elderwood® health plan

A Medicaid Managed Long Term Care Program
serving Erie, Niagara, Orleans, Genesee, Wyoming and Monroe counties

PROVIDER MANUAL

Contact Provider Relations Department at 1-866-THE-PLAN (1-866-843-6526)
www.ElderwoodHealthPlan.com

Elderwood Health Plan
Provider Relations
500 Seneca St., Suite 100
Buffalo, NY 14204

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INTRODUCTION

Welcome and thank you for participating in the Elderwood Health Plan Provider Network!

Elderwood Health Plan is owned and operated by Post Acute Partners, an innovative and integrated health care company whose primary focus is to provide the highest quality care and services in the most appropriate setting for each individual we serve.

We are proud to be a part of New York State's Partial Capitated Managed Long-Term Care Program. Elderwood Health Plan's Managed Long Term Care (MLTC) program provides Medicaid covered services to people 21 years and older determined eligible for community based long-term care services for more than 120 days.

We depend on our quality network of providers to service our members well. By participating in Elderwood Health Plan, you are helping us provided high-quality and accessible long-term care services and supports. You are one of the most critical components of our service delivery approach and Elderwood Health Plan is thankful you share in our goal to help those with chronic conditions be as independent as possible living in the community.

This Provider Manual includes valuable information to help you understand our program, provides key points on how to work with Elderwood Health Plan, and should be a helpful resource for you and your office staff. Consider this manual as an extension of the Provider Agreement. In the event of a dispute or conflict regarding the contents of this manual or any interpretations of its contents, the terms of the Provider Agreement and the member contract will prevail. Please keep this manual in a convenient, accessible location for your use. Its contents are subject to periodic updates and modifications in compliance with federal and state regulations and Elderwood Health Plan policy changes.

Please visit our website at www.elderwoodhealthplan.com for the most up-to-date information.

If you or your staff have any questions about the policies and procedures in this manual, please contact my office at (716) 631-1327 or toll-free at 1-866-THE-PLAN (1-866-843-7526).

Sincerely,

Alicia Kenyon, LMSW
Executive Director

What is Managed Long-Term Care and How Does it Work?

A managed long-term care plan is an organization that provides, arranges, and coordinates community-based health and long-term care services on a capitated basis for the population it serves. The MLTC program provides long-term home health care, dental, vision, and other community-based health related services to adults who have been determined eligible to receive these services for 120 days or more. Non-covered services, paid by Medicare and Medicaid fee-for-service, such as physician and hospital care, are coordinated through an assigned Elderwood Health Plan Care Manager. This program is designed to link primary, specialty, and community-based services for New York's most vulnerable residents. Members of Elderwood Health Plan benefit because:

- The member continues to use their own primary care physician and if they are in in the EHP network, their medical specialty physicians. The Care Manager may work with the primary care physician to coordinate the member's health care needs. If a member needs help finding a physician, our Care Management Team will assist them with the process.
- The member continues to receive hospital and medical services covered by Medicare and Medicaid fee-for-service health plans.
- The Member receives care management coordination of all health care services including Medical and community services.
- An assigned Care Manager ensures the member is receiving the appropriate care they need. Each Care Manager has expertise in caring for individuals with chronic medical needs. Members are matched to a Care Manager to best meet their individual needs, such as language spoken and the geographic area in which they reside.
- The member, Care Manager, physician, and other health professionals work to design a service plan specifically formulated to meet that member's needs.

Provider Manual

This manual will enable providers to easily access information on the majority of Elderwood Health Plan provider issues. If you have a question, problem, or concern that the Provider Manual does not fully address, please call Provider Relations at 1-866-THE-PLAN (1-866-843-7526).
Elderwood Health Plan will update the Provider Manual annually and will distribute bulletins as needed to alert you about any changes. Please check our website regularly at www.ElderwoodHealthPlan.com for the most recent version of the Provider Manual and/or updates. The Provider Manual is available for download on our website and may be requested in hard copy form or on CD-ROM at no charge by contacting our Provider Relations Department at 1-866-THE-PLAN (1-866-843-7526).

Orientation

Elderwood Health Plan provides initial orientation for newly contracted providers after they join our network. Elderwood Health Plan conducts the orientation either through group sessions, webinars, or during visits to individual provider offices. Sessions cover various topics such as benefits, member and provider responsibilities, administrative processes, provider tools/resources, regulatory requirements, and Elderwood Health Plan contact information.

IMPORTANT PHONE NUMBERS:

Elderwood Administration, Provider Relations, and Member Eligibility	1-866-THE-PLAN (1-866-843-7526) (Fax: 716-568-8378)
Mediture eClusive Claims Processing and Claims Inquiry	952-400-7600
Language Assistance	1-866-THE-PLAN (1-866-843-7526)
Hearing and Speech Impaired	Please call NY Relay by dialing 7-1-1
Grievance and Appeals	1-866-THE-PLAN (1-866-843-7526)
Transportation	Member Services at 1-866-THE-PLAN (1-866-843-7526)
NYS MLTC Complaint Hot Line	1-866-712-7197
NYS Justice Center for the Protection of People With Special Needs	1-800-624-4143
To Report Abuse & Neglect	1-855-373-2122

Professional Advice to Elderwood Health Plan Members

Elderwood Health Plan may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled in Elderwood Health Plan about:

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

However, a provider's discussion of treatment options with the member does not require Elderwood Health Plan to provide coverage for benefits not otherwise covered.

Adherence to the Provider Agreement

Providers are contractually obligated to adhere to the terms of the Provider Agreement, including the requirements in this manual. Contracted network providers must comply with federal and state requirements governing NYS MLTC Plans and the provider.

Providers must comply with all administrative, patient referral, quality management, health services management, and reimbursement procedures as adopted and modified from time to time.

They must also cooperate and participate in all Elderwood Health Plan peer review functions, including Quality Management and Health Services Management programs and administrative and grievance procedures. Providers also agree to follow Elderwood Health Plan's appeals process as described in this Provider Manual.

All Providers Responsibilities

All providers must:

1. Comply with all regulatory and professional standards of practice and are responsible to acquire physician orders whenever required by regulation of local, state or federal law, as well as for the determination of medical necessity and/or third party reimbursement. The Case Manager may assist in obtaining orders if the Provider has been unsuccessful.
2. Notify Elderwood immediately whenever there is identification of a clinical issue of serious concern, change in Member status, refusal of service, inability to access Member's home, or inability to provide service for any reason.
3. Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member and the Member's progress and status.
4. Cooperate with Elderwood on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to Elderwood within ten (10) working days of request.
5. Communicate to Elderwood any complaint made by or on behalf of the Member. The Provider may file a grievance on a member's behalf with the Member's written consent. The provider may act as the Member's advocate. Please note that Elderwood Health Plan will not terminate a provider contract if they advocate on behalf of a member, file a complaint against the plan, appeal a decision, request a hearing or provide information to NYSDOH.
6. Cooperate with the Elderwood quality assurance programs as needed.

7. Assure that all Provider's employees and agents involved in direct contact with Members carry proper agency identification and follow state and federal laws and requirements related to the services provided.
8. Notify Elderwood of the provision of any unauthorized urgent services within 48 hours.
9. Effectively communicate with the Case Manager/Care Management Team, along with the Member Services staff, ***regardless of primary payer***, in order to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, access appropriate reimbursement sources for services, increase continuity of care, and progress toward goal achievement.
10. Confirm ***prior*** to the addition of any new provider owner, director, employee, agent, contractor, or referral source, and on a monthly basis thereafter, that such individuals and entities are not included on the excluded parties lists maintained by the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services Office of Inspector General, and the United States General Services Administration.

Licensed Home Care Services Agencies (LHCSAs) Responsibilities

Licensed Home Care Services Agencies are responsible for providing part-time, intermittent personal care, attendant care, homemaker, or in-home respite services to members who require such assistance based on their individual care and service plan. Additional responsibilities include:

1. Coordination with Elderwood Health Plan Care Managers.
2. Receiving service authorizations from Elderwood Health Plan Care Managers.
3. Obtaining physician orders required to meet member needs adhering to the service plan developed by Elderwood Health Plan's Care Managers.
4. Overseeing the activities of direct-service staff.
5. Developing an Aide care plan for the requested services.
6. Ensuring staff is properly trained in meeting the Department of Health's requirements.
7. Having established after hours care or having on-call arrangements with qualified providers on a 24 hours-a-day, 7 days-a-week basis. Provider's after hours care cannot be offered by an answering machine in lieu of a live response.
8. Assuring that family members that may be employed by the home care agency are NOT assigned to handle the care of their family member.
9. Notifying the Member in advance of name of the staff assigned to them.
10. Notifying Elderwood and Members in advance of need for staff replacements and name of replacement staff.
11. Submitting evaluation and progress notes following first assessment visit by any/all disciplines and every two weeks thereafter unless specified otherwise.
12. Cooperating fully with Elderwood Care Management and communicating verbally or in writing regarding the Member's progress, even if the episode of care does not result in any payment to the provider.
13. Confirming aide daily attendance. Provider must have an electronic call in/call out attendance program in addition to other manual random verification. Agency protocols on aide attendance verification must be available to Elderwood.
14. Submitting monthly Attendance Activity reports. Reports should indicate member, date and time of electronic calls in and out, and any gaps in home care services as defined as the difference between the number of hours of home care services scheduled in each member's care plan and the hours of home care services that are actually delivered to the member.
15. Licensed Home Care Services Agencies must provide home health services in accordance with applicable provisions of the regulations of the New York State Department of Health and with federal regulations governing home health services.

Durable Medical Equipment (DME) & Other Medical Supply Provider Responsibilities

DME and other medical supply provider responsibilities include:

1. Verifying primary payer coverage and eligibility prior to delivery.
2. Acquiring physician orders whenever required by regulation of local, state or federal law, as well as for the determination of medical necessity and/or third party reimbursement.
3. Ensuring that a prior authorization request has been approved by Elderwood Health Plan for any DME supplies provided (for supplies not covered by another payer).
4. Timely Delivery of requested products.
5. Having established after hours care or having on-call arrangements with qualified providers on a 24 hours-a-day, 7 days-a-week basis.
6. Exhausting all other payment sources prior to billing Elderwood Health Plan. For members who have other health care coverage such as Medicare, covered DME supplies should be billed to the member's primary payer.
    - It is the responsibility of the provider to determine whether Medicare covers the item or service being billed.
    - If the service or item is covered or if the provider does not know if the service or item is covered, the provider must first submit a claim to Medicare, as Elderwood is always the payer of last resort.
    - If the item is normally covered by Medicare but the Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the Elderwood Case Manager prior to delivery.

Residential Health Care Provider Responsibilities

Residential Health Care Provider responsibilities are outlined by duration of stay and include:

Short-term Stay:

1. Verifying health insurance coverage of the prospective resident and obtaining prior authorization.
2. Submitting bi-weekly progress notes to the Elderwood Care Manager.
3. Obtaining authorization for any covered service outside of the daily rate.
4. Assisting in the Medicaid recertification process.

Long-term Care:

1. Determining eligibility for Institutional Medicaid and other Third Party Health Insurance.
2. Submitting conversion applications for members placed for long-term care. (Members must be eligible for Institutional Medicaid to remain in the LTC facility.)
3. Identifying the admission as a Managed Long Term Care admission.
4. Collecting the NAMI (NAMI will be deducted from payments).
5. Submitting Resident Monthly Summaries to the Elderwood Care Manager.
6. Including the Elderwood Care Manager in case conferences.
7. Obtaining authorization for any covered service outside of the daily rate.
8. Assisting in the Medicaid recertification process.

Transportation Provider Responsibilities

Transportation providers are responsible for:

1. Arriving within thirty (30) minutes of scheduled pick up time and within one (1) hour of will call time.
2. Assuring that all transportation is to medical appointments, unless specifically noted in the authorization.
3. Notifying Elderwood when a requested trip is to a non-medical destination not noted in the authorization.
4. Notifying Elderwood when a member cancels or does not show for a pick up.
5. Notifying Elderwood when it is determined, upon arrival, that the driver is unable to transport a member safely.
6. Obtaining documentation for each trip provided. Documentation must include: Member's name and ID number, date of transport, pick-up address and time of pick-up, drop-off address and time of drop-off, vehicle license plate number, and the full printed name of the driver.
7. Ensuring that all ambulettes and car services follow the safety criteria in accordance with the New York State Department of Transportation when transporting members, including the following securement systems:
    - Tie-down Straps: Vehicles must contain four (4) tie-down straps for each wheelchair position.
    - Seat Belts: Vehicles must also contain a passenger seat belt and shoulder harness for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device, which secures the mobility aid itself.
8. Ensuring that each vehicle is equipped with a body fluid spill kit, three (3) reflector triangles, a first aid kit, and a fire extinguisher.

Access to Service Standards

All providers must alleviate barriers to accessing and receiving high-quality services. Providers participating in the Elderwood Health Plan shall provide service to Members in accordance with the standards set by Elderwood, except when a longer time frame is required by the Member or arranged by the Care Manager. These standards are outlined below:

1. Adult Day Health Care: Placement must occur within fourteen (14) days.
2. Audiology: Routine care within fourteen (14) days and urgent care within 48 business hours.
3. Dentistry: Routine care within twenty-eight (28) days and urgent care within twenty-four (24) business hours.
4. DME/Supplies: Delivery must occur within seventy-two (72) hours, unless custom order or otherwise noted.
5. Home Health Care: Initial visit must occur within twenty-four (24) hours or as otherwise arranged by the Care Manager (24 hours-a-day,7 days-a-week telephone access).
6. Meals (Home Delivered/Congregate): Date and time arranged by Elderwood.
7. Skilled Nursing Facility: Placement must occur within seven (7) days or as otherwise noted.
8. Nutritional Counseling: Service must be provided within fourteen (14) days.
9. Optometry: Routine care within fourteen (14) days and urgent care within twenty-four (24) business hours.
10. Personal Care: Initial visit must occur on the date and time arranged by Elderwood.
11. Physical, Occupational and Speech Therapy (not in home): Initial visit must occur within seven (7) days.

12. Physical, Occupational and Speech Therapy (in home): Initial visit must occur within seventy-two (72) hours or as otherwise arranged by the Care Manager.
13. Podiatry: Routine care within fourteen (14) days and urgent care within twenty-four (24) business hours.
14. Private Duty Nursing: Date and time arranged by Elderwood (24 hours-a-day, 7 days-a-week telephone access).
15. Prosthetics/Orthotics: Measurement within fourteen (14) days.
16. Respiratory Therapy: Initial visit must occur within twenty-four (24) hours, (24 hours-a-day, 7 days-a-week telephone access).
17. Social Day Care: Placement must occur within fourteen (14) days.
18. Social and Environmental Supports: Delivery within fourteen (14) days, unless custom ordered.
19. Social Work Services: Service must be provided within fourteen (14) days.
20. Transportation: Pick up within thirty (30) minutes of scheduled time.

Clinical notes should be submitted within forty-eight (48) hours of assessment visit. Progress notes/summaries should be submitted every two (2) weeks thereafter, unless otherwise requested or there is a decrease in member health status.

On the day of an appointment, a member should not wait more than sixty (60) minutes past their scheduled appointment time. If a situation arises for the provider and the wait time will be more than sixty (60) minutes, the member must be notified of the delay and given the option to reschedule.

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

Ethical Health Care Practice

The provider must provide services in accordance with generally accepted **standards** of their professional practice. Provider practices will be in accordance with the customary rules of ethics and conduct of the relevant Professional Association and other bodies, formal or informal, governmental or otherwise, from which the provider seeks advice and guidance, or by which they are subject to licensing and control.

Providers in Good Standing

The Provider must be in good standing with the New York State Department of Health's programs or applicable licensing/certification board.

Elderwood Health Plan is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a provider is guilty of professional misconduct.

The provider must disclose the required information at the time of application, credentialing and/or re-credentialing, and/or upon request in accordance with 42 C.F.R.§ 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP, and/or other Federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.

Billing Practice

The provider agrees not to bill any Elderwood Health Plan members for services covered under the MLTC Contract. The providers must not hold members liable for payment of any fees that are the legal obligation of Elderwood Health Plan. Providers must indemnify the member for payment of any fees for authorized services furnished as long as the member follows Elderwood Health Plan's rules for accessing services described in the approved Member Handbook.

If Elderwood Health Plan fails to pay the Provider, the Provider will not seek payment from the New York State Department of Health or our members. Providers may not collect copayments or deductibles from Elderwood Health Plan members or bill members for covered services. If a member is requesting a non-covered service, the Provider must advise the member, prior to initiation of service, that the service is uncovered and explain what the service will cost the member.

Elderwood Health Plan reimburses its contracted providers according to the Department of Health's fee schedule or other contracted rates. The type of reimbursement you receive and the services you are eligible to provide are part of your agreement. Please contact your Provider Relations Representative with any further questions.

Medicaid Fraud and Abuse

If you suspect fraudulent practices from an Elderwood provider, please report it by contacting our Executive Director at 1-866-THE-PLAN (1-866-843-7526). To contact us anonymously call 1-855-663-0144. You can report Medicaid fraud to NYSDOH by calling the Fraud Hotline at 1-877-873-7283 or by filing a complaint online at: http://www.omig.ny.gov/data/content/view/50/224/index.php?option=com_content&view=article&id=650. You may also send an e-mail to Medicaid@health.state.ny.us. Remember to include your contact information in the e-mail. Some examples of health care provider fraud and abuse include:

- Billing or charging members for services that Elderwood Health Plan covers.
- Offering members gifts or money to receive treatment or services.
- Offering members free services, equipment, or supplies in exchange for use of an Elderwood Health Plan member ID number.
- Providing members with treatment or services that they do not need.
- Billing for services that were not provided.

Medical Record Maintenance

Visits with our members, authorizations, contacts, member education, advance directives, or follow-up with members should be documented and maintained in the member's record. Notations regarding follow-up for canceled and missed services should also be evident. Records must be signed, dated, and legible. Providers must safeguard the member's Personal Health Information (PHI).

Records may be requested from a provider when Elderwood Health Plan is researching complaints, grievances, requests for a Department of Health Fair Hearing, or quality of care issues. It is important that these requests be responded to promptly and within the timeframe request.

Elderwood Health Plan may conduct audits of records to see that documentation meets standard requirements. In addition, providers must grant the Department of Health or other governmental entities timely access to books, records, or other information for purposes of audits, investigations, inspections, or reviews.

Providers must adhere to the following record retention practices:

1. The Provider must make records available to Elderwood Health Plan, MLTC program and NYSDOH, its members, and their authorized representatives within ten (10) working days of the record request.
2. The Provider must maintain current records for each MLTC member, including documentation of all services provided to the member as well as verification of services coordinated by the Care Manager.
3. The Provider must comply with all applicable laws and regulations pertaining to the confidentiality of member records, including, but not limited to, obtaining any required written member consents to disclose confidential records for complaint and appeal review.
4. The Provider must keep medical records for six (6) years after the death or disenrollment of a member from Elderwood Health Plan. The record shall be kept in a place and form that is acceptable to the Department of Health and in accordance with New York State Article 44.

Confidentiality Requirements

Providers are required to comply with federal, state, and local laws and regulations governing the confidentiality of medical information, including laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are contractually required to safeguard and maintain the confidentiality of data that addresses member records and confidential provider and member information, whether oral or written in any form or medium.

Participating Provider Leaves the Plan

The Provider must notify Elderwood Health Plan sixty (60) days prior to terminating their agreement with Elderwood Health Plan. When a provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, Elderwood Health Plan will authorize our member to continue an ongoing course of treatment for a period of up to ninety (90) days. The request for continuation of care will be authorized provided that the request is agreed to or made by the member, and the provider agrees to accept Elderwood Health Plan's reimbursement rates as payment in full. The provider must also agree to adhere to Elderwood Health Plan's quality assurance requirements, abide by Elderwood Health Plan's policies and procedures, and supply Elderwood Health Plan with all necessary medical information and encounter data related to the member's care. The Care Management Department will assist with and coordinate the transition of the care plan.

Termination

Providers who have been excluded from participation in any federally or state-funded health care programs are not eligible to be an Elderwood Health Plan provider. If the New York State Department of Health excludes or terminates a provider from its Medicaid program, Elderwood Health Plan shall, upon learning of such exclusion or termination, immediately terminate the Provider Agreement with the Participating Provider, and will no longer utilize the services of the subject provider, as applicable.

Elderwood Health Plan is legally obligated to report to the appropriate professional disciplinary agencies within thirty (30) days of the occurrence of any of the following:

- Termination of a provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.
- The voluntary/involuntary termination of contract/employment or other affiliation with such organization to avoid the imposition of disciplinary measures.
- The termination of a provider contract in the case of a determination of fraud or in a case of imminent harm to member wellbeing.

Elderwood Health Plan will follow the procedures outlined by the New York State Department of Health when terminating or electing to not renew a contract with a network provider. Upon termination, a written explanation will be sent to the provider outlining the reasons for termination along with information on how the provider can request a review hearing and the associated timeframes. Elderwood Health Plan may immediately terminate a provider contract if the provider presents imminent harm to a member's wellbeing, has actions against his/her license, or in the case of fraud or misconduct. Upon non-renewal, Elderwood Health Plan will provide a sixty (60) day notice to the provider. A non-renewal of a contract does not constitute a termination.

MEMBER RIGHTS AND PROTECTIONS

Mandated Reporting for Suspected Maltreatment of Members

As mandated by New York Public Health Law §§ 2801, 2803-d (2009), all persons who work with or have any contact with Elderwood Health Plan MLTC program members are required to report any suspected incidents of physical abuse, neglect, mistreatment, and any other form of maltreatment.

Non-Discrimination

Members are entitled to receive covered services without concern for race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, genetic information, medical history, or ability to speak English. Providers must not differentiate or discriminate in the treatment of patients on the basis of race, sex, age, religion, sexual orientation, marital status, place of residence, actual or perceived health status, or source of payment. Elderwood Health Plan providers are obligated to observe, protect and promote the fair and equitable treatment of our members as patients.

Elderwood Health Plan and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds.

Cultural Competence and Sensitivity

Cultural competency refers to the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding toward enhancing the effectiveness of health care delivery to diverse populations.

The provider must practice culturally competent care by understanding the disability, racial, ethnic, and cultural differences between the provider and member. Providers must provide services in a way as to ensure members of various racial, ethnic and religious backgrounds, as well as disabled individuals, are communicated within a comprehensible manner, accounting for different needs. The member must clearly understand the diagnosis and treatment options that are being presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

Limited English Proficiency

Elderwood will reimburse Article 28 outpatient departments, diagnostic and treatment centers, federally qualified health centers, and office-based practitioners to provide medical language interpreter services for members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing.

An Enrollee with limited English proficiency shall be defined as an individual whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit the Enrollee to interact effectively with health care providers and their staff.

The need for medical language interpreter services must be documented in the medical record, and medical language interpreter services must be provided during a medical visit by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics, and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI).

Americans with Disabilities Act (ADA)

Providers will comply with Title III of the Americans with Disabilities Act (ADA) that mandates that all public accommodations be accessible to individuals with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

HIPAA Privacy Practices

Providers are expected to maintain strict privacy and confidentiality standards for member records and member health care information in accordance with federal and state standards. Members have a right to access, amend, request confidential communication, request privacy protection, restrict use and disclosure, and receive an accounting of disclosures of protected health information (PHI). The Elderwood notice of privacy practices is available on our website at: www.ElderwoodHealthPlan.com.

Member Rights and Responsibilities

Treating a member with respect and dignity is a good business practice and can often improve outcomes. Your agreement with Elderwood Health Plan requires compliance with member rights and responsibilities, including treating members with respect and dignity.

Understanding members' rights and responsibilities is important because you can help members to better understand their role in complying with treatment or care plans. Please review the list of member rights and responsibilities below. Please assure that your staff is aware of these requirements and the importance of treating members with respect and dignity.

Member Rights

Elderwood Health Plan Members have the following Rights:

1. The Right to receive medically necessary care.
2. The Right to timely access to care and services.
3. The Right to privacy about their medical record and when they get treatment.
4. The Right to get information on available treatment options and alternatives presented in a manner and language they understand.
5. The Right to get information in a language they understand; members can get oral translation services free of charge.
6. The Right to get information necessary to give informed consent before the start of treatment.
7. The Right to be treated with respect and dignity.
8. The Right to get a copy of their medical records and ask that the records be amended or corrected.
9. The Right to take part in decisions about their health care, including the right to refuse treatment.
10. The Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
11. The Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
12. The Right to be told where, when and how to get the services they need from their managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
13. The Right to complain to the New York State Department of Health or your Local Department of Social Services; and the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
14. The Right to appoint someone to speak for them about their care and treatment.
15. The Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

Elderwood Health Plan Members have the responsibility to:

1. Learn and understand each Right they have under the Managed Long Term Care program.
2. Ask questions if they do not understand their Rights.
3. Know the name of their Primary Care Provider (PCP) and their Care Manager.
4. Know about their health care and the process for getting care.
5. Use providers who work with Elderwood Health Plan for covered services.
6. Get approval from their Primary Care Provider, Care Manager, or Care Management Team, as required, before getting a covered service.
7. Know when they should and should not go to the emergency room.
8. Contact their Care Management Team any time they use the emergency room, are hospitalized, get new prescriptions, or receive a referral for another medical provider.
9. Treat the health care professionals respectfully.
10. Tell Elderwood Health Plan about care needs, concerns, questions, or problems.
11. Give health care providers all the information they need.
12. Ask for more information if they do not understand their treatment or health condition.
13. Participate in managing their own health by telling their provider about their health care concerns and needs.
14. Notify Elderwood Health Plan when they go away or out of town.
15. Make all required payments to Elderwood Health Plan.
16. Follow their Care Manager's advice or talk to their Care Manager if they are unable or are unwilling to follow the care plan.
17. Protect their member ID card and show it when they get service.
18. Tell Elderwood Health Plan about any other insurance they have.
19. Tell Elderwood Health Plan if they are applying for other health care benefits.
20. Contact their Care Management Team or Member Services toll free at 1-866-THE-PLAN (1-866-843-7526), right away if their address or phone number changes.

COVERED SERVICES & LIMITATIONS, MEDICAL NECESSITY, AND NON-COVERED SERVICES

Covered Services

In general, covered services must be provided by a participating (in-network) provider with an authorization for services in place arranged by a Elderwood Care Manager. Exceptions exist as indicated below. **Please refer to the Prior Authorization section for important information on the prior authorization process**. Under the Medicaid Managed Long Term Care (MLTC) program, Elderwood Health Plan is responsible for administering the following covered services:

Adult Day Health Care
Requires authorization in advance.

Audiology/Hearing Aids
May be self-selected and self-scheduled by the Member from the Provider Network for audiology screening, evaluation for a hearing aid, and hearing aid batteries without a prior authorization. All other services require prior authorization. Follow Medicaid coverage and coding guidelines. Members are entitled to one (1) hearing examination every twelve (12) months without a referral when using a provider within the Elderwood Health Plan network. **Hearing aids are covered by Elderwood Health Plan, but must be authorized prior to supplying.** When the member is in your office, please call 1-866-THE-PLAN (1-866-843-7526) to update existing authorizations, indicating the services you will be providing during the visit. If this authorization is not updated, payment for these services may be denied.

Care Management
One of the most important benefits for Elderwood members is having a personal Care Manager to assess needs and coordinate services. The Care Manager is a registered nurse who will work with members to seek and coordinate solutions to meet member health and long-term care needs. The Care Manager will create an individual person-centered service plan that will outline the services that are medically necessary for each member. The Care Manager will authorize the start or continue services and will work with health care providers to coordinate both covered and non-covered services.

Consumer Directed Personal Assistance Services
Requires authorization in advance.

Dental Services
May be self-selected and self-scheduled by the Member for a Network Provider for initial evaluation and preventive services without a prior authorization. Follow Medicaid coverage and coding guidelines. Covered services from a dentist listed the Elderwood provider directory include:

- One (1) exam each year and one (1) cleaning every six (6) months
- X-rays
- Restorative Dentistry (fillings)
- When medically necessary:
    - Root Canals (pre-authorization is required)
    - Crowns and Dentures (pre-authorization is required)

When the member is in your office, please call 1-866-THE-PLAN (1-866-843-7526) to update an existing authorization, indicating the services you will be providing during the visit. If this authorization is not updated, payment for these services may be denied.

A referral from a General Dentist is required prior to visiting a dental specialist. Dental care from a State Academic Dental Center does not require referral or authorization.

Dietary/Nutrition Counseling
May be self-selected and self-scheduled by the Member for a Network Provider for routine visits without a prior authorization. All other service require prior authorization.

Durable Medical Equipment (DME) & Supplies
Require prior authorization Services include: home medical equipment, medical/surgical supplies, enteral and parenteral formula, hearing aid batteries, prosthetics, orthotics, and orthopedic footwear. When applicable, DME items must meet all requirements for Medicare approval and should be billed to Medicare primary. Elderwood Health Plan will then cover any patient responsibility (up to the Medicaid allowed amount for the item(s).

Home Care
Requires authorization in advance. Services include nursing, Home Health Aide, physical therapy, occupational therapy, speech-language pathology, and medical social services. *No payment to a home health care agency will be made unless the claim for payment is supported by documentation of the time spent providing services to each member.*

Home Delivered or Congregate Meals
Arranged through Care Management.

Medical Social Services
Requires authorization in advance.

Non-Emergency Transportation
Requires authorization in advance. Transportation services are offered to members for medical appointments by in-network providers. Members must contact Elderwood Health Plan Member Services at 1-866-THE-PLAN (1-866-843-7526) for medically necessary transportation. Members who qualify may only use the transportation for the approved visit. The Member Services coordinator arranges transportation with our contracted vendor and sends an authorization with an agreed upon rate based on the contract. To be reimbursed for tolls, a receipt must be attached to the invoice.

Nursing Home Care
(Institutional Medicaid eligible) Admission to a nursing home requires prior authorization from Elderwood Health Plan. Elderwood Health Plan's Care Manager must be notified at least three (3) days in advance of a scheduled admission to a nursing home or procedure date whenever possible.

Optometry
No prior authorization is needed for an annual eye exam. Members are entitled to one (1) routine vision examination each year by an in network provider, and eye glasses every two (2) years, or more frequently if medically necessary. Eye care at a SUNY College of Optometry Center does not require a referral or authorization. No prior authorization is needed to see an ophthalmologist.

Occupational Therapy
Requires authorization in advance. Up to twenty (20) outpatient visits per year.

Orthopedic or Prescription Footwear and Inserts
Requires authorization in advance.

Personal Care
Requires authorization in advance. Assistance with bathing, eating, and dressing, household services, and meal shopping and preparation.

Personal Emergency Response System (PERS)
Requires authorization in advance. *All bills for Personal Emergency Response Systems shall contain a dated certification by the provider that the care, services, and supplies itemized have in fact been furnished.*

Physical Therapy
Requires authorization in advance. Up to twenty (20) outpatient visits per year.

Private Duty Nursing
Requires authorization in advance.

Podiatry
May be self-selected and self-scheduled by the Member for a Network Provider for initial visit without a prior authorization. All other services require prior authorization. Follow Medicaid coverage and coding rules. Services include routine foot care when it is medically necessary (four (4) visits per year), such as serious foot condition or diabetic foot care. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet is not routinely covered but may be covered if the Care Manager deems it necessary. For most members, podiatry care is covered by Medicare. An authorization is required if the services that are NOT covered by Medicare. When the member is in your office, please call 1-866-THE-PLAN (1-866-843-7526) to update an existing authorization, indicating the services you will be providing during the visit. If an existing authorization is not updated, payment for these services may be denied.

Respiratory Therapy
Requires authorization in advance.

Social and Environmental Supports
Requires authorization in advance and is arranged by Care Management.

Social Day Care
Requires authorization in advance and is arranged by Care Management.

Speech Therapy
Requires authorization in advance. Up to twenty (20) outpatient visits per year.

Support Stockings/Compression Hose
Requires authorization in advance.

Telehealth
Requires authorization. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a member.

Elderwood Health Plan will only pay for covered services. Call our Provider Services Department at 1-866-THE-PLAN (1-866-843-7526) for information about exclusions and limitations. A list of covered services will also be available online via our website at www.ElderwoodHealthPlan.com.

Medical Necessity

Services must meet medical necessity criteria and most services require prior authorization. Medical necessity criteria are guidelines that help Elderwood Health Plan make decisions about appropriate care for specific circumstances. When appropriate, Elderwood Health Plan uses evidence-based clinical guidelines. You can view a current list of the services that require authorization on our website at www.ElderwoodHealthPlan.com.

Covered services must be provided in accordance with your agreement with Elderwood Health Plan. Elderwood Health Plan will give you at least sixty (60) days advance notice of any changes to the Managed Long Term Care (MLTC) program, including new services, expanded services, or eliminated services. You will be notified by one or more of the following methods: provider newsletter, e-mail, updates to the Elderwood Health Plan website, letter (U.S. Mail), or telephone call.

Non-covered Services

Elderwood Health Plan members may require services that are not covered by Elderwood. These services are included in the Member's plan of care and are coordinated by the Care Manager in collaboration with the Member's PCP and other providers involved in their care. These services are billed directly by the Provider to Medicaid, Medicare, or other third party payers. Non-covered services include:

1. AIDS Adult Day Health Care
2. Alcohol and Substance Abuse Services
3. Assertive Community Treatment (ACT)
4. Chronic Renal Dialysis Services
5. Day Treatment and Continuing Day Treatment
6. Case Management for Seriously and Persistently Mentally ill
7. Emergency Transportation
8. Emergency Department Services
9. Family Planning Services
10. Hospice Services
11. Inpatient Hospital Stay and Partial Hospitalizations
12. Intensive Psychiatric Rehabilitation Treatment Programs
13. Laboratory Services
14. Mental Health Services (listed below)
15. Methadone Maintenance Treatment
16. Office of Mental Retardation and Developmental Disabilities (OMRDD) Services
17. OMH Licensed Community Residences and Family Based Treatment Programs
18. Personalized Recovery Oriented Services (PROS)
19. Physician Services
20. Prescription & Non Prescription Medications
21. Radiology and Radioisotope Services

All non-participating provider requests for service require authorization in advance.

Emergency Services are not an Elderwood benefit. No Prior Authorization is required. In the event of an emergency medical condition, the member is instructed to go to the nearest emergency room or hospital, or to call 911 for assistance. Members are requested to contact Elderwood Health Plan and/or their Primary Care Physician within 48 hours of the emergency room visit or hospitalization.

Credentialing/Re-credentialing

Elderwood Health Plan bases its credentialing and re-credentialing processes on nationally recognized accreditation standards as well as applicable state and federal requirements. Our credentialing/re-credentialing process includes primary source verification consistent with NYSDOH requirements. Elderwood Health Plan conducts provider credentialing prior to participation and re-credentials providers every three years.

Provider performance measures may be taken in consideration for re-credentialing. These performance measures include, but are not limited to, member related grievances, appointment availability, adherence to clinical guidelines, compliance with medical record documentation standards, and overall cooperation with mandated Quality Improvement projects. These measures are constantly reviewed. Time sensitive credentialing documents, such as copies of license registration and malpractice insurance, must be updated without waiting for re-credentialing and sent to Elderwood Health Plan in order to keep individual files current at all times. A site visit may also be performed based on the Provider's specialty.

All Elderwood Health Plan providers are required to provide any and all credentialing/re-credentialing information and supporting documents, as requested by Elderwood Health Plan.

Provider Notification Time Frames

Participating Providers must notify Elderwood Health Plan within the timeframe indicated for any of the following reasons:

- As soon as a new associate is anticipated, so that we may furnish you with the necessary materials to begin the credentialing process.
- As soon as there is any lapse in malpractice coverage, change in malpractice carrier, or coverage amounts.
- At least sixty (60) days in advance (in writing) if there is any change, addition, or deletion of office hours, associate, or billing address so that we may have ample time to reflect the correct information in our directories and databases.

Within two (2) business days if their professional or state license or certifications become revoked or restricted, or if any reportable action is taken by a City, State, or Federal agency.

Enrollment and Eligibility

Potentially eligible individuals of Elderwood Health Plan are contacted by a Member Services Representative to arrange for an in-home meeting with our Enrollment Coordinator and an RN visit to conduct an assessment using the state-mandated UAS-NY tool. During the assessment process, Elderwood Health Plan will also evaluate applicants to determine if they are capable (at the time of enrollment) of living in their home or community setting without jeopardizing their health or safety, based on criteria provided by the New York State Department of Health. If the individual is determined ineligible, Elderwood Health Plan will notify the individual and refer them to other community resources for assistance. Elderwood will also notify the Local District Social Services (LDSS) and other appropriate entities of their ineligibility. For additional member enrollment or eligibility criteria, please contact Provider Relations at 1-866-THE-PLAN (1-866-843-7526) or review the Member Handbook online at www.ElderwoodHealthPlan.com

Member Services Department

Member Services Representatives are available by telephone to assist members with any questions that they may have regarding Elderwood Health Plan, including inquiries about the benefit package, what services are or are not covered, scheduling appointments, or the arrangement of transportation. These staff members work with the Care Team to schedule appointments and order the supplies and services that are needed. They will also work with the Care Manager and vendors to ensure that the Member receives the services they need, or they will help resolve any problems the member has with their current services. Member Services Representatives can answer most questions regarding the plan of care. If necessary they will make sure that a Care Manager contacts the member to answer any medical questions they might have.

CARE MANAGEMENT

Elderwood Health Plan's MLTC program focuses on relationship building, promoting choice among members and caregivers, and assisting in the coordination of the full continuum of physical, behavioral, social, financial, and environmental care and services. The objective is to assure that members receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Member Needs

Once identified as a candidate (or potential candidate) for MLTC services, a clinically licensed and experienced Assessment Registered Nurse (RN) will conduct an initial face-to-face home visit. The RN will explain services in detail and complete a comprehensive evaluation of the individual in the community using the state-mandated UAS-NY instrument to determine eligibility considering:

1. The individual's overall health, functionality, and ability to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).
2. Communication/sensory patterns.
3. Emotional and cognitive functioning, including orientation to surroundings and behavior (e.g., wandering, aggression).
4. The individual's social, environmental, and financial circumstances.
5. The availability of informal supports.
6. Whether the individual is able to remain in his or her home or in a community setting without jeopardizing health or safety.
7. The need for referrals for physical and/or behavioral health care services in addition to long-term care services and supports.

When an applicant is eligible for the MLTC program and is enrolled with Elderwood Health Plan, the Care Management Team will initiate the member-centered care/service planning process. The member will be assigned to a Care Management Team that will use the assessment tool to gain a perspective of the member's status. The case formulation and subsequent care plan will be developed through collaboration with the member, the assigned Care Management Team, and the caregiver. As appropriate, the Care Management Team will also consult with the member's PCP, specialist providers, and other relevant professionals involved in the member's care. Elderwood Health Plan's assessment process is holistic, focusing on the individual's long-term care needs along with their medical, social, cultural, financial, and environmental circumstances.

Social Work

An Elderwood Health Plan Social Worker will work closely with the member and Care Manager. The Social Worker may visit a member in their home upon the member's request, or by the request of their informal supports, Care Manager, or primary care physician. He or she will assist the member with applying for any entitlements (i.e. Home Energy Assistance Program, Medicaid, and/or Food stamps) and other benefits for which the member is eligible, as well as assist in maintaining eligibility through the certification process of all entitlements. The Social Worker is also available to advise the member and their family on how to cope with chronic illness and social problems.

Care Management Communication

Elderwood Health Plan's Care Management Teams will be responsible for coordinating members' care throughout the continuum of covered and non-covered services. They will employ a number of strategies to accomplish this objective, including:

- Communicating with Members and their Informal Support Systems: Care Management Teams will regularly communicate with members and members' families/caregivers by telephone, online, and during in-person visits to discuss an array of issues relating to the member's health and well-being. They may discuss things such as physician visits, medications, therapies, nutrition, and member safety. As needed, Care Management Teams will make referrals, schedule appointments, arrange out-of-network access, arrange transportation, and conduct follow-up discussions with the member and/or provider.
- Communicating with Providers: Ideally, Care Management Teams will regularly confer with treating providers, and other professionals involved in the delivery of covered and non-covered services, to support their prescribed course of treatment and ensure that authorized long-term services and supports are consistent with the member's health-related needs and preferences. They will also collaborate with the member's physicians/practitioners in the development of the care/service plan and keep them informed of any updates, modifications, or revisions to the member's plan of care and authorized services.
- Telephonic or In-Person Visits: The Care Management Team will contact the member on a monthly basis. The Assessment RN will conduct an in-person visit every six (6) months and as the member's condition requires. Elderwood Health Plan's Care Management Team will conduct an evaluation of our members at their residences to perform assessments, confer with the member's informal supports, evaluate the residence for safety issues, and ensure that the member's care plan remains responsive to the member's needs and preferences. Elderwood Health Plan's Managed Long-Term Care (MLTC) program provides necessary tools to evaluate and re-evaluate members in their home settings. The Care Management Team may also consult with Elderwood Health Plan's Medical Director and the member's treating providers and practitioners about any health-related questions or concerns, schedule any necessary appointments and follow-up visits, and revise the member's plan of service as needed.

*Please note: When transitioning members from Medicaid fee-for-service or another Medicaid community-based long term care program, Elderwood Health Plan will continue to provide services authorized under the enrollee's pre-existing care plan for a minimum of 90 days. EHP will authorize and cover community-based long term care services and institutional long term services and supports at the same level, scope, and amount as the member received under the Medicaid fee-for-service program for 90 days following enrollment, or until the member's person-centered service plan is in place, whichever is later. Where an existing medical order has or is about to expire, and a new medical order is required for the provision of services during the transitional period but cannot be obtained after reasonable effort, Elderwood Health Plan will work with providers to arrange a safe transition for the member, which may be to a higher level of care. Elderwood will work closely with each new member's family, caregivers, and providers to ensure a smooth transition of care.

REFERRAL MANAGEMENT AND PRIOR AUTHORIZATION

The referral management process is designed to address medical necessity and appropriateness, referral patterns, and the appropriate use of Elderwood Health Plan network providers. The Care Manager is responsible for coordination of the referral management process for covered services to ensure that appropriate care is provided when medically necessary.

Prospective Review

Prospective review is the process of evaluating requested medical services *before* the services are rendered in order to:

- Establish adequacy of the member benefits.
- Determine appropriateness of the provider/facility.
- Evaluate the proposed treatment plan.
- Determine if care is medically necessary.
- Identify alternatives to proposed care.
- Ensure care is rendered at the most appropriate level.
- Identify and refer cases that may benefit from additional management programs.
- Identify quality of care issues.

Prior Authorization

Members and providers may submit a request to the Care Management Team to add a new service or support, or to modify existing services. If the request is to modify an existing service or support, the Care Management Team will work with the member, the member's informal supports, and health care providers to evaluate the medical necessity and appropriateness of the request.

Initial referrals will only include the initial office visit. Any subsequent visits, procedures, services, or equipment that is provided must be amended to the original authorization by calling the Elderwood Health Care Management Department at 1-866-THE-PLAN (1-866-843-7526). The provider must give all applicable information for the authorization including diagnosis, units, and procedure codes at the time of the authorization. ***Services performed that have not been authorized will NOT be reimbursed by Elderwood Health Plan.** Prior Authorizations are needed for most services. The Member's Care Manager should be informed of all the services you are planning to provide. The authorizations process helps to get the services paid for and to update the member's service plan.

Prior Authorization is needed for all services, with the exception of seeing a podiatrist, ophthalmologist, dentist, or audiologist for basic service such as an evaluation or repair. The Care Manager can help make arrangements for these services. Please refer to the list of covered services (p. 20-23) for the services requiring prior authorization.

To ensure continuity of care, upon request from Elderwood Health Plan, the specialist is required to submit a consult report within fifteen (15) days. If the specialist determines that treatment beyond the scope of the initial referral is necessary, Elderwood Health Plan must be consulted prior to recommending treatment to the member or proceeding with the treatment plan.

Elderwood Health Plan's Medical Management staff will review provider requests for authorization for covered ancillary medical services (nursing care, physical therapy, occupational therapy, speech therapy, podiatry, audiology, and vision care) not previously authorized in the member's service plan for medical necessity, and either approve or pend the request for further review, as appropriate. Only the Medical Director can deny a clinically related service authorization request or approve a reduction, suspension, or elimination of an existing medical service.

Payment to a provider will be denied if:

- The requested clinical information is not provided or is insufficient for screening.
- The length of stay or period of time exceeds the authorized length of stay or period of time, and an approval for extension is not obtained from Elderwood Health Plan.

In the event that prior authorization for a service is required during non-business hours, the provider should arrange for or provide the necessary services and contact the Care Management Department for authorization the next business day.

The Authorization form assures the provider that Elderwood Health Plan has approved the member's care. It also authorizes Elderwood Health Plan's Claims Department to process the claim for payment.
Authorization for services, revised authorizations, and authorization terminations are faxed to the Provider. Each authorization contains the following information:

1. Authorization or request number
2. Authorization effective date and expiration date
3. Name, address, and Elderwood Member ID number
4. Diagnosis
5. Service code and description of service, along with amount, frequency, and duration of service
6. Name and address of the Provider
7. Name of the Member Services staff person entering authorization
8. Name of the Member's Case Manager

(Additional information is documented in the "Notes" section of the authorization. This information would include relevant clinical information and reason for referral.)
In addition, if the request is unusual, time-sensitive, especially complicated, or requires a particular customization, additional written or verbal communication with the Provider will take place. The Provider should review the authorization to confirm the vendor name, dates of service, service code, and number of units authorized. If any of these fields do not match the service/item requested, call the Elderwood representative issuing the authorization immediately and request a corrected authorization. Authorization is not required for payment of Medicare or other Primary Payor Co-Insurance, with the exception of Skilled Nursing Facilities.

Except where a Participating Provider Agreement describes an alternate arrangement for authorization of transitional care, Elderwood Health Plan will not deny payment to providers of transitional care community-based long term care services and institutional long term services and supports solely on the basis that the provider failed to request prior authorization. (See note on page 25 regarding transitional care authorizations.)

Out-of-network or Out-of-plan Services

If a particular specialty/specialist is not listed in the Elderwood Health Plan provider directory, or is not within a reasonable travel distance from the member's home, please contact the Provider Relations Department at 1-866-THE-PLAN (1-866-843-7526) for assistance in locating a provider with the required specialty. If the Elderwood Health Plan network does not have a participating provider with the appropriate training and experience to meet the needs of a member, Elderwood Health Plan will work with the member to coordinate care with a non-participating provider. Such service will be provided at no additional cost to the member. All requests for non-participating providers require prior authorization and must be directed to the Elderwood Health Plan Care Management Department before the delivery of service. These requests are subject to approval by the Elderwood Health Plan Medical Director.

Requesting New or Additional Services

Requests for new or additional covered services can be obtained through the Care Management Team. Requests can be verbal or in writing. New or additional services require the review and authorization of the Care Management Team. Some requests require a medical necessity determination to ensure that the requested service is most appropriate and is medically needed. In most cases, service authorizations will be sent in writing. Requests for new or additional services will be handled in one of the following ways:

Prior Authorization (New Services)

There are two kinds of prior authorizations:

1. **Standard Prior Authorization (New Services)**
   A request for a new service or a request to change a service for a future authorization period is considered a Standard Prior Authorization. A standard prior authorization will be given within three (3) business days of receiving all pertinent information we need to make the decision, but no more than fourteen (14) days after receipt of a request for service, unless the member health status requires a more expedited (faster) review.
2. **Expedited Authorization (Prompt New Services)**
   If Elderwood, the Member, the Member Representative, or the Provider feel that a delay would jeopardize the member's life, health, or ability to regain maximum function, the decision will be expedited.
   - Elderwood Health Plan will provide an expedited authorization if the provider indicates the standard authorization time frames could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.
   - Elderwood will provide expedited authorization within three (3) working days, or as expeditiously as the health condition requires.
   - Elderwood may extend the three (3) working day time period up to fourteen (14) calendar days if the provider or member request an extension, or if it is justified that the extension is in the member's best interest.

Concurrent Review (Additional Services)

This is for a request for additional services, or more of the same services that are currently authorized in the member's service plan. Elderwood Health Plan will make a Service Authorization Determination as fast as the member's condition requires and no more than:

- **Standard Concurrent Review**
  one (1) business day after receipt of necessary information, but no more than fourteen (14) days of receipt of the Service Authorization Request.
- **Expedited Concurrent Review**
  one (1) business day after receipt of necessary information, but no more than three (3) business days of receipt of the Service Authorization Request.
- **In the case of a request for Medicaid covered home health care services following an inpatient admission**
  one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

The timeframe for Service Authorization Determinations may be extended up to 14 calendar days. An extension may be requested by the member or provider on their behalf (written or verbal). Elderwood Health Plan may also initiate an extension if we can justify the need for additional information and if the extension is in the member's interest. If we initiate an extension, we will notify you of the deadline for our review of your service request. We will explain the reason for the delay and how the delay is in the member's best interest.

Concurrent Review (Hospital)

Elderwood Health Plan focuses on the tracking and monitoring of those resources not covered under the Plan, such as an inpatient or outpatient episode of care. Elderwood Health Plan will participate in hospital discharge planning while the member is an inpatient. Elderwood Health Plan will then have a good understanding of the care needs of the member once discharged home. Concurrent Review can also be a request by a member or provider on the member's behalf for additional home care services that are currently authorized in the plan of service, or for Medicaid covered home health care services following an inpatient admission. Additionally, Elderwood Health Plan must be notified within 48 hours of any emergency admission. Notification may come from the member or representative of that member, staff at the admitting facility, or the provider's office.

Retrospective Review

For those Members who have Medicare or receive care or services without Elderwood knowing about it, we may do a retrospective review to review the care after it has already been provided. We use this information to make sure that the benefits are being used correctly. Elderwood Health Plan is always a secondary payer to Medicare.

Duration and frequency of services are outlined in the individual member service plan. Providers can request to amend the duration or frequency of covered services. Elderwood will make a clinical determination and will inform the provider in writing. Pre-payment retrospective reviews are completed within thirty (30) days of the receipt of medical record information. Post-payment reviews are completed within sixty (60) days of receipt of the medical record information.

If the services requested are not authorized, the member and provider will receive a Notice of Plan Action Letter (denial) by mail that will explain the decision. The provider may appeal the decision rendered by Elderwood. For more information, please refer to the Grievances and Appeals section of this manual.

Adverse Determination

If a service or continued use of a service is not medically necessary or not covered by Elderwood Health Plan, a decision may be made to deny coverage of the service or deny authorization of further services for that episode of care. Such decisions are based upon a review of the clinical findings by the Care Management Staff and/or the Medical Director, and follow discussions with the attending physician.

When the decision is made to deny coverage of a service or authorization for further service for an episode of care, the appropriate parties (physician, facility representative, member, and member's family or legal guardian) will be notified in writing of the denial. The notification will include the reason for the denial and the right to appeal the decision. The Physician Adverse Determination Letter informs the physician about the opportunity to discuss the denial.

QUALITY MANAGEMENT

Quality Program

The goal of the Quality Management Program is to systematically monitor, evaluate, and improve the quality and appropriateness of care provided or coordinated in order to maximize member satisfaction. The following areas are reviewed annually:

1. Quality and quantity of services
2. Management of care (including availability, access and continuity, and early identification of problems)
3. Identification and correction of operational and clinical practice issues
4. Outcomes in clinical and non-clinical areas
5. Records of grievances, appeals, and compliments

Elderwood Health Plan supports and fulfills these functions through several cross-functional committees and the Quality Management Committee.

Work Plan Activities

An annual work plan is designed to conduct activities in support of the Quality Program. Activities include a review of all departments and selected operations to comply with regulatory requirements and business and operational goals. Sources of data include record reviews, grievances, incidents, hospitalizations and nursing home admission data, high risk/high volume utilization data, and other customer service and provider performance data reports. Data is reported to the Board of Managers. A report on the outcomes of the quality program will be posted on the Elderwood website. A hard copy is available upon request.

Provider Quality

When concerns about the quality of care given to Elderwood Health Plan members occurs, a medical record review or incident report may be required as part of the investigation. Providers may be asked to investigate individual or aggregate grievances. After investigating the concern, Elderwood Health Plan may refer the matter for further action to the Quality Improvement Committee. If quality concerns are substantiated, the Committee may direct the Quality Management Coordinator to continue to monitor the situation, or it may require that a provider corrective action plan be implemented. Incident Reports that are requested must be submitted to Elderwood Health Plan within two (2) business days of the request. Elderwood will provide feedback, as appropriate, to providers regarding performance with information gathered from grievances, utilization data, staff, and member feedback.

Example of an Elderwood Health Plan ID Card

elderwood health plan

Member Photo Here

Member ID#: 000000000

Member Name: Last name, First name

Effective Date: 00/00/0000

Member Services (Available 24 hours):

1-866-THE-PLAN (1-866-843-7526)

Hearing and Speech Impaired: NY Relay 7-1-1

www.ElderwoodHealthPlan.com

Emergency: **call 911** or go to Emergency Room

Notify Member Service of ER use or Admission to the hospital.

Prior Authorization is required for selected outpatient services. Prior Authorization and Eligibility information: Call 1-866-843-7526 available 24 hrs. /7 days a week.

For a complete list of covered and non-covered services, please see your member handbook.

For any care-related questions or needs, please contact your care manager at the member services number listed.

This card is not a guarantee of eligibility, enrollment or payment. Send Claims to**: Peak/eClusive**, 11010 Prairie Lakes Dr, Ste 175 Eden Prairie, MN 55344 Electronic Claims Payer ID: 03964

Co-payments

Elderwood Health Plan members are not required to pay a co-payment. Your office should not collect a co-payment from the member at the time of service. **For members eligible for both Medicare and Medicaid, co-payments are waived.**

Elderwood Health Plan processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules, and regulations. Elderwood Health Plan will not pay claims submitted by a provider who is excluded from participation in Medicaid (or any program under federal law) or is not in good standing with the New York State Department of Health.

Elderwood Health Plan accepts both electronic and paper claims submissions. To assist us in processing and paying claims efficiently, accurately, and timely, Elderwood Health Plan encourages providers to submit claims electronically.

Providers must inform Elderwood Provider Relations of any changes in Tax ID, corporate name, or addresses as soon as they are known. Allow thirty (30) days for record updates.

Claims Timeliness

Elderwood Health Plan requires clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or a third party. It does not include claims submitted by providers under investigation for fraud or abuse, or those claims under review for medical necessity. Please refer to these claim timelines:

- Elderwood Health Plan requires that clean claims be submitted within 120 days from the date of service, or within 120 days from the date an explanation of benefits was issued from a primary payor.
- Claims for services partially covered by Medicare or another primary payor must be accompanied by a Medicare or other primary payor EOB.
- Elderwood may pay claims denied for untimely filing when the provider can demonstrate that a claim submitted after 120 days of the date of service resulted from an unusual occurrence *and* the provider has a pattern of timely claims submissions.
- Claims submitted beyond 120 days will be paid at a discount up to 25%.
- Claims for dates of service beyond 365 days will not be considered for payment.
- Clean electronic claims will be paid within 30 days and clean paper claims will be paid in 45 days if the claims contain prior authorization number and are pursuant to the Elderwood Utilization Management process. If applicable, providers paid on a capitation basis will be paid according to the time period specified in your provider agreement with Elderwood Health Plan.

Claim Submission

Claims for authorized services must be submitted within 120 days of the date of service or 120 days from receipt of Primary Payor EOB. To ensure timely claims adjudication, the following information must be included on the claim form:

- Member's first and last name, date of birth, and the eleven digit Elderwood Member ID number
- Provider's name and address, Elderwood Provider NPI number, HCFA 2-digit location code, and tax ID number
- Valid ICD diagnosis code(s) coded to the highest specificity
- Date and place of service code
- Current procedure code
- Charge amount
- Number of units
- Copy of the primary insurer EOB for co-insurance claims

Elderwood Health Plan has contracted with Mediture eClusive to provide claims processing and administrative services for the MLTC Program. For services rendered to Elderwood Health Plan participants, submit all claims for services to eClusive at the following address:

Peak TPA Elderwood/eClusive
11010 Prairie Lakes Drive, Suite 175
Eden Prairie, MN 55344

Electronic Claims

For electronic claims submission, please contact eClusive. Electronic billing details are:
Clearinghouse: Change Healthcare (formerly Emdeon)
Payer Name: Elderwood Health
Payer ID: 03964
Group #: WILLI
Authorization #: Provided on Authorization from Elderwood Health Plan
Participant Account #: Provided on Authorization from Elderwood Health Plan

Providers can submit electronic claims to Change Healthcare by accessing http://www.changehealthcare.com/.
Note: Use the following Payer ID: 03964.

For questions regarding the status or payment of a claim for services rendered contact eClusive at 952-400-7600.

For authorization or medical management issues regarding our MLTC members, contact Elderwood Health Plan 1-866-THE-PLAN (1-866-843-7526).

Elderwood is committed to improving care while reducing costs. One important way to achieve this is to make use of industry standards and established technology in both the coordination of care and in back office operations. We use a HIPAA-compliant Electronic Data Interchange (EDI) to improve speed and accuracy of claims adjudication. In order to fully achieve the efficiencies offered by EDI, we encourages our provider-partners to submit claims to us via 837 electronic transactions.

Clearinghouse

In order for us to receive an incoming electronic claim, Providers must "address" the claim to the right Payer and then send the claim using a clearinghouse for delivery. The following information is needed: Clearinghouse, Payer Name, Payer ID, Group Number and Member ID number. Elderwood has contracted with Mediture eClusive to provide claims processing and administrative services for the MLTC Program.
Claims are processed through the Change Healthcare clearinghouse exclusively for sending remittances and receiving claims. If you use a different clearinghouse, please verify with your clearinghouse whether they have a forwarding agreement with Change Healthcare and to verify *Elderwood Health* as a payer. If *Elderwood Health* is not currently established as a payer, then ask your clearinghouse to add them.
The following information is needed for electronic claims:

Clearinghouse: Change Healthcare (formerly Emdeon)
Payer Name: Elderwood Health
Payer Id: 03964
Group Number: WILLI
Member ID number: Provided on Authorization from Elderwood Health Plan
Authorization #: Provided on Authorization from Elderwood Health Plan

If your clearinghouse is not listed below then you will need to work with them to establish Elderwood Health as a payer. Please let us know if and when this happens, so we can update our records accordingly. Once we are set up in your billing system to receive electronic claims, you will also need the Member ID number for your patient. This information is on the member ID card and provided on every Authorization that we send to you. From a workflow standpoint, if we provide you with an authorization for service, then we require that you provide the authorization number on the claim. This number should be entered in the "Prior Authorization" field of your billing system.

For your reference, here are the proper 837 fields and loops to populate:

Payer: Loop ID-2010BB
Group Number: Loop ID-2000B-SBR03.
Member Number: Loop ID-2000B-NM109
Prior Authorization Number: Loop ID-2300-REF02

Partial list of clearinghouses with Elderwood Health Plan pre-established as a Payer: Capario, Change Healthcare and Netwerkes. If you use RelayHealth as a clearinghouse, please contact eClusive directly at 952-400-7600 to discuss your billing options.
Payment is subject to the member's eligibility, authorization requirements at the time of service, and all other applicable administrative procedures.
If you have any questions please call Provider Relations at 1-866-THE-PLAN (1-866-843-7526).

Paper Claims

Elderwood Health Plan requires providers to use one of the following forms when submitting paper claims:

1. **CMS 1500**
   A CMS 1500 (formerly HCFA 1500) billing form is used to submit paper claims for services such as individual practitioners, DME & medical supplies, transportation, or private rehab therapies.
   - Before submitting a claim, a provider should ascertain that all required attachments are included.
   - All claims that involve other insurance must be accompanied by an Explanation of Benefits(EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.
   - Include a *place of service* and a *valid diagnosis code*.
   - Use current CPT-4 or HCPCS codes and the 2-digit place of service codes.
   - Claim forms should be typed or printed legibly with black ink in order to reduce delays inprocessing. Claim forms may be submitted weekly and in batches.
   - All required fields must be completed.

2. **UB-04 Form**
   Home health care, skilled nursing, Adult Day Care, PERS, rehab in a clinic setting, and nursing home room and board must be billed on the UB-04 billing form. All required fields must be completed, including *bill type* and *valid diagnosis code*.

3. **ADA Form**

   Dental claims should be submitted on an ADA form and:
   (Before submitting a claim, a provider should ascertain that all required attachments are included.)
   - Include a place of service and a valid diagnosis code.
   - Use current CDT codes and the 2-digit place of service codes.
   - Claim forms should be typed or printed legibly with black ink in order to reduce delays in
   - processing. Claim forms may be submitted weekly and in batches.
   - All required fields must be completed.

   PLEASE NOTE: ALL CLAIMS MUST INCLUDE AN AUTHORIZATION NUMBER.

   Providers can submit hard copy claims via mail to the following address:

   Peak TPA Elderwood/eClusive
   11010 Prairie Lakes Drive, Suite 175
   Eden Prairie, MN 55344

Elderwood Health Plan requires clean claim submissions for processing. A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse, or those claims under review for medical necessity.

Claims Resubmission

Elderwood Health Plan will consider a claim for resubmission *only if* it is re-billed in its entirety. Providers have 45 days from the date of receiving the plan written notice to request claims adjustments. Providers must include the nature of the request, member's name and date of birth, member identification number, service/admission date, location of treatment, service or procedure, documentation supporting request, copy of claim, and a copy of remittance advice on which the claim was denied or incorrectly paid. Providers must additionally stamp or write RESUBMISSION, REBILL, CORRECTED BILL, and CORRECTED OR REBILLING on the paper claim to indicate resubmission of the claim.

Providers can resubmit hard copy claims via mail to the following address:

Peak TPA Elderwood/eClusive
11010 Prairie Lakes Drive, Suite 175
Eden Prairie, MN 55344

Special Requirements for Billing

Please refer to the following requirements for PERS and HHA billing:

- Personal Emergency Response System
  All bills for Personal Emergency Response Systems shall contain a dated certification by the provider that the care, services, and supplies itemized have in fact been furnished.
- Home Health Agencies
- No payment will be made unless the claim for payment is supported by documentation of the time spent providing services to each member.

Coordination of Benefits

- Medicare and Other Primary Payer Sources
  Eligible Elderwood Health Plan members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. Generally, members with comprehensive third party insurance are considered to be an excluded population from the Elderwood Health Plan Managed Long-Term Care program.
  For the Managed Long-Term Care (MLTC) program, Elderwood Health Plan is the payer of last resort for Medicaid-covered MLTC services. As applicable, providers must bill third party insurance before submitting a claim to Elderwood Health Plan. Elderwood Health Plan will pay the difference between the primary insurance payment and the Elderwood Health Plan allowable amount. Providers cannot balance bill members.
  If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Elderwood Health Plan for a coverage determination.
  It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members that have insurance in addition to Elderwood Health Plan. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential in order for Elderwood Health Plan to coordinate benefits.
  If a service is not covered or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third party insurance is indicated will be denied in most cases. Providers have a maximum of 365 days from the date of the EOB for Coordination of Benefits.

If assistance with the billing of third party payers is required, please contact a Provider Relations Representative at 1-866-THE-PLAN (1-866-843-7526).
To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from Elderwood Health Plan's requirements should be clearly marked with "COB Form Type Conversion."

- Overpayment/Underpayment/Errors:
  Providers and Elderwood shall notify one another of overpayments, underpayments, or payment errors within twenty (20) business days of becoming aware, in order to arrange for correction of the payment made in error. After 120 days of the receipt of an erroneous payment it will be considered a final payment. Elderwood Health Plan provides thirty (30) days written notice to health care providers before engaging in overpayment recovery efforts, allowing the health care provider the opportunity to challenge the recovery, unless the recovery is for duplicate payment. If the New York State Department of Health excludes or terminates a provider from its Medicaid program, Elderwood Health Plan shall, upon learning of such exclusion or termination, immediately terminate the provider Agreement with the Participating Provider, and will no longer utilize the services of the subject provider, as applicable. If payment is made to the provider for dates of service after the provider's exclusion or termination effective date, Elderwood Health Plan will engage in efforts to recoup the payment upon learning of the exclusion or termination.

Claims Inquiries

For questions regarding the status or payment of a claim for services rendered contact eClusive at 952-400-7600.

For authorization or medical management issues regarding our MLTC members, contact Elderwood Health Plan 1-866-THE-PLAN (1-866-843-7526).

All claim inquiries/appeals must be submitted within **45 days** of receipt of claim determination.

Compare the claim to the authorization. Only authorized services are paid. If the service is provided on an urgent basis or requested outside of business hours, an authorization should be requested on the next business day. Changes or Retroactive Authorizations will only be considered if there is documentation that Elderwood intended to authorize the service provided.

Call eClusive Claims Processing at 952-400-7600:

- To inquire about the status of a claim for which no payment or denial has been received within 45 days.
- If a line/claim that was submitted in a batch with other claims that were paid on an EOB is missing from that EOB.
- For paper claims: If any of the fields (date of service, code, amount charged, etc.) are not the same as what you submitted on your claim. If your claim matches the authorization, compare all fields of the claim line printed on the EOB with your claim. Be sure to provide the claim number and the information that was entered incorrectly.

Call Elderwood Provider Relations at 1-866-THE-PLAN (1-866-843-7526):

- If you are denied for a claim and subsequently find that there is an error on the authorization.
- If you provided a service different from the service requested (changed hours or days, completed visit after expiration date, etc.) contact the Member's case manager or staff person who issued the authorization to discuss the situation. (*Note:* Case Management is *not required* to change an authorization if a different service was provided).
- If your claim is incorrect, resubmit the claim with the corrections clearly noting "CORRECTED CLAIM".
- For paper claims: Denials or partial payments due to authorization issues, member status, or fee schedule.

Common Reasons for Denial

The following are common reasons for denial of a claim:

- **Denied for "No Auth" or "Services Not Authorized"**
  This means that there is no authorization found for date of service or that there is an authorization but not for the service (code) billed. Check your authorization dates and codes.
- **Denied for Duplicate or Paid Authorized Units**
  This means that a payment for that code and that day of service was previously paid in full.
- **Denied for Diagnosis Code (DX Code)**
  This means that the diagnosis code on your claim is either missing or inactive.
- **Denied for Incorrect Bill Type**
  This means that you may have used the wrong Claim Form or that your Bill Type is inconsistence with service.
- **UNA - "Units Not Authorized"**
  This means that the number of units charged is in excess to the amount authorized or that the date of service falls within the authorization effective date range but no units are authorized for that particular day (i.e. authorized for MWF but billed for Tuesday).
- **FNF - "Service Not in Fee Schedule"**
  This means that the code billed is not among the list of codes attached to your contract with Elderwood. For paper claims, check to see if the service code on the EOB is the same as the service code on your claim.
- **ALL - "Reimbursement limited to Prevailing Medicaid or Contractual Amount"**
  Please contact Provider Relations for Unit Rate inquiry.
- **PAU - Claim Units Are in Excess of Units Billed for Date of Service**
  The claim paid the authorized number of units for that day or authorization.

NOTE: A corrected authorization does not automatically reprocess denied claims. You must submit a corrected claim.

PARTICIPATING PROVIDER DISPUTES

Elderwood Health Plan and our contracted providers are responsible for timely resolution of any disputes between both parties. Disputes will be settled according to the terms of our contractual agreement and there will be no disruption or interference with the provision of services to members as a result of disputes. Providers can obtain information or assistance with the provider dispute process by calling the Provider Relations Department at 1-866-THE-PLAN (1-866-843-7526).

In the case of a claim dispute, the provider must complete and submit the Provider Dispute Form and any appropriate supporting documentation to Elderwood Health Plan's Provider Relations Manager. The Provider Dispute Form is accessible on Elderwood Health Plan's website, via fax, or by mail.
A participating provider has sixty (60) days from the date of the Explanation of Benefits (EOB) determination to file a request for reconsideration. In the event that there is a dispute concerning the original submission of a claim (i.e. your records indicate that services were billed but Elderwood Health Plan has no record of the claim being submitted), you will be given *150 days from the date of service* to submit the request for payment.
Disputes must be submitted in writing to:

Elderwood Health Plan
500 Seneca St., Suite 100
Buffalo, NY 14204

Requests should contain any additional information that would support the provider's request to overturn the initial determination. The provider must include the following:

1. A completed Provider Dispute Form (available on our website)
2. Nature of the request (legal and factual basis for dispute)
3. Member's name, date of birth, and ID number
4. Service or admission date
5. Location of treatment, service, or procedure
6. Clinical information and/or records and documentation supporting request
7. Copy of claim
8. Copy of remittance advice on which the claim was denied or incorrectly paid

Upon receipt, the request will immediately be logged and an acknowledgement letter will be sent to the provider. Elderwood Health Plan has sixty (60) days to respond to a provider's request for reconsideration.
The claim and all related information, including the additional information submitted on reconsideration, will be forwarded to the appropriate department at Elderwood Health Plan for review and a reconsideration determination:

- For technical denials (i.e. missing CPT codes or diagnosis codes) or questions of payment, the reconsideration review will be performed by the Elderwood Health Plan Claims Department.
- For denials for medical necessity, the Elderwood Health Plan Medical Director will perform the reconsideration review.

Upon determination, Elderwood Health Plan's Claims Department will send out a written notification of the determination to the provider.No further appeal rights are available after a determination is made.

Provider Complaints

Both in-network and out-of-network providers may file a complaint orally or in writing directly with Elderwood Health Plan regarding to our policies, procedures, or any aspect of our administrative functions.
The complaint will be researched and all related documents will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider from the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will then consider all relevant information and render a decision. You will be provided with a written response to the complaint.

Grievance and Appeals

This section is a copy of the language of grievance and appeals from the Elderwood Member Handbook. A provider may file a grievance or appeal payment on the member's behalf.

Elderwood Health Plan will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Elderwood staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please call: 1-866-THE-PLAN (1-866-843-7526) or write to:

Elderwood Health Plan
500 Seneca St., Suite 100
Buffalo, NY 14204

When you contact us, you need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

The Grievance Process

You may file a grievance orally or in writing with us. The person who receives your grievance will record it, and appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process. We will review your grievance and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information.
2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your grievance and our decision about your grievance.

How do I Appeal a Grievance Decision?

If you are not satisfied with the decision we make concerning your grievance, you may request a second review of your issue by filing a grievance appeal. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your grievance. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When Elderwood Health Plan denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

The notice will also tell you about your right to a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that you do not have to file an appeal before asking for a Fair Hearing;
- It will explain how to ask for a Fair Hearing; and
- If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 business days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-866-THE-PLAN (1-866-843-7526) or writing to:

Elderwood Health Plan
500 Seneca St., Suite 100
Buffalo, NY 14204

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than 10 days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 60 calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your Internal Appeal.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides your appeal and then ask for a Fair Hearing. In either case, the same 60 calendar day deadline applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending, or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing an internal or external appeal will not guarantee that your services will continue.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear that you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. In all cases, you must make your request within 10 days of the date on the notice, or by the intended effective date of our action (whichever is later).

Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing Decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx
- Mail a Printable Request Form

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023 Albany, New York 12201-2023
- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:

  Standard Fair Hearing line: 1-(800) 342-3334
  Emergency Fair Hearing line: 1-(800) 205-0110
  TTY line: 711 - Request that operator call: 1-(877) 502-6155
- Request in Person:

  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

  Albany
  40 North Pearl Street, 15th Floor
  Albany, New York 12243

For more information on how to request a Fair Hearing, please visit: http://otda.ny.gov/hearings/request/

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

ELDER ABUSE

Whenever it is suspected that a member is being abused, Elderwood Health Plan will provide a full assessment in partnership with the member's primary care physician. The following are types of elder abuse /maltreatment/neglect to which all health care providers must be alert:

- Physical Abuse – The infliction of physical pain or bodily harm to an older person. Examples: Beating, hitting, pushing, and restraining.
- Sexual Abuse – Any form of sexual contact or exposure without the older person's consent or when the older person is incapable of giving adequate consent.
- Psychological/Emotional Abuse – The infliction of mental anguish. Examples: threatening, humiliating, intimidating, isolating, infantilizing.
- Financial/Material Abuse – The illegal or improper exploitation and/or use of funds or other resources. Examples: stealing possessions, money or property, misusing money.
- Neglect – Refusal or failure to fulfill a care taking obligation including abandonment or isolation, denial of food, shelter, clothing, medical assistance or personal needs, or the withholding of necessary medications or assistive devices (i.e. hearing aids, glasses).

Abuse and neglect can be intentional or unintentional. Intentional refers to the conscious and deliberate attempt to inflict physical, emotional or financial harm. Unintentional refers to an inadvertent action, which results in physical, emotional, or financial harm usually due to ignorance, inexperience or lack of desire or inability to provider proper care.

Reporting Possible Elder Abuse

If you suspect Elder Abuse, you should immediately notify Elderwood Health Plan Provider Relations at 1-866-THE-PLAN (1-866-843-7526). In addition, you must initiate the proper notifications to any agency or authority that are required by the law in effect at the time. Providers are encouraged to contact Adult Protective Services within their service area.

MARKETING

The provider must comply with marketing standards as set forth in 42 CFR §438.104 and applicable State Laws. The provider is never required to distribute marketing materials but may distribute NYSDOH approved Elderwood Health Plan pamphlets to patients.

If the provider displays materials for Elderwood, then the materials for all the Medicaid Managed Care programs the provider participates with must also be displayed.

The provider may not distribute marketing materials that mislead, confuse, or defraud an eligible person or the public. Providers cannot misrepresent the Medicaid Managed Long-Term Program. Elderwood will not conduct any provider site marketing activity without the permission of the provider.

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