- The benefits, drawbacks and likelihood of success of each option
- The possible consequences of refusal of care or non-compliance with a recommended course of care.

Patients are involved in the planning and implementation of their care including any mental health or substance abuse problems, chronic illnesses or those patients at the “end of life”.

Patients who are unable to fully participate in their treatment decisions may be represented by parents, guardians, other family members or other conservators, as appropriate, and per the Patient’s wishes. Minors can be represented by their parents. Advance directives may dictate who can represent the Patient, and family members with power of attorney can represent patients unable to represent themselves.

The determination as to who represents those patients who are unable to fully participate in their treatment decisions will be made based on the law and the circumstances.

**AUTHORIZATION OF SERVICES**

Services should be recommended by the PCP or the Specialty Care Provider (SCP) as appropriate. Patients have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP.

The services may require approval through CareMore Health’s utilization management system

- Some of the services may be obtained via self-referral as described in the Members Evidence of Coverage (EOC)

Whenever possible, services will be coordinated through community and social services that are available through both contracted and non-contracted providers in the designated service area.

Patients who are unable or unwilling to participate in their own care will be assessed through case management and appropriately counseled and given all of their health care options in order to be channeled into the most appropriate community agencies.
The areas where patients need to be able to fully participate in their care include, but are not limited to the following:

- Self-care
- Medication management
- Use of medical equipment
- Potential complications and when those should be reported to providers
- Scheduling of follow-up services
- Patient education, especially as it relates to discharge planning.

**TRANSITION OF CARE**

*Transition of Care When Benefits End*

CareMore Health Case Management staff will provide assistance to patients in the transition of their care.

- When coverage of services ends while a patient still needs care, the patient must be offered education on the alternatives to continuing care and how to obtain that care.

*Terminated Provider - Transition/Continuity of Care*

In order to provide for the continuity of care during the transition of patients from a terminated practitioner to a contracted practitioner, with minimum disruption to the patient’s healthcare, coverage to continue care with a non-participating practitioner for a transitional period will be provided, when appropriate.

CareMore Health allows for continued access when a practitioner’s contract is discontinued for reasons other than professional review actions, utilizing at a minimum:

- Continuation of treatment through the lesser of the current period of active treatment for patients undergoing active treatment for a chronic or acute medical condition.
- Active course of treatment – treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

CareMore Health assists the patient in selecting a new provider.

The terminating physician will be requested to transfer all medical records to the receiving physician by contacting the patient and obtaining a “Release of Medical Information.”

*Patient Requests Continuity of Care with a Terminated Physician*

If the patient requests continuity of care with a terminated physician, CareMore Health will review the following information:

- Rationale for termination (e.g., physician voluntarily terminated his/her contract,
terminated for business reasons, disciplinary action, etc.)

- Willingness of the physician to agree to continue present contractual agreement if he/she will continue to provide treatment to patients undergoing continuity of care.

There is no obligation by the CareMore Health to continue the provider’s services beyond the contract date if:

- The terminated provider does not agree to comply or does not comply with the same contractual terms and conditions that were imposed upon the provider prior to termination.
- The terminated provider voluntarily leaves the Health Plan.
- The provider’s contract has been terminated for reasons relating to medical disciplinary causes or reasons.

The patient must meet one of the following criteria for continuity of care associated with physician termination:

- Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention with a limited duration.
- Serious Chronic Condition: A medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:
  - Persists without full cure or worsens over an extended period of time.
  - Requires ongoing treatment to maintain remission or prevent deterioration.
- High Risk Pregnancy: A condition identified during the prenatal assessment or during subsequent examinations, which predisposes a women to fetal or maternal compromise.

CareMore Health will document clearly and concisely what services may or may not be provided to avoid patient or physician confusion on what has been authorized and the length of the time period the authorization covers.

**DISCLOSURE OF OWNERSHIP AND EXCLUSION FROM FEDERAL HEALTH CARE PROGRAMS**

As a CareMore Health Provider, you must fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare and Medicaid programs, as described in 42 CFR § 455 Subpart B.

Please familiarize yourself with federal requirements regarding Providers and entities excluded from participation in federal health care programs (including Medicare and Medicaid programs). Screen new employees and contractors to verify they have not been excluded from participation from these
programs, and verify monthly that existing employees or contractors have not been excluded. The Federal Health and Human Services – Office of Inspector General (HHS-OIG) and the GSA Excluded Parties List System (EPLS) prior to the hiring of any employee supporting CareMore Health Medicare Part C or D functions, and monthly thereafter to ensure individuals are not excluded from participation in federal programs. Excluded individuals require immediate removal from CareMore Health Medicare Programs Work.

CareMore Health utilizes the Anthem (and all its affiliates) Compliance Help Line. If you discover any exclusion information, please immediately report to us by calling the Anthem Helpline at 1-877-725-2702.

For questions related to Disclosure of Ownership or Exclusions from Federal Health Care Programs, please contact our Plan Compliance Officer hotline at 1-562-741-4303. Callers may leave a message on voicemail and remain anonymous, if so desired.

**Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance. In 2009, HIPAA was enhanced by the American Recovery and Reinvestment Act’s section on Health Information Technology for Economic and Clinical Health Act (HITECH). Provisions of HITECH improve Patient privacy and security by:

- Requiring patient notification of breaches of unsecured Protected Health Information (PHI) while creating a safe harbor for encrypted electronic PHI and shredded paper PHI.
- Applying certain provisions of the privacy and security rules to business associates.
- Modifying the marketing and fundraising rules.

Information regarding the breach notification rule can be found on the federal Department of Health and Human Services (DHHS) website at:


CareMore Health strives to ensure that both we and contracted participating Providers conduct business in a manner that safeguards Patient information in accordance with the privacy regulations enacted pursuant to HIPAA. Effective April 14, 2003, contracted Providers shall have the following procedures in place to demonstrate compliance with the HIPAA privacy regulations.

We recognize our responsibility under the HIPAA privacy regulations to request from Providers the minimum Patient information necessary to accomplish the intended purpose. Likewise, network Providers should request only the minimum necessary patient information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of Patient information, such as a patient’s medical record. We may request this information in order to:
¶ Conduct business and make decisions about care
¶ Make an authorization determination
¶ Resolve a payment appeal

Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically-sensitive information should be maintained in an environment where access is restricted to individuals who need patient information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at CareMore Health and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing patient information to us (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, post office box or CareMore Health department.

Our voice mail system is secure and password-protected. When leaving messages for our associates, please leave the minimum amount of patient information that is necessary to accomplish your intended purpose of the call.

When contacting us, please be prepared to verify your name, address and Tax Identification Number (TIN) or National Provider Identifier (NPI) numbers.

Providers shall agree to maintain the confidentiality of patient information and information contained in a patient's medical records in accordance with applicable laws including Health Information Privacy and Accountability Act (HIPAA) standards. Unless otherwise allowed by HIPAA, HIPAA prohibits a Provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority and will only release such information as permitted by applicable federal, state and local laws and that is:

¶ Necessary to other Providers and is related to treatment, payment or health care operations; or
¶ Upon the patient’s signed and written consent

**Misrouted Protected Health Information**

Providers and facilities are required to review all patient information received from CareMore Health to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about patients that a Provider or facility is not treating. PHI can be misrouted to Providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or facilities permitted to misuse or re-disclose misrouted PHI. If Providers or
facilities cannot destroy or safeguard misrouted PHI, please contact Provider Relations.

**Security**

Medical records must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the Provider’s office, CareMore Health, a federal or state regulator, or to persons authorized through a legal instrument.

Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

**Storage and Maintenance**

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic record keeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to ensure that recorded input is unalterable.

**Availability of Medical Records**

The medical records system must allow for prompt retrieval of each record when the patient comes in for a visit. Providers must maintain patients' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective professional medical review and medical audit processes

Medical records must be legible, signed and dated.

Providers must offer a copy of a patient’s medical records upon reasonable request by the patient at no charge, and the provider must facilitate the transfer of the patient’s medical records to another provider at the patient’s request. Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit CareMore Health and representatives of a federal or state regulator to review patients’ medical records for the purposes of:

- Monitoring the provider’s compliance with medical record standards
- Capturing information for clinical studies or HEDIS
- Monitoring quality
- Any other reason
MEDICAL RECORDS DOCUMENTATION

CareMore Health requires providers to maintain medical records in a manner that is current, organized and permits effective and confidential patient care and quality review. We perform medical record reviews of all PCPs upon signing of a contract and, at a minimum, every three years thereafter to ensure that network Providers are in compliance with these standards.

Confidentiality of Information

Providers shall agree to maintain the confidentiality of patient information and information contained in a patient's medical records in accordance with applicable laws including Health Information Privacy and Accountability Act (HIPAA) standards. Unless otherwise allowed by HIPAA, HIPAA prohibits a provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority and will only release such information as permitted by applicable federal, state and local laws and that is:

- Necessary to other providers and the health plan related to treatment, payment or health care operations; or
- Upon the patient’s signed and written consent

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- Monitoring the provider’s compliance with medical record standards
- Capturing information for clinical studies or HEDIS
- Monitoring quality
- Any other reason

**Medical Record Documentation Standards**

Every medical record is, at a minimum, to include:

- The patient’s name or ID number on each page in the record
- Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day, and year
- All entries contain the author’s identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all providers participating in the patient’s care, and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on Advance Directives
- Past medical history, including serious accidents, operations, illnesses, and substance abuse
- Physical examinations, treatment necessary and possible risk factors for the patient relevant to the particular treatment
• Prescribed medications, including dosages and dates of initial or refill prescriptions
• Information on the individuals to be instructed in assisting the patient
• Medical records must be legible, dated, and signed by the physician, physician assistant or nurse practitioner providing patient care
• Appropriate immunization history
• Documentation attempts to provide immunizations. If the patient refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the patient or guardian shall be documented in the patient’s medical record
• Evidence of preventive screening and services in accordance with CareMore Health preventive health practice guidelines
• Documentation of referrals, consultations, diagnostic test results, and inpatient records.
• Evidence of the provider’s review may include the provider’s initials or signature and notation in the patient’s medical record of the provider’s review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information
• Notations of patient appointment cancellations or “No Shows” and the attempts to contact the patient to reschedule
• No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure
• Documentation on whether an interpreter was used, and, if so, that the interpreter was also used in follow-up

Provider Training

CareMore Health offers a variety of self-paced required training to our network providers. You can access these trainings through the CareMore Health website at [www.caremore.com](http://www.caremore.com). If you have any questions on any of these trainings you can contact Provider Relations.
**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>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Exam</strong>: Serious condition requiring immediate intervention-no authorization</td>
<td>Immediately</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>
<td>Less than 24 hours of patient request for an appointment</td>
</tr>
<tr>
<td><strong>Non-urgent (PCP)</strong></td>
<td>Within 7 calendar days of patient request for appointment</td>
</tr>
<tr>
<td><strong>Adult Health Assessment</strong>: Unless a more prompt exam is warranted that is termed “urgent”</td>
<td>Within 30 calendar days of patient request for appointment</td>
</tr>
<tr>
<td><strong>Non-Urgent Consult/Specialist Referral</strong></td>
<td>Within 14 calendar days of patient request for appointment</td>
</tr>
<tr>
<td><strong>Waiting time in practitioner’s office</strong> excludes walk-in/same day appointments</td>
<td>30 minutes or less</td>
</tr>
<tr>
<td><strong>After-hours access</strong></td>
<td>Answering service or answering system with an option to page a practitioner or provides instructions for further care access, to include calling 911 or present to the nearest Emergency Room for serious medical conditions</td>
</tr>
<tr>
<td><strong>Behavioral Health non-life threatening emergency</strong></td>
<td>Within 6 hours of patient request for appointment</td>
</tr>
<tr>
<td><strong>Behavioral urgent care</strong></td>
<td>Within 48 hours of patient request for an appointment</td>
</tr>
<tr>
<td><strong>Behavioral Health routine office visit</strong></td>
<td>Within 10 business days of a patient request for an appointment</td>
</tr>
</tbody>
</table>
SECTION VI: CLAIMS PROCESSING
GUIDELINES

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

We encourage the submission of claims electronically through Office Ally™. 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

Strategic National Implementation Process (SNIP) Compliance Levels

In January 2009, the U.S. Department of Health and Human Services published final rules requiring the health care industry to upgrade electronic standard transactions under HIPAA to version 5010 and support the international classification of diseases version 10 (ICD-10) for diagnosis and hospital inpatient procedure coding.

The new rules apply to the health care industry – health plans, hospitals, doctors and other health care professionals – and impact others who currently use the HIPAA version 4010 to transmit data. The implementation date for version 5010 was January 1, 2012.

CareMore Health will conduct compliance checks for SNIP Levels 1 through 5 for claims transactions sent as an 837I (institutional electronic claim) and 837P (professional electronic claim).
PAPER CLAIMS

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare and Medicaid Services standards.
- Use black or blue ink (do not use red ink, as the scanner may not be able to read it).
- Use the “Remarks” field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to CareMore Health, and retain a copy for your records.
- Separate each individual claim form. Do NOT staple original claims together; CareMore Health will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form; leave a ¼-inch border on the left and right side of the form after removing perforated sides. This helps our scanning vendor scan accurately.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Don’t highlight any fields on the claim forms or attachments; doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use “draft mode” since the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following Provider information:

- Provider name
- Rendering Provider Group or Billing Provider
- Federal Provider Tax Identification Number (TIN)
- The CareMore Health Payer Identification Number
- National Provider Identifier (NPI)
- Medicare number

**Please Note:** Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper:

CareMore Health
Attn: Claims Department
P.O. Box 366
Artesia, CA 90702-0366
CLAIMS PROCESSING TIMELINES

Claims are processed from the date of receipt and per your agreement and/or contract with CareMore Health.

Additional Payer

A determination should be made as to whether an additional payer has primary responsibility for the payment of a claim. If CareMore Health finds that another payer is responsible for payment, we will coordinate benefits with that payer. With the payment from the primary carrier and CareMore Health, you will be paid up to the amount allowed in your Agreement with CareMore Health.

PAYMENT POLICY

CareMore Health currently uses a comprehensive nationally recognized code auditing system to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards.

Claims will be reviewed to:

- Reinforce compliance with standard code edits and rules
- Ensure correct coding and billing practices are being followed
- Determine the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Ensure compliance with industry standards

Correct coding guidelines are establish by:

- The Centers for Medicare and Medicaid Services (CMS)
- The American Medical Association (AMA) CPT® Coding Guidelines
- National and Local Coverage Determinations (NCD/LCDs)
- National specialty and academy guidelines

CLAIMS TIMELY FILLING LIMITS

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

Determine filing limits as follows:

- If CareMore Health is the primary payer, use the length of time between the last date of service on the claim and CareMore Health’s receipt date.
- If CareMore Health is the secondary payer, use the length of time between the other payer’s notice or Remittance Advice (RA) date and CareMore Health’s receipt date.

**Please Note:** CareMore Health is not responsible for a claim never received. Additionally, if a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing
To avoid missing deadlines, submit “clean” claims as soon as possible after delivery of service.

CareMore Health does not reimburse claims submitted more than one year after the date of service. Providers who have questions about claims submittal timelines should call Provider Customer Service at 1-800-300-7011.

**Other Filing Limits**

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Time Limit to File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Party Liability (TPL) or Coordination of Benefits (COB)</td>
<td>If the claim has TPL or COB and requires submission to a third party before submitting to us, the filing limit starts from the date on the notice or Remittance Advice (RA) from the third party.</td>
<td>From the date of notice or RA from the third party, follow the applicable claim filing limits.</td>
</tr>
<tr>
<td>Checking Claim Status</td>
<td>Claim status may be checked any time on providers.caremore.com, or by calling the Provider Customer Service Team.</td>
<td>[TRACER will not be picked up and will automatically be denied as a duplicate] Within contract filing limit.</td>
</tr>
<tr>
<td>Claim Resubmittal</td>
<td>To submit a corrected claim following CareMore Health’s request for more information and/or correction to a claim.</td>
<td>Provider must return request information to the CareMore Health within 45 days from the date of the Plan's request for correction.</td>
</tr>
<tr>
<td>Non Contracted Provider Dispute</td>
<td>Providers may request claim reconsideration in writing.</td>
<td>The request for claim reconsideration must be received within 365 days from the receipt of the CareMore Health’s RA.</td>
</tr>
<tr>
<td>CareMore Health’s Response to Provider Dispute Resolution Request</td>
<td>CareMore Health’s response time to investigate and make a determination based on guidelines.</td>
<td>Determination is made within 60 business days from CareMore Health’s receipt of dispute or amended dispute.</td>
</tr>
</tbody>
</table>
CLAIMS AND ENCOUNTER DATA INQUIRIES

**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 Office Ally and include:

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

**Provider Inquiry**
A telephone call for information, including questions, regarding the following:

- Claim status
- Submission of corrected claims
- Patient eligibility
- Payment methodology rules (bundling/unbundling logic, multiple surgery rules)
- Medical policy
- Coordination of benefits
- Third party liability/workers compensation issues submitted by a provider to CareMore Health
- A telephone discussion or written statement questioning the manner in which CareMore Health processed a claim (e.g., wrong units of service, wrong date of service, clarification of payment calculation)

Claims processing errors should be brought to the attention of the Claims Department as soon as possible so that the claim(s) may be corrected. These types of errors may be submitted to Provider Customer Services.

**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.

**Claim Payment Options offered through Change Healthcare**

**Change Healthcare:**

**[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 transaction into existing Point of Service terminal and the funds are deposited to the provider’s existing merchant account. Remittance advices are securely faxed to providers.

**OVERPAYMENT PROCEDURES**

CareMore Health seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, CareMore Health initiates the overpayment recovery process by sending written notification.

If you are notified by CareMore Health of an overpayment, or discover that you have been overpaid, mail the check, along with a copy of the notification or other supporting documentation within 30 days to the following address:

CareMore Health  
Attn. Claims Recovery MS 6110  
P.O. Box 366  
Artesia, CA 90702-0366

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CareMore Health  
2019 Provider Manual  
[https://www.caremore.com](https://www.caremore.com)
If CareMore Health does not hear from you or receive payment within 60 days, the overpayment amount is deducted from future claims payments.

**PROVIDER PAYMENT DISPUTES**

CareMore Health has established fair, fast and cost-effective procedures to process and resolve Provider Disputes. The following definitions apply to this process:

*Provider Dispute Resolution Is:*

- Contracted provider contending that the amount paid by CareMore Health for a covered service that is less than the amount that would have been paid based on the provider’s contract.
- Contracted provider disputing a claim denied by CareMore Health for a covered service.
- Disagreement between a contracted provider and CareMore Health’s decision to pay for a different service than what was billed.

*Provider Dispute Resolution is not:*

- Payment disputes for which no initial determination has been made.

*Provider Payment Dispute – 1st Level*

You have the right to dispute CareMore Health’s initial decision on a previously paid claim. CareMore Health must receive a written request within 120 calendar days from the date of the remittance notification. Once the payment dispute is received and reviewed, you will receive a response within 60 calendar days of our decision.

*Provider Dispute Decision – 2nd Level*

You have the right to dispute CareMore Health’s uphold decision for a provider payment dispute for a previously paid claim. CareMore Health must receive a written request within 180 calendar days from the date of the uphold notification. Once the dispute is received and reviewed, you will receive a response within 60 calendar days of our decision.”

*Requirements for Filing a Provider Dispute*

A written notice to CareMore Health, submitted to the designated Provider dispute address should include the following:

- Copy of the original claim
- Remittance notification
- Justification for reimbursement
- Clinical records and other documentation that supports the justification for reimbursement
COORDINATION OF BENEFITS

When a patient is assigned to CareMore Health, we will ask the patient whether he/she has healthcare insurance other than CareMore Health. Providers should always inquire whether a patient has other health insurance coverage. For those patients who are over 65 years of age and retired, CareMore Health will generally be the primary payer.

When CareMore Health is the primary payer, the provider may bill the secondary carrier for usual and customary fees and receive reimbursement in addition to that received from CareMore Health.

Please note: a patient may not be billed for any balance due. CareMore Health will be the secondary payer in the following situations:

- The patient is age 65 or older and has coverage under an employer group health plan through an employer with 20 or more employees, either through the patient’s own employment or the enrollee's spouse's employment.
- The patient is under age 65 and is entitled to Medicare due to disability other than ESRD, and the patient has coverage under a large employer (100 or more employees) group health plan, either through the patient's own employment or that of their spouse.
- The patient is being treated for an accident or illness that is work-related or otherwise covered under Workers' Compensation.
- The patient has End Stage Renal Disease (ESRD) and is covered under an employer group health plan. In such cases, CareMore Health will be the secondary payer for up to 30 months. After 30 months, Medicare will be the primary payer.
- The Patient is being treated for an injury, ailment, or disease caused by a third party and automobile or other liability insurance is available.

Questions regarding COB can be directed to Provider Customer Service.

CLAIMS FILED WITH WRONG PLAN

If you file a claim with the wrong insurance carrier, CareMore Health will process your claim without denying it for failure to file within the filing time limits if:

- There is documentation verifying that the claim was initially filed in a timely manner.
- The corrected claim was filed within 90 days of the date of the other carrier’s denial letter.
CareMore Health has a Utilization Management (UM) Program that defines structures and processes and assigns responsibility to appropriate individuals. The mission of this program is to:

- Ensure consistent delivery of quality health care and optimum patient outcomes; and
- Provide and manage coordinated, comprehensive, quality health care, without discrimination toward any individual and in a culturally competent manner

The purpose of the UM Program is to provide a process in which prior authorization (PA) review of inpatient and outpatient services are performed in accordance with health plan and regulatory/accreditation agencies. This process ensures the delivery of medically necessary and quality patient care through appropriate utilization of resources in a cost-effective and timely manner.

The UM Program’s focus is to ensure efficiency and continuity of this process by identifying, evaluating, monitoring and correcting elements which may impact the overall effectiveness of the UM process. The Program’s activities are developed and approved, through the Utilization Management (UM) Committee and the CareMore Health Board of Directors.

The Program is reviewed on an annual basis and revised when appropriate. All revisions are approved by the UM Committee and the CareMore Health Board of Directors.

Goals and objectives of the UM Program include, but are not limited to:

- Ensure appropriate levels of care in a timely, effective and efficient manner
- Monitor, evaluate and optimize health care utilization resources, on a continuous basis, by applying UM policies and procedures to review medical care and services
- Monitor, document and submit for review any potential quality of care concerns
- Monitor utilization practice patterns of contracted Providers and/or their practitioners to identify variations
- Conduct medical review of all potential denials of service for medical necessity
- Approve utilization criteria annually

**MEDICAL REVIEW CRITERIA**

The UM team takes a multidisciplinary approach to meet the medical and psychosocial needs of our patients. Authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM team is evidence-based. These criteria are available to patient, Physicians and other health care Providers upon request by contacting the UM Department.
Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior Authorizations
- Post-Service Clinical Claims Reviews

Decisions affecting the coverage or payment for services are made in a fair, impartial, consistent and timely manner. The decision-making incorporates nationally recognized standards of care and practice from source

- Medicare National Coverage Determinations (NCD)
- Medicare Local Coverage Determinations (LCD)
- Health Plan Clinical Guidelines and Medical Policies
- MCG Clinical Guidelines
- CareMore Health Clinical Guidelines and Medical Policies
- United States Preventive Task Force (USPSTF) Guidelines
- Centers for Disease Control (CDC)
- American College of Physicians (ACP)
- Federal Food and Drug Administration (FDA)
- American Hospital Formulary Services Drug Information
- United States Pharmacopeia-Drug Information
- National Comprehensive Cancer Network (NCCN)
- DRUGDEX Information System (for prescription drugs)

Please Note: We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization.

If you disagree with a UM decision and want to discuss the decision with the physician reviewer, you can call the UM Department

**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
- Fall clinic
- 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 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 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 following 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 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 service 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 request
- Expedited: within 72 hours from receipt of request

Average turn-around-time of service requests is approximately four business days. However, as per 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 a 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.

**Medical Necessity**

Utilization decisions are based on medical necessity as indicated by the supporting clinical documentation, approved criteria and the patient’s health plan benefits. These guidelines are available to contracted Providers and assigned patient upon request. Providers may contact the UM Department and patient may contact Members Services Department.

**Authorization Expiration Timeframe**

The majority of approved authorizations are valid for 365 days from the date the approval was given. The authorized care provided by a specialist must occur within the 365-day period. If the patient is unable to see the specialist within the 365-day period, the referring physician must call the UM Department to request an authorization extension. They may also submit a new Service Request Form via the Provider Portal.

**Unauthorized Care**

The UM Department does not retrospectively review all services that have been rendered without prior authorization. Reviews for retrospective services will need to be submitted through CareMore Claims Department.

During the retrospective review, rendered services are compared to the Evidence of Coverage (EOC) as well as the CMS guidelines for medical necessity, appropriateness of setting and length of stay.
This review process may result in disallowing inappropriate services and the patient may be financially responsible for the cost of the unauthorized service when rendered from a non-contracted provider.

The Provider is responsible for completion of the claims review/appeals process. The patient is not financially liable for any administrative denial related to Provider contract issues and cannot be balance billed.

**Retrospective Review**

The UM Department may review authorized services retrospectively in order to match the preauthorized information with the clinical findings and the services performed. If any discrepancies are discovered during the retrospective review process, UM staff may recommend for non-payment for unauthorized services. Please refer to our provider portal at providers.caremore.com to access our Incidental Code lists for a listing of additional services that will not require a pre-approved request at the time of visit/procedure and not subject to a retrospective review.

**Extended/Standing Referrals**

If a Member’s condition is complex and requires specialist care, the patient may receive authorization for ongoing services by that specialist. The specialist is required to:

- Submit a plan of treatment to the UM Department
- Communicate patient’s progress to their PCP on a regular basis

**INFORMATION FOR SPECIALISTS ONLY**

**Additional Services**

If additional care or diagnostic testing is required, the specialist must submit a Service Request to the UM Department, along with supporting clinical documentation, (e.g., history and physical, diagnostic studies, lab results, treatment to date, and plan of care) to the CareMore Health Utilization Management Department via the On-Line Provider Portal.

The request for authorization will be reviewed by UM staff and the specialist will be notified of the approval to perform the services. If the timeframe of that authorization is exhausted and the specialist determines that additional care is required, a subsequent Service Request must be submitted to UM staff via the online Provider Portal.

**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 his 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.
**New Medical Problem**

If the patient presents with a new medical problem while undergoing treatment, the specialist must submit a Service Request for authorization prior to treating the new problem. There is no need to direct the patient back to his or her PCP for an initial referral. However, if six (6) months or more have passed since the patient’s last visit to the specialist, please refer the patient back to his or her PCP. The PCP will then submit a Service Request Form requesting a referral to the specialist, if appropriate. The service request for evaluation and treatment of a new medical problem will be reviewed by UM staff for medical necessity based on established clinical criteria.

**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.

**MEDICALLY NECESSARY SERVICES**

Medically necessary behavioral health services:

- Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
- Are acceptable clinical guidelines and standards of practice in behavioral health care
- Are available in the most appropriate and least restrictive setting in which services can be safely provided
- Are at the appropriate level or supply of service that can safely be provided
- If omitted, would adversely affect the patient’s mental and/or physical health or the quality of care rendered

Medically necessary health services mean health services other than behavioral health services that are:

- Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a patient or endanger life
- Available at appropriate facilities and at the appropriate levels of care for the treatment of the patient’s health condition(s)
- Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies
- Consistent with the diagnosis of the conditions
No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency

Note: We do not cover the use of any experimental procedures or experimental medications except under certain circumstances.

EMERGENCY ROOM UTILIZATION

Prior authorization is not required for treatment of emergency medical conditions. In the event of an emergency, patients can access emergency services 24 hours a day, 7 days a week. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

“Emergency medical condition” is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- The health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) is placed in serious jeopardy
- The patient will suffer serious impairment to bodily functions
- The patient will suffer serious dysfunction of any bodily organ or part

Emergency service claims are retrospectively reviewed, after all pertinent clinical information is obtained, by the ER Claims Coder and/or Medical Director of Quality Management or Utilization Management for coding appropriateness.

All reviews are performed in accordance with the established emergent diagnosis criteria and as interpreted by a “prudent layperson.” While ER claims are not denied, claims are monitored for physician and patient education relative to emergency services. All patients admitted to non-contracted hospitals will be transferred to contracted hospitals as soon as medically stable. CareMore Health’s Utilization Management Department must be notified of any ER authorizations by the morning of the next business day.

SECOND OPINIONS

A patient, parent and/or legally appointed representative or the patient’s PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the patient.

The second opinion must be obtained from a network Provider (see Provider Directory) or a non-network Provider if there is not a network Provider with the expertise required for the condition. Once approved, the requesting provider will forward copies of all relevant records to the consulting Provider.
We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- If there is a concern about care expressed by the patient or the Provider
- If potential risks or outcomes of recommended or requested care are discovered by the health plan during its regular course of business
- Before initiating a denial of coverage of service
- If denied coverage is appealed
- If an experimental or investigational service is requested

When we request a second opinion, we’ll make the necessary arrangements for the appointment, payment and reporting. We’ll inform the patient and the PCP of the results of the second opinion and the consulting Provider’s conclusion and recommendations regarding further action.

**UM COMMITTEE**

The CareMore Health of Board of Directors has granted the UM Committee the authority to:

- Develop and monitor the UM Program.
- Oversee the activities to develop clinical criteria.
- Serve as an expedited and standard appeals panel, if necessary.
- Communicate with participating physicians, as necessary.

The UM Committee reports to the QM Committee and submits a quarterly report of all activities to the QM Committee for presentation to and approval by the CareMore Health Board of Directors. The Medical Director serves as the chairperson of the UM Committee and presides over the meetings.

The UM Committee is composed of:

- Physician Members, who serve a two-year term on the committee and are either primary or specialty care physicians. There is also a panel of advisors, consisting of board certified physicians in many specialty areas, (i.e., behavioral health) that is available to the Medical Director for consultation, if needed.
- Non-physician Members from Health Care Services, Pharmacy, Member Services and Provider Relations.

This committee meets on a regularly scheduled basis, no less than quarterly to:

- Develop, evaluate and implement the UM Program.
- Assist the QM Committee to develop, implement and monitor clinical guidelines relating to quality of care.
- Investigate, resolve and monitor daily operations relating to UM activities.
- Monitor appropriate levels of healthcare and timeliness of the delivery of healthcare services.
- Review proposed UM policies and procedures for utilization by the clinical and non-clinical staff.
- Review clinical appeals.
- Evaluate new and existing technology.
- Coordinate quality issues with the QM Department/Committee.
Monitor effectiveness of the UM process through patient and practitioner satisfaction survey results.

Provide information for inclusion in the annual UM Work-plan.

Monitor practice patterns of practitioners and Providers from Medical Group (MG)/Independent Physician Associations (IPAs).

Assist the MG/IPA in providing continuing education programs for their practitioners.

Assess pharmacy utilization.

In order to hold a meeting, there must be at least three physicians present. Minutes are maintained for the meeting and all discussions are considered confidential.

UM Management develops and the UM Committee approves a work-plan for the year, which outlines the Program activities and corresponding timeframes for progress and completion dates. This work-plan, along with monthly, quarterly or semi-annual reports which focus on measuring progress toward the goals, is then presented, along with the UM Committee and the CareMore Health of Directors for review and approval.

On an annual basis, the UM Committee performs a retrospective evaluation of its activities to measure the performance achievements and activities for the year. If goals and objectives are not met, changes are recommended to the subsequent UM Program/Work-plan. This annual evaluation is also presented to the UM Committee and the CareMore Health Board of Directors for review and approval.
OVERVIEW

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.

The CareMore Health Pharmacy Department has expanded our services to include increased engagement with both patients and physicians. This includes neighborhood based patient-facing roles to work with the challenged population whose advanced disease states are complicated by low health literacy, reduced access to care, an abundance of physical and mental impairments, and significant social barriers. Patients are seen at the CareMore Care Centers under a collaborative practice agreement and the primary care physician is notified of any changes within 24 hours.

The literature is filled with articles indicating clinical pharmacists in ambulatory clinics provide clinical expertise that promotes the use of evidence-based therapies. Our pharmacists’ interventions are not only designed to keep the patient well, but also to improve adherence and reduce copayments and overall healthcare expenses. These interventions include elimination of duplicate therapy, increasing generic usage, improving quality metrics such as HEDIS/STARS measures, improving medication adherence, and ensuring patients are treated using evidence-based medicine.

AMBULATORY CARE PHARMACIST

Core Duties of Ambulatory Care Pharmacists

1. Pharmacy collaboration with care center providers to increase evidence-based medicine
2. Drug regimen review for CareMore Health patients at home and in skilled nursing facilities
3. Medication Reconciliation Post Hospital Discharge
4. High risk patients as stratified through population health analytics
5. Cost Containment
6. Diabetic patients with A1C ≥10.5% (HEDIS)
7. Patients with HTN ≥140/90mmHg and 3 or more prescriptions (HEDIS)
8. Polypharmacy defined as patients with 10 or more chronic medications
9. Regular in-services by CareMore Care Center pharmacists to the other providers on the Medicare formulary, clinical guidelines, and pharmacy initiatives to enhance quality care
10. Collaboration with primary care physician groups to implement department initiatives relating to improved health outcomes and reduction in pharmacy drug spend
Prior Authorization/ Exception Requests

Prior authorization/exception requests are used for formulary drugs that require a Prior Authorization or to request non-formulary drug coverage. For drugs that have coverage rules or have limits on the amount that a patient can get, please refer to the Health Plan’s Formulary List. Requests may be sent to the PBM (Pharmacy Benefit Manager) to coordinate Prior Authorization with your patient’s Health Plan.

NOTIFICATION OF FDA RECALLS

The Health Plan’s Pharmacy Benefit Manager will notify you and any affected patient of any Food and Drug Administration (FDA) recalls that may impact existing patients. If a drug is taken off the market and is not safe for your patient to take or the drug’s manufacturer takes a drug off the market, the Health Plan will remove it off the Drug List and inform the Prescriber in advance of the changes to the Formulary Drug list.

PART B MEDICATION PATIENT COST SHARE

As a contracted CareMore Health Provider, you may need assistance in providing coinsurance information to your patients. CareMore Health’s authorizations do not include the patient’s cost share for Medicare Part B drugs. Upon request, we will provide the coinsurance so that your office staff may inform your patients.

If you are accustomed to serving Medicare Fee-For-Service patients, your office staff may be familiar with determining a patient’s cost sharing responsibility. To assist in the calculation, please visit the following links:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.html
  OR

If you need assistance in understanding how to calculate the copayment for Medicare Part B Medications, please the Pharmacy Department.
SECTION IX: FRAUD WASTE AND ABUSE
FRAUD, WASTE AND ABUSE DETECTION

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 member 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 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.
SECTION X: QUALITY MANAGEMENT
QUALITY MANAGEMENT PROGRAM

CareMore Health has a Quality Management (QM) Program that defines structures and processes and assigns responsibility to appropriate individuals. The mission of this program is to:

- Ensure continuous quality improvement; and
- Provide for quality health care and optimal patient outcomes

The purpose of this program is to provide an ongoing, integrated program committed to the delivery of optimal care consistent with current medical science capability. The program is designed to ensure that the responsibility to patients is fulfilled throughout the health care delivery continuum.

The focus of the program is to demonstrate a consistent endeavor to deliver safe, effective and optimal patient care and services in an environment of minimal risk. This focus includes delivering activities that have both a direct and an indirect influence on the care and service delivered to patients.

The QM Program’s activities are developed and approved, through the Quality Management (QM) Committee, by the CareMore Health Board of Directors. The program is reviewed on an annual basis and revised when appropriate. All revisions are approved by the QM Committee and the CareMore Health Board of Directors.

Goals and objectives include, but are not limited to:

- The establishment, support, maintenance and documentation of improvement in quality of care and service.
- The establishment of priorities for the improvement or resolution of known or potential issues that impact directly or indirectly on care or services.
- The maintenance of a consistently high level of quality of service, which meets and/or exceeds the needs and expectations of the patient.
- The measurement, assessment and improvement in processes and outcomes of care;
- The coordination of QM activities with other performance-monitoring and management activities.
- The coordination of the collection of objective, measurable data based on current knowledge and clinical experience, in order to monitor and evaluate functions and dimensions of care.
- The provision of data for practitioner/provider performance appraisal through the identification of trends and patterns of quality of care and service.
- The compliance with requirements of health plans and federal, state and local regulatory and accreditation entities.

Quality Management Committee

The CareMore Health Board of Directors has granted the QM Committee the authority to:

- Develop and monitor the QM Program.
- Oversee the activities to develop clinical criteria.
- Serve as an expedited and standard appeals panel, if necessary.
- Communicate with participating physicians, as necessary.

The QM Committee reports to the CareMore Health Board of Directors and presents a quarterly report of all activities for approval. The Medical Director serves as the chairperson of the QM Committee and presides over the meetings. In order to conduct a meeting, there must be at least three physicians present. Minutes are maintained for the meeting and all discussions are considered confidential.

The QM Committee is composed of:

- Physician Members who serve a two-year term on the committee and are either primary care physicians or specialists. There is also a panel of advisors, consisting of board certified physicians in many specialty areas, (e.g., behavioral health) that is available to the Medical Director for consultation, if needed.
- Non-physician Members from CareMore clinical and operations areas.

The QM Committee meets on a regularly scheduled basis, but no less than quarterly, to:

- Improve and assure the provision of quality patient care and services.
- Develop and maintain the QM Program description, policies and procedures, work plan and evaluation.
- Adopt clinical practice guidelines that are based on scientific evidence with quality indicators to monitor performance.
- Analyze data to detect trends, patterns of performance or potential problems and implement corrective action plans.
- Review and resolve grievances related to quality of care and/or service.
- Prioritize activities to ensure the greatest potential impact on care and service.
- Recommend to the CareMore Health Board of Directors any actions for follow-up on identified opportunities to improve.
- Oversee monitoring and reporting of clinical compliance activities.
- Oversee monitoring and reporting of managed care services delegated to CareMore Health.
- Review the scope, objectives organization and effectiveness of the QM Program at least annually and revise as necessary.

CareMore Health Quality Management develops and the QM Committee approves a work plan for the year, which outlines the program activities and corresponding timeframes for progress and completion dates. This work-plan, along with quarterly reports that focus on measuring progress toward the goals, is then presented, along with the QM Program, to the CareMore Health Board of Directors for review and approval.

On an annual basis, the QM Committee performs a retrospective evaluation of its activities to measure the performance achievements and activities for the year. If goals and objectives are not
met, changes are recommended to the subsequent QM Program and work plan. This annual evaluation is also presented to the CareMore Health Board of Directors for review and approval.
SECTION XI:
CULTURAL AND LINGUISTIC SERVICES
OVERVIEW

CareMore Health regards cultural competency as a process in which we strive for the ability to effectively and respectfully bridge differences between one’s own culture and the culture of others. Cultural competency refers to the practices and behaviors that ensure that all patients receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, disability and other factors that shape patient’s characteristics. In this way, patients feel like they have been understood and that their beliefs, values, and behaviors are considered.

CareMore Health is committed to following the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and requires our providers to commit to the same. CareMore Health complies with applicable federal civil rights laws and does not discriminate against patients based on race, color, national origin, age, disability or sex, or any other basis that is prohibited by law. CareMore Health expects contracted providers to comply with the National Culturally and Linguistically Appropriate Services (CLAS) Standards, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 and Section 1557 non-discrimination provision of the Affordable Care Act, in the provision of covered services to patients. CareMore Health expects contracted providers to treat all patients with dignity and respect as required by federal law including honoring patient’s beliefs, being sensitive to cultural diversity, and fostering respect for patient’s cultural backgrounds for all patients.

All CareMore Health contracted providers are responsible for:

- Providing interpreters services for limited English proficiency (LEP) and/or hearing and speech impaired patients.
- Using qualified interpreters, as defined by section 1557 of the ACA, to interpret during any patient/provider encounter.
- Actively discouraging the use of family members and friends as interpreters.
- Prohibiting the use of minors to interpret, except in an emergency involving an imminent threat to the safety or welfare of an individual.
- Promoting the availability of interpreter services by posting signage in languages of the population they served.
- Providing educational materials in the patient’s preferred written language or alternative formats (Braille, large print and/or audio).
- Taking reasonable steps to provide meaningful access to each LEP patients.
- Making reasonable accommodations to meet the needs of persons with disabilities.
- Referring patients to multi-ethnic community-based services.
- Treating individuals consistent with their gender identity.

Written policies and procedures are to be maintained by each provider office or facility regarding their process for obtaining such services. Provision of such services must be documented in the patient’s chart.
24-Hour Access to Interpreter Services

Contracted Providers are required to provide interpreter services at no cost to their patients. Providers can request interpreter services for CareMore Health patients, whose primary language is other than English, by calling Member Services. When a CareMore Health patient needs interpreter services for health care services, the provider should:

- Verify the patient’s eligibility and medical benefits.
- Inform the patient that interpreter services are available, at no cost including Sign Language (ASL) and tactile interpreting.
- Document the language and service provided in the patient’s chart.

Interpreter services can be provided through different venues. These include:

- Telephonic Interpretation Services - Providers may call Member Services to request assistance with interpreter services. The patient and Provider are then connected to our telephonic interpreter service vendor.
- Face-to-face interpreters - If a patient requires face-to-face interpretation, including ASL, the Provider may call Member Services to schedule a face-to-face interpreter. These services should be provided for scheduled medical visits, if needed, due to the complexity of information exchange or if requested by the patient. When scheduling an appointment with a LEP patient or a patient who has a hearing/speech disability, please allow time, if possible, to coordinate for a face-to-face interpreter. A 3-5 day request notice is recommended.
- It is recommended that Providers use a face-to-face interpreter services for certain complex medical situations. These can range from the need to give complex instructions-- such as discharge instructions, how to inject insulin or use a glucometer--to discussing a terminal prognosis, a critical healthcare issue or one requiring major lifestyle changes. Interpreter services should be provided if a patient believes that his or her rights to equal access to medical care, under Title VI or the ADA, will not be met without the use of an interpreter.
- TTY - To communicate with patients who have a speech or hearing disability, via phone, the Provider must call the Relay Services at 711
- Certified bilingual staff – Providers may only use qualified bilingual office staff, as defined by section 1557 of the ACA, to communicate with LEP patients. Providers must have a process in place to document language proficiency assessment of bilingual staff used as interpreters.

Providers should never ask a patient to bring their own interpreter, ask a family member, friend or minor to interpret. Use of a family member or minor may pose issues for the family and it creates liability risk for the Provider when information is not exchanged with LEP patient through a qualified interpreter. State and Federal mandates state that it is never permissible:

- To turn a patient away or limit the services provided to them because of language
barriers.

- To subject a patient to unreasonable delays due to language barriers
- To provide services that are lower in quality than those offered in English

All contracted providers can call the Member Services Department to request interpreter services for patients requiring these services. These include LEP patients and patients with speech and hearing disabilities.

**Documenting Language Services**

Providers are responsible for documenting patient’s language services/need. Here are some guidelines:

- Record the patient’s language preference in a prominent location in the patient’s medical record.
- Document patient’s requests for interpreter services in the patient’s medical record.
- Document refusal of interpreter services. Documentation must include the date and notes indicating that member was counsel on the importance of using a qualified interpreter.
- All counseling and treatment done via interpreter should be noted in the medical record by stating that such counseling and treatment was done by utilizing interpretive services.

**Facility Signage**

Providers are required to post signs informing patients of the availability of interpreter services. If you need assistance in locating appropriate signage, go to providers.caremore.com, or you can contact the Provider Relations.

**Materials in Other Languages and Alternative Formats**

Providers are required to provide LEP and patients with visual impairments with materials in the patient’s preferred written language or alternative formats (Braille, large print or audio). Additionally, all patient materials must be written at the appropriate reading and/or grade level. Providers may call Member Services Department for assistance with locating materials that are:

- Translated into other languages
- In alternative formats, including large print, Braille or audio

**DISABILITY ACCESS**

All health care facilities – primary care, specialty care, behavioral health and diagnostic centers (such as mammography facilities) must be accessible for persons with disabilities (PWD). These include:

- Accessible parking area and walkways
- Accessibility into and throughout the facility
- Restrooms and exams rooms accessible to people with disabilities
• Waiting area has adequate seating, lighting and space
• Auxiliary aid and services to effectively communicate with PWD

Providers are required to provide communications in alternative formats such as Braille, large print, and/or audio for patients with visual impairments. To ensure effective communication with persons with disabilities, providers should:

• Access the Relay Services (711) for phone communications
• Use sign language interpreters for in-person encounters.
• Use the appropriate auxiliary aids needed to aid the communication with the patients
• Make available assistive listening devices. These devices enhance the sound of the provider’s voice to facilitate a better interaction with the patient.

For more information and guidance to meet these requirements visit http://www.ada.gov/

CULTURAL COMPETENCY TRAININGS AND RESOURCES

Providers are required to participate in and cooperate with CareMore Health’s Provider education and training efforts. Providers are also to comply with all cultural and linguistic requirements, and disability standards as noted above.

CareMore Health recognizes the challenges that may arise when Providers need to cross a cultural divide to treat patients who may have a disability or who may have different cultural behaviors, attitudes and beliefs concerning health care. To assist Providers in meeting the needs of a diverse patient population, inclusive of person with disabilities, CareMore Health makes available a variety of cultural and linguistic (C&L) and disability resources and trainings for all contract Providers. Trainings are offered through a variety of venues including but not limited to:

• Web-based Provider training programs
• Written communications

Training will include but not be limited to the following:

• Cultural and linguistic requirements including disability (CLAS and ADA)
• Health care disparities
• Cultural influences in the Provider encounter (i.e., health literacy, past experiences with health care, language, religious and family beliefs and customs, etc.)
• Exploring the Provider-patient exchange
• The availability of cultural and linguistic resources, interpreter services, translated materials and alternate formats through the health plan
• How to effectively and optimally engage persons with disabilities including:
  • Person-center planning and self-determination
  • Social model of disability
  • Independent living philosophy
- Recovery models
- Self-determination
- Special considerations for persons with mental health or behavioral health conditions
- Use of evidenced-based practices and specific levels of quality outcomes
- Working with Members with mental health diagnoses, including crisis prevention and treatment
- Working with Members with substance use conditions, including diagnosis and treatment

Additional cultural and linguistic resources are available through the provider portal. These include but are not limited to:

- Provider tool kits
- Provider bulletins
GLOSSARY OF TERMS

- **Healthy Start**: Comprehensive assessment completed with every new CareMore Health patient to assess their medical, social and behavioral needs. The assessment is completed at a CareMore Care Center facility by a specially trained clinician. A patient care plan is completed as part of the assessment.

- **Health Journey**: Comprehensive assessment completed annually with all existing CareMore Health patient to monitor their medical, social and behavioral needs. The assessment is completed at a CareMore Care Center facility. The patient’s care plan is updated with any changes to their health captured as this visit.

- **Extensivist**: A CareMore Health physician who serve a unique role of caring for patients across multiple settings, serving as an extension of the role of the Primary Care Provider during and after hospitalization to ensure sustained care. They coordinate with PCPs and CareMore clinicians so patients don’t fall through the cracks of a complicated healthcare system.

- **CareMore Care Center (CCC)**: A CareMore Health facility where patients have access to an interdisciplinary team that helps them manage chronic condition or other complex Healthcare need.

- **Approved**: The referral is approved as requested. The Utilization Management (UM) authorization system will fax the authorization to the PCP, referring physician and the authorized specialist, facility, or vendor (e.g. DME). The authorization will detail the services approved. Additional services not included and detailed on the authorization will require prior authorization.

- **Modified**: The authorization determination is changed from what had been requested, such as place of service requested, Provider requested or even service requested. The modified authorization is faxed to the referring physician and the authorized specialist or facility.

- **Pended**: The determination of the request is placed on “hold” until additional medical necessity information is received. The requesting Provider will need to submit any necessary additional information the UM Department requires in order to make an appropriate decision. The total timeframe for processing a request that requires additional information is not to exceed the maximum allotted by Medicare or Medicaid, respectively.

- **Denied**: The services requested are not authorized. A detailed explanation of the denial decision and an alternative treatment plan are faxed to the referring Provider. The patient is sent a letter in which we explain why the service was denied. A CareMore Health Medical Director is responsible for all denial decisions when the determination is based on medical necessity. The Medical Director reviews requests on a case-by-case basis and takes into consideration special circumstances that may deviate from established protocols. Both the referring Provider and the patient are informed of the appeal process at the time they are notified of the denial.
• **Health risk assessment**: A review of a patient’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

• **Individualized Care Plan (ICP or Care Plan)**: A plan that outlines services that will be provided to patients and how they will receive them. The plan may include medical services, behavioral health services, and long-term services and supports.

• **Model of care**: The coordination and road map of a patient's care activities that are delivered through a care team that includes the patient and all those involved in the patient's care.

• **Primary care provider (PCP)**: A primary care provider is the doctor or other provider who patients see first for most health problems. They provide patients the care they need to keep them healthy.

• **Specialist**: A doctor who provides health care for a specific disease or part of the body.
CAL-MEDICONNECT PROGRAM
CAL MEDICONECT

CareMore Health manages patients enrolled in the Cal MediConnect Plan (MMP) in Los Angeles and Santa Clara counties. Cal MediConnect began in 2014 as a three-year demonstration pilot program and has been extended annually since the initial three year period ended and is expected to be extended for additional years. This program began as a partnership between the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to provide comprehensive health services to individuals eligible for both Medicare and Medi-Cal (dual eligible). This national demonstration program provides physician, hospital, behavioral health, Long Term Services and Supports (LTSS) and other services through a single organized delivery system. The goal of the program is to improve the quality of care for dually eligible patients by providing access to seamless, integrated care, and to increase the availability and access to home- and community-based services, so patients have better health outcomes and remain in their homes and communities as long as possible.

Enrollment Criteria for Cal MediConnect

Cal MediConnect is available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment
- Entitled to benefits under Medicare Part A, enrolled under Medicare Part B and eligible for Part D
- Eligible for full Medi-Cal benefits, including:
  - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
  - Individuals who meet the share-of-cost provisions below:
    - Nursing facility residents with share-of-cost.
    - MSSP members with share-of-cost.
    - In-Home Supportive Services (IHSS) recipients who met share-of-cost on the first day of the month, in the fifth and fourth months prior to effective date with Cal MediConnect.
  - Individuals eligible for full Medi-Cal per the spousal impoverishment rule.
- Reside in a Cal MediConnect county.

Eligible Cal MediConnect beneficiaries can enroll or disenroll from a participating plan on a month-to-month basis any time during the year and will be effective on the first day of the month following the request to do so. Patients must work directly with Health Care Options (designated DHCS enrollment broker) for any enrollment/disenrollment requests.

Health Care Options (HCO): 1-844-580-7272

Provider Rules of Participation

To ensure high quality care is provided to Cal MediConnect patients, CareMore Health requires that all providers meet the following criteria to participate in its CMC provider network:

- Have a signed contract with CareMore Health for the Cal MediConnect program.
• Meet all requirements set forth by the Health Insurance Portability Accountability Act (HIPAA).
• Have a current and valid Facility Site Review (FSR) completed by an FSR Nurse from a Medi-Cal or Cal MediConnect participating Health Plan in California, and must have a passing score as outlined in the DHCS Plan Policy.
• Comply with Cal MediConnect Health Education requirements as outlined in the Health Education section (Section IV) of this manual
• Share a commitment to working with culturally and linguistically diverse population including those living with disabilities
• Participate in Interdisciplinary Team meetings as required by DHCS as part of the Individual Care Plan created for all Cal MediConnect patients

**Cal MediConnect Ombudsman Program**

Cal MediConnect patients can receive support and assisting in resolving issues that they may encounter with Cal MediConnect health plans from the Cal MediConnect Ombudsman Program. Patients can contact them by calling:

**Phone:** 1-855-501-3077  
**TTY:** 1-877-735-2929  
**Monday through Friday, 9:00 a.m. to 5:00 p.m.**

**Facility Site Review**

All primary care sites serving Cal MediConnect managed care patients must undergo an initial facility site review with attainment of a minimum passing score of eighty percent (80%) on the site review and medical record review. The facility site review (FSR) is a comprehensive evaluation of the facility, administration and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The California statute requires that all PCP sites or facilities rendering services to Medi-Cal and Cal MediConnect eligible patients must be certified and compliant with all applicable DHCS standards.

The facility site review includes the following site surveys:

• Full Scope Site Review  
• Medical Record Review  
• Physical Accessibility Review Survey (PARS)

An initial FSR is the first on-location inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal or Cal MediConnect managed care program and has not had a full scope survey within the past three (3) years with a passing score. The same procedure applies to a site review visit when a PCP relocates or opens a new site.

DHCS also requires that all high volume specialist locations undergo a PARS to ensure their site is accessible to people with disabilities.
Long Term Services and Support (LTSS)

Cal MediConnect patients have access to a wide range of Long Term Services and Supports (LTSS) to help them meet daily needs and improve their quality of life. LTSS services are provided over an extended period, mainly in their homes and communities, but also in facility-based settings such as nursing facilities.

Services include:
- In-Home Supportive Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long Term Care (LTC) provided in skilled nursing facilities.

CareMore Health is responsible for coordinating access to, paying for, and overseeing LTSS services for CareMore Health patients.

Depending on the LTSS service, there are different qualifying criteria for a patient to participate in this program, such as:
- Qualifies for nursing home placement, but wants to stay home
- Has a condition that indicates a possible need for MLTSS in the future
- Needs social supports or caregiver support
- Needs assistance with Activities of Daily Living (“ADLs”) such as walking, bathing, dressing, toileting, brushing teeth, and eating
- Needs assistance with Instrumental Activities of Daily Living (“IADLs”) such as cooking, driving, using the phone or computer, shopping, keeping track of finances, and managing medication
- Receives LTSS services, but has unmet needs
- Is preparing to transition into long term care or from long term care into the community

Women’s Health Access

CareMore Health allows patient the option to seek obstetrical and gynecological (OBGYN) care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by CareMore Health as providing OBGYN services. These services must be provided when requested regardless of the gender status of the member.

Health Risk Assessment (HRA) and Individual Care Plan (ICP)

CareMore Health completes an HRA with each CMC patient to assess their risk level and health needs. Responses to HRA questions, along with other tools assist in the development of the ICP which is completed with patient and their caregiver by a Case Manager. As part of this process PCPs are invited to participate in Interdisciplinary Care Team (ICT) meetings to review all goals included in the patient’s care plan. PCP are required to participate in regularly scheduled ICT meeting for their patients.