SECTION I: Introduction

WELCOME

We would like to welcome you to ONECare by Care1st Health Plan Arizona, Inc. (ONECare). As a provider you play a very important role in the delivery of health care services to our members.

The ONECare Provider Manual is intended to be used as a guideline for the provision of covered services to ONECare members. This manual contains policies, procedures, and general reference information, including minimum standards of care which are required of ONECare Providers.

As a ONECare Provider, we hope this information will help you better understand how ONECare operates. This Manual is applicable to the ONECare line of business only, which pertains to members who qualify for both Medicare Part A and B in conjunction with AHCCCS (sometimes referred to as Medicare Advantage Special Needs Plan). Should you or your staff have any questions about any information contained in this manual or anything else about ONECare, please feel free to contact our Provider Network Operations Department at any time. See Section II for phone numbers for your Provider Network Operations Department and for other departments that you may need to contact.

ONECare works closely with our contracted Primary Care Physicians (PCPs), Specialists, and other Providers to ensure that our members receive medically necessary and appropriate covered services. We are a managed care delivery system in which the PCPs serve as a "gatekeeper" for member care. PCPs are responsible for coordinating and overseeing the delivery of services to members on their patient panel. We look forward to working with you and your staff to provide quality health care services to ONECare members.

MISSION STATEMENT

ONECare will be the most provider-oriented managed care organization that will strive to continuously improve the quality of services rendered to its members.

INTRODUCTION TO ONECARE

ONECare is an Arizona corporation which is contracted with the Department of Health and Human Services Centers for Medicare and Medicaid to provide health care services to Medicare beneficiaries. We are committed to working closely with our providers in order to deliver the highest quality services in a provider-friendly environment.

ONECare has a locally-based Chief Medical Officer (CMO) and senior management team. All health plan functions are conducted locally in our Phoenix office. All day-to-day operational decisions are made at the local health plan.

SECTION I: Introduction

ONECARE'S DEPARTMENTAL ORGANIZATION

PROVIDER NETWORK OPERATIONS

The Provider Network Operations Department is made up of provider services, contracting and data maintenance and is responsible for the contracting, maintenance and education of the provider network. Provider Network Operations serves as the liaison between providers and the health plan.

The Provider Network Representative is the provider's primary point of contact within ONECare. The Provider Network Representative will answer any questions you may have or direct you to the appropriate department within the organization. The Provider Network Representative is assigned to your office by geographic location and provider type.

MEMBER SERVICES

Member Services has primary responsibility for assigning members to PCPs and changing PCP assignments. The Member Services Department is the members' primary point of contact with ONECare. Member Services provides members with informational materials and educates members on use of the health plan. The majority of concerns, complaints, and grievances from members are logged through the Member Services Department.

MEDICAL/QUALITY MANAGEMENT

The Medical Management and Quality Management Departments include the functions of Medical Management, Quality Management, Behavioral Health and Prior Authorization. Detailed descriptions of these functions are found later in this manual. The ONECare CMO has oversight responsibility for all actions and decisions made within the Medical Management and Quality Management Departments. Medical Management includes prior authorization, concurrent review, case and disease management and medical claims review.

ONECare has a Credentialing/Peer Review Committee, Pharmacy and Therapeutics Committee, and Dental Network Oversight Committee which report to the Clinical and Service Quality Improvement/Medical Management Committee and ultimately to the Board of Directors.

CLAIMS

The Claims Department reviews and adjudicates submitted claims and reports all encounters to Center's for Medicare and Medicaid Services (CMS). In addition, Claims Customer Service has a "help line" to address any questions or concerns that providers may have about their submitted or paid claims.

CLAIM DISPUTES AND APPEALS

The Claim Disputes and Appeals Team is responsible for the timely adjudication of non-contracted provider claim disputes and member appeals.

COMPLIANCE

The Compliance Department oversees the ONECare Compliance Program which includes Health Insurance Portability and Accountability Act (HIPAA), Privacy, Fraud and Abuse, the Appeals process and the Cultural Competency Program.

PHARMACY

The Pharmacy Department is responsible for overseeing the consistent administration of the pharmacy benefit for ONECare members by ensuring appropriate and cost-effective pharmacy services.

FINANCE

Finance oversees the accounting and financial activities of the organization which includes processing payments for the provider network.

SECTION II: Quick Reference Contact List

DEPARTMENTAL CONTACTS

ONECare
602.778.8345 or 1.877.778.1855
Claims Address:
2355 E. Camelback Rd #300 Phoenix, AZ 85016

Department	Phone	Fax
Behavioral Health Coordinator	602-778-1834	N/A
Case Management	Extension 8301	602.778.1810
Claims Customer Service	Options 5, 4	602.778.8346
Claim Disputes and Appeals	Options 5, 9	602.778.8371
Claim Liaison	Extension 1877	602.778.8346
Compliance	Extension 8343	602.778.1814
Disease Management	Extension 8301	602.778.1810
Hospital/SNF Admission Notification	See Prior Authorization – Medical	602.778.8386
Member Services	Options 5, 3	602.778.1814
Prior Authorization-Pharmacy	Options 5, 5	602.778.8387
Prior Authorization-Medical **Status Inquiry** **Urgent Telephonic Requests or Revisions To Existing Prior Authorizations or Questions Denied Authorizations**	Options 5, 6, 2 Options 5, 6, 3	602.778.1838
Quality Management	602-778-1839	N/A
Provider Network Operations	Options 5, 7	602.778.1875
Fraud Waste and Abuse Hotline	877.837.6057	N/A

SECTION II: Quick Reference Contact List

WEBSITE www.care1st.com/az

Our website is an additional resource for our provider network. It contains up to up-to-date information including but not limited to the following:

- Blast Fax Communications
- Forms
- Mailings
- Formulary
- Provider Listings
- Prior Authorization Guidelines

Network providers may also complete a one-time registration process in order to obtain a log on and temporary password for secure access to the ONECare website that will provide additional functionality to:

- Check Claims Status
- Verify Eligibility
- View Remittance Advices

To complete the registration process:

1. Choose "Provider Logon" under the Provider menu
2. Complete the Request Access On-Line Form
3. You will receive your logon and temporary password via email

ONECARE CONTRACTED VENDORS

Please reference our Prior Authorization Guidelines to determine authorization requirements.

DME & MEDICAL SUPPLIES (colostomy/ostomy, catheters, supplies, etc.)
Preferred Homecare
Phone: 480.446.9010
Fax: 480.446.7695

ENTERAL
Option 1 Nutrition Solutions
Phone: 480.883.1188
Fax: 480.883.1193

HOME HEALTH (Skilled Nursing and Home Therapy)
Professional Cares
Phone: 602.395.5114
Fax: 480.666.0248

INFUSION
Preferred Homecare
Phone: 480.446.9010
Fax: 480.446.7695

SECTION II: Quick Reference Contact List

GLUCOSE MONITORS

ONECare members use monitors by Abbott Diabetes Care like FreeStyle Freedom® meter or FreeStyle Lite. A meter can be obtained by contacting Abbott Diabetes Care at 866.884.8892 or www.myfreestyle.com/meterprogram. Once a physician script is written, members obtain the meter, test strips and lancets at a contracted pharmacy.

LABORATORY SERVICES

Sonora Quest Phone: 602.685.5000

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

OPTOMETRY/VISION

Nationwide Vision Phone: 480.354.7976

PEAK FLOW METERS

In order to ensure that asthma is managed as effectively as possible, it is vital that a PCP driven asthma action plan be developed for each member as they use the peak flow meter in order to ensure that asthma is managed as effectively as possible. When a peak flow meter is indicated, the physician/practice contacts the contracted DME provider who dispenses the peak flow meter to the member.

WOUND VAC

MedOne Phone: 480.729.6984
Fax: 480.729.6999

PHARMACY BENEFITS MANAGER

MedImpact Phone: 800.788.2949

NATIONAL BENEFIT INTEGRITY MEDICARE DRUG INTEGRITY CONTRACTOR (NBI MEDIC)
Phone:
877-7 SAFERX or (877) 772-3379
Fax:
(410) 819-8698

OFFICE OF INSPECTOR GENERAL HOTLINE (FRAUD & ABUSE)
Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950
Fax: 1-800-223-8164
Online:
https://forms.oig.hhs.gov/hotlineforms/report-fraud-form.aspx

HEARING IMPAIRED

ONECare has an agreement with Valley Center for the Deaf (VCD) (Maricopa County) and Community Outreach Program for the Deaf (Pima County) to schedule American Sign Language interpreters to meet members at their appointments. ONECare reimburses for the service. We do need at least 7 days to schedule the service. The provider's office may contact the Member Services Department once the member's appointment has been made and Member Services will make the necessary arrangements.

In addition, if the provider's office needs to contact a member by telephone, they may do so via Arizona Relay Service. Providers may dial 800.367.8939 for TTY users or go to the website at (www.azrelay.org) to see other alternatives for members that do not use TTY. This is a state program and there is no charge associated with this service.

TRANSLATION SERVICES

ONECare is dedicated to working with its contracted providers to effectively deliver quality health care services to its culturally and linguistically diverse membership. Moreover, ONECare members have a right to interpretation services. To assist in meeting this challenge, ONECare offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All ONECare contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to ONECare so that you can focus on ensuring effective communication with your ONECare non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

SECTION III: Provider Roles & Responsibilities

CENTERS FOR MEDICARE & MEDICAID SERVICES REQUIREMENTS

The Centers for Medicare & Medicaid Services (CMS) require that ONECare provide compliance related training materials to health plans' contracted First tier, down stream and related entities (FDRs) and their employees who are involved in the administration or delivery of Medicare benefits. The training is performed as part of initial contracting and must be completed September 30th annually. As a contracted provider you and your staff are considered to be an FDR. There are two attestations ONECare providers must submit to meet this requirement.

PCP GATEKEEPER ROLE

The Primary Care Physician (PCP) serves as the gatekeeper for the health care services of his/her assigned members. Care1st contracts with PCPs for the specialties of Internal Medicine, Family Practice, General Practice, Pediatrics and sometimes OB/GYNs. The PCP is responsible for coordinating, supervising, and delivering care rendered to assigned members. PCPs are responsible for providing Medicare covered services that are included in their contracts and are within the scope of the physician's practice. If a referral to a specialist or ancillary medical service is necessary, the PCP is to follow the established process for obtaining such services (described in Section X). Only contracted providers should be used for referrals, except in extenuating circumstances, given prior approval by ONECare.

Additional responsibilities include:

- Coordinating care when provided without a PCP referral.
- Ensuring behavioral health information is included in the member's medical record.
- Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.

ONECare has no policies which prevent the PCP from advocating on behalf of the member.

PCP ASSIGNMENTAND PANEL RESTRICTIONS

All members are provided with the opportunity to choose their PCP. If the member does not select a PCP on their ONECare application, Member Services contacts the member to ensure a PCP is chosen to provide care.

A PCP may limit the size of their panel by making a request to voluntarily close their panel. When a provider closes his/her panel, the provider is no longer open for the auto-assignment default process or member choice selection. Exceptions may be made for immediate family of members already on the PCP's panel or other reasons requested by the PCP. PCPs may also request a maximum number of members to be assigned at the time of contracting.

Conversely, ONECare may elect to close or limit a provider's panel if the provider has difficulty meeting appointment or wait time standards, or if there are concerns regarding quality, utilization, or related issues. The provider's panel may be re-opened upon ONECare's approval of a corrective action plan.

SPECIALIST RESPONSIBILITY

Specialists are qualified and licensed to provide Medicare covered services within the scope of their specialty. Contracted Specialists will accept referrals from PCPs when referred for medically necessary services covered by ONECare. After providing the requested services, Specialists who would like to refer the member to additional or different Specialists are to follow the procedure outlined in Section X. Specialists are expected to provide appropriate visit documentation to the PCP.

Care1st has no policies which prevent providers from advocating on behalf of the member.

SERVICE DELIVERY RESPONSIBILITIES

Providers are responsible for member coverage 24 hours a day, 7 days a week. This may be accomplished through an answering service that contacts the physician or on-call physician. The provider may also use an answering machine that directs the patient to the on-call physician. An answering machine on which the member is expected to leave a message is not acceptable. It is likewise unacceptable to use a hospital emergency department as a means of providing 24 hour coverage

APPOINTMENT AND WAIT TIME STANDARDS

ONECare has established appointment availability and office wait time standards to which the provider is expected to adhere. These standards are monitored on an ongoing basis to ensure compliance. Appointment availability standards are measured for both "Established" and "New" patients for Primary Care, Specialist and Dental providers.

An "Established" Patient is defined as a member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

A "New" Patient is defined as a member that has not received any professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

SECTION III: Provider Roles & Responsibilities

APPOINTMENT AVAILABILITY STANDARDS

PCP	SPECIALTY / DENTAL	MATERNITY	BEHAVIORAL HEALTH
Immediate Need Same day or within 24 hours of the member's phone call or other notification ***Urgent** Within 2 days of request **Routine** Within 21 days of request	**Immediate Need** Within 24 hours of referral ***Urgent** Within 3 days of referral **Routine** Within 45 days of referral	**First Trimester** Within 14 days of request **Second Trimester** Within 7 days of request **Third Trimester** Within 3 days of request **High Risk Pregnancies** Within 3 days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists	**Immediate Need** Within 24 hours of identification of need **Routine Care Appointments** Assessment Within 7 days of referral **Referrals for Psychotropic Medications** Assess urgency of need immediately, then schedule a follow up based on need but no greater than 30 days.

*Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.

APPOINTMENT WAIT TIME STANDARDS:

A member should wait no more than 45 minutes for a scheduled appointment with a PCP or specialist, except when the provider is unavailable due to an emergency.

PROVIDER NETWORK CHANGES

All provider changes must be submitted in writing to your ONECare Provider Network Representative in advance. The provider changes affected by this policy include terminations, office relocations, leaves of absence, or extended vacation.

PCP TERMINATIONS/MEMBER REASSIGNMENT

a. If the terminating PCP practices under a group vendor contract, the members may remain with the group if ONECare determines that to be the appropriate course of action.

b. If the terminating PCP practices under a solo vendor contract, the members will be reassigned to another contracted PCP.

PROVIDER LEAVE OF ABSENCE OR VACATION

PCPs must provide adequate coverage when on leave of absence or on vacation. PCPs must submit a coverage plan to their ONECare Provider Network Representative for any absences longer than four (4) weeks. Absences over ninety (90) days may require transfer of members to another PCP.

REMOVAL OF MEMBER FROM PANEL

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Member Services Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. To request a member be removed from a panel, follow the procedure outlined in Section V, Eligibility and Enrollment.

PROVIDER INQUIRIES, COMPLAINTS/GRIEVANCES AND REQUESTS FOR INFORMATION

Providers are instructed to contact Provider Network Operations regarding an inquiry, complaint/grievance and requests for information. Acknowledgement of provider inquiries, complaints/grievances and requests for information occurs within three business days of receipt.

The Provider Network Representative (PNR) works with internal departments, the provider and other applicable parties to facilitate the resolution of inquiries, complaints/grievance and requests for information. Every effort is made to resolve the provider's concern within five working days. Resolution and communication of resolution does not exceed 30 business days unless a different time frame is agreed upon by the PNR and the provider.

MEMBER APPEALS

See Section IX, Provider and Member Appeals.

PROVIDER DIRECTORY

The ONECare Provider Search is updated on a regular basis. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their assigned PNR. The Provider Search is available on our website - www.care1st.com/az, or you may contact Provider Network Operations for a printed version.

SECTION III: Provider Roles & Responsibilities

ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to rendering medical services. To verify eligibility providers can use the Interactive Voice Response system, visit our website www.care1st.com/az or contact Member Services.

Specialists should always verify member eligibility on the day of the appointment. PCPs must verify both eligibility and member assignment on the date of service. ONECare will not reimburse providers for services rendered to members who are not eligible on the date of service. Providers should not rely solely on member identification cards to verify eligibility.

CANCELLED AND MISSED APPOINTMENTS

Providers are expected to develop a system for documenting and following up on cancelled or missed appointments. Providers should contact the Quality Management Department for assistance with members who are chronic "no shows".

COPAYMENTS

Copays applicable to pharmacy only.

Service	Copay
Generic Prescriptions	$1.00
Brand Name Prescriptions when Generic is available	$3.10

PROVISION OF COVERED SERVICES

Physicians are responsible for providing all covered services described in Section VI as medically necessary and appropriate.

REFERRALS AND PRIOR AUTHORIZATION

PCPs are responsible for initiating and coordinating referrals for their assigned members when medically appropriate. Providers are responsible for receiving prior authorization, as required. Refer to the Prior Authorization Guidelines available on our website and the Prior Authorization process outlined in Section X, Medical Operations.

SUBMITTING CLAIMS AND ENCOUNTERS

All services, including capitated services, provided to ONECare members must be documented and submitted to the health plan on the appropriate claim form. Providers must adhere to claim submission and encounter reporting requirements pursuant to their contracts. Refer to Section XII, Billing, Claims and Encounters for additional information.

INAPPROPRIATE USE OF THE EMERGENCY ROOM

PCPs are expected to discourage the inappropriate use of the emergency room by members. Members should be instructed to call 911 any time they believe they have a life-threatening emergency. In non-emergent situations, PCPs should not refer members to the Emergency Department as a means of resolving appointment availability issues.

A more detailed description of covered emergency services is found in Section VI, Covered Services.

DOCUMENTATION

Please refer to Section X for Medical Record requirements. Providers are required to keep a medical record on each patient that is consistent with accepted medical standards. Records should include the patient's advance directives and notations of any recommendations or discussions regarding patient education, family planning, or preventive services.

The PCP must also establish a medical record for those members for whom information is received by another provider even if the PCP has not yet seen the assigned member. In lieu of an actual medical record, the information may be kept in an appropriately labeled file until the member's medical record is established.

ADVANCE DIRECTIVES

PCPs are required to notify their adult members about advance directives and to document such discussion and member preferences in the medical record. Advance directives include living wills and health care/medical powers of attorney. A living will clarifies what life-saving or life-sustaining measures an individual chooses in the event that they become critically ill. A health care or medical power of attorney names a responsible party to make decisions in the event that the patient/member becomes unable to make decisions him/her self. For more information on health care directives refer to Section IV, Member Rights and Responsibilities.

SECTION III: Provider Roles & Responsibilities

NON-DISCRIMINATION POLICY

ONECare members have the right to receive courteous, considerate care regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, or source of payment or coverage under a health benefit program. Providers must be compliant with the Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability.

CULTURALLY COMPETENT CARE

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds. Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location. Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction.

Refer to our website for additional resources:
https://www.care1st.com/az/providers/resources.asp, then click on "Cultural Competency"

LANGUAGE SERVICES

ONECare is dedicated to working with its contracted providers to effectively deliver quality health care services to its culturally and linguistically diverse membership. Moreover, ONECare members have a right to interpretation services. To assist in meeting this challenge, ONECare offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All ONECare contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to ONECare so that you can focus on ensuring effective communication with your ONECare non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

American Sign Language Interpretation

Valley Center of the Deaf (Maricopa County) and Community Outreach Program for the Deaf (Pima County) are contracted to provide American Sign Language Interpreters. Services are available and arranged through Member Services at least 7 days in advance at no cost to members or providers.

SECTION IV: Member Rights & Responsibilities

MEMBER RIGHTS

Members have the following rights and responsibilities, and are informed of these in the Evidence of Coverage (EOC) booklet.

As a ONECare member, each individual has the right to:

- Receive polite and courteous care. Members must be treated fairly and with respect no matter their race, ethnicity, national origin, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or ability to speak English.
- Timely access to covered services and drugs
- Have their medical records and any information about their health care kept private and confidential.
- Be given information about ONECare, ONECare providers, including their qualifications and the languages that they speak, and covered services.
- Receive services in a language that the member understands. They have the right to get an interpreter if they have limited English or if they are hearing impaired.
- Know and understand their medical problems and health care conditions so that they can make informed decisions about their health care.
- Provide instructions about what is to be done when they are not able to make medical decisions for themselves.
- File a complaint with ONECare and request reconsideration of decisions.

MEMBER RESPONSIBILITIES

Members have the responsibility to:

- Be considerate.
- Carry their ONECare ID card with them at all times, and identify themselves as a ONECare member PRIOR to receiving any services.
- Tell us if they move.

- Give their PCP, or other ONECare providers, complete information about their health. Tell providers about past problems or illnesses the member has had, if they have ever been in the hospital, and all drugs and medicines that they are taking.

- Tell ONECare Member Services, their PCP, and other ONECare providers about any other insurance they have.

- Follow their doctor's instructions carefully and completely. Make sure that they understand the instructions before they leave the doctor's office.

- Pay what they owe.

GRIEVANCES

Members may call or write to Member Services if they have a grievance or problem regarding their health care services, or if they think they have not been treated appropriately. Member Services may request the provider's assistance to resolve the issue. Providers may be contacted to clarify the situation and/or to provide education regarding CMS and ONECare policies and procedures. Member Services works to settle grievances as quickly as possible, but no longer than 30 days from receipt.

ADVANCE DIRECTIVES

The Patient Self-Determination Act, passed by Congress in 1991, requires that health care providers educate patients on issues related to Advance Directives, which may include a living will or a health care power of attorney. The Act requires all Medicare and Medicaid providers to furnish timely information so patients have the opportunity to express their wishes regarding the refusal of medical care. ONECare as well as CMS must comply with this Act, and request your cooperation in helping us become compliant. Documentation is required in the medical record as to whether or not an adult member has completed an Advanced Directive. Below are suggestions to assist in bringing your medical records into compliance with this standard:

1. Add a line to your initial patient assessment record stating
    a. Advance Directive discussed - Yes or No
    b. Do you have a Living Will or Power of Attorney - Yes or No

2. Stamp the front of the member's chart or provide a "sticker" on the chart with the above statements(s). Please be sure to address the above questions with the member.

SECTION IV: Member Rights & Responsibilities

For more information on health care directives, the following organizations offer assistance and resources:

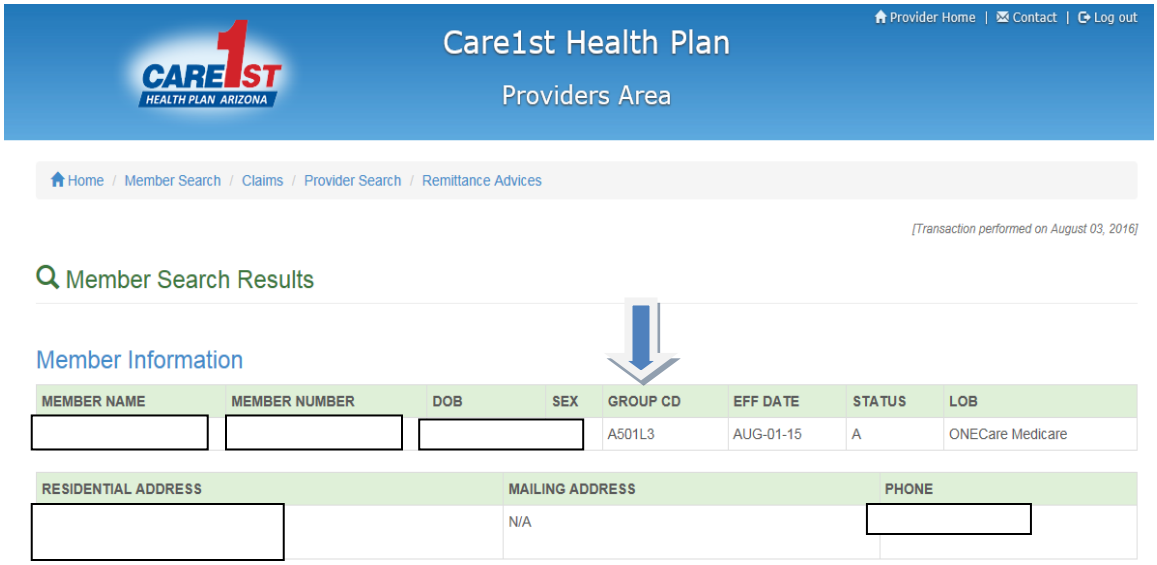
Arizona Medical Association	www.azmedassn.org
Arizona Hospital & Healthcare Association	www.azhha.org
Arizona Aging and Adult Administration	www.azdes.gov/aaa
American Academy of Family Physicians	www.aafp.org
American Association of Retired Persons	www.aarp.org
American Hospital Association	www.putitinwriting.org

SECTION V: Eligibility and Enrollment

ELIGIBILITY DETERMINATION AND ENROLLMENT

Eligibility for ONECare is determined by the Centers for Medicare and Medicaid Services. Members must be enrolled with an AHCCCS health plan or program contractor and be covered by both Medicare Part A and Part B.

The member's group code is available via the Member Eligibility section of the secure Provider Portal.



The group code definitions are outlined in the table below and denote if the member is a QMB full dual or full dual and if Care1st is the member's AHCCCS Plan.

Group	Group Code	Medicare Plan	AHCCCS Plan	Type of Dual
"A" group	A501xx	ONECare	Care1st	Full Dual
"N" group	N501xx	ONECare	Other	Full Dual
"W" group	W501xx	ONECare	Care1st	QMB Dual
"X" group	X501xx	ONECare	Other	QMB Dual
"T" group*	T501xx	ONECare	None	NA

*"T" group members are not AHCCCS eligible. These members continue to be eligible for ONECare for no longer than 90 days. Member cost share is not taken for these members; services are reimbursed at 100% by ONECare when the service is a ONECare benefit. AHCCCS only benefits are not covered for members in a "T" group.

SECTION V: Eligibility and Enrollment

MEMBER IDENTIFICATION CARDS

ONECare issues identification cards for ONECare members. **Members may not be refused service because they do not have their ID card.** The identification card does not guarantee that the member is still eligible for services. To verify eligibility providers can visit our website www.care1st.com/az or contact Member Services as outlined below.

PCP ASSIGNMENT

Directions on how to obtain a listing of contracted PCPs is included with the Member Packet so members may change their PCP. Members that do not choose a PCP at time of enrollment will be assigned a PCP based on geographic location, provider availability, the member's age, and any special medical needs of the member.

PCP ASSIGNMENT CHANGES

MEMBER INITIATED

Members may request a PCP change at any time and for any reason by contacting the Member Services Department. Each eligible member in a family may select a different PCP.

Most change requests received by the Member Services Department will be effective the same day the request is received. Members who request frequent PCP changes will be contacted by the Member Services Department to determine why they are unable to establish an ongoing relationship with a PCP.

PROVIDER INITIATED

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Member Services Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. Providers must notify the member (with a copy to the Member Services Department) in writing that they can no longer provide services to the member and must:

- Be sent on the provider's letterhead and include the member's name, ONECare ID, date of birth, the specific reason for the change request, and the signature of the Provider,
- Request that the member choose a new PCP,
- Indicate that the provider will continue to provide emergency care for 30 day period following their written request, or, until that member is reassigned to another PCP

SECTION V: Eligibility and Enrollment

Upon receipt of a change request, the Member Services will contact and reassign the member considering member choice as well as geographic, linguistic, medical needs, and other member variables. The transferring provider is responsible for forwarding the member record to the new provider within ten (10) days of the re-assignment.

The following are not acceptable grounds for a provider to seek the transfer of a member:

- Member's Medical Condition
- Amount, variety, or cost of covered services required by a member
- Demographic and Cultural characteristics

ONECare does not condone discrimination against its members for any reason and will investigate any allegations or indications of such.

ELIGIBILITY VERIFICATION

To ensure payment, **all providers must verify eligibility at the time of service.** Eligibility and PCP assignment can be verified using any of the verification methods defined below.

WEBSITE - www.care1st.com/az

Our website offers member eligibility, claims status and online remittance advice viewing and printing. A one-time registration process is required in order to obtain a log on and password. To complete the registration process:

1. Choose "Login" under the Provider menu
2. Complete the Registration On-Line Form
3. You will receive your logon and temporary password via e-mail

MEMBER SERVICES

To speak with a representative from our Member Services Department dial 602.778.8345 or 1.877.778.1855 (options 5, 3)

COPAYMENTS

Copays applicable to pharmacy only and are based on the drug, where the drug is filled, and the member's subsidy level.**Service**	**Copay**
Generic Prescriptions	$0, $1.20, or $2.95
Brand Name Prescriptions when Generic is available	$0, $3.60, or $7.40

SECTION VI: Covered Services

COVERED SERVICES

"Covered services" include all the medical care, health care services, supplies, and equipment that are covered under the plan. As a Medicare health plan, ONECare must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules for these services.

The covered services are listed in the Evidence of Coverage (EOC) with a benefit chart noted that services are covered only when the following coverage requirements are met:

- Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of a medical condition and meet accepted standards of medical practice.
- Care is received is from a network provider. In most cases, care received from an out-of-network provider will not be covered.
- A primary care provider (a PCP) who is providing and overseeing care.
- Some of the services listed in the Evidence of Coverage (EOC) benefits chart are covered *only* if a doctor or other network provider gets approval in advance (called "prior authorization").

Covered Services included though not limited are:

1. Inpatient Services
    - Inpatient Hospital Care
    - Inpatient Mental Health Care
    - Skilled Nursing Facility Care
2. Home Health Services
3. Physician Services, Including Office Visits
4. Chiropractic Services
5. Podiatry Services
6. Outpatient Mental Health Care
7. Outpatient Substance Abuse Services
8. Outpatient Surgery
9. Ambulance Services
10. Emergency Care
11. Urgently Needed Care

12. Outpatient Rehabilitation Services (Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, Speech and Language Therapy)
13. Outpatient Diagnostic Tests and Therapeutic Services and Supplies
14. Durable Medical Equipment
15. Prosthetic Devices
16. Diabetes Self Monitoring, Training and Supplies
17. Medical Nutrition Therapy
18. Preventive Care and Screening Tests
    - Bone Mass Measurement
    - Colorectal Screening
    - Immunizations
    - Mammography Screening
    - Pap Smears, Pelvic Exam and Clinical Breast Exams
    - Prostate Cancer Screening
    - Cardiovascular Disease Testing
    - Physical Exams
    - Dental Services (Supplemental – see Summary of Benefits)
    - Vision Services (Supplemental – see Summary of Benefits)
19. Renal Dialysis
20. Prescription Drugs
21. Health & Wellness Education Programs

EXCLUDED SERVICES

The following are examples of services not covered by the plan:

1. Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by the plan and Original Medicare to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary.
4. Private room in a hospital, unless medically necessary
5. Private duty nurses
6. Personal convenience items, such as a telephone or television in the member's room at a hospital or skilled nursing facility
7. Nursing care on a full-time basis in the member's home

8. Custodial care is care provided in a nursing home, hospice or other facility setting when skilled medical care and/or skilled rehabilitation services is not medically necessary. Custodial care is personal care that does not require the continued attention of trained medical personnel, such as care that helps with activities of daily living, like bathing and dressing.
9. Homemaker services
10. Fees charged by immediate relatives or members of the member's household
11. Meals delivered to the member's home
12. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance) except when medical necessary.
13. Cosmetic surgery or procedures, unless because of accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Dentures
15. Chiropractic care other than manual manipulation of the spine consistent with Medicare coverage guidelines.
16. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
17. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
18. Reversal of sterilization procedures, sex change operations and non-prescription contraceptive supplies.
19. Acupuncture
20. Naturopathic services
21. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under our plan, we will reimburse veterans for the difference. Members are still responsible for the cost sharing amount.

EMERGENCY SERVICES

DEFINITION

"Emergency Medical Condition" means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

SECTION VI: Covered Services

EMERGENCY CARE

ONECare members are entitled to access emergency care without prior authorization. However, the Plan requires that when an enrollee is stabilized but requires additional medically-necessary health care services, that providers notify ONECare prior to, or at least during the time of rendering these services. ONECare wishes to assess the appropriateness of care and assure that care is rendered in the proper venue.

LIFE THREATENING OR DISABLING EMERGENCY

Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be done either concurrently with the provision of care or as soon after as possible.

BUSINESS HOURS

In an emergency situation, if a member is transported to an emergency department (ED), the ED physician will contact the member's PCP as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care.

MEDICAL SCREENING EXAM

Hospital EDs under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. ONECare will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

AFTER BUSINESS HOURS

After regular ONECare business hours member eligibility is obtained and notification is provided by calling the telephone number on the member ID card, which is the regular Member Services telephone number. During these hours the number connects to a 24-hour information service, which is available to members as well as to providers. Nurse triage services are available in the event that a member calls for advice relating to a clinical condition that they are experiencing during, before or after business hours. In these cases the member will be given advice or directed to go to the nearest urgent care facility, ED, or to call 911 depending on the circumstances and the nurse triage protocols.

SECTION VI: Covered Services

FAMILY PLANNING SERVICES

Family planning services for male and female members are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Physicians and other practitioners should discuss and document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. Family planning and family planning extension services include covered medical, surgical, pharmacological and laboratory benefits specified below. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about the specific family planning methods available.

HOME HEALTH

Home health care is a covered service when members require part-time or intermittent care but do not require hospital care under the daily direction of a physician. Twenty-four (24) hour care is not a covered service.

LABORATORY

Sonora Quest is contracted for all outpatient laboratory work for all lines of business, lab draws in the office must be sent to Sonora Quest for processing. Service locations are available at www.sonoraquest.com by clicking the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY CARE SERVICES

The plan provides a full continuum of maternity care program services to all eligible, enrolled members. All maternity care services must be delivered by contracted qualified physicians and non-physician practitioners and must be provided in compliance with American College of Obstetrics and Gynecology (ACOG) standards. Our plan will allow licensed midwife services if the member is anticipated to have an uncomplicated prenatal course, a low-risk labor and delivery, and the member has requested the services of a licensed midwife.

SECTION VI: Covered Services

The prior authorization department authorizes OB Care and Delivery packages for newly identified pregnant members when an Authorization/Pregnancy Risk Assessment tool is received or the office requests an authorization. If a provider office requests an authorization, they are informed to fax in the Authorization/Pregnancy Risk Assessment tool. This tool is used to screen members for case management and monitor risk factors for other interventions such as smoking cessation materials and harmful affects of alcohol products while pregnant.

When a member is identified as high risk and is assigned to OB case management, the OB case manager will contact the member by telephone and will assist the member with coordination of any services the member may require, scheduling of appointments and follow-up with providers on members compliance, provide ongoing member education on prenatal care, family planning health issues including sterilization services, and post partum care. Other services the case manager can assist the member with include assistance with obtaining community services such as WIC, assistance for the provider office with noncompliant members to receive appropriate services, coordination of referrals to the Regional Behavioral Health Authority (RBHA) when services are required, and assistance for the provider office with referral to a perinatologist. Our plan's policy states that the woman and her newborn are allowed to receive 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery.

SERVICES INCLUDED IN THE TOTAL OB PACKAGE

• Physical Exams • Initial and subsequent history • Weight and blood pressure • Breast stimulation studies • Genetic counseling (*excludes testing) • Artificial rupture of membrane • Follow up visits • Fetal scalp monitoring • Induction of labor • Delivery (includes multiple births) • 5+ prenatal visits & 1 post partum (pap smear included) • Laboratory services and handling fees by TOB provider	• Family planning • Maternity counseling • Nutritional Evaluation • Inpatient & Observation services • Wet preps and wet mounts • External cephalic versions • Risk Screening per ACOG Standards • All Prenatal Visits, including EPSDT Visits • WIC Referrals for Medically Eligible Members • Physical Exams (Including sick exams) • Prostaglandin Gel Insertion

SECTION VI: Covered Services

SERVICES EXCLUDED FROM THE TOTAL OB PACKAGE & REIMBURSED SEPARATELY - Prior authorization may be required

• Amniocentesis • Amnioinfusion (requires prior authorization) • Colposcopy (CPT codes 56820-56821, 57420-57421, 57452, 57454-57456 and 57460-57461 • OB Ultrasound (3 or more 2D ultrasounds require prior authorization)	• Non-stress test • Post Delivery D & C (59160) • Post-partum Tubal Ligation (requires prior authorization) • RhoGAM Injection • Surgical Assist

HIGH RISK PRENATAL HOME CARE INFUSION

Please contact our Case Management Team at 602.778.8396 x8336 for assistance with high risk members.

MATERNITY CARE APPOINTMENT SCHEDULING

• First trimester • Second trimester • Third trimester • High risk pregnancies	• Within 14 days of request • Within 7 days of request • Within 3 days of request • Within 3 days of identification of high risk by the health plan or maternity care provider, or immediately if an emergency exists

Return appointments are scheduled per the ACOG standards indicated below:

- Monthly through 28 weeks
- Bi-weekly between 29 and 36 weeks
- Weekly after the 36th week

PHARMACY

FORMULARY

The Care1st Formulary, including updates, are communicated and made available on our website www.care1st.com/az. Providers may also contact Provider Network Operations for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting the Pharmacy Prior Authorization Request Form for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation are faxed to 602.778.8387.

MedImpact is our Prescription Benefit Manager and they manage all prescription drug transactions and pharmacy networks for all lines of business.

SPECIALTY MEDICATIONS PURCHASING PROGRAM

Specialty oral and injectable drugs may be obtained through our contracted vendor, Avella Specialty Pharmacy (fka Apothecary Shop). Please use the following procedure to procure specialty drugs:

Prior Authorization Process

- Complete the Pharmacy Prior Authorization Request and fax to us at 602.778.8387.
- Once approved, the Pharmacy Department will fax back the approval to the practice.
- The practice then completes the Avella Specialty Pharmacy (Avella) request form (form is provided by the Pharmacy Team at the time of approval) and faxes the script and the completed Avella form to Avella at 866.792.7684. The phone number for Avella is 877.792.7684.
- Avella completes the order and ships the medication.

Prior authorization requests must first come to the health plan before an order is placed. If prior authorization is not obtained before the order is placed, the plan decision and patient care may be delayed.

*This program does not include vaccines. Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization and are evaluated on a case by case basis for approval and reimbursement.

Contact Pharmacy Prior Authorization at 602.778.1800 (Options 5, 5) if you have any questions.

RADIOLOGY

Radiology services required in the course of diagnosis, prevention, treatment and assessment are covered services.

REHABILITATION

OCCUPATIONAL THERAPY

Occupational therapy services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury. Occupational therapy is intended to improve the member's ability to perform those tasks required for independent functioning.

SECTION VI: Covered Services

ONECare covers medically necessary inpatient occupational therapy services for all members.

Occupational therapy consists of evaluation and therapy. Therapy services may include:

a. Cognitive training
b. Exercise modalities
c. Hand dexterity
d. Hydrotherapy
e. Joint protection
f. Manual exercise
g. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint
h. Perceptual motor testing and training
i. Reality orientation
j. Restoration of activities of daily living
k. Sensory re-education, and
l. Work simplification and/or energy conservation

PHYSICAL THERAPY

Physical therapy is a covered service when provided by, or under the supervision of, a registered physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

SPEECH THERAPY

Speech therapy is the medically prescribed provision of diagnostic and treatment services provided by, or under, the direct supervision of a qualified speech pathologist.

Speech therapy consists of evaluation and therapy. Therapy services may include:

a. Articulation training
b. Auditory training
c. Cognitive training
d. Esophageal speech training
e. Fluency training
f. Language treatment
g. Lip reading
h. Non-oral language training
i. Oral-motor development, and
j. Swallowing training

SECTION VII: Behavioral Health Services

OVERVIEW

ONECare provides mental health and substance abuse services for members through our network of contracted providers. ONECare members are assured timely response to behavioral health needs, referral to an appropriate behavioral health provider and use of our primary care providers (PCP's) or specialists to provide psychotropic medication management services for general mental health conditions.

Covered behavioral health services include, but are not limited to the following:

Inpatient Mental Health/Substance Abuse Care:

- Emergent Inpatient Psychiatric Hospitalization
- Inpatient Substance Abuse Detoxification
- Inpatient Substance Abuse Treatment

Outpatient Mental Health/Substance Abuse Care:

- Psychotherapy/Counseling (by a licensed Psychologist or Social Worker)
- Psychotropic Medication Management (by a Physician, Physicians Assistant, Psychiatrist, Psychiatric Nurse Specialist or Psychiatric Nurse Practitioner)
- Prescriptions for Psychotropic Medication
- Diagnostic Tests, Labs and X-Rays
- Neuropsychological and Neurobehavioral Testing
- Psychological Tests and Central Nervous System Assessments
- Electroconvulsive Therapy (ECT)
- Mental Health Partial Hospitalization Program

SECTION VII: Behavioral Health Services

BEHAVIORAL HEALTH CRISIS SERVICES

If there is any indication that a member is currently a danger to themselves, to others, or is otherwise in need of immediate behavioral health services, call 911.

If the situation is not imminently dangerous, the member or their PCP may call:

Maricopa County:	**Maricopa 24-Hour Behavioral Health Crisis Line** 800.631.1314 or 800.327.9254 (TTY)
Pima County:	**Pima 24-Hour Behavioral Health Crisis Line** 866.495.6735 or 877.613.2076 (TTY)

PCPs may also contact ONECare for assistance with a member crisis during business hours:

- Medicare Behavioral Health Coordinator 602.778.1800 x4145
- Behavioral Health Manager 602.778.1800 x1834

BEHAVIORAL HEALTH REFERRALS

The ONECare Behavioral Health Team coordinates all behavioral health services for our members. Behavioral health coordination is provided to assure that a member's mental health and/or substance abuse treatment is appropriate, timely and easy to access.

ONECare behavioral health staff are responsible for educating members regarding behavioral health issues, available benefits, access to services and referral procedures. This education facilitates appropriate use of behavioral health services.

Members can initiate a self referral to a behavioral health provider by contacting the ONECare Behavioral Health Team to coordinate the referral to a mental health and/or substance abuse provider that accepts ONECare. Behavioral Health staff assists the member until the behavioral health referral process is completed.

COORDINATION OF CARE

ONECare facilitates coordination of care between the behavioral health provider and the PCP to ensure that a member's behavioral health services are provided in collaboration with their medical services.

ONECare addresses access to care and coordination of care issues with the behavioral health provider by tracking and analyzing behavioral health data pertaining to referral sources, service utilization, behavioral health department follow-up and complaint data.

SECTION VII: Behavioral Health Services

PROVIDER INFORMATION

Providers may access the most recent behavioral health information, including the ONECare Formulary and Provider Search, on our website at www.care1st.com/az.

PROVIDER SUPPORT

For questions regarding behavioral health, please contact the Behavioral Health Team at the following numbers during business hours:

- Medicare Behavioral Health Coordinator 602.778.1800 x4145
- Behavioral Health Manager 602.778.1800 x1834

SECTION VIII: PHARMACY

OVERVIEW OF PHARMACY PROGRAM

Medicare Part D covers prescription drugs for persons that are Medicare eligible. Neither Medicare Part A (Hospital Coverage) nor Medicare Part B (Physicians Office Coverage) covers most outpatient prescription drugs.

The Medicare Modernization Act (MMA) provides the rules that govern coverage under Part D. These rules are:

- The drug must be approved by the Food and Drug Administration (FDA)
- The drug must be used and sold in the United States
- The drug is available by prescription
- The drug is used for medically accepted indications

A Part D drug includes prescription drugs, biological products, insulin, and medical supplies associated with injection of insulin. As per regulation, the supplies associated with insulin injection include syringes, needles, alcohol swabs, and gauze.

Part D coverage also requires that the drug be used for medically accepted indications. Medically accepted indications are defined by statute under the Part D benefit. This definition includes:

- FDA approved indications
- Drugs listed as safe and effective for a specific use in one of four drug compendia[1]

Based on this statutory definition, indications supported in peer-reviewed literature or practice guidelines are not medically accepted unless they appear in one of the compendium. Therefore, the use of a drug for indications outside the FDA labeling and compendia does not meet the definition of a Part D drug and payment is not allowed.

In addition to the drugs that are covered under Part D, the regulation also specifies which drugs are excluded. The definition of an excluded drug includes any drug that is covered under either Medicare Part A or Medicare Part B.

The exclusions for Medicare Part D are drugs that are also excluded from Medicaid coverage, with the exception of smoking cessation. The drugs or classes that are currently restricted are:

[1] These include: American Hospital Formulary Service Drug Information (AHFS); United States Pharmacopeia-Drug Information (USP-DI); DRUGDEX Information System; American Medical Association Drug Evaluations (no longer available)

- Agents used for weight loss
- Agents used for weight gain (including cancer and HIV)
- Agents used to promote fertility
- Agents used for cosmetic purposes
- Agents that promote hair growth
- Agents used for symptomatic relief of cough and colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations)
- Nonprescription drugs (OTC drugs)
- Outpatient drugs where the manufacturer requires associated tests or monitoring services be purchased from the manufacturer or its designee as a condition of sale
- Barbiturates
- Benzodiazepines

There are 13 categories of drugs for which separate payment is made under Medicare Part B[2]. These drugs include:

- Drugs furnished incident to a physician's service
- Separately billable end stage renal disease drugs in patients undergoing dialysis
- Osteoporosis drugs provided by home health agencies under certain conditions
- Drugs used in immunosuppressive therapy for a transplant covered under Medicare
- Parenteral nutrition for individuals with a nonfunctioning digestive tract
- Infusable Durable Medical Equipment (DME) supply drugs
- Intravenous immune globulin (IVIG) provided in the home for individuals with a diagnosis of primary immune deficiency
- Certain oral chemotherapy agents used in cancer treatment for which there is an infusible version of the drug and have a medically accepted indication
- Oral anti-emetics used in cancer treatment as a FULL replacement for intravenous treatment
- Hepatitis B vaccine for individuals at high or intermediate risk of contracting hepatitis B
- Inhalation DME supply drugs when a nebulizer has been provided by Medicare

[2] It is important to note that if a drug is determined to be a Part B drug, but the individual does not have Part B coverage, the drug may **not** be billed through Part D instead.

SECTION VIII: PHARMACY

Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) Program ensures optimum therapeutic outcomes for targeted beneficiaries (multiple chronic medical conditions, taking many prescription medications, minimum medication cost threshold) through improved medication use. The goal of the program is to reduce the risk of adverse events, including adverse drug interactions and improve the quality and cost effectiveness of the pharmacy benefit. The ONECare MTM program is offered at no additional cost. By assisting in the reduction of both over and underutilization, this program helps us make sure that our Members are using the appropriate drugs to treat their medical conditions and to identify possible medication problems. This is a voluntary program. This program is administered by SinfoniaRx.

Pharmaceutical Quality Assurance

ONECare established measures and systems to conduct drug utilization reviews for all of our Members to make sure that they are getting safe and appropriate care. The programs include real-time and historic review of prescriptions claims to reduce medications errors and adverse drug interactions. These reviews are especially important for Members who have more than one doctor who prescribe their medications, use more than one drug, or have more than one pharmacy.

ONECare conducts drug utilization reviews when the pharmacy fills a prescription at the point-of-sale. The claim may be electronically reviewed for the following:

- Screen for duplicate drugs that are unnecessary because Member is taking another drug to treat the same medical condition.
- Age-related contraindications
- Gender-related contraindications
- Drug-Drug interactions
- Incorrect drug dosage
- Drug-Disease contraindications
- Drug-Pregnancy precautions
- Clinical abuse or misuse

In addition, retrospective drug utilization reviews identify inappropriate or medically unnecessary care. We perform ongoing, periodic review of claims data to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

SECTION VIII: PHARMACY

Pharmaceutical Utilization Management

This program incorporates utilization management tools to encourage appropriate and cost-effective use of Part D medications. The ONECare Pharmacy & Therapeutics Committee developed these requirements and limits to help us provide quality coverage to our Members. These tools include, but are not limited to: prior authorization, clinical edits, quantity limits and step therapy.

- Age Limits: Some drugs may require a prior authorization if the patient's age does not meet the manufacturer, FDA, and clinical practice guidelines.
- Quantity Limits: For certain drugs, we limit the amount of the drug we cover per prescription or for a defined period of time. Similar to the age limit, the quantity limit threshold is based on manufacturer, FDA, and clinical practice guidelines.
- Prior Authorization: Prior authorization is required for certain drugs. Typically, a prior authorization is established to ensure appropriate utilization.
- Step Therapy: In some cases, ONECare requires that the patient has a trial of a first-line medication, prior to approving a second-line medication.
- Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies automatically dispense the generic version, unless the prescription indicates "brand only". If an FDA-approved generic alternative is available on the ONECare formulary, the prescribing physician must submit medical justification for the use of the brand product.

The ONECare formulary is available on the ONECare website (www.care1st.com/az). ONECare Members shall have access to all FDA-approved drugs that are medically necessary via the drug formulary or prior authorization procedures. In order to ensure Members receive high quality, cost-effective and appropriate drug therapy, ONECare maintains drug formularies consistent with the required pharmacy benefit design for all contracted product lines. The formularies are maintained by the ONECare Pharmacy & Therapeutics (P&T) Committee.

Prior Authorizations

The ONECare Pharmacy Department ensures a timely and accurate review of all medication authorization requests. Prior authorization requests are determined 72 hours after receipt of complete information from the provider for Standard determinations. Expedited reviews are determined within 24 hours after receipt of complete information from the provider. ONECare shall provide an expedited determination if it determines that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

SECTION VIII: PHARMACY

Medication authorization requests may be submitted by the member, member's representative, member's prescribing physician, or other physicians.

Medications requiring authorization include (but are not limited to):

- Medications on the ONECare formularies requiring a prior authorization (PA) review
- Non-formulary medications
- Part B versus Part D determinations

The ONECare Pharmacy Department provides written communication of the prior authorization determination to the Member and provider.

Definitions

"***Approved***" – ONECare agrees to cover the requested medication.
"***Denied***" – The medication request is not approved.
"***Non-formulary***" – A medication not listed on the ONECare formulary.
"***PA Required***" – A medication on the ONECare formulary that requires P.A. review.
"***Specialty Pharmaceutical***" – Defined by the criteria included in AB2420.

Procedure

1. Most medications on the ONECare drug formulary do not require prior authorization. The Member simply obtains a prescription from his/her provider and has it filled at a participating pharmacy.
2. The P&T Committee may require PA for certain medications in order to promote appropriate use. Products designated as requiring PA are not covered unless approved in advance for a specific patient, product and length of therapy
3. The P&T Committee reviews and approves the medications included in the ONECare formularies on an ongoing basis to ensure that the formularies are clinically appropriate and consistent with current pharmaceutical treatment guidelines. In a situation where the provider identifies a need for the Member to receive a medication not on the ONECare formularies, he/she may submit a request by completing the ONECare Medication Prior Authorization Form.
4. The prescriber or prescriber's staff, may make an exception request based on medical necessity by submitting a PA request by telephone, fax, or the ONECare website to the ONECare Pharmacy Department. The member may also make an exception request by calling member services, at which point the ONECare Pharmacy Department initiates a prior authorization request. The ONECare formularies identify the medications requiring PA Providers may not utilize a third party agent to assist with the preparation of a medication PA Third party agents may not submit PA requests on behalf of the provider.
5. The ONECare Pharmacy Department captures the date and time of the PA request by the fax received stamp on the PA form. If a provider telephones in the request the ONECare Pharmacy staff completes the request and document the date and time received in the Pharmacy PA database.

6. The request is reviewed pursuant to the P&T Committee's approved PA guidelines to ensure the safe, efficacious, appropriate and cost-effective use of the medication.
7. If a Member presents a prescription at a retail pharmacy requiring a PA that has not been processed, the pharmacy contacts the prescribing practitioner and requests a therapeutic substitution. The pharmacy staff may contact the ONECare Pharmacy Department for assistance with the identification of formulary alternatives.
8. If the practitioner does not agree to the substitution, the retail pharmacy informs the prescriber that he/she may contact the ONECare Pharmacy Department.
9. Once contacted, the ONECare Pharmacy staff initiates the process for obtaining medical necessity information from prescribing practitioners. In most circumstances, this is done via fax on a standardized form. Due to the need for timeliness, it may be necessary to discuss the request telephonically with the prescribing practitioner:
    a. The ONECare Pharmacy staff reviews the request against a written protocol which the P&T Committee has approved. If the PA information submitted does not meet the criteria outlined in the PA guidelines, it is forwarded to the ONECare clinical pharmacist.
    b. The clinical pharmacist reviews the request and may consider it appropriate as requested, or may determine another formulary medication may be a reasonable therapeutic substitution.
    c. If the request is medically appropriate an override is entered in the pharmacy benefit manager's (PBM) system so the medication can be processed.
    d. If there is a formulary alternative available the clinical pharmacist advises the ONECare Pharmacy staff in providing the appropriate communication to the provider. For medications requiring immediate attention, the clinical pharmacist contacts the provider directly. For non-urgent medication requests, the suggestion of an alternate formulary agent may be communicated by written notification
    e. If the clinical pharmacist determines the need for additional medical information he/she provides written documentation requesting that the ONECare Pharmacy staff assist in requesting the necessary data.
    f. The Pharmacy staff documents the date and time for each request submitted to the provider's office. This includes requests for routine PA information and additional information as authorized.
    g. The Pharmacy staff solicits a response from the physician's office daily for three (3) consecutive business days. The request for information is sent by facsimile. If the request for information is made verbally, this action is documented in the ONECare PA database.
    h. If the required information is not obtained by the third business day from receipt of the initial PA request, a request for additional information letter is sent to the member providing notice that ONECare is unable to render a determination due to the fact that the required information has not been submitted to ONECare. The PA request is placed in a deferred or pended status and remain active for fourteen (14) calendar days, upon which ONECare provides written notice informing the member that the required information is still outstanding and the request cannot be approved due to the lack of information submitted. If the required information is submitted prior to the expiration of the fourteen (14) calendar day period the

PA request is reviewed by the Clinical Pharmacist and Chief Medical Officer or designated physician reviewer, and a decision is rendered within one (1) business day of receipt of complete information. If the required information is submitted after the fourteen (14) calendar day period, the PA review process is reinstated.

10. If the clinical pharmacist cannot approve the medication, the PA request along with all applicable information is forwarded to the ONECare CMO or designated physician reviewer.
11. The CMO or designated physician reviewer reviews all deferred cases for medical appropriateness and to identify opportunities to educate providers.
12. All PA denials are determined by the ONECare Chief Medical Officer or designated physician reviewer except administrative denials to include but not limited to denials due to member's non-eligibility with ONECare Health Plan or due to carve out medications, which can be denied by the reviewing pharmacist. If a PA request is denied, a denial letter is sent by the Pharmacy Department to the member within one business day of the determination. In addition, a copy of the denial letter is faxed to the prescribing physician or PCP. The notification includes the following elements:
    a. A clear and concise explanation of the reason for the denial or modification.
    b. For denials of medications based on the absence of a trial or failure of formulary agents, ONECare provides a list of the potentially applicable formulary agents.
    c. Criteria, clinical guidelines or medical policies used in reaching the determination.
    d. Information regarding the member's right to appeal the decision and the steps for submitting either a standard or expedited grievance.
    e. The ONECare toll-free phone number and address for submitting grievances.
    f. For denials based on the fact that the requested service is not a covered benefit, the notification identifies the document and page where the provision is found and provide a clear concise explanation of the application of the exclusion to the service requested.
13. Additionally, the information regarding the denial/modification including the Member outcome is logged into the pharmacy database system. When the decision is made and sent out to the provider, Member or pharmacy, it is dated and time stamped to comply with the turn-around-time requirement for processing. Turn-around-time measurements are based on the date and time of receipt of all information necessary to make an informed clinical determination.
14. If a PA request is approved, the prescriber or PCP receives a faxed override letter as notice of the approval. The override letter informs the physician of the date and term of the approval.
15. If a PA request from the prescriber or PCP is modified, the prescriber or PCP receives, within one business day, an information notice of the modification. However, if the PA request was initiated by the member, a denial notice is provided to the prescriber/PCP. The member also receives the denial notice informing him/her of the modification to a formulary alternative medication by the physician.
16. If a PA approval is required for coverage of an antibiotic or life-sustaining medication (other than excluded products), an emergency supply is covered under the following

circumstances if the outlined procedure is followed (even if a subsequent formal application for PA is denied):

a. A pharmacist receives the prescription and attempts, but is unable, to contact the prescriber to prompt a request for a PA medical necessity approval or prescription change to a product not requiring such approval for coverage,
b. If the pharmacist telephones or faxes ONECare and is unable to get through due to technical difficulties during ONECare's normal business hours.
c. If the pharmacist determines the situation warrants it the pharmacist dispenses an emergency supply of the product, usually a 72-hour supply (although up to a four- or five-day supply may be dispensed under extenuating circumstances, e.g., a Friday evening or holiday weekend).
d. On the following business day the pharmacist contacts the ONECare Pharmacy Department providing the Member's demographic information, the medication dispensed (including the amount and strength), the prescriber's name and office phone number, and the circumstances of the emergency.
e. The pharmacist contacts the prescriber regarding the need to apply for the required PA approval or to change the prescription to a product not requiring approval for coverage.

17. Routine Pharmacy Denial Activity reports are submitted to the P&T Committee for review.

Member Coverage Determination, Exceptions, and Appeals

ONECare follows the policy and procedures set forth in the ONECare Beneficiary Coverage Determination, Exceptions (Prior Authorization) P&P to administer and comply with the Medicare Part D requirements for performing these functions.

Providers may access the Pharmacy Prior Authorization request on the ONECare website (www.care1st.com/az) or by calling the ONECare Pharmacy Department. Verbal requests are accepted from medical providers.

SECTION IX: Provider & Member Appeals

OVERVIEW

CMS utilizes specific terminology in the appeals process. An initial decision made by the health plan regarding a service for the Part C benefit is identified as an organization determination. Appeals of an organization determination are identified as reconsiderations. An Initial decision made by the health plan regarding a prescription drug benefit, Part D, is identified as a coverage determination. Appeals of a coverage determination are identified as redeterminations.

All coverage and organization determinations may be appealed to ONECare.

Providers dissatisfied with an organization determination (Part C) are encouraged to first contact the Claims Customer Service Department at 602.778.8345 or 877.778.1855, options 5,4.

Providers dissatisfied with a coverage determination (Part D) are encouraged to first contact the Pharmacy Department at 602.778.8345 or 877.778.1855, options 5,5

Medicare does not permit Managed Care plans to offer appeal rights to contracted providers. Contracted providers who are unable to find satisfaction by speaking to the Claims or Pharmacy Department are encouraged to notify their assigned Provider Network Representative of the matter. A contracted provider may file an appeal of a pre-service organization determination on an enrollee's behalf, if the provider has an established relationship with the enrollee. A provider may not charge a fee for representing an enrollee in the appeal process. A contracted provider must seek resolution of a post-service (i.e. claim) issue with their assigned Provider Network Representative.

Contact the Provider Network Operations Department:

Attn: PNO
ONECare Health Plan, Arizona
2355 E. Camelback Rd., Ste 300
Phoenix, AZ 85016

PNO Department: 602.778.8345
or 877.778.1855 (options 5,7)
Fax: 602.778.1875
Email: PNOAZ@care1st.com

Medicare requires Managed Care plans offer appeal rights to non-contracted providers. Non-contracted providers may file an appeal of both a pre-service organization determination for an established patient, and a post-service (i.e. claim) determination when the provider agrees to indemnify the enrollee regardless of the result of the appeal.

Contact the Claim Dispute & Appeals Department:
Attn: ONECare Appeals
ONECare
2355 E. Camelback Rd, Suite 300
Phoenix AZ 85016

SECTION IX: Provider & Member Appeals

ONECare is required to comply with CMS's Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Manual **and** Chapter 18 - Part D Enrollee Grievances, Coverage Determinations, and Appeals Manual.

Appeals should be filed within sixty (60) calendar days from the date of the initial determination being appealed. All appeals must be in writing and state with specificity the action being appealed and what resolution is being requested. The provider should provide documentation supporting the request. A provider should never wait longer than the required time frames to file an appeal; however, **providers are encouraged to exhaust all other available means of resolving an issue before filing an appeal.**

Decisions will be issued in writing within the time frame allowed for the kind of appeal requested as specified in the CMS Managed Care Manuals Chapters 13 & 18. If the appeal resolution is not in the provider's favor, the rights and obligations to challenge the plan determination will be provided in the resolution letter, as appropriate with the kind of determination being appealed.

SECTION X: Medical Operations

OVERVIEW

The ONECare Medical Management (MM) program ensures that members get the right care from the appropriate service provider at the right place and at the right time. The framework of ONECare's MM Program drives the processes used to identify utilization patterns such as recidivism, adverse outcomes, and under/over utilization which may indicate quality of care issues. The program is further designed to identify and manage care for high risk members to ensure that appropriate care is delivered by accessing the most efficient resources. Finally, the MM program identifies opportunities to promote preventive health measures to decrease acute and chronic health care conditions. ONECare does not provide financial incentives for MM decision makers to encourage decisions that result in underutilization. ONECare does not reward practitioners, or other individuals involved in utilization review, for denying a service.

PRIOR AUTHORIZATION AND REFERRAL PROCESS

Prior authorization (PA) is a process by which ONECare determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be pended until the receipt of required clinical documentation to substantiate compliance with criteria used by ONECare. Criteria used by ONECare to make decisions are available upon request.

The MM Department uses clinically sound, nationally developed and accepted criteria for making medical necessity decisions. Clinical criteria utilized in decision making include, but is not limited to:

- **CMS Guidelines**
- **Milliman Care Guidelines**
- **AHCCCS Guidelines**
- **American College of Obstetrics and Gynecology**
- **The American Academy of Pediatrics**
- **Official Disability Guidelines (ODG)**
- **Care1st Guidelines /ONECare Guidelines**
- **ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd edition**

These criteria are used only as a guideline and individual needs and local standards of practice are taken into consideration when making decisions. ONECare utilizes board certified physicians to make medically necessary decisions. When necessary, ONECare utilizes outside resources to have board certified physicians review cases for medical necessity, with the expertise that is necessary.

SECTION X: Medical Operations

PA is not a guarantee of payment. Reimbursement is dependent upon the accuracy of the information received with the original PA request, whether or not the service is substantiated through concurrent and/or medical review, eligibility, and whether the claim meets claims submission requirements.

AUTHORIZATION FORMS

PAs for medical services (including in-office injectables) are requested on the *Treatment Authorization Request (TAR) Form*. Requests for Non-Formulary drugs are submitted on the *Pharmacy Prior Authorization Form*. The *TAR* and the *Pharmacy Authorization Form are* available on the ONECare website www.care1st.com/az under the *Forms* section of the Provider menu. The Prior Authorization Guidelines and Formularies are also available on our website under the provider link. Providers without internet access may contact Provider Network Operations for a copy to be mailed or faxed to your office.

PRIOR AUTHORIZATION TIPS

- Please refer to the Prior Authorization Guidelines for procedures that require PA in addition to the visit.
- Please direct members to contracted providers, vendors and facilities. Services requested for a non-contracted provider require prior authorization.
- For Specialties that require authorization for the initial consultation and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range approved.
- Your PA request will be processed more expeditiously if you fax the completed TAR with all supporting documentation and medical records. Allow sufficient time to process your request (especially on Friday afternoons following hospital discharges).
- Please contact ONECare for the status of your PA request before sending a duplicate request.
- Provide the past year's medical records and/or any supporting documents to justify request. Failure to submit supporting documents may delay processing.
- Provide laboratory results such as cultures and sensitivities, cholesterol panels, or any other pertinent lab results to expedite the medical necessity reviews for both medical and pharmacy requests.
- PA is required on all non-formulary drugs. A 5 day supply of medication following a hospital or ED discharge can be obtained by calling MedImpact at 800.788.2949.

AUTHORIZATION TIME FRAMES

Inpatient and outpatient referral requests for ONECare members that are received from primary care and specialty care physicians will be processed according to status within the following designated time frames:

1. For standard pre-service organization determinations, ONECare makes the determination as expeditiously as the member's health condition requires,

but no later than 14 days after receipt of the request for the organization determination.

2. For expedited pre-service organization determinations, ONECare makes the determination as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for the organization determination.
    a. The 72-hour timeframe begins as soon as the request is received by any department within ONECare.
    b. If additional information is needed from a provider, the Prior Authorization Representative contacts the provider in question within 24 hours of receipt of the organization determination request, to request the additional information.
3. ONECare does not deny services ordered by contracted providers due to lack of information.

For routine requests that are pended for more information, the PA Department will make three attempts to obtain any outstanding medical information that is required for a determination based on medical necessity. If three documented attempts have been made by the ONECare PA Department on a pended authorization to get further information from a provider and no additional information has been submitted, the CMO will make a determination to approve, modify, or deny the authorization based on the medical information sent by the provider.

REFERRAL/PRIOR AUTHORIZATION PROCESS FROM PCP TO SPECIALIST

1. Select a ONECare specialist contracted with ONECare.
2. Refer to the PA Guidelines to determine if an authorization is required.
3. If PA is NOT required, the PCP may contact the contracted specialist and schedule an appointment.
4. If PA is required, complete the TAR, which must contain all supporting documentation including ICD-10 and/or CPT codes, and office fax number of the requesting provider for all services that require an authorization. Supporting documentation should include physician progress notes, lab results, diagnostic test results and reports, consultant notes, or any other medical documentation from the medical record that is pertinent to the service being requested that will assist in making the decision.
5. Fax the TAR and supporting documentation to the ONECare Prior Authorization Department.
6. For urgent requests, the PCP may call the Prior Authorization Department.

7. The Prior Authorization Department will return the TAR with the authorization number by fax.
8. After the approved TAR has been received, contact the specialist and schedule the member's appointment. After the appointment has been made, send approved TAR Form to the authorized specialist.
9. Notify the member of the time, date, and location of the scheduled appointment.

SPECIALIST RESPONSIBILITIES

1. Schedule appointments for members, in accordance with appointment standards, when an appointment is requested by a PCP.
2. For Specialists that require an authorization, if a member fails to appear for a scheduled visit, the specialty care provider may reschedule the appointment within ninety (90) days without obtaining another prior authorization number, as long as the member remains eligible with ONECare.
3. Use the prior authorization number for billing purposes.
    - The PA number is valid for a consultation and two follow-up visits unless otherwise noted on the TAR.
    - The prior authorization number for a consultation is valid for 90 days or longer.
    - Authorizations for follow up visits are valid for 120 days when given with a consultation, as long as the member retains eligibility with ONECare.
4. Verify member eligibility prior to all appointments (see note below)
5. Provide scheduled services.
6. Provide a copy of the consultation notes to the member's PCP.
7. If the Specialist plans to perform a surgery or a special procedure, a TAR must be completed and faxed to the Prior Authorization Department.
    - The Specialist must attach a legible consult note or clearly written documents to support the request along with appropriate ICD-10 and CPT code and name of the contracted facility where service is to be rendered.
    - Upon receipt of the TAR, the PA Department will review and make a decision as necessary. An authorization number will be issued and noted on the TAR and faxed back to the specialist. Authorization numbers for procedures remain valid for 90 days; after that time, the request must be re-submitted to ONECare.

NOTE: Claims may not be reimbursed if authorization is not obtained prior to date of service or if the member is not eligible with ONECare on the date of service. To verify member eligibility, providers should contact the Member Services Department or our website. It is the responsibility of the providers to verify eligibility prior to rendering routine services.

SECTION X: Medical Operations

REFERRAL PROCESS FROM SPECIALIST TO ANOTHER SPECIALIST

When a specialist needs to refer a member to another specialist, it is not necessary for the member to be referred back to the PCP. The referring specialist should follow the guidelines as outlined above.

ELECTIVE INPATIENT CARE

For ONECare members who require elective inpatient care (acute hospital), the admitting physician should:

- Complete the TAR, which must contain all supporting documentation including ICD-10 codes, CPT codes, and office fax number of the requesting provider.
- Fax the TAR to the PA Department.
- For urgent requests, the PCP may call the PA Department. NOTE: Medical information will be required over the phone to justify medical necessity for approval of the service being requested.
- The PA Department will return the TAR with the authorization number via fax.
- After the approved TAR has been received, contact the hospital and schedule the member's hospitalization and send approved TAR Form to the authorized facility.

Providers who provide services on a fee-for-service basis for inpatients must use the applicable hospital's PA number on the claim.

EMERGENCY DEPARTMENT CARE

ONECare does not require PA for a member to receive emergency services. Members may seek care at any emergency department in the event of an emergency.

REFERRALS TO ANCILLARY PROVIDERS

Providers should follow the instructions outlined above under "Referral Process from PCP to Specialist", considering the following:

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or specialist. DME can be obtained by directly contacting the ONECare contracted DME Provider.

Please include the following information when faxing your request:

1. Member information
    - Name
    - ONECare identification number

- Phone number
- Address
- Diagnoses
- Weight

2. Amount, type and size of equipment desired including HCPC code
3. Completed and signed Certificate of Medical Necessity (for oxygen and motorized wheelchair).

HOME HEALTH CARE AND HOME INFUSION

- Home Health Care and Home Infusion is obtained by directly contacting a ONECare contracted provider.
- If a ONECare member requires long term Home Health Care or Home Infusion a referral to the Case Management Division is made by the PA Department.

OUTPATIENT RADIOLOGY SERVICES

- Refer to the ONECare PA Guidelines for imaging services which require prior authorizations.
- Select a ONECare contracted provider from the Radiology Grid.
- Contact the contracted provider to schedule an appointment.
- It is the responsibility of the imaging service provider to verify member eligibility prior to rendering services.

OUTPATIENT LABORATORY SERVICES

- Complete laboratory requisition and direct member to a ONECare contracted laboratory site.
- If specimen is collected in office, contact the contracted laboratory for pick-up.

ORTHOTICS AND PROSTHETICS

When referring a ONECare member for orthotic/prosthetic services, the provider's office must submit a TAR along with supporting documentation and appropriate HCPC code(s). Once approved, the orthotic/prosthetic provider will contact the member for fitting and delivery.

REHABILITATION SERVICES (OCCUPATIONAL/PHYSICAL/SPEECH THERAPY)

Select a contracted provider for referral and fax a completed TAR to the PA Department for review and approval.

SECTION X: Medical Operations

CASE MANAGEMENT

The ONECare Case Management (CM) program is a collaborative program between Case Managers, members and providers which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the members' health care needs. The Case Management Program is developed to specifically address the needs of the members with high cost, high volume, medically complex and high-risk health care experiences. The ONECare case managers complete a Health Risk Assessment on all ONECare members within the first 90 days of enrollment and annually.

Our objectives include:

- Increasing member engagement with the PCP and PCP-referred specialists
- Increasing member understanding and use of plan benefits
- Increasing member awareness of community resources available to help improve their quality of life
- Decreasing unnecessary emergency room utilization
- Decreasing unnecessary hospital visits and admissions
- Optimizing members health outcomes

Case Management is available to all members and includes an initial and ongoing assessment of risks, needs and benefits, and the development of an individualized care plan for all members accessing these services. Potential candidates for CM include, but are not limited to the following:

- Members or populations with complex, chronic or co-morbid medical conditions (e.g., diabetes, asthma, end-stage renal disease, organ transplant, chronic hepatitis C) or social needs
- Members recently discharged from a hospital
- Members requiring care coordination
- High utilizes of services such as pharmacy or emergency departments (either by cost or volume)
- Special populations (e.g., aged, blind, disabled, HIV-positive, substance abusers, pregnant women, special needs children, members with behavioral health needs)

Case management process

- Screening and identification of members with high risk health problems or situations
- Identifying and implementing effective interventions, including exploration of alternative resources that could be accessed to meet members' healthcare needs
- Working collaboratively with members' practitioners and providers as well as with other disciplines inside and outside the plan to achieve positive outcomes

Coordinating care for defined conditions/diseases to attain optimal clinical outcomes for the members and to improve their quality of life/

- Providing education, support, and monitoring for the member, member's family, and others involved in care
- Encouraging members to self manage their conditions effectively and develop and sustain behaviors that may improve the member's quality of life
- Working to ease barriers to needed healthcare and psychosocial services for members with special needs or cultural or language requirements

Candidates for further targeted case management are identified by:

1. Member self-referral into care management programs
2. The medical management team and managements' review of hospital records regarding ER visits and/or inpatient admissions
3. Data provided by the member to the care coordinator while completing or reviewing the health risk assessment
4. A referral from the ONECare medical director, Medical Management managers, Prior Authorization staff, Concurrent Review staff, Marketing staff, DDD coordinator, Member Services staff, or Case or Disease Management staff
5. A referral from a primary care or specialist physician
6. A referral from a facility case manager or social worker
7. A referral from an external agency working with the member, including AHCCCS, CMS, DDD a RBHA, or home health agency.
8. A referral from a member or someone associated with the member, such as a family member, friend, or neighbor
9. Case manager review of member's health care utilization data from a pharmacy, hospital, or lab, as well as internal claims data
10. Predictive modeling information allowing care management leadership to identify members at high risk for increased utilization of the healthcare system due to poorly controlled medical conditions.

To refer a patient for case management, please contact our Team at 602.778.8345 X 8301.

DISEASE MANAGEMENT

ONECare provides Disease Management programs to assist practitioners in managing members diagnosed with targeted chronic illnesses. Conditions included in disease management initiatives are those that frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources, and that have been shown to respond to coordinated management strategies.

Disease management activities include interventions such as:

- Assessment of member's risk and needs
- Education about disease, medications and self management
- Adherence monitoring
- Assistance with finding or coordinating resources and/or exploring alternative resources
- Working to ease barriers for members with special needs or cultural or language requirements

Potential candidates for Disease Management are identified thought:

- Administrative data such as medical and pharmacy claims
- Laboratory data
- HEDIS data
- Self reported data through health risk assessments
- Provider referrals
- Member and family self referrals
- Internal referrals from ONECare staff members

Disease management programs are structured around nationally recognized evidence-based guidelines. The guidelines are posted on the ONECare website: https://www.care1st.com/az/providers/diseasemanagement.asp

A paper copy of the guidelines is available to providers upon request.

Please contact our Team at 602.778.8345 X 8301 for more information and assistance.

CONCURRENT REVIEW

ONECare provides for continual reassessment of all acute inpatient care. Concurrent review includes both admission certification and continued stay review. Concurrent review is performed by nurses who work closely with the medical director in reviewing documentation for each case. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review at ONECare's discretion. Review may be performed on-site or may be done via telephone or fax. Authorization for payment of inpatient services is generally on a per diem basis or DRG basis depending upon the specific contractual terms between ONECare and the hospital. The authorization is given for the admission day and from then on, on a day-to-day basis contingent upon the inpatient care day satisfying the criteria for that level of care for that day. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e. procedures, diagnostic studies, or professional services

provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment. ONECare uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. A copy of individual guidelines pertaining to a specific case is available for review upon request. Providers are notified when there are denials given for a specific day.

RETROSPECTIVE REVIEW

ONECare reserves the right to perform retrospective review of care provided to its member for any reason. Additionally, care is subject to retrospective review when claims are received for services not authorized. There may also be times, during the process of concurrent review (especially telephonic) that the Concurrent Review Nurse is not satisfied with the concurrent information received based on the Milliman Care Guidelines®. When this occurs the case will be pended for a full medical record review by the Chief Medical Officer.

PRACTICE GUIDELINES

ONECare utilizes practice guidelines, criteria, quality screens and other standards for certain areas of medical management, disease management, and preventive health. Our guidelines follow nationally accepted standards and are reviewed and approved by our Medical Management Committee, which is comprised of both clinical staff and network physicians. Updates occur annually or more frequently if needed. If you have questions on our guidelines or would like a hard copy of our guidelines mailed to your office may contact Provider Network Operations.

SECTION XI: Quality Management

OVERVIEW

The Quality Management (QM) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services, and the structures and processes by which they are delivered to Plan members, and to continuously pursue opportunities for improvement and problem resolution.

SCOPE

The scope of the QM Program is comprehensive and includes activities that have a direct and indirect influence on the quality and outcome of clinical care and services delivered to all Care1st Plan members. The scope of the QM Program encompasses both quality of care and quality of service. Responsibility for monitoring the scope of care rests with the QM Department.

This QM Program covers all programs and products. All QM standards and procedures are applicable to all ONECare members.

Quality Management/Quality Improvement activities may include but are not limited to:

- Access to and availability of care
- Provider satisfaction
- Credentialing/Re-credentialing
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility/Office site review results
- Member satisfaction, complaints and grievances
- Timeliness of handling claims
- High risk and high volume services
- HEDIS results
- Performance Improvement Measures
- Quality Improvement Projects
- Patient Safety Measures

ONECare adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Practice guidelines are available on our website (www.care1st.com/az) under the Providers drop down menu. For requests for training, obtaining additional

information or if you do not have internet access and would like a coy mailed to your office, please contact Provider Network Operations.

Compliance with standards is measured using a variety of techniques, including but not limited to:

- Quality of service concerns
- HEDIS
- Quality of care concerns
- Performance Indicators
- Medical record audits
- Facility/Office site review results
- Outcome measures
- Focused review studies
- Member satisfaction surveys
- Peer Review
- Access to care audits
- Disease management outcomes
-

CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the QM process is considered confidential. All QM data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated and secured area within the QM Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All persons attending the Clinical and Service Quality Improvement Committee and Medical Management (CASQIC) or any related committee meetings will sign a Confidentiality Statement. All Care1st/ONECare personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in the review process of QM issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

Furthermore, information provided to physicians within the network may be proprietary and/or confidential. When this occurs it is expected that physicians will hold this information in confidence and treat the handling of such information with care.

SECTION XI: Quality Management

RELEASE OF MEMBER INFORMATION

To ensure the confidential release of member information, the following apply:

- Providers should submit all necessary documentation when submitting a request for a referral.
- Providers may release a member's medical information to other health care providers, ONECare or CMS as long as it is necessary for treatment of the member's condition, or administration of the program.
- Member's records are to be transferred to a new PCP within ten business days when one is selected.
- Release of medical information to out of network providers generally requires authorization from the member or guardian.
- Medical records must be released in accordance with Federal or State laws, court orders, or subpoenas.

CREDENTIALING

The Credentialing/Peer Review Committee (CPRC) is delegated the responsibility of monitoring credentialing and re-credentialing activities for providers and practitioners. The Credentialing Committee meets at least ten times annually, but may meet more frequently as needed.

Scope of responsibilities include but are not limited to:

- Review, recommend, approve or deny initial credentialing and re-credentialing of contracted network.
- Ensure appropriate reporting to regulatory/national data banks.
- Ensure the provision of a fair hearing process.
- Oversight of delegated credentialing.
- Peer review for adverse outcomes.
- When a practitioner's contracting/re-credentialing status is denied or restricted based upon a quality concern, the practitioner is provided appeal rights and procedures upon notice of the denial or restriction.

SECTION XI: Quality Management

PEER REVIEW

Peer Review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific provider or to review aspects of care, behavior or practice, as may be deemed inappropriate. The CMO is responsible for authorizing the referral of cases for peer review based on an outcome severity level.

All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice. At least one consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.

If the Peer Review Committee makes a recommendation to the Chief Medical Officer (CMO) to deny, limit, suspend or terminate privileges based on a medical disciplinary cause or reason, the affected provider shall be entitled to a formal hearing pursuant to the Fair Hearing Procedure.

FAIR HEARING

A provider is entitled to an appeal and/or hearing if the Peer Review Committee makes a recommendation to:

- Suspend
- Terminate or
- Non-renew a physician's contract.

The provider will be notified of the committee's recommendation and has 30 days following the date of notice, to request a hearing. The request must be submitted in writing to the CMO.

The CMO will schedule a hearing as soon as practicable. The CMO will appoint at least 3 providers and an alternate who have the requisite expertise to ensure a fair hearing. At least 1 provider will be of the same specialty as the practitioner requesting the hearing. No provider will be in direct economic competition with the affected provider and will not stand to gain direct financial benefit from the outcome.

Both parties are entitled to legal representation. Expert testimony and presentation of supporting documents are allowed.

The committee will complete its investigation within 30 days unless both parties agree to a longer period of time to obtain information.

The committee will issue a final decision which may consist of one of the following:

- Continue the immediate action effect
- Impose other sanctions structured to prevent harm to member or to correct identified issues
- Remove the immediate action.

A provider may appeal an action only after the committee renders a final decision. Any action taken as a result of the recommendation of the committee becomes a part of the provider's Credentialing file. ONECare reports to the appropriate authorities such as licensing or disciplinary bodies, CMS or to other appropriate authorities, any provider who are terminated for quality of care issues.

MEDICAL RECORD GUIDELINES

PCPs must maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures, and/or for whom a provider receives medical/behavioral health records from other providers who have seen the enrolled member. The record must be kept up-to-date, be well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record whether a hard copy chart or electronic medical record (EMR) is used, that incorporates at least the following components:

1. Member identification information on each page of the medical record. (i.e., name or ONECare identification number)

2. Identifying demographics including the member's name, address, telephone number, ONECare identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative

3. Initial history for the member that includes family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history

4. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received

5. Immunization records (recommended for adult members if available)

6. Dental history if available, and current dental needs and/or services

7. Current problem list

8. Current medications

9. Documentation, initialed by the member's PCP to signify review of:

    a. Diagnostic information including:

        i. Lab tests and screenings
        ii. Radiology reports
        iii. Physical examination notes, and/or other pertinent data

    b. Reports from referrals, consultations and specialists

    c. Emergency/urgent care reports

    d. Hospital discharge summaries, and

    e. Behavioral health referrals and services provided, if applicable

10. Documentation as to whether or not an adult member has completed advance directives

11. Documentation related to requests for release of information and subsequent release

12. Documentation that reflects diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's health care

13. Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool [MICA] or American College of Obstetrics and Gynecology [ACOG]). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.

14. Documentation that each member of reproductive age is notified verbally or in writing of the availability of family planning.

SECTION XI: Quality Management

MEDICAL RECORD RETENTION

All providers must maintain medical records in accordance with all federal and state regulations.

SECTION XII: Billing, Claims And Encounters

CLAIM SUBMISSION

ELECTRONIC DATA INTERCHANGE (EDI)

ONECare encourages you to submit your medical claims electronically.

Advantages include:

- decreased submission costs
- faster processing and reimbursement
- allows for documentation of timely filing

EDI is for primary claims only with the exception of claims when a member's primary insurance is ONECare and their secondary insurance is Care1st as our system automatically coordinates processing for these services submitted. Any other claims that require secondary payments submit on paper with a copy of the primary remittance advice attached.

Medical (CMS 1500) Claims

ONECare works with CHANGE Healthcare fka Emdeon (WebMD) 800.215.4730 for acceptance of EDI CMS 1500 claims. Our CHANGE Healthcare (WebMD) Payer I.D. is **57116**.

Claims may be submitted electronically directly to CHANGE Healthcare (WebMD) or from your clearinghouse to CHANGE Healthcare (WebMD). If you experience problems with your EDI submission, first contact your software vendor to validate the claim submissions and upon verification of successful submission, contact CHANGE Healthcare directly at 800.215.4730.

Medical (UB-04) Claims

We work with SSI for acceptance of EDI UB-04 claims. Questions may be directed to SSI Help Desk at 800.880.3032.

Dental (J430D) Claims

The submission of dental claims electronically may be sent one of four ways:

- Providers can also submit claims, check eligibility and confirm benefits through Advantica's online provider portal. To register, go to www.advanticabenefits.com/providers and click on "Dental Provider Registration".

- Directly to CHANGE Healthcare or from your clearinghouse to CHANGE Healthcare. Advantica works with CHANGE Healthcare. Advantica's CHANGE Healthcare Payer I.D is 43168. To enroll, go to https://www.emdeondental.com/ and enter Advantica Payer ID 43168. If you are already enrolled, be sure to link

your CHANGE Healthcare account with the Advantica Payer ID. **EHG – EDI Health Group, Inc. – DentalXChange**. To enroll go to: http://www.dentalxchange.com/partners/WebClaim and click on Services > Provider Services > Claims Connect > Get Started or call 800.576.6412 ext. 455. Advantica Payer ID 43168

Tesia. To enroll contact call 800.724.7240 or e-mail sales@TesiaSupport.com. Visit the Tesia website at www.tesia.com. Advantica Payer ID 43168.

Attachments such as x-rays (submitted as a TIF or JPG document) or reports may be submitted electronically to www.nea-fast.com. You will receive an assigned NEA number to reference on the electronic claim submission.

To register with NEA simply go to www.nea-fast.com and click on "REGISTER NOW". Choose "Dental Online Registration". Or you may register by phone at 800-782-5150 (Select Option 2).

ELECTRONIC FUNDS TRANSFER (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

Providers also have the ability to view remits online; allowing no delay between receipt of dollars and the ability to post payment.

Medical Claims

The EFT form is available on our website under the Forms section of the Provider menu. If you do not have internet access, contact Provider Network Operations and we will provide you with the form.

Dental Claims

Advantica selected CHANGE Healthcare fka Emdeon as its electronic (EFT) payment and electronic remittance advice (ERA) reporting partner. There is no cost to you to use these services and enrollment is free! To enroll in CHANGE Healthcare ePayment, visit www.emdeondental.com to create a Dental Provider Services (DPS) account. If you have questions about the enrollment process, please call CHANGE Healthcare at 888.255.7293.

HIPAA 5010 TRANSACTIONS

ONECare is compliant with the CMS implementation timeline for all 5010 transactions. Trading partners are required to begin sending electronic transactions in the 5010 format. We encourage you to reach out to your respective clearinghouse to obtain specific instructions to ensure you understand how the changes with 5010 may impact your submissions and receipt of data. Some of the major changes with the 5010 claims submission process are listed below:

- Service and billing address: The service and billing address must be the physical address associated with the NPI and can no longer be a post office box or lock box. The pay to address may still contain a post office box or lock box.

- State and Postal Codes: State and zip codes are required when the address is in the US or Canada only. Postal codes must be a 9-digit code for billing and service location addresses.

- Rendering tax identification number: The rendering provider tax identification number requirement has been removed. The only primary identification number allowed is the NPI. Secondary identification numbers are only for atypical providers (such as non-emergent transportation) and we recommend you use the G2 qualifier. The billing tax ID is still required.

- Number of diagnosis codes on a claim: For electronic submissions, it is a requirement that diagnoses are reported with a maximum of 12 diagnosis codes per claim under the 5010 format and paper CMS 1500 submissions contain a maximum of 12 diagnosis codes per claim.

ICD-10 IMPLEMENTATION REMINDER

ICD-10 replaced ICD-9 coding for the classification of disease or health condition, symptoms, and causes, used by hospitals, providers, and others, and is required to be implemented for *outpatient dates of service on or after October 1, 2015 and inpatient dates of discharge on or after October 1, 2015.*

Provider Information

- Provider resources are available from CMS to help with the transition of ICD-9 to ICD-10. The CMS link is http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.
- ICD-10 is used for:
  - Diagnosis codes (ICD-10-CM) for all providers
  - Inpatient hospital procedures (ICD-10-PCS)
- Provider documentation:
  - Codes must be supported by medical documentation and because ICD-10 codes are more specific, more documentation may be necessary
  - Revenue may be impacted by specificity

Claim Submissions

- Claims for dates of service or dates of discharge on or before September 30, 2015 are submitted with ICD-9 codes.
- Claims for dates of service or dates of discharge on or after October 1, 2015 are submitted with ICD-10 codes.

  - For example:
    - UB04 claims with dates of service than span across 10/1 are submitted with ICD-10 codes.(recurring outpatient services, such as physical therapy, chemotherapy, etc, must be split for ongoing treatment that spans 10/01/15.
    - CMS1500 claims must be split to submit services with dates of service 9/30/15 and prior with ICD-9 codes and services with dates of service 10/1/15 and after with ICD-10.
- Claims for dates of service 10/1/15 and after may be billed with an ICD-10 code and can be processed without issue even if the authorization was obtained prior to 10/1/15 with an ICD-9 code(s).

Prior Auth Submissions

- Authorization requests submitted on or before September 30, 2015 are submitted with ICD-9 codes.
- Authorization requests submitted on or after October 1, 2015 are submitted with ICD-10 codes.
  - Please follow the guidelines above. Requests with incorrect coding will be pended for more information and delay the processing of your request and your request may be voided as incomplete if we are unable to obtain the proper coding information from your office.

CLAIM ADDRESSES

Medical Claims:

Direct CMS 1500 and UB-04 claim forms (initial submissions and resubmissions) and medical records to:

Attn: Claims Department
2355 East Camelback Rd #300
Phoenix, AZ 85016

Dental Claims:

Direct dental claim forms (initial submissions and resubmissions) and dental records to:

Advantica Administrative Services, Inc.
PO Box 8510
St. Louis, MO 63126

CLAIMS CUSTOMER SERVICE

Medical Claims (CMS 1500 and UB-04 Claim Types):

Claim status can be checked 24 hours a day, seven days a week online at www.care1st.com/az.

Our Claims Customer Service Team is also available to assist you during the business hours listed below:

Monday – Friday 8:00 AM - 12:00 PM & 1:00 PM - 4:30 PM
Ph. 602.778.8345/877.778.1855 (options in order 5, 4)

Dental Claims:
Advantica manages the dental benefits provided to ONECare members on behalf of Care1st.

Claim status can be checked 24 hours a day, seven days a week online at Advantica's website, www.advanticabenefits.com.

For questions on dental claim submissions, contact Advantica directly at the following:
Monday – Friday 8:30 AM – 4:30 PM
Ph: 800.429.0495

CLAIM LIAISON
Our *Claim Liaison* is an excellent resource and is available to assist your office via phone or in person with questions regarding claim submission and processing. The Claim Liaison can be contacted directly at 602.778.1800 x1877.

REQUIRED ID NUMBERS

FEDERAL TAX ID
The Provider must also report the Federal Tax Identification Number (TIN) under which they will be paid. The Federal TIN (Employer Identification Number, EIN) must also be billed on the CMS 1500 form in Field 25.

NATIONAL PROVIDER IDENTIFICATION (NPI)
ONECare requires all providers to submit the rendering/servicing provider's NPI on every claim. ONECare requires that when applicable, the prescribing, referring, attending and operating provider NPI(s) also be present on claim submissions. Claims without the required NPI(s) will be developed for the NPI.

Please work with your billing team to ensure that NPI(s) are submitted appropriately with each claim submission and call us if you have any questions or need assistance.

- To apply for your Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or contact National Provider Identifier Enumerator Call Center 800.465.3203 to request a paper application.

- If you have not yet notified ONECare of your NPI(s), please fax a copy of your NPI(s) confirmation to Provider Network Operations at 602.778.1875.

SECTION XII: Billing, Claims And Encounters

BILLING FOR SERVICES RENDERED

CLAIM FORMS

The Centers for Medicare and Medicaid Services (CMS) now requires providers to submit all claims on the newest version of each claim form.

- Practitioners – CMS 1500 (version 02/12)
- Facilities – UB-04
- Dental – J430D

Claims submitted on the old claim form will be developed to resubmit on the appropriate claim form.

Services can be billed on one of three forms: the CMS 1500 (version 02/12) claim form for professional services, the UB-04 for inpatient and outpatient facility services, dialysis, nursing home and hospice services or the J430D for dental services. All providers must submit claim forms as documentation of services rendered, even if the provider has a capitated agreement with the health plan for the service.

TIMELY FILING GUIDELINES

When ONECare is primary, the initial claim submission must be received within six months from the date of service for contracted providers. For non-contracted providers, the initial claim submission must be received within twelve months from the date of service.

Secondary claim submissions must include a copy of the primary payer's remittance advice and be received within 60 days of the date of the primary payer's remittance advice or twelve months from the date of service, whichever is greater.

- Acceptable proof of timely filing documentation must establish that ONECare or its agent has <u>received</u> a claim or claim related correspondence
    - Acceptable examples of proof of timely filing include:
        - Signed courier routing form documenting the specific documents contained
        - Certified mail receipt that can be specifically tied to a claim or related correspondence
        - Successful fax transmittal confirmation sheet documenting the specific documents faxed
        - Acceptable confirmation report from CHANGE Healthcare fka Emdeon (our sole electronic clearinghouse) documenting successful transmittal

- Unacceptable examples of proof of timely filing include:
  - Provider billing history
  - Any form or receipt that cannot be specifically tied to a claim or related correspondence
  - Acceptance confirmation report from any electronic clearinghouse other than CHANGE Healthcare

DUPLICATE CLAIMS

ONECare receives a large number of duplicate claim submissions as a result of claims being frequently resubmitted within 30 days from the date of initial submission.

To avoid duplicate claims, we recommend validating claims status after 14 days following submission and allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments. Resubmission of claims prior to 60 days causes slower payment turnaround times.

Verify claim status prior to resubmitting a claim. Your claim status can be verified 24-hours a day, seven days a week on our website. Minimizing duplicate submissions reduces your administrative costs.

SCANNING TIPS

All paper claims are input into our system using a process called data lifting.

1. Printing claims on a laser printer will create the best possible character quality
2. If a dot matrix printer must be used, please change the ribbon regularly
3. Courier 12 pitch non proportional font is best for clean scanning
4. Use black ink for all claim submissions
5. Always attempt to ensure that clean character formation occurs when printing paper claims *(i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number)*
6. Ensure that the claim form is lined up properly within the printer prior to printing
7. If a stamp is required, refrain from red ink as this may be removed during the scanning process
8. Make every effort to not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. *(characters on the claim from outside of the lined boxes have a tendency to "throw off" the registration of the characters within a box)*
9. Use an original claim form as opposed to a copied claim form as much as possible
10. Use a standard claim form as opposed to a form of your own creation *(individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly)*

SECTION XII: Billing, Claims And Encounters

REQUIRED CLAIM FIELDS

The "required" fields to be completed on a **CMS 1500** Claim Form* are as follows:

Field	Description
1a	Insurer's I.D. Number
2	Patient's Name (last, First, Middle Initial)
3	Patient's Birth Date/Sex
5	Patient's Address
9	Other Insurer's Name
9a	Other Insurer's Policy or Group Number
9b	Other Insurer's Date of Birth/Sex
9c	Employer's Name or School Name
9d	Insurance Plan Name or Program Name
10	Patient Condition Related to: a,b,c
12	Patient's or Authorized Person's Signature
13	Insurer's or Authorized Person's Signature
14	Date of Current Illness; Injury; Pregnancy
17	Name of Referring Physician or Other Source
17a	Other ID Number
17b	NPI Number (only required if box 17 is populated)
21	Diagnosis or Nature of Illness or Injury 1,2,3,4
23	Prior Authorization Number
24a	Date(s) of Service
24b	Place of Service
24d	Procedures, Service or Supplies
24f	Charges (usual and customary amount(s))
24g	Units
24j	Rendering Provider's NPI
25	Federal Tax ID Number or Social Security Number
28	Total Charge
31	Signature of Physician or Supplier and Provider Identification Number
32	Name and Address of Location Where Services were rendered – when the address in box 33 is not the address where services where rendered, box 32 must be populated with the service location. **Note:** For transportation claims, the complete pick up and drop off address is required. If the Pick-Up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80')
33	Provider's Facility Name, Supplier's Billing Name (as registered with the IRS), Address, Zip code, and Phone Number
33a	Provider's Organizational NPI

*Operative reports, consult notes, consent forms and/or any other documentation required in order to determine reimbursement status of a claim must also be attached.

SECTION XII: Billing, Claims And Encounters

The "required" fields to be completed on a **UB-04** Claim Form are as follows:

Field	Description
1	Provider Name, Address, and Phone Number
3b	Medical Record Number
4	Bill Type
5	Federal Tax Number
6	Statement Covers Period
9	Patient Name
9	Patient Address
10	Patient Date of Birth
11	Patient Sex
12	Admission Date
13	Admission Hour
14	Type of Admission
15	Source of Admission (Inpatient and observation only)
16	Discharge Hour (Inpatient and observation only)
17	Patient Status (Inpatient and observation only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/ Rates
45	Service Date – Required for outpatient billings with more than 1 DOS in box 6
46	Service Units
47	Total Charges by Revenue Code
50	Payer
51	Health Plan ID Number
52	Release of Information
56	Rendering Provider's NPI (field required)
58	Insurer's Name
59	Patient's Relationship to Insured
60	Patient I.D. Number
61	Group Name
62	Insurance Group Number
63	Treatment Authorization Codes
65	Employer Name
66	Other Diagnosis Codes
69	Admitting Diagnosis Codes
74	Principal Procedure Code and Dates
74 a-e	Other Procedure Codes
76	Attending Physician Name (required for bill types 11x, 12x, 21x and 22x) and NPI Number (required if name field is populated)
77	Operating Physician Name and NPI Number (NPI Number only required if name field is populated)
78-79	Other Physician Names and NPI Numbers (NPI Number only required if name field is populated)

SECTION XII: Billing, Claims And Encounters

OTHER INSURANCE

ONECare follows Medicare guidelines for coordination of benefits. When the member has primary commercial coverage, the primary insurance carrier must be billed first. When a patient notifies the provider of other insurance, ONECare must be notified. Please note that the allowed amount shall be based upon the lesser of ONECare's or third party carrier's fee schedule, less the paid amount by the third party carrier(s) any remaining balance shall be paid by ONECare as coordination of benefits. Please refer to our Prior Authorization Guidelines for prior authorization requirements. Prior authorization is required for some services when ONECare is the secondary payer.

BALANCE BILLING

ONECare members are eligible for both Medicare and Medicaid. Providers shall not hold ONECare members liable for Medicare Part A and B cost sharing when the AHCCCS is responsible for paying such amounts. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will (a) accept the ONECare payment as payment in full, or (b) bill the appropriate AHCCCS Plan.

BALANCE DUE CLAIMS

When submitting a claim for balance due, the provider must include a complete copy of the claim along with the other insurance carrier's Explanation of Benefits (EOB) or Remittance Advice (RA), include the remark code/remittance comments section of the RA. ONECare must receive any balance due claim within 60 days of the receipt of the primary carrier's EOB or RA or 180 days from the date of service, whichever is greater.

When a member is ONECare primary and Care1st secondary our system automatically coordinates processing for these services and submission of the primary remittance advice along with another claim is not necessary. This is only when the member is both ONECare and Care1st. Please contact our Claims Customer Service Team if you have not received a remittance advice for both lines of business within 90 days.

CLAIMS RESUBMISSION POLICY

Resubmissions/reconsiderations must be received within the following time frames:

- 12 months from date of service
- 60 days of the date of recoupment or last adverse action, if greater than 12 months from the date of service
- 60 days from the date on the primary payer's remittance advice, if greater that 12 months from the date of service

Note: ONECare will re-adjudicate claims re-submitted by providers if an initial claim was filed within the original prescribed submission deadline.

SECTION XII: Billing, Claims And Encounters

RESUBMISSIONS/CORRECTED CLAIMS

When submitting a corrected claim, please include an attachment indicating the reason for resubmission along with the corrected claim/resubmission and the original claim number to expedite handling. If you feel that you have identified a billing issue that may result in a larger volume of resubmissions, please work directly with your Provider Network Representative or our Claims Liaison.

DUPLICATE OR ERRONEOUS PAYMENTS

Providers will refund promptly to ONECare any payment incorrectly collected from ONECare for services for which another carrier or entity has or should have primary responsibility. In the event of any overpayment, erroneous payment, duplicate payments or other payment of an amount in excess of which the provider is entitled, ONECare may, in addition to any other remedy, recover the same by offsetting the amount overpaid against current and future reimbursements due to the Provider.

EXPLANATION OF REMITTANCE ADVICE

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claims payment to the provider. The report identifies key payment information. If you have any questions regarding a RA, please contact Claims Customer Service or Provider Network Operations.

REMITTANCE ADVICE REPORT COLUMNS AND DESCRIPTIONS

The following are the report columns and descriptions included in the RA:

Company	Number, name, address, and telephone number of the company defined in the general ledger on the Company Name and Address Maintenance screen and assigned to the LOB on the Enter/Update Line-of-Business Codes screen.
Vendor/Subscriber	Name and address of either the vendor or subscriber, depending on who is being paid for the claim. The vendor is defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. The subscriber information is defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Vendor No.	The code identifying the claim vendor defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. If the vendor has multiple addresses, "*An" displays to the right of the vendor number, where n represents the vendor's address number used.
Check No.	The check number pulled from the MASTER. CLAIM file.
Payment	The amount being paid by the check. The payment amount is pulled from the MASTER. CLAIM file.
Document Number	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Date Approved	The approval date of the general claim. The claim is approved on the Enter/Update General Claims screen and the date is stored in the MASTER.CLAIM file.
Member	The member's number and name defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Procedure	The claim document number defined either during claim entry on the Enter/Update

	General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Qty	The number of times the procedure was performed between the From and thru dates. This information is entered on the Procedure Information screen.
Req. Amt	The requested amount for the procedure entered on the Procedure Information screen.
Elig. Amt	The eligible amount for the procedure. The eligible amount is The lesser of the requested amount or the maximum allowable amount, both of which are entered on the Procedure Information screen.
COB. Amt	The coordination of benefits amount entered on the Procedure Information screen.
W. Hold	The amount withheld by the health care organization from the payment amount. The amount withheld is based on the agreement made with the vendor, provider, or LOB and is entered on the Procedure Information screen.
Discount	The amount withheld by the health care organization for discounts. This is also based on the agreements made with the vendor, provider, or LOB. The discount is defined on the Regional Vendor Information screen and entered on the Procedure Information screen.
Copay	The amount the member paid for copayment defined on the Copay/Coinsurance Maintenance screen and entered on the Procedure Information screen.

CLAIM PAYMENT DETAIL

Provider/ Member	The provider code, or the member number and name of the person who should receive the corresponding payment amount. Provider codes are defined on the Enter/Update Provider Codes screen and entered on the Enter/Update General Claims screen. Member numbers are defined either on the Enroll Subscribers screen or the Enroll Additional Members screen and entered on the Enter/Update General Claims screen.
Payment	The payment amount due to the provider or member. This amount is entered on the Enter/Update General Claims screen.

OTHER A/P TRANSACTIONS

Invoice No.	Invoice number (defined on the Enter Invoices screen) or memo number (defined on the Debit and Credit Memo Entry screen).
Type	The batch source of the invoice or memo. The type is defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Date Approved	The invoice or memo approval date defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Description	The invoice or memo description defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen. If the invoice was for a capitation payment, the comment will be "*Capitation Payment*."
Amount	The invoice or memo total amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Payment	The invoice or memo payment amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Less Discount	The total discount amount of the invoices and memos.
Total Transactions	The total payment amount of A/P invoices and memos that affect the amount of the check for the vendor or family.

REMITTANCE ADVICES AVAILABLE ON WEBSITE

Medical

For your convenience, remittance advices are available for reviewing and printing on our website minimizing delay between receipt of dollars and the ability to post payment. Contact Provider Network Operations to obtain a login or confirm your login status.

SECTION XII: Billing, Claims And Encounters

Dental
Advantica selected CHANGE Healthcare fka Emdeon as its electronic remittance advice (ERA) reporting partner. There is no cost to you to use these services and enrollment is free! To enroll in CHANGE Healthcare ePayment, visit www.emdeondental.com to create a Dental Provider Services (DPS) account. If you have questions about the enrollment process, please call CHANGE Healthcare at 888.255.7293.

IMPORTANT NOTES

- When box 31 on the CMS 1500 form has "Signature on File," this is acceptable as long as the processor can determine the servicing provider. When only the group name appears in Box 33 and the processor is unable to determine the servicing provider, the claim will be developed for a corrected claim. Box 33 should always indicate the facility name as provided to the IRS and CMS.

- If the same service is performed on the same day and by the same provider, the claim must be submitted with the applicable modifier and supporting documentation attached.

- If a claim is received with dates of service that fall after the received date the entire claim will be developed for a corrected claim.

- Diagnosis codes that require a 4th or 5th digit will be developed for a corrected claim if not submitted with appropriate code. ONECare never changes or alters a diagnosis code.

MODIFIERS

Valid modifiers should be used when submitting claims to ONECare. Claims that are submitted with an inappropriate or missing modifier will be developed for a corrected claim. The following are a few commonly used modifiers and tips on appropriate usage:

***MODIFIER 50* (bilateral procedure)**
Modifier 50 is required for all bilateral procedures. Please refer to the current coding guidelines for a listing of appropriate bilateral procedures.

Bilateral procedures are billed on one line with 1 unit and the 50 modifier:

EXAMPLE:
Line 1: 69436, with "50" modifier, full dollar amount, 1 unit
Total payment: 150% of fee schedule

***MODIFIER 59* (distinct procedural service)**
Modifier 59 is required to identify a truly distinct and separate service and should not be used if the procedure is performed on the same site. When an already established

modifier is appropriate, it should be used instead of modifier 59 (example modifier 91 for repeat clinical procedures). ONECare applies NCCI (National Correct Coding Initiative) bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. As a reminder, it is not appropriate to use this modifier with the following CPT ranges: 77421-77427 or 99201-99499. Effective 01/01/15 four new HCPCS modifiers to define subsets of the modifier 59, used to define a "Distinct Procedural Service", are available for use:

- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Similar to modifier 59, records to support the use of these modifiers are required for codes within the following ranges:

CPT Code	Brief Description
36600	Blood Draw/Arterial Catherization
43210 - 43239	Upper Gastrointestinal - Diagnostic
45380 - 45398	Colonoscopy - Diagnostic
45900 - 45999	Rectal/Colon - Diagnostic
46600 - 46615	Anoscopy - Rectal/Colon - Diagnostic
49560 - 49568	Hernia Repair
51600 - 51720	Bladder - Diagnostic
51725 - 51798	Cysometrogram – Bladder - Diagnostic
52000 - 52318	Cystourethroscopy – Bladder - Diagnostic
58100 - 58120	Endometrial Biopsy - Diagnostic
62310 - 64640	Lumbar and Sacral Pain Management
69100 - 69999	Ear Procedures
94640 billed with 94060 on same date of service	
96372 when billed with pain management procedures	

***MODIFIER 76* (repeat procedure by same physician)**

Modifier 76 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 76 are subject to medical review and records are required with the claim submission in order to be considered.

***MODIFIER* 77 (repeat procedure by a different physician)**

Modifier 77 is required to identify repeat procedures performed by different physicians. Claims submitted with modifier 77 are subject to medical review and records are required with the claim submission in order to be considered.

MODIFIER 91 (repeat clinical diagnostic laboratory test)
Modifier 91 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 91 are subject to medical review and records are required with the claim submission in order to be considered

MODIFIER **SG (Ambulatory Surgical Center facility service)**
Modifier SG is not required on surgical procedures to identify the facility billing and is not used for professional services; however it is recommended to clearly indicate facility billings.

MODIFIERS AD, QK, QX & QY **(Anesthesia with CRNA oversight)**
When anesthesia services are provided by a CRNA with oversight from a physician, the appropriate modifier is required (AD, QK, QX, or QY).

Services are reimbursed to each provider (CRNA and supervising physician) at 50%.

ADDITIONAL MODIFIER CRITERIA

- When a complete laboratory service is performed (both professional and technical component), the service should be billed on a single service line with no modifier.

- Modifiers are required for all DME, Prosthetics and Orthotics and Ambulance services.

- When both the technical and professional component are performed by the same provider of service, the service code(s) should be billed on a single service line without a modifier, and not billed on two separate lines with the TC and 26 modifiers.

OPERATIVE REPORT

An operative report is required for the following surgical procedures:

- Multiple procedures with a total allowed amount greater than $5000.00
- Any surgical procedure billed with modifier(s) 59, 62, 66, 76, 77, or 78
- Any unlisted procedures
- Any surgical procedure billed for a higher level of care than originally prior authorized

SECTION XII: Billing, Claims And Encounters

REFUNDS

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable).

If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Refunds are mailed to ONECare, Attention: Finance, 2355 E Camelback Rd, Suite 300, Phoenix, AZ 85016.

ANESTHESIA

Notes are required for all timed procedures and authorization are subject to medical review. The specific anesthesia start and end time must be submitted on the CMS-1500 form. The total number of minutes is required in the unit field (25G).

- Consultations of other evaluation and management code on the same day as an anesthesia administration are not payable. Consultations provided the day before anesthesia services are payable separately when prior authorization is obtained.

- Daily pain management following surgery is not a covered expense.

When services are provided by a CRNA and oversight is provided by a supervision physician, the applicable modifier must be submitted on each claim. The QX modifier is billed with the CRNA service when medical direction is provided by a physician. The QY modifier is billed by the supervising physician to indicate medical direction was provided to the CRNA. Either AD or QK modifiers are billed by the supervising physician to indicate that medical direction was provided to multiple concurrent anesthesia procedures.

As a reminder, the anesthesia record is required anytime the anesthesia starts and stops during a procedure.

ASSISTANT SURGEONS

Assistant surgeon bills are submitted with a modifier -80 or -81. These charges are reimbursed at 10% of the reimbursement rate of the assistant surgeon. Assistant surgeon charges submitted for a physician assistant, nurse practitioner, or clinical nurse specialist should be submitted with modifier AS.

DENTAL PROVIDERS

All dental providers must submit claims on the current ADA Dental Form. ADA dental codes, as published in the most current CDT manual, should be used for claims

submission. Please include the information below on each claim to avoid delay in payment:

1. Member's name
2. Member's Medicaid number
3. Member's date of birth
4. Rendering dentist's name
5. Rendering dentist's office location
6. Rendering dentist's TIN
7. Rendering dentist's NPI
8. Billed Amount
9. Date of service for each line submitted
10. Other Insurance Information
11. Quadrants, arches, tooth numbers and surfaces for dental codes that require identification.

Please refer to Section VI Covered Services for detailed information regarding covered services.

DIALYSIS

- For facility billings, the type of bill must be 72x and the appropriate modifiers must be billed for the specific dialysis services.

- Physicians do not require their own authorization. They may use facility authorization.

DURABLE MEDICAL EQUIPMENT

- Canes, crutches, standard walkers, standard wheelchairs and supplies do not require an authorization when provided by a contracted provider.

- Valid modifiers must be submitted with DME services to indicate NU (new) or RR (rental rate). Claims submitted without one of these modifiers will be developed for a corrected claim.

EMERGENCY TRANSPORTATION PROVIDERS

Claims for emergent transportation, including transport transfer services to a higher level of care (such as member transfer from Skilled Nursing Facility to Hospital), must indicate Emergency in Box 24C. Emergent services do not require prior authorization; however non-emergent services must be authorized accordingly. Inter-facility transports require authorization.

The appropriate modifier for ambulance services must also be billed.

The full pick up address address (or location if an address is not available) and drop off address are required in box 32 for ambulance services. If the pick up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80'). Claims that do not contain this information will be developed for a corrected claim.

For electronic claims, the pick up location must be billed in loop 2310E and the drop off location must be billed in loop 2310F. No trip ticket is required if these fields are populated correctly.

For paper claims, a trip ticket is required on each claim. Pick-up and drop-off requirements are as follows:

1. Pickup and/or drop off location = facility, i.e. hospital, SNF
   - Facility name, city, state, zip OR street address, city, state, zip required in box 32
2. Pick up and/or drop off location ≠ facility
   - Street address, city, state, zip required in box 32
3. Pick up location = area where there is NO street address

Description of where service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80') required in box 32

Supplies provided during emergency transportation are to be billed by the ambulance service and not the supply company. Supplies are included in the reimbursement for the ambulance transport and not paid separately.

Ambulance wait time is not a covered benefit.

HOME HEALTH

- Nursing supplies are not considered routine. All supplies require prior authorization to be reimbursed.

HOSPICE SERVICES

- When a member elects hospice, hospice services are reimbursed by traditional Medicare and not ONECare.

IMMUNIZATIONS/INJECTABLES

COVERED IMMUNIZATIONS

- A complete list of covered immunizations and additional quick reference information can be located at the following link: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf

OTHER INJECTABLES

- Vitamin B-12 injections (J3420) are payable for diagnosis codes 266.x, 281.0 and 579.8 only and must be billed with the applicable NDC.

- J3490 (unclassified drug code) requires description & dosage and should only be used if there is no other appropriate code. A description of the specific drug is required along with the applicable NDC.

DRUG BILLING/NATIONAL DRUG CODE (NDC)

Since all ONECare members are dual-eligible, ONECare follows AHCCCS guidelines regarding requirements for NDC billing. AHCCCS implemented new billing requirements for drugs administered in outpatient clinical settings in accordance with Federal Deficit Reduction Act of 2005. All paper and electronic UB-04 and CMS 1500 claims must include the appropriate National Drug Code (NDC) number on claims for payments for drugs administered in an outpatient setting.

NDC is billed with an N4 qualifier when submitted electronically and must be billed in the following format: With 11 digits for the NDC, the unit of measure (F2, GR, ML, or UN) and the quantity (examples: N411111111111 F210 for electronic submission or 11111111111 F210 for paper submission)

Claim lines billed without the NDC code are developed for a corrected claim.

For more information, please visit:

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1234.pdf

LABORATORY

PCPs and Specialists may bill in office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by CMS. In order for a lab to be payable, the lab must be allowed to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on. All other laboratory services must be performed by Sonora Quest.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24 hours per day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

SECTION XII: Billing, Claims And Encounters

MATERNITY SERVICES

When submitting prenatal care and delivery claims, the following guidelines and coding procedures will apply:

ONECare reimburses obstetrical care as a total OB (TOB) package. To qualify for a TOB package, a minimum of 5 ante partum visits must be rendered in addition to the delivery. To confirm this requirement was satisfied, the appropriate delivery CPT procedure code is billed in addition to the ante partum visits. Ante partum and post partum visits are billed with the appropriate E&M CPT code (99211-99215) on individual service lines with 1 in the 'units' field for each date of service.

ONECare collects all dates of service for obstetrical care. This does not impact policies related to global billing, however it requires that all dates of service be reported on the claim. Consequently, each ante partum date of service must be billed individually. Claims received ***November 1, 2014 and later*** that are not billed in this format will be denied.

Total OB Example:

OB physician performs 6 ante partum visits between January 1 and April 30 and delivery occurs May 5.

- Line 1: Appropriate total OB care delivery CPT code
- *Line 2: 1st Ante partum visit billed with the date of service and E&M CPT code
- *Line 3: 2nd Ante partum visit billed with the date of service and E&M CPT code
- *Line 4: 3rd Ante partum visit billed with the date of service and E&M CPT code
- *Line 5: 4th Ante partum visit billed with the date of service and E&M CPT code
- *Line 6: 5th Ante partum visit billed with the date of service and E&M CPT code
- *Line 7: 6th Ante partum visit billed with the date of service and E&M CPT code
- *Line 8: Post partum visit billed with the date of service and E&M CPT code. *Claims for the total OB package can be billed prior to the post partum visit being rendered. Please be sure to submit the post partum visit once it is completed.*

*****Each visit must be billed on a separate line with the specific date of service and a unit of 1.

All services included in the TOB package are billed with the delivery. Reimbursement is made on the total OB care delivery CPT code.

To report services related to maternity care, use the appropriate CPT-4 office visit codes and the appropriate ICD-9-CM pregnancy diagnosis codes.

Prenatal care can be billed as fee-for-service if patient transfers to a high risk OB doctor or patient terminates from ONECare.

CPT Procedure Codes, Vaginal Delivery

59400 Package Routine obstetric care including antepartum care (a minimum of five visits), vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Total OB package should be billed after delivery.

59409 Vaginal delivery only (with or without episiotomy), forceps or breech delivery. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59410 Vaginal delivery only (with or without episiotomy), forceps or breech delivery including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

CPT PROCEDURE CODES, CESAREAN DELIVERY

59510 Package Routine obstetric care including antepartum care (a minimum of five visits), cesarean delivery, and postpartum care. Total OB care should be billed after delivery.

59514 Cesarean delivery only with no postpartum or antepartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59515 Cesarean delivery only including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59525 Subtotal or total hysterectomy after cesarean delivery.

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

*Multiple births should be paid using the total OB code for the first birth and the delivery only code with a 51 modifier for subsequent births.

LABOR AND DELIVERY

Providers should use ASA code:

00857 Continuous epidural analgesia for labor and cesarean section

00955 Continuous epidural analgesia for labor and vaginal delivery

00850 Base (7) + time for cesarean section-8 total time units max

00946 Base (5) + time for vaginal delivery-8 total time units max

01960 Anesthesia for vaginal delivery only-8 total time units max

01961 Cesarean delivery only-8 total time units max

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery-8 total time units max

01968 Cesarean delivery following neuraxial labor analgesia/anesthesia-8 total time units max

01969 Cesarean hysterectomy following-8 total time units max

OB anesthesia does not require documentation. Providers should not bill 01996 with anesthesia for delivery.

ADDITIONAL OB INFORMATION

- If a provider different from the provider with the total OB authorization performs the delivery only, the provider with the total OB authorization shall be reimbursed for all prenatal visits on a fee-for-service basis. The prenatal visits should be submitted indicating each individual date of service and separate charges for each visit. Should provider change facility affiliation, ONECare must be notified regarding disposition of members. The authorization may follow the physician but final billings must be initiated by each facility and each facility must indicate the dates of service and charges that apply. The physician's facility that provides the delivery will be eligible for total OB reimbursement if the authorization is on file and the minimum numbers of visits have taken place.

- A total OB authorization includes all prenatal visits and postpartum care. When a patient transfers care to another provider, a new OB auth must be obtained.

- Any additional surgical procedures performed during the delivery admission must also be reported along with appropriate diagnosis. If a postpartum tubal ligation is performed, the signed consent form must be submitted with the claim.

- No prior authorization is required for assistant surgeon services on cesareans. Assistant surgeon services are not covered for vaginal deliveries, **only** for cesareans.

- OB claims need a minimum of five visits in order to qualify and be paid for a total OB package rate. If no prenatal visits are billed with total OB package codes 59400, 59510, 59610, or 59618 the claim will be developed for a corrected claim.

- If a claim indicates pregnancy terminated, patient transferred care, or patient moved out of state, the provider(s), total OB authorization will still cover all charges incurred up to that point to be paid fee-for-service. The reason for discontinuation of care should be indicated on the CMS 1500 form.

- The operative report, prior authorization and the Federal consent form are required for sterilization services. Consent form must be signed 30 days prior to sterilization. Total Hysterectomies do not require an authorization if performed on an emergency basis and they never require a federal consent form.

- 2D OB ultrasounds (3 or more) require prior authorization

MID-LEVEL PROFESSIONALS (NP'S & PA'S)

NPs and PAs are reimbursed at the ONECare Midlevel Fee Schedule.

RADIOLOGY

Providers must bill with either a 26 (professional) or TC (technical) modifier for correct reimbursement. When billed with no modifier, provider is indicating they provided both the technical and professional services. All services performed for a specific service date or date span must be billed on a single claim.

SKILLED NURSING FACILITY (SNF)

- The type of bill for facility billings must be 21x
- Revenue codes for room & board for SNFs is 190-194 and 199
- *SNF providers cannot bill with overlapping months

SURGERY PROVIDERS

- An operative report is required for the following surgical procedures:
  1. Multiple procedures with a total allowed amount greater than $5000.00
  2. Any surgical procedure billed with modifier(s) 59, 62, 66, 76, 77, or 78
  3. Any unlisted procedures
  4. Any surgical procedure billed for a higher level of care than originally prior authorized

- Multiple procedures are paid at 100% of the applicable fee schedule for the first, and 50% of the applicable fee schedule for the next five procedures. When an operative report is required and not submitted, the claim will be developed for the operative report. Office procedures require office note's if

an OP report is not available. In order to eliminate any delay in payment, submit an OP Report with a surgery claim.

- Planned surgeries require their own prior authorizations. Surgical trays (A4550) are not reimbursable.

MEDICAL CLAIMS REVIEW

The Medical Management (MM) Department has assigned the medical claims analysis responsibility to the medical claims analysts who are responsible for reviewing and analyzing all claims deemed appropriate for retrospective review. The MM Department uses the following guidelines, criteria, and coding indexes to review a claim:

- International Classification of Diseases-Tenth Edition (ICD-10)
- Current Procedural Terminology (CPT)
- CMS Common Procedure Coding System (HCPCS)
- Medicare Guidelines
- Milliman Care Guidelines®
- National Correct Coding Guide: Correct Coding Initiatives (CCI)
- UB Editor
- McKesson Claim Check

The following types of claims are reviewed by MM on a regular basis. Please note that this is not an all-inclusive list and is subject to change at any time.

- All Level-V Emergency Medicine Physician charges
- Inpatient claims that are set to pay at the inpatient outlier rate
- Multiple and Bilateral Surgeries over $500.00
- Observation over 24-hours
- Critical care
- Prolonged services
- Anesthesia unusual services
- Unlisted/ By report procedures

As needed, the results of the MM analysis are forwarded to the CMO for review and decision. All identified claims that do not meet the criteria may be subject to denial or reduction of reimbursement and are reviewed by the CMO or designee. All cases of potential fraud or abuse are referred to CMS in accordance with ONECare's Fraud and Abuse policy.

The outcomes and aggregate adjustments are compiled, tabulated and presented monthly to the MM Committee by the CMO.

If appropriate, members will be referred to MM for monitoring and assistance with continuity of the member's care.

SECTION XIII: Fraud, Waste and Abuse

FRAUD, WASTE AND ABUSE

The Centers for Medicare & Medicaid Services (CMS) requires that ONECare provide compliance related training materials to health plans' contracted First tier, down stream and related entities (FDRs) and their employees who are involved in the administration or delivery of Medicare benefits. The training is performed as part of initial contracting and must be completed September 30th annually. As a contracted provider you and your staff are considered to be an FDR. There are two attestations ONECare providers must submit to meet this requirement.

The first required attestation pertains to Fraud, Waste & Abuse, and General Compliance Training. The second required attestation pertains to Policies & Procedures, Anti-Fraud Plan, Standards of Conduct for Providers, and HIPAA Training. Providers who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse. Providers that meet the FWA certification still must train on general compliance. ONECare makes available FWA and Compliance Training online for those that do not have their own alternate equivalent training at https://www.care1st.com/az/providers/compliance.asp?healthplan=onecare (click on "FDR/General Compliance Information" and scroll to "FWA/General Compliance Training Materials"). The principal officer with contract signatory authority must submit an Attestation on behalf of its ONECare providers/staff at the time of contracting and additionally, no later than September 30 annually. The attestation and instructions for submitting it are found at the above link.

If a ONECare provider does not have internet access or have questions, please contact the Compliance Department at 602-778-8345 or via email at ComplianceDepartmentAZ@care1st.com (please do not email protected health information, unless it is sent ***securely***).

Fraud, Waste and Abuse Reporting

CMS requires providers to immediately report suspected fraud and abuse. Members or providers who intentionally deceive or misrepresent in order to obtain a financial gain or benefit they are not entitled to must be reported to the Office of Inspector General (OIG) & the health plan's corporate compliance officer. Any suspected fraud, waste, or abuse within the Medicare program, should be referred to ONECare or the the Department of Health and Human Services Office of Inspector General using the contact information below. Fraud cases may involve beneficiaries, pharmacies, physicians or other providers, health plans, or other organizations.

SECTION XIII: Fraud, Waste and Abuse

It is imperative that ONECare providers continue to partner with ONECare to ensure that the reported millions of dollars lost to fraud and abuse does not originate with Arizona providers. Members and providers who act fraudulently hurt honest providers and exhaust limited resources available to serve those in need.

To report fraud and abuse to ONECare, contact the Compliance Department via:

Phone:
602.778.8345
Compliance Hotline (available 24/7; Anonymous)
866.364.1350
Mail:
ONECare
Attn: Compliance Department
2355 E. Camelback, Ste. 300
Phoenix, AZ 85016
Fax:
602.778.1814

Please remember to submit as much information as possible regarding the reported matter.

To report Medicare Fraud to the Department of Health and Human Services Office of Inspector General (OIG), contact the OIG Hotline via:

Phone: 800.HHS.TIPS (800.447.8477)

Fax: 800.223.8164

Online Referral Submission: https://forms.OIG.HHS.gov/hotlineoperations/index.aspx

TTY: 800.377.4950

Mail:
Office of Inspector General
Department of Health and Human Services
Attn: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

SECTION XIII: Fraud, Waste and Abuse

ANTI-FRAUD PLAN

Most of the initial legislation and enforcement of health care fraud and abuse has been in the Medicare/Medicaid and Hospital (Stark) areas. However, health care fraud and abuse in managed care is beginning to receive attention and inquiry.

The federal Deficit Reduction Act of 2005 requires any entity, such as ONECare to establish written policies for its employees, subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections, and the organization's (ONECare's) policies and procedures for detecting and preventing fraud, waste and abuse.

ONECare's Anti-Fraud Plan addresses these requirements of federal and state laws and is a useful tool on the subject of fraud, waste and abuse. The Anti-Fraud Plan is available at the following location: https://www.care1st.com/az/providers/compliance.asp; then, click on "FDR/General Compliance Information".

DEFICIT REDUCTION ACT

ONECare providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:

- The False Claims Act, Including Examples of False Claims and Remedies
- Federal Whistleblower Protections

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid and Medicare.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that a person, with respect to information:

- had actual knowledge of falsity of information in the claim, or
- acted in "deliberate ignorance" of whether or not the information was true, or
- acted in "reckless disregard" of the truth or falsity of the information in a claim.

It is not necessary that the person had a specific intent to defraud the government.

SECTION XIII: Fraud, Waste and Abuse

The False Claims Act prohibits seven types of conduct:

1. **False Claim:** Filing false or fraudulent claims. A Claim includes any request or demand for money that is submitted to the U.S. government or its contractors (like ONECare). So a provider or hospital claim, or a vendor billing, submitted to ONECare involving Medicaid or Medicare programs counts as a claim.
2. **False Statement:** Making or using false statements or records.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.
5. **Delivery of Improper Receipt:** Delivering a receipt for property without knowing whether the information on the receipt is true.
6. **Unauthorized Seller:** Knowingly buying or receiving property from a government employee or official who is not authorized to sell it.
7. **Reverse false claims:** A reverse false claim involves using a false statement to conceal, avoid or decrease the amount of an obligation.

EXAMPLES OF A FALSE CLAIM

1. Billing for procedures not performed
2. Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals)
3. Falsifying information in the medical record or in a claim
4. Improper bundling or coding of charges, and
5. Misrepresentation by a member or provider to seek benefits provided by Care1st or other Medicaid or Medicare contractor/health plan.

REMEDIES

1. Violation of the False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages that the Government sustains because of the violation
2. A federal false claims action may be brought by the U.S Attorney General
3. An individual also may bring what is called a qui tam action for violation of the False Claims Act. This means the individual files a civil action on behalf of the government
4. An individual who files a qui tam action receives an award only if, and after, the Government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the Government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action

5. A statute of limitations provides the amount of time that may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed

FEDERAL WHISTLEBLOWER PROTECTIONS

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Clams Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for such relief. (31 USC 3730(h))

REMEDIES

A person who violates one of the provisions above is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.