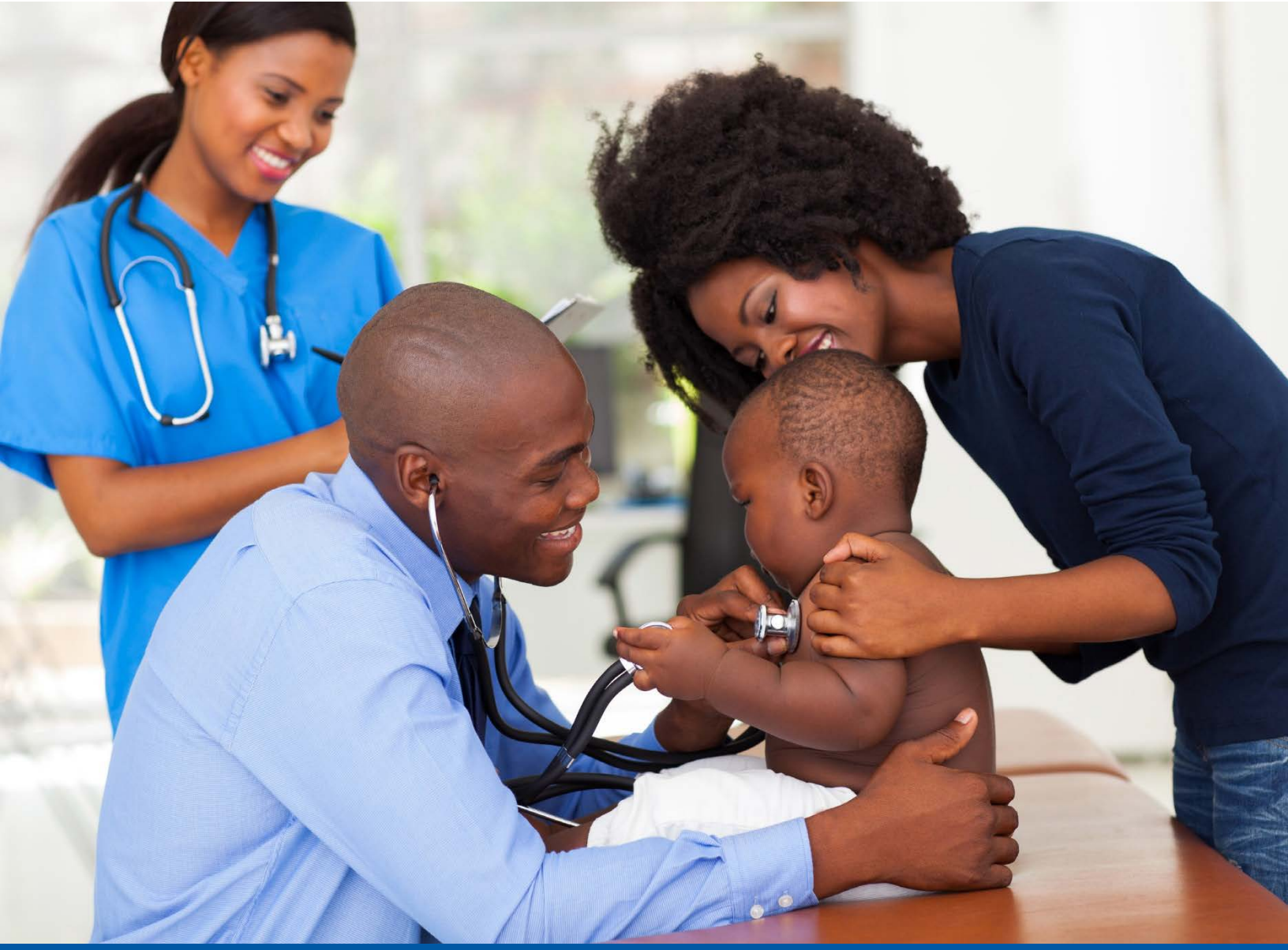

2026 Provider Manual

Revised January 2026

www.amerihealthcaritasdc.com

AmeriHealth Caritas District of Columbia

HEALTHY DC PLAN

WELCOME

Welcome to AmeriHealth Caritas District of Columbia ("AmeriHealth Caritas DC") – a mission-driven managed care organization located in Washington, D.C. We offer AmeriHealth Caritas DC Medicaid (for beneficiaries of the D.C. Healthy Families Program) and the Healthy DC Plan for enrollees in all eight District Wards.

This Provider Manual was created to assist you and your office staff with providing services to our Healthy DC Plan enrollees, your patients. As a provider, you agree to use this Provider Manual as a reference pertaining to the provision of medical services for enrollees of AmeriHealth Caritas DC.

This Provider Manual may be changed or updated periodically. AmeriHealth Caritas DC will provide you with notice of updates; providers are also responsible to check the Plan's website, www.amerihealthcaritasdc.com, regularly for updates.

Thank you for your participation in the AmeriHealth Caritas DC provider network. We look forward to working with you!

SHARING OUR MISSION

As our provider partner, we invite you to share our mission: To help people get care, stay well, and build healthy communities. We have special concern for those who are poor.

HEALTHY DC PLAN PRODUCTS

AmeriHealth Caritas District of Columbia offers the Healthy DC Plan to eligible enrollees. This is a federally-funded, no-cost health insurance program for residents with low incomes who are no longer eligible for Medicaid but would qualify for coverage under the Affordable Care Act through DC Health. The Healthy DC Plan covers essential health benefits such as primary and specialty care, hospitalization, and prescriptions. Please refer to the "Provision of Services" section of this Provider Manual for information on covered services for the Healthy DC Plan. Healthy DC Plan enrollees are identified by enrollee identification cards, as shown in the first section of this publication.

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SECTION I

GETTING STARTED

I. GETTING STARTED

WHO WE ARE

AmeriHealth Caritas District of Columbia ("AmeriHealth Caritas DC" or "the Plan") is a managed care organization that is part of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality health care to populations covered by publicly funded programs, including Medicaid, Medicare and State Children's Health Insurance programs. We are proud to partner with the District of Columbia to provide health care for DC residents covered by:

- DC Healthy Families Program (DCHFP) or Medicaid
- Healthy DC Plan

Through our partnership with you – our dedicated providers – we intend to help our enrollees achieve healthy lives and build healthy communities.

ABOUT OUR PROGRAMS

The Healthy DC Plan is administered through DC's Health Benefit Exchange. AmeriHealth Caritas DC is contracted to provide covered services for Healthy DC Plan enrollees in all eight District Wards.

PROGRAM ELIGIBILITY

Starting January 1, 2026, DC residents are eligible for Healthy DC Plan if they are:

- 21-64 years old;
- US Citizen or lawfully present;
- Not eligible for Medicaid;
- Not eligible for employer or other coverage; **and**
- Have an annual income between 138% and 200% of the Federal Poverty Level. For more information, see the Income Eligibility for Healthy DC Plan table below.

HEALTHY DC PLAN ENROLLMENT

Medicaid eligibility changed in DC effective January 1, 2026. AmeriHealth Caritas DC Medicaid enrollees who lost Medicaid coverage were automatically enrolled in the AmeriHealth Caritas DC Healthy DC Plan. Eligible DC residents can enroll in the Healthy DC Plan through DC's Health Benefit Exchange during open enrollment.

BECOMING A PLAN ENROLLEE

AmeriHealth Caritas DC accepts all voluntary and assigned enrollees without restriction and in the order in which they enroll. AmeriHealth Caritas DC does not discriminate on the basis of religion, political beliefs, gender, sexual orientation, marital status, race, color, age, national origin, health status, pre-existing physical or mental condition, or need for health care services and will not use any policy or practice that has the effect of such discrimination.

PRIMARY CARE SELECTION & ASSIGNMENT

New AmeriHealth Caritas DC Healthy DC Plan enrollees are encouraged to select a Primary Care Provider (PCP). If not selected by an enrollee, the Plan:

- Informs the enrollee of their right to choose a PCP.
- Assists the enrollee in selecting a PCP.

- Informs the enrollee that each eligible family member has the right to choose his/her own PCP.
- Automatically assigns a PCP to enrollees who do not proactively choose a PCP within ten days of enrollment with the plan.

The Plan considers the following when assigning a PCP:

- The enrollee's previous PCP (If known and if the provider's capacity and location allows).
- The closest PCP to the enrollee's ZIP code location.

Once the selection and/or assignment has been made, the AmeriHealth Caritas DC Healthy DC Plan enrollee's identification (ID) card and selected or assigned PCP name (or group name) will be distributed by mail to the enrollee within ten days of selection or assignment. AmeriHealth Caritas DC enrollees who were automatically assigned to a PCP will be notified of the opportunity and procedures to change PCPs.

VERIFYING ENROLLEE ELIGIBILITY

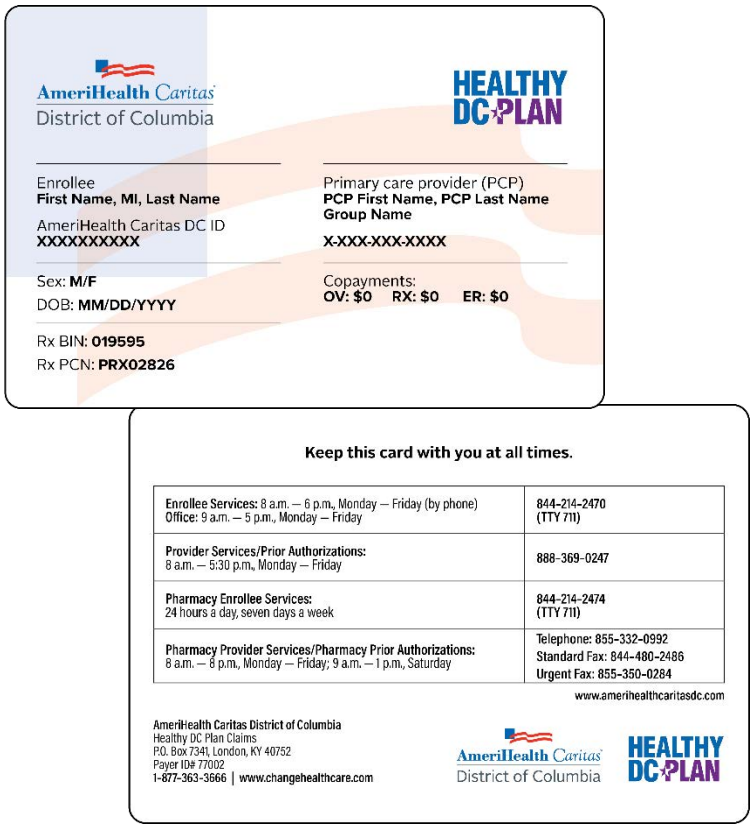
AmeriHealth Caritas DC enrollee eligibility varies. As a participating provider, you are responsible to verify enrollee eligibility with AmeriHealth Caritas DC before rendering services, except when an enrollee requests services for an emergency medical condition.

Eligibility may be verified by:

- Visiting the Healthy DC Plan provider area of AmeriHealth Caritas DC's website, www.amerihealthcaritasdc.com, to access a free, web-based application for electronic transactions and information through a multi-payer portal.
- Using the Interactive Voice Response (IVR) by calling 202-408-2237 or toll-free at 888-656-2383 and selecting the appropriate prompts.
- Calling Provider Services at 1-888-369-0247
- Using AmeriHealth Caritas DC's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.

NOTE: AmeriHealth Caritas DC ID cards are not returned to the Plan when an enrollee becomes ineligible. Presentation of an AmeriHealth Caritas DC ID card is not proof that an individual is currently an enrollee of AmeriHealth Caritas DC. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using an enrollee's ID card, please report the occurrence to the Fraud Waste and Abuse Hotline at 1-866-833-9718.

AmeriHealth Caritas DC Healthy DC Plan Enrollee ID Card



ENROLLEE RIGHTS AND RESPONSIBILITIES

As a Plan provider, it is your responsibility to recognize the following enrollee rights and responsibilities:

ENROLLEE RIGHTS

- Get information about:
- AmeriHealth Caritas DC and its health care providers
- Your rights and responsibilities
- Your benefits and services
- The cost of health care services and any required cost sharing
- Have AmeriHealth Caritas DC and its health care providers treat you with dignity and respect and recognize your right to privacy.
- Get materials or help in languages and formats other than written English, such as Braille, audio, or sign language, as indicated, at no cost to you.
- Receive help with interpretation services, as indicated, at no cost to you.
- Receive materials that are written in a manner and format that are easily understood and culturally sensitive.
- Have personal and health information and medical records kept private and confidential in accordance with all applicable requirements under federal and state law and regulations.
- Expect that AmeriHealth Caritas DC Healthy DC Plan will give you a copy of its Notice of Privacy Practices without your request, and approve or deny the release of identifiable medical or personal information, except when the release is required by law.
- Request a list of disclosures of protected health information that fall outside of treatment, payment, or health care operations.
- Request and receive a copy of your medical and claims records as allowed by applicable state and federal law.
- Ask that AmeriHealth Caritas DC amend certain protected health information.
- Ask that any AmeriHealth Caritas DC communication that contains protected health information be sent to you by alternative means or to an alternative address.
- Receive health care services consistent with applicable state and federal law.
- Talk with your health care provider about:
- Treatment plans
- Information on available treatment options and alternatives, given in a way you understand
- The kinds of care you can choose to meet your medical needs, regardless of cost or benefit coverage
- Be a part of decisions about your health care, including the right to refuse treatment. Your decision to do so will not negatively affect the way AmeriHealth Caritas DC, its health care providers, or the U.S. Department of Health and Human Services (HHS) treat you.
- Make a complaint (grievance) or appeal about AmeriHealth Caritas DC or its health care providers about the care provided to you, and for you to receive an answer.
- File a fair hearing with applicable regulatory agencies if you are not satisfied with the outcome after completing the AmeriHealth Caritas DC appeals process.
- Make an advance directive.
- Be given an opportunity to provide suggestions for changes to AmeriHealth Caritas DC enrollee rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free from discrimination prohibited by state and federal law.
- Receive treatment in the least restrictive setting.
- Fully participate in the community and to work, live, and learn to the fullest extent possible.
- Be free to exercise your rights without adverse treatment from AmeriHealth Caritas DC, its health care providers, or HHS.
- Have access to, and receive, quality health care services that are available and accessible to you in a timely

manner.

- Receive health care services that are sufficient in amount, duration, or scope and provided in a culturally competent manner to meet your specific needs.

ENROLLEE RESPONSIBILITIES

- Communicate, to the extent possible, information that the plan and network providers need to care for you.
- Follow the plans and instructions for care that you have agreed on with your providers; this responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand your health problems and participate in developing mutually agreed-on treatment goals to the degree possible.
- Review all benefits and membership materials carefully, and follow health plan rules.
- Ask questions to ensure understanding of the provided explanations and instructions.
- Treat others with the same respect and courtesy as you expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

PLAN PRIVACY AND SECURITY PROCEDURES

AmeriHealth Caritas DC complies with all Federal and District regulations regarding enrollee privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All enrollee health and enrollment information is used, disseminated and stored according to Plan policies and guidelines to ensure its security, confidentiality and proper use. As an AmeriHealth Caritas DC provider, you are expected to be familiar with your responsibilities under HIPAA and to take all necessary actions to fully comply.

SECTION II

PROVIDER AND NETWORK INFORMATION

II. PROVIDER AND NETWORK INFORMATION

This section provides information for maintaining network privileges and sets forth expectations and guidelines for Primary Care Providers (PCPs), Specialists, Allied Health, and Facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is also provided in the "Behavioral Health Care" section of this Provider Manual.

BECOMING A PLAN PROVIDER

Health care providers are invited to participate in the AmeriHealth Caritas DC network based on their qualifications and an assessment and determination of the network's needs. Health care providers interested in participating in the AmeriHealth Caritas DC network are required to be screened and enrolled and shall be periodically reenrolled (in accordance with 42 C.F.R. §438.602 (b). Please note that this does not require you to render services to "Fee for Service" beneficiaries. For specific instructions on how to become an AmeriHealth Caritas DC network provider, please visit our website at www.amerihealthcaritasdc.com and select **Providers > New to the plan > Become a provider** or call Provider Services at 1-888-369-0247.

PROVIDER CREDENTIALING AND RE-CREDENTIALING

AmeriHealth Caritas DC is responsible for credentialing and re-credentialing its network of medical or physical health providers. Additional information pertaining to behavioral health providers, including specific credentialing and re-credentialing requirements, is provided in the "Behavioral Health Care" section of this Provider Manual.

Hospital-based practitioners are not required to be independently credentialed if those practitioners serve AmeriHealth Caritas DC enrollees only through the hospital-based setting and are credentialed by the hospitals. Practitioners practicing in certain free-standing facility may be to be credentialed by the Health Plan.

AmeriHealth Caritas DC maintains criteria and processes to credential and re-credential the following practitioners:

- Medical Doctors (MDs)
- Doctors of Osteopathic Medicine (DOs)
- Doctors of Podiatric Medicine (DPMs)
- Doctors of Chiropractic Medicine (DCs)
- Certified Registered Nurse Practitioners (CRNPs)
- Certified Nurse Midwives (CNMs)
- Optometrists (ODs)
- Doctors of Dental Surgery (DDS)
- Doctors of Dental Medicine (DMDs)
- Audiologists
- Occupational Therapists
- Physical Therapists
- Speech and Language Therapists
- Oral Surgeons
- Telemedicine practitioners who have an independent relationship with the Plan
- Licensed Physicians
- Licensed Psychologists

- Licensed Behavioral Health Clinicians (LPC, LMFT, LCISW, LSW, LMFT)
- Registered Behavioral Health Technicians
- Substance Abuse Treatment Practitioners
- Behavioral Healthcare providers providing mental health or substance abuse services in the Inpatient, Residential, and Ambulatory Care settings

AmeriHealth Caritas DC maintains criteria and processes to credential and re-credential the following provider types:

- Hospitals – Acute Care and Acute Rehabilitation
- Home Health Agencies/Home Health Hospice
- Inpatient Hospice Facility
- Long-term Acute Care Facility
- Skilled Nursing Facilities
- Skilled Nursing Facilities, Providing Sub-Acute Services
- Nursing Homes
- Ambulatory Surgery Centers
- Sleep Center/Sleep Lab - Freestanding
- Durable Medical Equipment (DME) Suppliers
- Free standing Radiology Centers
- Home Infusion
- Portable X-Ray Suppliers/Imaging Centers
- Certified Outpatient Clinics
- Department of Behavioral Health Core Service Agencies
- Rural Health Clinics
- Federally Qualified Health Centers
- Partial Hospitalization Programs
- Free Standing Psychiatric Facilities
- Chemical Dependency Treatment Centers
- Accredited Outpatient Facilities
- Department of Behavioral Health Care Services Agencies
- Other Behavioral Health Facility-Based Services/Programs

The criteria, verification methodology and processes used by AmeriHealth Caritas DC are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed.

AmeriHealth Caritas DC's credentialing/re-credentialing criteria and standards are consistent with the District's requirements and National Committee for Quality Assurance (NCQA) requirements. Practitioners and facility/organizational providers are re-credentialed at least every three years.

AmeriHealth Caritas DC works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing.

Through CAQH, providers submit credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. AmeriHealth Caritas DC's goal is to have all providers enrolled with CAQH.

There is no charge for providers to submit applications and participate in CAQH. Providers may access the application forms via AmeriHealth Caritas DC's website at www.amerihealthcaritasdc.com and submit to AmeriHealth Caritas DC as follows:

- Submit application to participate with AmeriHealth Caritas DC via CAQH.
- Complete practitioner information form found on our website making sure you have added your CAQH number
- Register for CAQH if not already enrolled via a link from www.amerihealthcaritasdc.com to the CAQH website.

PRACTITIONER CREDENTIALING RIGHTS

During the review of the credentialing and re-credentialing applications, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- Review the information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by Keystone First;
- Correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy;
- Upon request, to be informed of the status of their credentialing or re-credentialing application. The Credentialing department will share all information with the provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision; and,
- Appeal any re-credentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the provider should contact AmeriHealth Caritas District of Columbia's Credentialing Department at the following address:

Attn: Credentialing Department
AmeriHealth Caritas District of Columbia
200 Stevens Drive
Philadelphia, PA 19113
Phone – 1-877-759-6186
Fax: 1-215-863-6369

AmeriHealth Caritas DC's Quality Assessment and Performance Improvement (QAPI) Program provides oversight of the Credentialing department. For more information on the QAPI Program, please refer to the "Quality Assurance and Performance Improvement Program" section of this Provider Manual.

CREDENTIALING/RE-CREDENTIALING CRITERIA AND STANDARDS

AmeriHealth Caritas DC verifies credentialing and re-credentialing criteria for all professional providers. AmeriHealth Caritas DC's criteria include:

1. Current medical licensure;

2. No revocation or suspension of the provider's medical license by the D.C. Board of Medicine;
3. Enrolled in the District of Columbia Medicaid Program;
4. Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
    a. The National Provider Data Bank – Health Integrity and Provider Data Bank (NPDB)
    b. Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
    c. Federation of Chiropractic Licensing Boards (CIN-BAD)
    d. Excluded Parties List System (EPLS)
    e. System for Award Management (SAM)
    f. Any other relevant State sanction and licensure databases as applicable.
5. Disclosure related to ownership and management, business transactions and conviction of crimes, in accordance with Federal and District regulatory requirements;
6. Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training;
7. Evidence of specialty board certification, if applicable; and,
8. A valid DEA or CDS certificate, if applicable. The DEA certificate must list the State on the address where the practitioner is treating our enrollees. The DEA certificate is non-transferrable by location;
9. Individual/Group NPI number;
10. Work history containing current employment, as well as explanation of any gaps within the last (5) years;
11. History of professional liability claims resulting in settlements or judgments paid by or on behalf of the provider in the past (5) years;
12. Current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of $1 million/$3 million);
13. Confirmation of completion of required HealthCheck Training for HealthCheck providers (PCPs) within 30 days of enrollment and every two years thereafter;
14. Practitioners who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with AmeriHealth Caritas DC. PCPs must have the ability to admit as part of their hospital privileges. As an alternative, those practitioners who do not have hospital privileges, but require them, may enter into an agreement with a participating practitioner who is able to admit. CRNPs and CNMs must have agreements with a covering participating practitioner; and,
15. Current CLIA certificate if applicable.

INITIAL SITE VISIT REVIEW

1. AmeriHealth Caritas DC conducts initial site surveys for all Primary Care Practitioners (PCPs), Obstetricians/Gynecologists (OB/GYNs) and Earlier Intervention Providers. All initial site surveys are completed prior to credentialing.
    a. AmeriHealth Caritas DC does not conduct an on-site survey when a new practitioner joins an existing network office site.
    b. If a practitioner's office is located in an accredited facility, AmeriHealth Caritas DC will accept a survey report from the facility in lieu of an on-site visit.
    c. AmeriHealth Caritas DC conducts a single on-site survey for staff and group-model practice sites.
2. AmeriHealth Caritas DC uses a site survey tool to facilitate consistent and objective on-site reviews.
3. The Provider Network Management Account Executive is responsible for ensuring that the site survey tool is completed in its entirety during the on-site visit.
4. The tool is scored on a pass/fail basis. Key elements of the tool are starred to indicate a more significant

weight to the indicator. Practitioners must attain a score of 100% on asterisked items in: (I) Facility Information/Physical Accessibility; (II) Physical Appearance/Safety and (V) Waiting Rooms/Treatment Areas.

   a. A score of 85% or better is required for (VIII) Medical Record Keeping Practices. Overall combined score must be 85% or better.

5. If all starred indicators receive a passing score, the tool is marked "pass" by the reviewer, and a copy of the site survey tool and any additional documentation is forwarded to the Credentialing department. A copy of the site survey tool is also mailed to the practitioner's office.
6. If any of the starred indicators are not within compliance, the survey tool is marked "fail" by the reviewer.
   a. The Provider Network Management Account Executive develops an individualized written corrective action plan (CAP) with the practitioner's office to ensure the area of concern is addressed.
   b. A representative of the practitioner's office signs the CAP. A copy of the office site evaluation tool is given to the practitioner.
   c. The Provider Network Management Account Executive monitors the CAP to ensure that deficiencies are remedied. Monitoring of the CAP may involve telephone/fax communications with the practitioner's office, submission of additional documentation by the practitioner, and/or additional site visits.
   d. If the practitioner does not resolve the initial concern within six (6) months, the Account Executive will document the applicant's lack of compliance and forward the file to the Chief Medical Officer. Copies of the documentation will be sent to AmeriHealth Caritas DC Risk Management department and placed in the applicant's credentialing file.
   e. AmeriHealth Caritas DC will terminate all further consideration of the practitioner's application and notify the practitioner accordingly.
   f. The Credentialing Committee will be notified of the practitioner's failure to comply (for information purposes only).
7. The Account Executive is responsible for accumulating appropriate documentation and for finalizing the report. Copies of all site survey tools and related documentation will be retained in the Provider Network
   a. Management department.

FOLLOW-UP SITE SURVEYS

1. AmeriHealth Caritas DC conducts follow-up site surveys when PCPs, OB/GYNs and Early Intervention Providers relocate an existing office, open a new office, or leave a group practice to open an individual practice.
2. AmeriHealth Caritas DC also conducts follow-up site surveys to assess a practitioner's compliance with a corrective action plan.

COMPLAINT-RELATED SURVEYS

1. AmeriHealth Caritas DC conducts on-site visits, as necessary, to address enrollee complaints.
   a. AmeriHealth Caritas DC conducts an on-site visit when an enrollee complaint concerns any element of the practitioner's office that is evaluated by the site survey tool.
   b. For on-site reviews occurring due to an enrollee complaint, the on-site review must demonstrate that the practitioner meets the Plan's quality, privacy and record keeping standards.
   c. If AmeriHealth Caritas DC standards are not met, the Account Executive develops an individualized written corrective action plan (CAP) with the practitioner's office to ensure that the area of concern is addressed.
   d. A representative of the practitioner's office signs the CAP. A copy of the site survey tool is given to

the practitioner.

e. The Account Executive monitors the CAP to ensure that deficiencies are remedied. Monitoring of the CAP may involve telephone/fax communications with the practitioner's office, submission of additional documentation by the practitioner, and/or additional site visits.

f. The Account Executive is responsible for accumulating appropriate documentation and for finalizing the report.

g. Should AmeriHealth Caritas DC receive another complaint about the practitioner within a six (6) month period, and for the same or similar issue, the Plan will review the issue with the practitioner and expand the CAP as necessary.

h. If the practitioner does not resolve the concern(s) within six (6) months, the Account Executive will document the application's lack of compliance. AmeriHealth Caritas DC will take appropriate disciplinary action, which may include suspension of network participation and/or termination of the practitioner's network contract.

2. Copies of all site survey tools and related documentation are retained by AmeriHealth Caritas DC in the Provider Network Management department.

RE-CREDENTIALING

AmeriHealth Caritas DC will re-credential network practitioners at least every three years. The following information is requested in order to complete the re-credentialing process:

- Application CAQH Universal Provider Data Source or Paper Application;
- Practitioner CAQH Reference Number;
- Credentialing Attestation and Release Form;
- Office Hours/Service Addresses;
- Supporting Documents – State Professional License, Federal DEA Registration, State-Controlled Substance Certificate, Malpractice Face Sheet and Clinical Laboratory Improvement Amendments (CLIA) Certificate (if applicable); and

All applications and attestation/release forms must be signed and dated 305 days prior to the Credentialing Committee or Medical Director decision date for initial credentialing and re-credentialing. Additionally, all supporting documents must be current at the time of the decision date.

FACILITY CREDENTIALING PROCESS

AmeriHealth Caritas DC's credentialing process for facilities must include receipt of:

- Completed credentialing application
- An unrestricted and current License, if applicable
- Evidence of Eligibility with State and Federal Regulatory Bodies – including Medicare and Medicaid
- Current Malpractice Face Sheet; and,
- A copy of Accreditation Certificate from a Recognized Accrediting Body or a copy of the Centers for Medicare and Medicaid Services (CMS) State Survey – if the provider is not accredited and does not have a CMS State Survey, a Plan Site Visit will be required

AmeriHealth Caritas DC also performs initial site evaluations on facility providers who are not accredited or do not have a site survey. For those providers who are either accredited or have had a CMS site survey, a copy of the accreditation or site survey must be submitted with the initial credentialing documentation. Additional site visits for accredited facility providers may be performed at AmeriHealth Caritas DC's discretion.

All facility providers will go through a re-credentialing process at least every three years. This process includes collection and verification of the following:

- An unrestricted and current License, if applicable
- Current malpractice insurance facesheet; and,
- A copy of the Accreditation Certificate or CMS State Survey (as with initial credentialing, if the provider is not accredited and has not had a CMS survey, a Plan site visit will be performed).

As part of the initial and re-credentialing application processes for facility providers, AmeriHealth Caritas DC will:

- Conduct a site visit for all providers who are neither accredited nor have a CMS State Survey;
- Request information on practitioner sanctions prior to making a credentialing or re-credentialing decision. Information is collected from the NPDB, HIPDB, OIG, SAM, and EPLS;
- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assurance (NCQA), District, and Federal regulations;
- Performance review of complaints, quality of care issues and utilization issues will be reviewed by the Quality Department and the Quality Assessment and Performance Improvement (QAPI) Committee;
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing; and,
- Safeguard all credentialing and re-credentialing documents by storing them in a secure location only accessed by authorized Plan employees.

Note: All verifications for initial and re-credentialing must be completed within 120 days of the Credentialing Committee or Medical Director approval. All attestation signatures must be current within 305 days of the Credentialing Committee or Medical Director approval.

CREDENTIALING COMMITTEE/MEDICAL DIRECTOR REVIEW

All credentialing applications are reviewed by the Auditor for correctness and completeness. Upon completion of the Auditor review, all "clean" files are presented to the Medical Director for review and approval on a daily basis. All files with noted "issues" (e.g., settled malpractice cases, license sanctions, etc.) will be presented monthly to the Credentialing Committee for review and determination.

As part of the initial and re-credentialing application processes for practitioners, AmeriHealth Caritas DC will:

- Conduct a site visit and medical record keeping review upon initial credentialing and re-credentialing for all PCP and OB/GYNs. Scores for these reviews must be 85% or greater;
- Request information on practitioner sanctions prior to making a credentialing or re-credentialing decision. Information is collected from the NPDB, OIG, SAM, CIN-BAD, and EPLS;
- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assurance (NCQA), District, and Federal regulations;
- Performance review of complaints, quality of care issues and utilization issues will be reviewed by the Quality Department and the Quality Assurance and Performance Improvement (QAPI) Committee;
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing; and,
- Safeguard all credentialing and re-credentialing documents by storing them in a secure location only accessed by authorized Plan employees.

Note: All verifications for initial and re-credentialing must be completed within 120 days of the Credentialing Committee or Medical Director approval. All attestation signatures must be current within 305 days of the Credentialing Committee or Medical Director approval.

STANDARDS FOR PARTICIPATION

By agreeing to provide services to AmeriHealth Caritas DC enrollees, providers must:

- Be eligible to participate in any District or Federal health care benefit program.
- Comply with all pertinent District of Columbia and Federal regulations.
- Treat AmeriHealth Caritas DC enrollees in the same manner as other patients.
- Provide covered services to all AmeriHealth Caritas DC enrollees who select or are referred to you as a provider.
- Provide covered services without regard to religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status. All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of Rehabilitation Act of 1974.
- Not segregate enrollees from other patients (applies to services, supplies and equipment).
- Not refuse to provide services to enrollees due to a delay in eligibility updates.

PROVIDER SELECTION AND RETENTION

PRACTITIONER SELECTION PROCESS

1. Practitioner Availability is assessed and monitored on a quarterly basis via the following activities:
    a. High Volume (HV) and High Impact (HI) Specialists are identified using annual reports of encounter data by specialist type.
    b. GeoAccess reports for Primary Care Provider (PCPs), OB/GYNs, Behavioral Health and HV/HI are measured using the 30-minute travel time by public transportation or a 5-mile radius of an enrollee's residence standard.
    c. PCP to enrollee ratio is determined and measured against the 1:1,500 ratio guidelines.
    d. Practitioners providing services via Letters of Agreement will be pursued for contracting.
2. The Director of Provider Network Management will review findings and identify opportunities for improvement.
3. Provider recruitment action plans are developed and implemented.
4. Areas identified for improvement are re-measured to monitor effectiveness of the action plan(s).
5. GeoAccess is used at least annually to help identify gaps in the provider network.
6. Claims data is used quarterly to identify recruitment opportunities.
7. Action plans are modified as necessary following quarterly or annual reviews.
8. Results of the evaluation are reported quarterly to the District of Columbia Department of Health Care Finance (DHCF) and annually to the Quality Assessment Performance Improvement Committee (QAPIC) and Quality of Service Committee (QSC). The analysis is part of the Quality Improvement Work Plan, which is evaluated on an annual basis.

PROVIDER RETENTION PROCESS

1. AmeriHealth Caritas DC's Provider Network Management department provides daily support relative to

assistance with reimbursement, panel support and providing liaison function with AmeriHealth Caritas DC's Utilization Management (utilization management), Claims and Enrollee Services departments.

2. Provider profiling and performance monitoring support is provided by the Performance Analytics department.
3. AmeriHealth Caritas DC Medical Management department provides key support with disease management and outreach activities.

ACCESS TO CARE

AmeriHealth Caritas DC providers must meet standard guidelines as outlined in this publication to help ensure that Plan enrollees have timely access to care.

AmeriHealth Caritas DC endorses and promotes comprehensive and consistent access standards for enrollees to assure enrollee accessibility to health care services. AmeriHealth Caritas DC establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for enrollees.

Providers are required to offer hours of operation to AmeriHealth Caritas DC enrollees that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for enrollees should comply with the access standards defined below. The standards below apply to medical care services and medical providers; please refer to the "Behavioral Health Care" section of this Provider Manual for the standards that apply to behavioral health care services and behavioral health providers.

AmeriHealth Caritas DC monitors the following access standards on an annual basis per D.C. Department of Health Care Finance guidelines. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at 1-888-369-0247.

Access to Medical Care	
Emergency Medical Care (Life Threatening)	Immediately at the Nearest Facility
Urgent Medical Care	Within 24 Hours of Request
Routine Primary or Specialist Care	Within 30 Days of Request

Initial Appointments for New Enrollees Under Age 21	Within 60 Days
Initial Appointments for New Enrollees Ages 21 and Older	Within 30 Days of Request OR Within 45 Days of Becoming an Enrollee, Whichever is Sooner
Waiting Time in a Provider Office	Not to Exceed 45 Minutes for Enrollees Arriving at the Scheduled Appointment Time
Use of Free Interpreter Services	As Needed Upon Enrollee Request During All Appointments

APPOINTMENT WAIT TIMES

In compliance with Health Benefit Plan Network Access and Adequacy, of Title 26-A DCMR, carriers are required to establish the standards listed below for appointment wait times for services within the network. The standard shall not be defined in terms of an appointment with a specific provider, but rather any qualified in-network provider.

SERVICE TYPE	TIME FRAME
First appointment with a new or replacement Primary Care Physician	within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment	within 7 business days
First appointment with a new or replacement provider for Specialty Care treatment	within 15 business days

MISSED APPOINTMENT TRACKING

If an enrollee misses an appointment with a provider, the provider should document the missed appointment in the enrollee's medical record. Providers should make at least three documented attempts to contact the enrollee and determine the reason. The medical record should reflect any reasons for delays in providing medical care, as a result of missed appointments, and should also include any refusals by the enrollee. Providers are encouraged to advise AmeriHealth Caritas DC's Rapid Response team at 1-877-759-6224 if outreach assistance is needed when an enrollee does not keep an appointment and/or when an enrollee cannot be reached during an outreach effort.

AFTER-HOURS ACCESSIBILITY

AmeriHealth Caritas DC enrollees must have access to quality, comprehensive health care services 24 hours a day, seven days a week. PCPs must have either an answering machine or an answering service for enrollees during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider, or instruct the enrollee that the provider will contact the enrollee within 30 minutes. When an answering machine is used after hours, the answering machine must provide the enrollee with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the enrollee to call 911 or go to the nearest emergency room. AmeriHealth Caritas DC will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

MONITORING APPOINTMENT ACCESS AND AFTER-HOURS ACCESS

- AmeriHealth Caritas DC will monitor appointment availability, waiting times and after-hours access using various mechanisms, including:
- Reviewing provider records during site reviews;
- Monitoring administrative complaints and grievances; and,
- Conducting an annual Access to Care survey to assess enrollee access to daytime appointments and after-hours care.

Non-compliant providers will be subject to corrective action and/or termination from the network, as follows:

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

PANEL CAPACITY & NOTIFICATION

When enrollees choose a provider as their PCP, they are assigned to the provider's panel of enrollees.

The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her panel; or,
- The panel is closed by AmeriHealth Caritas DC due to enrollee access issues.

A PCP must provide written notice to AmeriHealth Caritas DC at least 30 days in advance of reaching 500 enrollees across all payers. Full-time equivalent PCPs in a clinic may have no more than a total of 2,000 enrollees across all payers. To provide this notice, PCPs are encouraged to complete and return the Practitioner Maximum Capacity Notice form. This form is available in the provider area of our website at www.amerihealthcaritasdc.com. A PCP must provide written notice to AmeriHealth Caritas DC at least 90 days in advance if the PCP decides to close their panel.

In evaluating the capacity of PCPs, AmeriHealth Caritas DC shall take into consideration both a PCP's existing AmeriHealth Caritas DC enrollee load, overall enrollee load (across all health plans), Healthy DC Plan patient load, as well as its total patient load and will assess the overall patient load against community standards for any specialty involved. AmeriHealth Caritas DC will also consider whether the provider is in compliance with the Access Standards set forth in this Provider Manual. AmeriHealth Caritas DC will not assign additional enrollees to a single PCP if the Plan believes that PCP has reached the capacity to provide high quality services to Plan enrollees.

PRACTITIONER & PROVIDER RESPONSIBILITIES

RESPONSIBILITIES OF ALL PROVIDERS

AmeriHealth Caritas DC is regulated by District of Columbia and Federal laws. Providers who participate in AmeriHealth Caritas DC have responsibilities, including but not limited to:

- Be compliant with all applicable Federal and/or District regulations.
- Treat AmeriHealth Caritas DC enrollees in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., vaccines for children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in the District.

- Provide information to AmeriHealth Caritas DC as required.
- Inform enrollees about all treatment options, regardless of cost or whether such services are covered by the Plan or other District programs.
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs enrollees such as accommodations for the deaf and hearing impaired experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer an enrollee or otherwise discriminate against an enrollee solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the enrollee's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept AmeriHealth Caritas DC payment or third party resource as payment-in-full for covered services.
- Comply fully with AmeriHealth Caritas DC's Quality Improvement, Utilization Management, Integrated
- Health Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by AmeriHealth Caritas DC, the District and/or CMS.
- Promptly notify AmeriHealth Caritas DC of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to AmeriHealth Caritas DC or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA, Administrative Simplification and HITECH requirements.
- Immediately notify AmeriHealth Caritas DC of adverse actions against license or accreditation status.
- Comply with all applicable Federal, State, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify AmeriHealth Caritas DC of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Verify enrollee eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform enrollee(s) of the availability of AmeriHealth Caritas DC's interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas DC of any changes in business ownership, business location, legal or

government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the AmeriHealth Caritas DC Provider Agreement.

- Maintain oversight of non-physician practitioners as mandated by District and Federal law.
- Agree to the use of claims data, medical records, practitioner and provider performance data, and other sources of information by AmeriHealth Caritas DC to measure and improve the healthcare delivery services to enrollees.

PRIMARY CARE PROVIDER (PCP) RESPONSIBILITIES

A Primary Care Provider (PCP) serves as the enrollee's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of AmeriHealth Caritas DC enrollees. Practitioners in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Osteopath
- Obstetrics/Gynecology
- Family Practice
- Sub-Specialties as Appropriate to Meet an Enrollee's Special Health Care Needs

Additionally, clinics, Federally Qualified Health Centers and nurse practitioners (practicing in the areas listed above) may also serve as PCPs.

A PCP is responsible to AmeriHealth Caritas DC and its enrollees for diagnostic services, care planning and Treatment Plan development. The PCP is expected to work with AmeriHealth Caritas DC to monitor treatment planning and provision of treatment.

All new AmeriHealth Caritas DC enrollees with a newly-assigned PCP who has not previously cared for the enrollee, must receive a comprehensive initial examination and a screening for mental health and substance abuse. The mental health and substance abuse screening must be completed using a validated screening tool, approved by AmeriHealth Caritas DC.

For on-going care, the mental health and substance abuse screening must also be administered as a routine part of every enrollee's preventive health examination.

AmeriHealth Caritas DC PCPs are also expected to assist enrollees with accessing substance abuse and mental health services, as needed. The AmeriHealth Caritas DC Rapid Response team is available to enrollees and providers to support care coordination and access to services. Enrollees and providers may request Rapid Response support by calling 1-877-759-6224.

In addition, the PCP is responsible for:

- Providing covered services to all AmeriHealth Caritas DC assigned enrollees and complying with all requirements for referral management and prior authorization.
- Providing AmeriHealth Caritas DC assigned enrollees with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health

services and other community based agency services.

- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the medical care of an enrollee with a participating specialist(s), and/or behavioral health provider;
- Early identification of all enrollees with special health care needs and notification to the AmeriHealth Caritas DC Rapid Response team regarding any such identification as soon as possible;
- Collaboration with AmeriHealth Caritas DC's Integrated Health Care Management programs to facilitate enrollee care;
- Use of a valid and standardized developmental screening tool, approved by AmeriHealth Caritas DC, to screen for developmental delays during well-child visits, episodic visits or as a stand-alone service;
- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation;
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan enrollees that meets AmeriHealth Caritas DC's Medical Record Documentation Requirements, as described in the "Quality Assurance and Performance Improvement Program" section of the Provider Manual;
- Providing follow-up services for enrollees who have been seen in the Emergency Department;
- Promptly and accurately reporting all enrollee encounters to AmeriHealth Caritas DC;
- Releasing medical record information upon written consent or request of the enrollee;
- Providing preventive healthcare to enrollees according to established preventive health care guidelines;
- Advising AmeriHealth Caritas DC's Rapid Response team at 1-877-759-6224 if outreach assistance is needed when an enrollee does not keep appointment and/or when an enrollee cannot be reached during an outreach effort.

OB/GYN PRACTITIONER AS A PCP

Participating Obstetricians are responsible for medical services and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to enrollees under their care. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma
- Treatment of minor physical injuries
- Preventive health screenings and maintenance
- Routine gynecological care

Healthy DC Plan does not cover pregnancy services, but the AmeriHealth Caritas DC Bright Start Team and Healthy DC Plan team will help AmeriHealth Caritas DC Healthy DC Plan enrollees transition their coverage to AmeriHealth Caritas DC Medicaid coverage. Healthy DC Plan enrollees should contact AmeriHealth Caritas DC Bright Start (877-759-6883) and Healthy DC Plan (833- 432-7526 / TTY:711) when they learn they are pregnant.

SPECIALIST RESPONSIBILITIES

An AmeriHealth Caritas DC specialist is responsible for:

- Providing specialty care as indicated by the referral;
- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the

enrollee, as requested by the referring practitioner via the referral;

- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan enrollees that meets AmeriHealth Caritas DC's Medical Record Documentation Requirements, as described in the "Quality Assurance and Performance Improvement Program" section of this Provider Manual;
- Refraining from referring enrollees to other specialists without the intervention of the enrollee's PCP;
- Verifying an enrollee's eligibility and reviewing the referral prior to the provision of services.

COMPLIANCE RESPONSIBILITIES

AmeriHealth Caritas DC providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities. Although not an exclusive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- District of Columbia Human Rights Act
- Fraud, Waste & Abuse (FWA)
- False Claims Act
- Advance Directives

THE AMERICANS WITH DISABILITIES ACT (ADA) AND THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require AmeriHealth Caritas DC's providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas DC expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

AmeriHealth Caritas DC is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any enrollee record containing clinical, social, financial, or any other data on an enrollee should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

FRAUD, WASTE AND ABUSE (FWA)

AmeriHealth Caritas DC has a designated Compliance Officer who carries out the provisions of AmeriHealth Caritas DC's compliance plan, which includes AmeriHealth Caritas DC's fraud, waste and abuse (FWA) programs. Designed in accordance with Federal and District rules and regulations, AmeriHealth Caritas DC's compliance program is aimed at preventing and detecting activities that constitute FWA. The program includes FWA policies and procedures, investigation of unusual incidents and implementation of corrective action. AmeriHealth Caritas DC has provider reference materials that are available by contacting the Provider Services department. The materials include information regarding:

FRAUD

"Fraud" is an intentional deception or misrepresentation made by a person with the knowledge that the deception

results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law. As applied to the federal health care programs, health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program.

WASTE

"Waste" means to use or expend carelessly, extravagantly, or to no purpose.

ABUSE

"Abuse" is defined as provider practices that are inconsistent with generally accepted business or medical practice and that result in an unnecessary cost to the Healthy DC Plan program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Healthy DC Plan program. In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs.

FALSE CLAIMS ACT

The Federal False Claims Act (FCA) is a federal law that applies to fraud involving any contract or program that is federally funded.It prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $5,000 to $11,000 for each false claim submitted to the United States government or its contactors, as well as possible exclusion from Federal Government health care programs.

The Federal FCA contains a "qui tam" or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a Federal FCA action.

REPORTING AND PREVENTING FWA

If you, or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas DC beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact AmeriHealth Caritas DC by:

- Calling the toll-free Fraud Waste and Abuse Hotline at 1-866-833-9718;
- E-mailing to FraudTip@amerihealthcaritasdc.com; or,
- Mailing a written statement to Special Investigations Unit, AmeriHealth Caritas District of Columbia, 200 Stevens Drive, Philadelphia, PA, 19113.

Below are examples of information that will assist AmeriHealth Caritas DC with an investigation:

- Contact Information (e.g. name of individual making the allegation, address, telephone number)
- Name and Identification Number of the Suspected Individual
- Source of the Complaint (including the type of item or service involved in the allegation)
- Approximate Dollars Involved (if known)
- Place of Service

- Description of the Alleged Fraudulent or Abuse Activities
- Timeframe of the Allegation(s)

Additionally, you may also report suspected provider or enrollee fraud or possible abuse, neglect or financial exploitation of Healthy DC Plan beneficiaries, by contacting the District of Columbia Office of the Inspector General at:

Phone: 1-202-724-TIPS (8477) or 1-800-521-1639

Email: hotline.oig@dc.gov

The Agency opens a preliminary investigation on all suspected fraud and abuse complaints. Upon suspicion of fraud, the case is referred to the State Attorney General's Office.

PROGRAM INTEGRITY

AmeriHealth Caritas DC is obligated to ensure the effective use and management of public resources in the delivery of services to its enrollees. AmeriHealth Caritas DC does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas DC, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- **Prospective (Pre-claims payment)**
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas DC medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe*.
    - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that AmeriHealth Caritas DC is only paying claims for enrollees where AmeriHealth Caritas DC is responsible, i.e. where there is no other health insurance coverage.
    - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- **Retrospective (Post-claims payment**)
    - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation –AmeriHealth Caritas DC is the payer of last resort. The effect of this rule is if AmeriHealth Caritas DC determines an enrollee has other health insurance coverage, payments made by AmeriHealth Caritas DC may be recovered.
    - Please also see Section IX for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, AmeriHealth Caritas DC identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation

of procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.

- *Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas DC will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*

- **Credit Balance Issues**
  - Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
  - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas DC reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the enrollee's eligibility changes between the time authorization was issued and the time the service was provided.

ADVANCE DIRECTIVES

All AmeriHealth Caritas DC providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under District law, relating to providing health care when an individual is incapacitated. If an enrollee is an adult (18 years of age or older), he/she has the right under Federal law to decide what medical care that he/she wants to receive, if in the future the enrollee is unable to make his/her wishes known about medical treatment. The enrollee has the right to choose a person to act on his or her behalf to make health care decisions for them, if the enrollees cannot make the decision for themselves.

AmeriHealth Caritas DC requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers and/or organizations as required by Federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.

- Implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive; District law allows any health care provider or any agent of such provider to conscientiously object.

PROVIDER MARKETING ACTIVITIES GUIDELINES

As a contracted provider, you are **permitted** to share the following with Plan enrollees:

- General and factual information about AmeriHealth Caritas DC and your participation in the Plan's network.
- Plan-provided enrollee education materials that have been approved by the Plan and the District.
- Contact information for the District's enrollment broker.

As a contracted provider, you are **prohibited** from participating in the following activities:

- Using written or oral methods of communication with enrollees to compare benefits or aspects of other plans.
- Using written or oral methods of communication to share false or misleading information regarding the Plan or the provision of services.
- Performing direct marketing activities or other marketing activities on behalf of the Plan.
- Performing or permitting any marketing activities on behalf of the Plan at your office location.
- Using marketing materials that have not been approved by the Plan and the District.
- Assisting with or making recommendations for enrollment with the Plan, except to refer prospective enrollees to the District's enrollment broker.

PROVIDER SUPPORT & ACCOUNTABILITY

PROVIDER NETWORK MANAGEMENT

AmeriHealth Caritas DC's Provider Network Account Executives function as a liaison between the plan and the provider community. Provider Network Account Executives provide orientation to new providers and assist providers in adopting new business policies and procedures. From time to time, providers will be contacted by AmeriHealth Caritas DC representatives to conduct meetings that address topics including, but not limited to:

- New Provider Orientation
- Mandatory Provider Training & Meetings
- Provider Complaints
- Provider Responsibilities
- Quality Enhancements
- Self-Service Tools

NEW PROVIDER ORIENTATION

Upon completion of AmeriHealth Caritas DC's contracting and credentialing processes, the provider is sent a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all AmeriHealth Caritas DC providers to online resources, including AmeriHealth Caritas DC provider orientation and training information and this Provider Manual. The Provider Manual serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this Provider Manual by contacting the Provider Services department at 1-888-369-0247.

PROVIDER EDUCATION AND ON-GOING TRAINING

AmeriHealth Caritas DC's training and development are fundamental components of continuous quality and superior service. AmeriHealth Caritas DC offers on-going educational opportunities for providers and their staff. Provider training and educational programs are based on routine assessments of provider training and educational needs. AmeriHealth Caritas DC has a commitment to provide all appropriate trainings and educations to ensure providers are compliant with AmeriHealth Caritas DC standards, and Federal and District regulations. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed training information is available in the provider area of the AmeriHealth Caritas DC website at www.amerihealthcaritasdc.com. Plan providers also have access to the Provider Services department at 1-888-369-0247and their Account Executive for questions.

PLAN-TO-PROVIDER COMMUNICATIONS

Providers will receive or have access to regular communications from AmeriHealth Caritas DC including, but not limited to the following:

- Provider Manual
- Provider Newsletters
- Website Updates and Information
- Provider Letters and Announcements
- Surveys
- Faxes
- E-mails
- Miscellaneous Other Materials

PROVIDER ADMINISTRATIVE COMPLAINT SYSTEM

AmeriHealth Caritas DC providers may file an informal dispute about AmeriHealth Caritas DC's policies, procedures, or any aspects of AmeriHealth Caritas DC administrative functions. AmeriHealth Caritas DC will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions. All pertinent facts will be investigated and considered. AmeriHealth Caritas DC's policies and procedures will also be considered.

Providers may call Provider Services at 1-888-369-0247to notify AmeriHealth Caritas DC of a complaint. A written notice of the outcome of the review will be sent to the provider within 90 days of receipt of the complaint.

Providers may also put their complaint in writing and send it to:

AmeriHealth Caritas DC
P.O. Box 7161
London, KY 40742

PROVIDER CONTRACTING

AmeriHealth Caritas DC Network Management department is responsible for building and maintaining a robust Network for AmeriHealth Caritas DC enrollees.

The Network Management staff is responsible for negotiating contracts with hospitals, physicians, ancillary, DME and other providers to assure our network can treat the full range of Healthy DC Plan enrollees. The primary contact

for Network Providers with AmeriHealth Caritas DC is the Account Executives who are responsible for orientation, continuing education, and diplomatic problem resolution for all Network Providers. The Account Executive will act as your liaison with AmeriHealth Caritas DC.

Call your Account Executive Representative to:

- Arrange for orientation or in-service meeting for Network Providers or staff
- Arrange a service call
- To report any changes in your status of your:
  - Phone number
  - Address
  - Tax I.D. Number
- Notify of additions/deletions of physicians affiliated with your practice
- Respond to any questions or concerns regarding your participation with AmeriHealth Caritas DC.

Network Providers are strongly encouraged to contact their Provider Account Executive with changes to their demographic information. Network Providers may verify their demographic data at any time using the "real-time" provider directory at www.amerihealthcaritasdc.com.

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices should be made on the Provider Change Form (the form is located in the Appendix of the Manual and or website at www.amerihealthcaritasdc.com. The completed form and supporting documents can either be faxed to 202-408-1277, or mailed to:

AmeriHealth Caritas DC Provider Network Management
1250 Maryland Avenue S.W., Suite 500
Washington, DC 20024

PROVIDER CONTRACT TERMINATIONS

AmeriHealth Caritas DC Provider Agreements specify termination provisions that comply with the District of Columbia Department of Health Care Finance requirements. Provider terminations are categorized as follows:

- Provider Initiated
- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"
- Mutual

Aside from those requirements identified in the Provider Agreement, AmeriHealth Caritas DC will comply with the following guidelines, based on category of termination.

PROVIDER INITIATED

- The provider must provide written notice to AmeriHealth Caritas DC if intending to terminate the Plan network. Written notice must be provided at least 90 days before the termination date if without cause and 60 days before termination date with cause. Under either circumstance, written notice must be delivered in accordance with the method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
- If the provider is a PCP, AmeriHealth Caritas DC will send a written notification to the enrollees who

have chosen the provider as their PCP no less than 15 calendar days after receipt of the termination notice or at least 30 days prior to the termination date, whichever is sooner.

- If an AmeriHealth Caritas DC enrollee has special health care needs and his or her treating provider gives notice of termination with the Plan, AmeriHealth Caritas DC Enrollee Services and/or Case Management staff will personally contact the enrollee by telephone and in writing to provide assistance in securing a new provider.

AMERIHEALTH CARITAS DC INITIATED "FOR CAUSE"

AmeriHealth Caritas DC initiates termination of a Provider Agreement if the provider breaches the AmeriHealth Caritas DC Provider Agreement. A "for cause" termination may be implemented when there is a need to terminate a provider's contract. If terminating a Provider Agreement for cause, AmeriHealth Caritas DC will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the provider and the enrollee immediately in cases where a AmeriHealth Caritas DC enrollee's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the District of Columbia Board of Medicine or other governmental agency.
- Provide reason(s) for termination for cause.

AMERIHEALTH CARITAS DC INITIATED "WITHOUT CAUSE"

AmeriHealth Caritas DC may terminate a Provider Agreement "without cause" for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, AmeriHealth Caritas DC will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify AmeriHealth Caritas DC network provider and enrollees in active care at least 30 calendar days before the effective date of the termination.
- Fax all AmeriHealth Caritas DC termination letters to the District of Columbia Department of Insurance, Securities and Banking.
- Offer appeal rights to physicians, as applicable.

MUTUAL TERMINATIONS

A mutual termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to the AmeriHealth Caritas DC Network's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas DC Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to enrollees. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas DC will notify enrollees in active care at least 30 calendar days before the effective date of the termination.

CONTINUITY OF CARE

Plan enrollees who are in active treatment at the time a Provider Agreement terminates will be allowed to continue

care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the enrollee was receiving care at the time of the termination; or,
- Until the enrollee changes to a new provider.

Note: None of the above may exceed six months after the termination of the Provider Agreement.

AmeriHealth Caritas DC will allow pregnant enrollees who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

For continued care, AmeriHealth Caritas DC and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the "Quality Assurance and Performance Improvement Program" section of this Provider Manual. These provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas DC for cause.

PROVIDER SERVICES

NAVINET – WWW.NAVINET.NET

Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks – patient care. NaviNet is a "one-stop" service that supports your office's clinical, financial and administrative needs. If you are not already a NaviNet user, it is simple to start the process. Log on to www.navinet.net to register, or call 1-888-482-8057 to speak to NaviNet Customer Service.

NAVINET SUPPORTS PRE-VISIT FUNCTIONS

- **Eligibility and Benefits Inquiry**
  - Real-time access to enrollee eligibility and benefits
- **Care Gaps**
  - A summary of the age/sex/condition appropriate health screens that an enrollee should have
- **Care Gap Alerts***
  - Care Gap notification that appears when checking enrollee eligibility
  - View and print for enrollees coming in to your office. Place them with the patient's medical chart so they can be addressed during the visit.
- **Care Gap Reports***
  - Customizable reports that can be used to target at risk enrollees
  - Can be downloaded and faxed back to AmeriHealth Caritas DC with updated information

Utilizing these tools to close gaps in care improves your opportunity for earning incentive compensation through AmeriHealth Caritas DC Pay for Performance Program.

ENROLLEE CLINICAL SUMMARY*

- A virtual snapshot of a patient's relevant clinical facts and demographic information in a user-friendly format. Enrollee clinical summaries enable your practice to secure a more complete view of established

patients and provide valuable information on new patients.

- The summary can be exported into EMR systems (CCD format). Enrollee Clinical Summaries include the following information:
  - Demographic information
  - Chronic conditions
  - Emergency Department Visits (within the past 6 months)
  - Inpatient Admissions (within the past 12 months)
  - Medications (within the past 6 months)
  - Office Visits (within the past 12 months)

NAVINET SUPPORTS PATIENT/PROVIDER VISITS

- Care Gaps (see Pre-Visit section above)
  - Use the care gap reports to provide your patients with appropriate and needed health screenings
  - Maximize your opportunity for incentive dollars
- Enrollee Clinical Summary (see Pre-Visit section above)
- Referral Submission/Inquiry
  - NaviNet functionality allows primary care providers to submit real-time electronic referrals (valid for 180 days)
  - PCPs, Specialists, Hospitals and Ancillary Providers can search, retrieve and print electronic referrals
- Prior Authorization Submission through JIVA (for detailed information, frequently asked questions and training materials, visit the dedicated JIVA section on AmeriHealth Caritas DC Provider Center (www.amerihealthcaritasdc.com), or AmeriHealth Caritas DC Plan Central on NaviNet.)
- Access JIVA, a web-based functionality that enables you to:
  - Request inpatient, outpatient, home care and DME services
  - Submit extension of service requests
  - Request prior authorization
  - Verify elective admission authorization status
  - Receive admission notifications and view authorization history
  - Submit clinical review for auto approval of requests to service

NAVINET SUPPORTS CLAIMS MANAGEMENT FUNCTIONS

- NaviNet functionality allows your practice to:
- Check the status of submitted claims
- View claim EOBs
- Perform claim adjustments

NAVINET SUPPORTS BACK OFFICE FUNCTIONS

- Panel Roster
  - Mirrors the report primary care providers receive in the mail
  - Provides easy and immediate access
  - Contains panel report plus historical reports for the past six months
  - Reports can be imported into Excel for sorting and/or mailing to targeted patients
  - Reports can be integrated with your practice management system
- Intensive Case Management Reimbursement Program
  - Identify enrollees with chronic and/or complex medical needs
  - Assure chronically ill enrollees are routinely accessing Primary Care services

- Report complete and accurate diagnosis and disease acuity information
- Update AmeriHealth Caritas DC on chronically ill patients and submit

***Note:** Your NaviNet Security Administrator will need to turn on access to this information for designated users in their NaviNet security profile, as this summary contains extensive personal health information.

SECTION III
PROVISION OF SERVICES

III. PROVISION OF SERVICES

The sections below provide a summary of covered services for Healthy DC Plan.

No content found in this publication or in the Plan's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically-necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of an enrollee who is his or her patient and may discuss the enrollee's health status, medical care, treatment options (including any alternative treatment that may be self-administered), information the enrollee needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan enrollees.

HEALTHY DC PLAN SUMMARY OF COVERED SERVICES

Complex Chronic or High-Risk Acute Disease Management

The following benefits are available to enrollees to manage the care of complex chronic or high-risk acute diseases when provided by designated providers.

A. Chronic Care Coordination Program (CCP). Benefits will be provided for a designated provider to work telephonically or otherwise with a chronically ill enrollee and his/her treating physician or nurse practitioner to develop and implement a treatment plan.
B. Complex Case Management (CCM). Specialty Case Managers will initiate and perform CCM services, as deemed medically necessary by the enrollee's treating physician or nurse practitioner. Benefits include:
    a. Assessment of enrollee/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
    b. Education of enrollee/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
    c. Assistance in navigating and coordinating health care services and understanding benefits;
        i. Assistance in arranging for a primary care physician to deliver and coordinate the enrollee's care with Specialty Case Managers;
    d. Assistance in arranging consultation(s) with physician specialists;
    e. Locating community resources, and other organizations/support services to supplement the care plan;
    f. Implementation of a care plan in consultation with the enrollee's treating physician or nurse practitioner.
C. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the enrollee to improve the effectiveness of pharmaceutical therapy.
D. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to an enrollee with a chronic condition or disease in conjunction with the EMP for maintenance of the enrollee's chronic condition or disease.
E. Expert Consultation Program (ECP). Benefits will be provided for a review by a specialist of an enrollee's medical records where the enrollee has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

F. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in the Home-Based Care Management Plan.
    a. The HBS coordinates care through an SCM or LCC for enrollees in a care plan who need considerable support at home, sometimes on a prolonged basis. Services provided may include a home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following a home-based assessment by an HCC and become part of the overall plan of care maintained by the LCC or SCM responsible for the enrollee.
    b. The need for a Home-Based Care Management Plan is determined by the SCM or LCC, working under the direction of the Enrollee's treating physician or nurse practitioner. Benefits will be provided for the HBS when the Enrollee is specifically referred to the HBS by an SCM or an LCC for full assessment and integrated home-based services pursuant to a Home-Based Care Management Plan. To be eligible for the HBS, the enrollee must have a home-based assessment performed and completed by a designated provider.
    c. A person is deemed to be in a Home-Based Care Management Plan only after the home-based assessment is completed and the plan is subsequently approved by the enrollee's treating physician or nurse practitioner and the SCM or LCC.
    d. To maintain participation in the HBS, the enrollee must:
        i. Participate fully with the care plan and Home-Based Care Management Plan and the enrollee's treating physician or nurse practitioner; and,
        ii. Engage in regular communication with the HCC, LCC and/or SCM.
    e. Covered Services rendered to the enrollee provided through or as a result of the Home-Based Care Management Plan will not count toward any visit limits stated in the Schedule of Benefits.

Covered Home Health Care Services

Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker, or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.
B. Drugs and medications directly administered to the patient during a covered home health care visit and incidental Medical Supplies directly expended in the course of a covered home health care visit are covered.
C. Home Health Care Services authorized or approved as Medically Necessary under the utilization management requirements as meeting the conditions for coverage.

Purchase or rental of Durable Medical Equipment is not covered under this provision but may be covered elsewhere in the plan.

This benefit is available for 90 visits per episode. A new episode of care begins if the enrollee does not receive home health care services for the same or a different condition for 60 consecutive days.

Conditions for Coverage

Benefits are provided when:

A. The enrollee must be confined to home due to a medical, non-psychiatric condition. "Home" cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled, or injured persons.
B. The Home Health Care visits are a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if

Home Health Care visits were not provided, the enrollee would have to be admitted to a hospital or Skilled Nursing Facility).

C. The enrollee requires and continues to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of Home Health Care Services.
D. The need for Home Health Care Services is not Custodial in nature.
E. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the enrollee.

Additional Home Health Care Benefits

A. Home Visits Following Surgical Removal of a Testicle
   For an enrollee who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, benefits will be provided for:
   a. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
   b. An additional home visit if prescribed by the Enrollee's attending physician.
   c. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

B. Home Visits Following a Mastectomy
   a. Inpatient coverage following a mastectomy, or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
      i. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
      ii. An additional home visit if prescribed by the Enrollee's attending physician.
   b. Inpatient Coverage Following a Mastectomy, coverage will be provided for a home visit if prescribed by the Enrollee's attending physician.
   c. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

C. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.
   a. **Benefits** will be provided for:
      i. One home visit scheduled to occur within 24 hours after hospital discharge; and
      ii. An additional home visit if prescribed by the attending physician.

   b. For a mother and newborn child who remain in the hospital, benefits will be provided for a home visit if prescribed by the attending physician.

   c. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

Covered Hospice Care Services

Benefits will be provided for the services listed below when provided by a Qualified Hospice Care Program. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with utilization management requirements.

A. Inpatient and outpatient care;
B. Intermittent Skilled Nursing Care;

C. Medical social services for the terminally ill patient and his or her Immediate Family;
D. Counseling, including dietary counseling, for the terminally ill Enrollee;
E. Non-Custodial home health visits.
F. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Enrollee;
G. Laboratory test and x-ray services;
H. Medically Necessary ground ambulance;
I. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Enrollee; and
J. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Enrollee for the six (6) month period following the Enrollee's death or fifteen (15) visits, whichever occurs first.

Hospice Eligibility Period

The hospice eligibility period begins on the first date hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill Enrollee, if sooner.

Covered Inpatient Hospital Services

An Enrollee will receive benefits for the Covered Services listed below when admitted to a hospital. Coverage of inpatient hospital services is subject to certification by utilization management for Medical Necessity. Benefits are provided for:

A. Room and Board
Room and board in a semiprivate room (or in a private room when Medically Necessary).
B. Physician, Medical, and Surgical Services
Medically Necessary inpatient physician, medical, and surgical services provided by or under the direction of the attending physician and ordinarily furnished to a patient while hospitalized.
C. Services and Supplies
Related inpatient services and supplies that are not Experimental/Investigational and ordinarily furnished by the hospital to its patients, including:
    a. The use of:
        i. Operating rooms;
        ii. Treatment rooms; and
        iii. Special equipment in the hospital.

    b. Drugs, medications, solutions, biological preparations, anesthesia, and services associated with the administration of the same.

    c. Medical and surgical supplies.

    d. Blood, blood plasma, and blood products, and related donor processing fees that are not replaced by or on behalf of the Enrollee. Administrations of infusions and transfusions are covered.

    e. Surgically implanted Prosthetic Devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants, and pacemakers. Available benefits under this provision do not include items such as dental implants, fixed or removable dental Prosthetics, artificial limbs, or other external Prosthetics, which may be provided under other provisions of this Description of Covered Services.

    f. Medical social services.

Hysterectomies

Coverage will be provided for vaginal and abdominal hysterectomies. Coverage includes a minimum stay in the hospital of:

A. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and
B. Not less than forty-eight (48) hours for a vaginal hysterectomy. In consultation with the Enrollee's attending physician, the Enrollee may elect to stay less than the minimum prescribed above when appropriate.

Medical Devices and Supplies

A. Durable Medical Equipment
Rental, or purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a health care provider for therapeutic use for an Enrollee's medical condition.

Payment for rental will not exceed the total cost of purchase. Payment is limited to the least expensive Medically Necessary Durable Medical Equipment adequate to meet the Enrollee's medical needs. Payment for Durable Medical Equipment includes related charges for handling, delivery, mailing, shipping, and taxes.

B. Medical Supplies

C. Medically Necessary Foods
Coverage will be provided for medically necessary food ordered as necessary by a provider for the following diseases or conditions:
   a. Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis;
   b. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
   c. Immunoglobulin E- and non-Immunoglobulin E-mediated allergies to food proteins;
   d. Food protein-induced enterocolitis syndrome;
   e. Eosinophilic disorders, including eosinophilic esophagitis, eosinophilic gastroenteritis, eosinophilic colitis, and post-transplant eosinophilic disorders;
   f. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction;
   g. Malabsorption due to liver or pancreatic disease;
   h. Inherited metabolic disorders; and
   i. Any other diseases or conditions as determined by the Mayor.

D. Nutritional Substances
Enteral and elemental nutrition when Medically Necessary.

E. Diabetes Equipment and Supplies
   a. Coverage will be provided for all Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

   b. Coverage includes Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of insulin- dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

c. Benefits for insulin syringes and other diabetic supplies described herein are covered on P. B31, Prescription Drugs. All other diabetic equipment is covered as a medical device or supply.

F. Hair Prosthesis

Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

G. Orthotic Devices and Prosthetic Devices Benefits include:

a. Supplies and accessories necessary for effective functioning of a Covered Service;

b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

Repairs

Benefits for the repair, maintenance, or replacement of covered Durable Medical Equipment are limited as follows:

A. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating, and checking of equipment.
B. Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Enrollee's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic, or equipment.
C. Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear, or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Enrollee or of a family member are not covered.

Benefit Limits

Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

Benefits will be limited to the lower cost of purchase or rental, taking into account the length of time the Enrollee requires, or is reasonably expected to require the equipment, and the durability of the equipment, etc. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Enrollee. If the Enrollee selects a deluxe version of the appliance, device, or equipment not determined to be Medically Necessary, will pay an amount that does not exceed payment for the basic device and the Enrollee will be fully responsible for paying the remaining balance.

Mental Health and Substance Use Services

Outpatient Mental Health and Substance Abuse Services

Covered Services include the following:

A. Diagnosis and treatment for Mental Illness and Emotional Disorders at health care provider offices, other outpatient health care provider medical offices and facilities, and in Qualified Partial Hospitalization Programs.
B. Diagnosis and treatment for Substance Abuse, including detoxification and rehabilitation services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program.
C. Other covered medical services and medical Ancillary Services for conditions related to Mental Illness, Emotional Disorders, and Substance Abuse.
D. Office visits for medication management in connection with Mental Illness, Emotional Disorders, and Substance Abuse.
E. Methadone maintenance treatment.
F. Partial Hospitalization in a Qualified Partial Hospitalization Program.

Inpatient Mental Health and Substance Abuse Services

Benefits are provided when the Enrollee is admitted as an inpatient in a hospital or other approved health care facility for treatment of Mental Illness, Emotional Disorders, and Substance Abuse as follows:

A. Hospital benefits will be provided, as described on P. B6 and P. B42, Inpatient Hospital Services, of this Description of Covered Services, on the same basis as a medical (non-Mental Health or Substance Abuse) admission.
B. Services provided to a hospitalized Enrollee, including physician visits, charges for intensive care, or consultative services, and that such services were medically required to diagnose or treat the Enrollee's condition.
   The following benefits apply if the Enrollee is an inpatient in a hospital covered under inpatient hospitalization benefits following certification of the need and continued appropriateness of such services in accordance with utilization management requirements:
   a. Health care provider visits during the Enrollee's hospital stay;
   b. Intensive care that requires a health care provider's attendance;
   c. Consultation by another health care provider when additional skilled care is required because of the complexity of the Enrollee's condition; and
C. Benefits are available for diagnosis and treatment for Substance Abuse, including inpatient detoxification and rehabilitation services in an acute care hospital or Qualified Treatment Facility. Enrollees must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs.

Outpatient Facility, Office, And Professional Services

Office Visits

Benefits are available for office visits for the diagnosis and treatment of a medical condition, including care and consultation provided by primary care providers and specialists.

Laboratory Tests, Radiologic Imaging, and Diagnostic Procedures.

Coverage is provided for laboratory tests, radiologic imaging (X-rays, CAT Scans, MRIs, MRAs, etc.), and diagnostic procedures.

Preventive Services

In addition to the benefits listed in this provision, the Insurer will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Enrollee's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. Updated new recommendations will be added to the preventive benefits listed in this provision at the schedule established by the Secretary of Health and Human Services.

Benefits for preventive care include the following:

Cancer Screening Services Benefits

A. Prostate Cancer Screening
   Benefits are available when rendered in accordance with the most current American Cancer Society's guidelines and include a medically recognized diagnostic examination, annual digital rectal examinations, and the prostate-specific antigen (PSA) tests.
B. Colorectal Cancer Screening
   Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.
C. Pap Smears
   Benefits are available for pap smears, including tests performed using FDA approved gynecological cytology screening technologies, at intervals appropriate to the Enrollee's age and health status.
D. Breast Cancer Screening
   At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer will be considered the most current other than those issued in or around November 2009.

Human Papillomavirus Screening Test

A. Coverage is provided for a Human Papillomavirus Screening Test at the screening intervals supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
B. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

Immunizations

Coverage is provided for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Immunizations required solely for travel or work are not covered.

A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered to be:

1. In effect after it has been adopted by the Director of the Centers for Disease Control and Prevention; and
2. For routine use if it is listed on the immunization schedules of the Centers for Disease Control and Prevention.

Well Child Care

With respect to infants, children, and adolescents, coverage is provided for evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children

Adult Preventive Care

Benefits include health care services incidental to and rendered during an annual visit at intervals appropriate to the Enrollee's age, sex , and health status, including evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Preventive Gynecological Care

Benefits include recommended preventive services that are age and developmentally appropriate as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Prevention and Treatment of Obesity

Benefits for preventive care and screening for obesity are available to all Enrollees.

Osteoporosis Prevention and Treatment Services

Bone Mass Measurement may be covered for an Enrollee:

1. Who is estrogen deficient and at clinical risk for osteoporosis;
2. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
3. Receiving long-term glucocorticoid (steroid) therapy;
4. With primary hyperparathyroidism; or,
5. Being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a Health Care Provider for an Enrollee.

Professional Nutritional Counseling and Medical Nutrition Therapy
Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy.

Family Planning Services

Benefits will be provided for:

A. Non-Preventive Gynecological Care
   Benefits are available for Medically Necessary gynecological care.
B. Contraceptive Methods and Counseling Covered Benefits:
   a. Contraceptive patient education and counseling for all Enrollees with reproductive capacity.
   b. Benefits will be provided for all FDA approved contraceptive drugs and devices for all Enrollees, and sterilization procedures and other contraceptive methods for female Enrollees that must be administered to the Enrollee in the course of a covered outpatient or inpatient treatment.
   c. Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA.
   d. Vasectomies for male Enrollees and surgical reversal of vasectomies for male Enrollees.
   e. Elective abortion for purposes for which federal funding is available.

Maternity Services

Healthy DC Plan does not cover pregnancy services, but the AmeriHealth Caritas DC Bright Start Team and Healthy DC Plan team will help AmeriHealth Caritas DC Healthy DC Plan enrollees transition their coverage to AmeriHealth Caritas DC Medicaid coverage. Healthy DC Plan enrollees should contact AmeriHealth Caritas DC Bright Start (877-759-6883) and Healthy DC Plan (833- 432-7526 / TTY:711) when they learn they are pregnant for assistance with this transition.

Allergy Services

Benefits are available for allergy testing and treatment, including allergy serum and the administration of injections.

Rehabilitation Services

Coverage includes benefits for rehabilitation services including Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury.

The goal of rehabilitation services is to return the individual to his/her prior skill and functional level. This benefit is available for 30 visits per episode. A new episode of care begins if the Enrollee does not receive rehabilitation services for the same or a different condition for 60 consecutive days.

Spinal Manipulation

A. Covered Services: Coverage is provided for Medically Necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.), or other eligible practitioner.
B. Limitations. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

Habilitative Services

Coverage includes Medically Necessary Habilitative services that help an Enrollee keep, learn, or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder.

This benefit is available for 30 visits per episode. A new episode of care begins if the Enrollee does not receive habilitative services for the same or a different condition for 60 consecutive days.

Outpatient Therapeutic Treatment Services

Benefits include services and treatments such as:

A. Hemodialysis and peritoneal dialysis;
B. Chemotherapy;
C. Radiation therapy, including oncology dialysis;
D. Cardiac Rehabilitation benefits are provided to Enrollees who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding recommendation for Cardiac Rehabilitation. Coverage is provided for all Medically Necessary services. Services must be provided at an approved place of service equipped and approved to provide Cardiac Rehabilitation.
E. Pulmonary Rehabilitation benefits are provided to Enrollees who have been diagnosed with significant pulmonary disease, or who have undergone certain surgical procedures of the lung. Coverage is provided for all Medically Necessary services. Services must be provided at a approved place of service equipped and approved to provide pulmonary rehabilitation.
F. Infusion and transfusion services;
G. Electroshock therapy;
H. and Radioisotope treatment.

Blood and Blood Products

Benefits are available for blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Enrollee.

Organ and Tissue Transplants

A. Coverage is provided for all Medically Necessary, non- Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures.
B. Covered Services include the following:
    a. The expenses related to registration at transplant facilities. The place of registry is subject to review.
    b. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ.
    c. Cost of hotel lodging and air transportation for the recipient Enrollee and a companion (or the recipient Enrollee and two companions if the recipient Enrollee is under the age of eighteen (18) years) to and from the site of the transplant.
    d. There is no limit on the number of re-transplants that are covered.
    e. If the Enrollee is the recipient of a covered organ/tissue transplant, Donor Services (as defined below) are covered to the extent that the services are not covered under any other health insurance plan or contract.
    f. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant

Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/ Investigational, when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

Clinical Trial Patient Cost Coverage

A. Benefits for Routine Patient Costs to a Qualified Enrollee in a clinical trial will be provided if the Qualified Enrollee's participation in the clinical trial is the result of:
    a. Treatment provided for a life-threatening disease or condition; or
    b. Prevention, early detection, and treatment studies on cancer.
B. Coverage for Routine Patient Costs will be provided only if:
    a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,
    b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition;
    c. The treatment is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug application, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;
    d. The treatment is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.
    e. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
    f. There is no clearly superior, non-investigational treatment alternative;
    g. The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.
C. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Enrollee's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Diabetes Equipment and Supplies, and Self-Management Training

A. If deemed necessary, diabetes outpatient self-management training and educational services, including Medical Nutrition Therapy, will be provided through an in-person program supervised by an appropriately

licensed, registered, or health care provider whose scope of practice includes diabetes education or management.

B. Coverage information for diabetic equipment and supplies is located on P. B9, Medical Devices and Supplies and P. B31, Prescription Drugs.

Dental Services

Benefits will be provided to all Enrollees for the following:

Accidental Injury

A. Covered Benefits
Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing, and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

B. Conditions and Limitations
Benefits are limited to Medically Necessary dental services as a restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or on P. B22, Treatment for Cleft Lip or Cleft Palate or Both, describing benefits for the treatment of cleft lip or cleft palate or both, dental care is excluded from coverage. Benefits for oral surgery are described below under the heading of Oral Surgery.

C. Exclusions
Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.

Oral Surgery

Benefits include:

A. Medically Necessary procedures, to attain functional capacity, correct a congenital anomaly (excluding odontogenic congenital anomalies or anomalies limited to the teeth), reduce a dislocation, repair a fracture, excise tumors, non-odontogenic cysts or exostoses, or drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures as needed as a result of an accidental injury, when the Enrollee requests oral surgical services or dental services for Sound Natural Teeth and supporting structures or the need for oral surgical services or dental services for Sound Natural Teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services will be provided up to three (3) years from the date of injury.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae (orthognathic surgery) for Cosmetic or other purposes or for correction of the malocclusion unrelated to a functional impairment that cannot be corrected non-surgically are excluded.

Treatment for Cleft Lip or Cleft Palate or Both

Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.

Outpatient Surgical Procedures

A. Benefits are available for surgical procedures performed by a health care provider on an outpatient basis including, but not limited to, colonoscopy, sigmoidoscopy, and endoscopy.

B. Benefits are available for services in a hospital outpatient department or in an ambulatory surgical facility, in connection with a covered surgical procedure, including:
    a. Use of operating room and recovery room.

b. Use of special procedure rooms.
c. Diagnostic procedures, laboratory tests, and radiology services.
d. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.
e. Medical and surgical supplies.
f. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Enrollee. Administration of infusions is covered.

Anesthesia Services for Medical or Surgical Procedures

Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, a health care provider other than the operating surgeon or assistant at surgery must administer the anesthesia. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

Reconstructive Surgery

Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

Reconstructive Breast Surgery

Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy.

A. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts.
   Reconstructive breast surgery includes:
   a. Augmentation mammoplasty;
   b. Reduction mammoplasty; and
   c. Mastopexy.
B. Benefits are provided for all stages of reconstructive breast surgery performed on the non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.
C. Benefits are provided regardless of whether the Mastectomy was performed while the Enrollee was covered under the Evidence of Coverage; Agreement.
D. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Enrollee and the Enrollee's attending physician.

Limited Service Immediate Care

Coverage is provided for treatment of common conditions or ailments which require rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services.

Services are provided in Limited Service Immediate Care Centers, which are mini- medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections, pink eye, flu, and strep throat.

Urgent Care Services

Benefits are available for Urgent Care received from an Urgent Care center.

Emergency Services

Benefits are available for Emergency Services received in or through a hospital emergency room. Benefits include coverage for the costs of a voluntary HIV test, performed during an Enrollee's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit.

Ambulance Services

Benefits are available for Medically Necessary air and ground ambulance services.

If the Enrollee is outside the United States and requires treatment by a medical professional, benefits will be provided to transport the Enrollee to the nearest location where more appropriate medical care is available. Benefits include air or ground ambulance services, when Medically Necessary.

Covered Skilled Nursing Facility Services

When the Enrollee meets the conditions for coverage, the services listed below are available to Enrollees in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;
B. Inpatient physician and medical services provided by or under the direction of the attending physician; and
C. Services and supplies that are not Experimental/Investigational, and ordinarily furnished by the facility to inpatients for diagnosis or treatment.

Conditions for Coverage

Skilled Nursing Facility care must meet the following conditions for coverage:

A. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Enrollee were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).
B. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.
C. The Enrollee must require Skilled Nursing Care or skilled rehabilitation services which are:
    a. Required on a daily basis;
    b. Not Custodial; and
    c. Only provided on an inpatient basis.

Custodial Care is Not Provided

Benefits will not be provided for any day in a Skilled Nursing Facility that is primarily for Custodial Care. Services may be deemed Custodial Care even if:

A. An Enrollee cannot self-administer the care;
B. No one in the Enrollee's household can perform the services;
C. Ordered by a physician;
D. Necessary to maintain the Enrollee's present condition; or
E. Covered by Medicare

Prescription Drugs

Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preferred Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber.
B. Human growth hormones. Prior authorization is required.
C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preferred Preventive Drug List.
D. Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preferred Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.
E. Injectable medications that are self-administered and the prescribed syringes.
F. Standard covered items such as insulin, glucagon and anaphylaxis kits.
G. Fluoride products.
H. Diabetic Supplies.
I. Oral chemotherapy drugs.

J. Hormone replacement therapy drugs.

EXCLUDED SERVICES

Adult Dental
Adult Vision
Non-Emergency Transportation
Acupuncture
Cosmetic Surgery
Spinal manipulation except for musculoskeletal conditions of the spine
Urgent Care Outside of the Service Area (Washington, DC)
Hearing Aids
Long-Term Care
Non-Emergency Care when Traveling Outside of the U.S.
Abortion for which Federal funding is not available
Private-Duty Nursing
Routine Foot Care
Weight Loss Programs

PHARMACY SERVICES

PerformRx, an affiliate of AmeriHealth Caritas DC and a member of the AmeriHealth Caritas Family of Companies, is the delegated manager of pharmacy services covered by the AmeriHealth Caritas DC health plan. For more information on the provision of pharmacy services or to view the searchable and printable AmeriHealth Caritas DC Drug Formulary, please visit www.amerihealthcaritasdc.com. For questions regarding pharmacy services, Plan enrollees and providers may contact:

	Healthy DC Plan
Pharmacy Provider Services	1-855-332-0992
Pharmacy Enrollee Services	1-844-214-2474 (TTY 711)
Pharmacy Prior Authorization Fax	1-844-480-2486
Pharmacy TTY/TDD	711

FORMULARY

AmeriHealth Caritas DC maintains comprehensive formularies for the Healthy DC Plan. The formularies represent therapeutic recommendations based on documented clinical efficacy, safety and cost- effectiveness.

All non-preferred medications will require prior authorization. AmeriHealth Caritas DC's criteria require a trial and failure or intolerance of one to three listed medications (step therapy), depending on the class. Please visit https://www.amerihealthcaritasdc.com/hdcp/enrollees.html to view the searchable and printable AmeriHealth Caritas DC Drug Formulary.

Providers may request the addition of a medication to the formulary. Requests must include the drug name, rationale for inclusion on the formulary, role in therapy, and medications that may be replaced by the addition. Please contact Pharmacy Provider Services to request the Pharmacy &Therapeutics Committee Request Form for a Formulary Addition, Deletion or Modification.

NOTE: Experimental drugs, procedures or equipment are excluded.

COVERAGE OF BRAND NAME PRODUCTS

Prior authorization is required for brand name products for which there are "A"-rated, therapeutically equivalent, less costly generics available. Prescribers who wish to prescribe brand name products must furnish documentation of generic treatment failure prior to dispensing. The treatment failure must be directly attributed to the patient's use of a generic form of the brand name product.

Please refer to the formulary posted on the AmeriHealth Caritas DC website at www.amerihealthcaritasdc.com for exceptions to the generic requirement.

PRIOR AUTHORIZATION

In a continuing effort to improve patient care and pharmaceutical utilization, AmeriHealth Caritas DC, in conjunction with our pharmacy benefits manager, PerformRx, has implemented a prior authorization (PA) program for the initial prescription of certain medications. Requests for PA medications should be directed to AmeriHealth Caritas DC Pharmacy Services at 1-855-332-0992or faxed to 1-844-480-2486. In most cases where the prescribing health care professional/provider has not obtained prior authorization, enrollees will receive a five-day supply of the medication and PerformRx may make a request for clinical information to the prescriber. All requests must be completed within five days from initial request.

To obtain the prior authorization request form, go to the AmeriHealth Caritas DC website at http://www.amerihealthcaritasdc.com/hdcp. Providers can save time and reduce paperwork with PerformRx's online prior authorization form.

ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATIONS

Our health plan offers our providers access to *Medical Authorizations* for electronic submission of requests for authorization inquiries and submission. The *Medical Authorizations* portal is accessed through NaviNet located on the Workflows menu.

In addition to submitting and inquiring on existing authorizations, you will also be able to:

- Verify if **No Authorization is Required**
- Receive **Auto Approvals**, in some circumstances
- Submit **Amended Authorization**
- **Attach supplemental documentation**
- Sign up for **in-app status change notifications** directly from the health plan
- Access a **multi-payer Authorization log**
- Submit inpatient concurrent reviews online if you have Health Information Exchange (HIE) capabilities (fax is no longer required)
- Review inpatient admission notifications and provide supporting clinical documentation

For more information about our electronic prior authorization process, visit our website at www.amerihealthcaritasdc.com and click on Healthy DC Plan → Providers → Resources → Prior Authorizations.

APPEAL OF PRIOR AUTHORIZATION DENIALS

The prescriber or the PCP, with the enrollee's written consent, may ask for reevaluation on any denied prior authorization request or suggested alternative by contacting AmeriHealth Caritas DC's Appeals department verbally or in writing at:

AmeriHealth Caritas DC
Attn: Healthy DC Plan
Enrollee Appeals Department - Pharmacy
200 Stevens Drive
Philadelphia, PA 19113-1570

CONTINUITY OF CARE (TRANSITION SUPPLY)

AmeriHealth Caritas DC will provide coverage of non-formulary prescriptions for the first 60 days after the enrollee's enrollment with the health plan.

MONTHLY LIMITS

Certain medications may have monthly limits of prescriptions or refills as indicated in the AmeriHealth Caritas DC Drug Formulary. In addition, AmeriHealth Caritas DC allows certain medications to be filled for a 90-day supply with a prescription. The prescriber or the PCP should direct prescription limit override requests to AmeriHealth Caritas DC Pharmacy Services at 1-855-332-0992.

OVER-THE-COUNTER MEDICATIONS

Certain generic over-the-counter medications are covered by AmeriHealth Caritas DC with a prescription from the prescribing physician and are limited to a 34-day supply. These include, but are not limited to, aspirin, acetaminophen, ibuprofen, cough and cold preparations, tobacco cessation products and antihistamines.

BLOOD GLUCOSE TESTING SUPPLIES

AmeriHealth Caritas DC covers the following blood glucose testing products without prior authorization:

Meter	Strips	Control Solution
ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA TEST STIPS or ACCU-CHEK AVIVA PLUS TEST STRIPS	ACCU-CHEK AVIVA CONTROL SOL
ACCU-CHEK NANO SMART VIEW METER	ACCU-CHEK NANO SMART VIEW STRIPS	ACCU-CHEK SMARTVIEW CONTROL SOL

Lancing Device	Lancets
ACCU-CHEK MULTICLIX LANCET DEVICE	ACCU-CHEK MULTICLIX LANCETS
ACCU-CHEK SOFTCLIX LANCET DEVICE	ACCU-CHEK SOFT TOUCH LANCETS
ACCU-CHEK FASTCLIX LANCET DEVICE	ACCU-CHEK FASTCLIX LANCETS

FAMILY PLANNING

AmeriHealth Caritas DC allows enrollees to receive up to a twelve (12) month supply of covered (formulary) contraceptives with a prescription from the prescribing physician at participating pharmacies.

LAB SERVICES

LabCorp is the outpatient laboratory provider for enrollees of AmeriHealth Caritas DC. LabCorp is a full-service reference laboratory that is able to provide both routine and STAT testing. Providers who use LabCorp may use the existing test-ordering method; Providers must include AmeriHealth Caritas DC enrollee ID numbers on all lab orders.

To quickly establish a LabCorp account, please call 1-888-LABCORP. For more information, please visit www.labcorp.com.

SECTION IV

MEDICAL MANAGEMENT PROGRAMS

IV. MEDICAL MANAGEMENT PROGRAMS

The following information is in regard to AmeriHealth Caritas DC's Integrated Health Care Management (IHCM) and Medical Management programs, which includes Case & Disease Management and Care Coordination for physical and mental health services provided to Plan enrollees.

INTEGRATED HEALTH CARE MANAGEMENT (IHCM) OVERVIEW

AmeriHealth Caritas DC's IHCM program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows enrollees to move seamlessly from one component to another, depending on their unique needs. From this integrated solution AmeriHealth Caritas DC delivers and coordinates care across all programs.

The IHCM program includes assessment, treatment and other care planning, as well as service coordination with alcohol and drug abuse providers and community resources. The IHCM program also incorporates health and illness self-management education. The program is structured around an enrollee-based decision support system that drives both communication and Treatment Plan development through a multidisciplinary approach to management. The IHCM process also includes reassessing and adjusting the Treatment Plan and its goals as needed.

AmeriHealth Caritas DC's IHCM team includes nurses, social workers, Care Connectors, clinical pharmacists, Plan medical directors, primary care providers (PCPs), specialists, enrollees and caregivers, parents or guardians. This team works to meet our enrollees' needs at all levels in a proactive manner that is designed to maximize health outcomes.

INTEGRATED HEALTH CARE MANAGEMENT COMPONENTS

There are three core components to our (IHCM) Program:

- Rapid Response
- Episodic Care Management (ECM)
- Complex Care Management (CCM)

RAPID RESPONSE

This team is designed to address the needs of enrollees and to support providers and their staff. The team is composed of registered nurses, social workers and non-clinical Care Connectors. Services provided by this team include, but are not limited to: reminders or coordination of physician appointments and other indicated or missed services, collaborating with specialists, connecting enrollees with wellness programs and community resources, verifying benefits, facilitating medication access, providing information about evidence-based care guidelines and diagnostic and treatment options (from care gaps), and identifying and addressing physical/socio-cultural/educational, and behavioral health barriers, thereby allowing the enrollee to get the services necessary to improve their health outcomes. Enrollees and providers may request Rapid Response support by calling 1-877-759-6224.

EPISODIC CARE MANAGEMENT (ECM)

This program coordinates services for new adult and pediatric enrollees, as well as existing enrollees, with short-term and/or intermittent needs. Enrollees in this program typically have singular issues and/or comorbidities. Program staff includes Care Managers with RN or MSW designations. Program staff supports enrollees by providing resolution for issues relating to access and care coordination. Program staff also provides Treatment Plan support by performing comprehensive enrollee assessments, addressing short- and long-term enrollee goals and developing a Treatment Plan in collaboration with the enrollee and the enrollee's physician(s).

COMPLEX CARE MANAGEMENT (CCM)

This program serves enrollees identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of short- and long-term goals and an individualized Treatment Plan, developed in collaboration with the enrollee, the enrollee's caregiver(s) and the enrollee's physician(s). Program staff includes Care Managers with RN or MSW designations.

Enrollees in the Complex Care Management program are screened for the following as part of standard protocol:

- Adult enrollees receive a Mental Health Screening, based on the Adults Needs and Strengths Assessment (ANSA; Lyons, 2009), to identify risk of depression, anxiety, trauma exposure, suicide and substance abuse.
- Children and adolescent enrollees receive a Mental Health Screening, based on the Child and Adolescent Needs and Strengths (CANS; Lyons, 2004), to identify risk of depression, disruptive behavior, trauma, substance abuse, autism and suicide.
- Subsequent detailed assessments are performed for any item that screens positive in the initial assessment.

PROGRAM PARTICIPATION

Participation in the IHCM program is offered to all Plan enrollees, with the ability for enrollees to opt out upon request. Enrollees may also self-refer into a program by contacting the Plan.

Enrollees are initially identified for specific IHCM needs upon joining the Plan. Through material and telephonic outreach, enrollees are encouraged to let the Plan know if they have a chronic condition, special health need or if they are receiving on-going care. A new enrollee assessment is included in the enrollees' welcome packet to identify current health conditions and health care services. Based upon their responses to the initial health assessment, enrollees are identified for participation in the appropriate care management program.

REFERRAL TO THE PROGRAM

Providers are encouraged to refer enrollees to the IHCM program as needs arise or are identified. If you recognize an enrollee with a special, chronic or complex condition who may need the support of one of our programs, please contact the Rapid Response team at 1-877-759-6224. Or, enrollees may also self-refer by calling the Rapid Response team at 1-877-759-6224.

Enrollees are also referred to the IHCM program through internal Plan processes. Identified issues and diagnoses that result in a referral to the IHCM program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Enrollees with dual medical and mental health needs
- Enrollees with substance abuse-related conditions
- Enrollees who are developmentally or cognitively challenged
- Enrollees with a special health care need
- Pregnant enrollees
- Enrollees with chronic conditions or diseases, including:
    - Heart failure
    - Diabetes
    - Asthma (including pediatric asthma)
    - Chronic obstructive pulmonary disease (COPD)
    - Sickle cell
    - Hypertension
    - HIV/AIDS
    - Cancer

CARE COORDINATION WITH THE PCP

AmeriHealth Caritas DC recognizes that the PCP is the cornerstone of the enrollee's care coordination and delivery system. Our care management staff contacts each PCP during an enrollee's initial enrollment into the care management program, as part of the comprehensive assessment and Treatment Plan development process. Program staff creates the enrollee's Treatment Plan using the PCP's plan as a foundation. Through this approach, program staff complements the PCP's recommendations in the development of an enhanced and holistic Treatment Plan specific to chronic care management. The Care Manager remains in close communication with the PCP during the implementation of the Treatment Plan, should issues or new concerns arise.

CARE COORDINATION WITH OTHER PROVIDERS

Program staff also contacts the enrollee's key and/or current providers of care, as well as the enrollee's mental health care providers, to determine the best process to support the enrollee. This process eliminates redundancies and supports efficiencies for both programs. Program staff also engages key providers to be part of the development of the enrollee's Treatment Plan. As the enrollee is reassessed, a copy of the Treatment Plan is supplied to both the provider and enrollee.

INTEGRATING MENTAL AND PHYSICAL HEALTH CARE

Enrollees with mental health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both mental and physical health conditions. AmeriHealth Caritas DC understands that coordination of care for these enrollees is imperative.

Plan staff will work with the appropriate primary care and mental health providers to develop an integrated Treatment Plan for enrollees in need of physical and mental health care coordination. Care Managers will also assure that communication between the two disciplines, providers and organizations, occurs routinely for all enrollees with physical and behavioral health issues. Care Managers will also work to coordinate with alcohol and drug abuse providers and community resources, as appropriate. Care Managers will proactively and regularly follow-up on required physical and mental health services, joint treatment planning and provider-to-provider communication to ensure that enrollee needs are continuously reviewed assessed and updated.

TREATMENT PLANS

Through the IHCM program AmeriHealth Caritas DC works with practitioners, enrollees, and outside agencies to develop Treatment Plans for enrollees with special or complex health care needs. AmeriHealth Caritas DC's Treatment Plan specifies mutually agreed-upon goals, medically-necessary services, mental health and alcohol and drug abuse services (as shared with the enrollee's consent), as well as any support services necessary to carry out or maintain the Treatment Plan, and planned care coordination activities. Treatment Plans also take into account the cultural values and any special communication needs of the enrollee, family and/or the child.

AmeriHealth Caritas DC treatment planning is based upon a comprehensive assessment of each enrollee's condition and needs. Each enrollee's care is appropriately planned with active involvement and informed consent of the enrollee, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the enrollee's practitioner and standards of practice.

AmeriHealth Caritas DC works with practitioners to coordinate care with other treatment

services provided by District agencies such as the Department of Behavioral Health (DBH), Addiction Prevention and Recovery Administration (APRA) and the D.C. Public Schools (DCPS).

Through AmeriHealth Caritas DC's Integrated Health Care Management program, the enrollee is assisted in accessing any support needed to maintain the Treatment Plan. AmeriHealth Caritas DC and the PCP are expected to jointly ensure that enrollees and their families (as clinically appropriate) are fully informed of all covered and non- covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment for enrollees will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether AmeriHealth Caritas DC provides coverage for those treatments.

Treatment Plans for enrollees with special health care needs are to be reviewed and updated every 12 months, at a minimum, or as determined by the enrollee's PCP on the basis of the PCP's assessment of the enrollee's health and developmental needs. The revised Treatment Plan is expected to be incorporated into the enrollee's medical record following each update.

HEALTH & LIFESTYLE EDUCATION

AmeriHealth Caritas DC PCPs are expected to provide Plan enrollees with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas DC will support Plan providers in this effort by developing and distributing District-approved health education materials for Plan enrollees, from time to time and as needed to address specific health education needs.

Additionally, AmeriHealth Caritas DC PCPs are expected to help educate Plan enrollees regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access other services such as dental care, mental health care and substance abuse services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the enrollee's age, culture and conditions.

SECTION V

UTILIZATION MANAGEMENT

V. UTILIZATION MANAGEMENT

The AmeriHealth Caritas DC Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization Management activities are designed to assist our providers with the organization and delivery of appropriate health care services to enrollees within the structure of the enrollee's benefit plan. AmeriHealth Caritas DC does not structure compensation to individuals or entities that conduct utilization management activities to incentivize the denial, limitation or discontinuation of medically necessary services to any enrollee.

Per the provider agreement with AmeriHealth Caritas DC, providers are required to comply fully with AmeriHealth Caritas DC's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service;
- Providing clinical information to support medical necessity when requested;
- Permitting access to the enrollee's medical information;
- Involving the Plan's medical management nurse in discharge planning discussions and meetings; and/or,
- Providing a plan of treatment, progress notes and other clinical documentation as required.

PRIOR AUTHORIZATION

The most up-to-date list of services requiring prior authorization will be maintained in the provider area of our website at www.amerihealthcaritasdc.com. The AmeriHealth Caritas DC utilization management and behavioral health utilization management department hours of operation are 8 a.m. to 5:30 p.m., Monday through Friday. The general utilization management department telephone numbers are 1-888-605-4807 or 1 -800-408-7510. The general utilization management department fax number is 1-877-759-6216.

The Behavioral Health utilization management department hours are 8:00 a.m. to 5:30 p.m. Monday through Friday. We can also be reached by phone at 1-877-464-2911 or by fax at 1-855-410-6638.

The review of prior authorization requests for radiology services has been delegated to Evolent (formerly National Imaging Associates, Inc.); those requests must be directed to 1-877-517-9177 or https://www1.radmd.com.

RADIOLOGY SERVICES

The following services, when performed as an outpatient service, require prior authorization by AmeriHealth Caritas DC's radiology benefits vendor, Evolent (formerly National Imaging Associates Inc. (NIA))

- Positron Emission Tomography
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology/MPI
- Computed Axial Tomography/Computed tomography angiography (CT/CTA)

To request prior authorization, contact Evolent via their provider web-portal at www.radmd.com or by calling the Evolent phone number for AmeriHealth Caritas DC at 1- 877-517-9177, Monday through Friday 8 a.m. – 8 p.m. (EST).

The ordering physician is responsible for obtaining a Prior Authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by Evolent and the ordering

physician should have this information available at the time of the call.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas DC reserves the right to adjust any payment made following a review of the medical record and determination of the medical necessity of the services provided.

CONTACTING UTILIZATION MANAGEMENT AFTER HOURS

After business hours, on weekends, and on holidays, health care providers, practitioners, and enrollees may contact the Utilization Management department through Enrollee Services at 1-844-214-2470 (TTY 711).. After obtaining key contact and enrollee information, the Enrollee Services representative will page the on-call nurse. The on-call nurse obtains the information necessary from the health care provider and/or enrollee as needed to process the request. The on- call nurse will call the on-call physician reviewer to review the request, if necessary. The on-call nurse is responsible to contact the requesting healthcare provider or enrollee with outcome of their request.

BEHAVIORAL HEALTH URGENT LEVELS OF CARE (INPATIENT):

The Behavioral Health utilization management department provides prior authorization for urgent levels of care (inpatient) 24 hours a day, 7 days a week by contacting BH utilization management at 1-877-464-2911.

SERVICES REQUIRING PRIOR AUTHORIZATION

The following is a list of services requiring prior authorization review for medical necessity and place of service. Please refer to the prior authorization lookup tool at www.amerihealthcaritasdc.com/hdcp/providers/resources/prior-auth for more detailed information.

- Hospital inpatient services (except for maternity and emergency admissions)
- Inpatient mental illness and alcohol and/or substance abuse services
- Organ and tissue transplants
- Inpatient hospice care services
- Home health services
- Skilled nursing facility services
- Outpatient services at hospital or ambulatory facility
- Medical devices and supplies
    - Beds - specialty beds such as heavy duty, pediatric, extra wide, and specialty mattresses
    - Prosthetic devices
    - Microprocessor limbs
        - Cochlear implants
        - Speech generating devices
    - Respiratory Devices
        - Oral airway devices
        - Apnea monitor
    - Mobility devices, wheelchairs (power and/or custom), and power operated vehicles
    - Phototherapy devices
    - Specialty Medical Devices and Equipment
        - Defibrillators
        - Wound therapy electrical pumps
        - Hair prosthesis
    - Repairs of durable medical equipment

SERVICES THAT DO NOT REQUIRE AUTHORIZATION, NOTIFICATION, OR REFERRAL

- Emergency services and Emergency room services, in network and out of network
- Imaging procedures related to emergency room services, observation care, and inpatient care
- Post-stabilization services, in network and out of network
- 48-hour observations, except for maternity, which requires notification
- Low-level plain films, such as X-rays and electrocardiograms (EKGs)
- Family planning services
- In-network obstetric and gynecological (OB/GYN) services
- OB/GYN services for one annual visit and any medically necessary follow-up care for detected conditions. The enrollee must use an AmeriHealth Caritas DC provider for these services.
- Women's health specialist services (to provide women's routine and preventive health care services)
- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and HIV/AIDS, as determined by county health departments
- Podiatry and some dermatology services. The enrollee must use an AmeriHealth Caritas DC provider for these services.
- Immunizations by county health departments and participating primary care providers
- Outpatient therapy — individual, family, or group — after the initial 10 sessions
- Behavioral health counseling and therapy

SERVICES EXCLUDED FROM COVERAGE FOR AMERIHEALTH CARITAS DC

- Sterilization reversals
- Cosmetic surgery
- Experimental or investigational services, surgeries, treatments and medications
- Services that are part of a clinical trial protocol
- Abortion, unless medically necessary to save the life or prevent long-lasting physical health damage if the pregnancy is carried to term or in cases of rape and incest
- Services that are not medically necessary and/or that are not described as a covered service in the Provider Manual

REFERRALS

Notification to AmeriHealth Caritas DC is **not required** when a PCP refers an enrollee to a participating specialist. In addition, no referral (i.e., paper document or electronic) is required to be sent to the specialist. Claim payments will no longer be tied to the presence of a referral; however, when submitting a claim for payment, the referring practitioner's information must be included in the appropriate boxes of the CMS 1500 form as required by CMS.

Note: There is no change to the prior authorization process or the services that require prior authorization. Although

specialty physician services will not require a referral form, AmeriHealth Caritas DC expects that primary care and specialty care providers will continue to follow and engage in a coordination of care process, in accordance with applicable laws and standards of care, which includes communication and sharing of information regarding findings and proposed treatments.

SPECIALIST REFERRAL PROCESS

The primary care provider may write a prescription, call, send a letter, or fax to request the specialist for the enrollee. The referral to the specialist must be documented in the enrollee's medical record. The referring provider should communicate all appropriate clinical information directly to the specialist without involving the enrollee. Providers are required to provide the following information:

- Enrollee Name
- Enrollee ID number
- Reason for referral
- Duration of care to be provided
- All relevant medical information
- Referring practitioner's name and AmeriHealth Caritas DC ID number

ROLE OF SPECIALIST FOLLOWING REFERRAL

- Contact the PCP if the enrollee presents at the office and there has been no communication or indication of the reason for the visit from the PCP.
- Provide the services indicated by the PCP.
- Communicate, in accordance with applicable laws and standards of care, findings, test results and treatment plan to the enrollee's PCP. The PCP and specialist should jointly determine how care should proceed, including when the enrollee should return to the PCP's care.
- While you should notify the PCP if the enrollee needs to be referred to another specialist for consultation/treatment, you are responsible for making that referral.

ORGANIZATION DETERMINATIONS

An organization determination is any determination (i.e. approval or denial) by AmeriHealth Caritas DC that a covered service has been reviewed, and based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness.

Examples include:

- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the enrollee believes should be furnished, arranged for or reimbursed by AmeriHealth Caritas DC
- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or,
- Failure of AmeriHealth Caritas DC to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, if the delay adversely affects the health of the enrollee.

The procedures for appealing an organization determination are described in the "Grievances, Appeals and Independent External Reviews" section of this Provider Manual.

DECISION TIMEFRAME

AmeriHealth Caritas DC must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, or no later than 3 business days from receipt via electronic portal request, and no more than 5 days from receipt via mail, telephone, or fax request. The timeframe may be extended up to 15 additional calendar days if:

the request. The timeframe may be extended up to 14 additional calendar days if:

- The provider or the enrollee requests an extension; and,
- The Plan justifies the need for additional information, and the extension is in the enrollee's best interest.

The enrollee's physician may request an expedited determination, including authorizations, from AmeriHealth Caritas DC when the enrollee or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the enrollee's life, health or ability to regain maximum function.

If AmeriHealth Caritas DC decides to expedite the request, Plan staff will render a decision as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request.

Providers may call the Peer-to- Peer telephone line at 1-877-759-6274 to discuss a medical determination with a physician in the AmeriHealth Caritas DC Medical Management department. This applies in the following circumstances:

- At any time while the Member is an inpatient
- Up to 5 business days after the Member's discharge date.
- Up to 5 business days after a determination for a prior authorization (Pre-Service) request has been rendered.

MEDICAL NECESSITY STANDARDS

"Medically Necessary" or "Medical Necessity" is defined as services or supplies that are needed for the diagnosis or treatment of the enrollee's medical condition according to accepted standards of medical practice. The need for the item or service must be clearly documented in the enrollee's medical record.

A service is medically necessary for an individual if a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for a patient for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, disease, or physical or mental health condition; and
- Not primarily for the convenience of the individual or treating physician, or other treating healthcare providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual's illness, injury, disease or physical or mental health condition.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically or appropriately on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed recommended or approved medical or allied goods or a service does not, in itself, make such care, goods or services medically necessary or a covered service/benefit.

AmeriHealth Caritas DC uses the following criteria as guidelines for determinations related to medical necessity:

- InterQual Level of Care Acute Adult Criteria
- InterQual Level of Care Acute Pediatric Criteria
- InterQual Level of Care Outpatient Rehabilitation & Chiropractic Criteria
- InterQual Home Care Criteria
- InterQual Care Planning Procedures Adult Criteria
- InterQual DME Criteria
- InterQual Radiology Guidelines
- InterQual Level of Care Rehabilitation Criteria
- InterQual Level of Care Subacute & SNF Criteria
- InterQual Level of Care Criteria Behavioral Health Psychiatry Geriatric
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adult
- InterQual Level of Care Criteria Behavioral Health Residential & Community Based Treatment
- American Society of Addictions Medicine (ASAM) Patient Placement Criteria (PPC)

When applying these criteria, Plan staff also considers the individual enrollee factors and the characteristics of the local health delivery system, including:

- **Enrollee Considerations**
  - Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.
- **Local Delivery System**
  - Availability of sub-acute care facilities or home care in the AmeriHealth Caritas DC service area for post-discharge support.
  - AmeriHealth Caritas DC benefits for sub-acute care facilities or home care where needed.

- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any request that requires secondary review is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the AmeriHealth Caritas DC Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by the AmeriHealth Caritas DC Medical Director or designee are based on the above definition of medical necessity, in conjunction with the enrollee's benefits, medical expertise, AmeriHealth Caritas DC medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the AmeriHealth Caritas DC Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The AmeriHealth Caritas DC Medical Director or designee makes the final decision.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas DC reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the enrollee's eligibility changes between the time authorization was issued and the time the service was provided.

Upon request by an enrollee or practitioner/provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the AmeriHealth Caritas DC Medical Director or designee. AmeriHealth Caritas DC will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the diagnosis, type of illness or condition of the enrollee.

The Utilization Management staff involved in medical necessity decisions are assessed annually for consistent application of review criteria. An action plan is created and implemented for any variances among staff outside of the specified range. Both clinical and non-clinical staff members are audited for adherence to policies and procedures.

REQUESTING UTILIZATION MANAGEMENT CRITERIA

AmeriHealth Caritas DC will provide its Utilization Management (UM) criteria to network providers upon request. If you have questions regarding the criteria used to make a determination of coverage, you may receive a copy of the criteria upon request. AmeriHealth Caritas DC personnel will fax you a copy of the criteria used for a determination or read the criteria over the phone.

To request this information, please call the UM team at 1-888-605-4807 or 1 -800-408-7510.

HOSPITAL READMISSION POLICY

AmeriHealth Caritas DC will not allow separate reimbursement for claims that have been identified as a readmission to the same hospital (including hospital affiliates in the same network) for the same, similar or related condition within 30 days of the original admission. These readmissions are combined with the initial admission when calculating the reimbursement amount. AmeriHealth Caritas DC uses the following standards when evaluating readmissions:

- Readmission up to 30 days from discharge.
- Same diagnosis or diagnoses that fall into the same grouping.
- The same or closely related procedure as the prior discharge.
- An infection or other complication of care.

- A condition or procedure indicative of a failed surgical intervention.
- An acute decomposition of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards during the prior admission.
- An issue caused by a premature discharge from the same facility.
- An admission that is deemed medically unnecessary based upon national criteria.

AmeriHealth Caritas DC reserves the right to recoup and/ or recover monies previously paid on a claim that falls within the guidelines of a readmission for a same, similar or related condition as defined above.

Specific Policy Exclusions

- Transfers from one acute IP facility to another acute IP facility.
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures or burns.
- Readmissions associated with cancer, transplants, and sickle cell anemia.
- Admissions to Skilled Nursing Facilities, Long Term Acute Care facilities, Inpatient Rehabilitation Facilities and Critical Access Hospitals (SNF, LTAC, IRF, and CAH).
- Readmissions where the first admission had a discharge status of “left against medical advice”.
- Obstetrical readmissions, prior to and up to delivery.
- Newborn to 1 year of age
- Admissions for psychiatric disease and substance abuse.

SECTION VI

GRIEVANCES, APPEALS, AND INDEPENDENT EXTERNAL REVIEWS

VI. GRIEVANCES, APPEALS, AND FAIR INPENDENT EXTERNAL REVIEWS

GRIEVANCE PROCESS

If an enrollee has a concern or question regarding the health care services he/she has received under AmeriHealth Caritas DC, he/she should contact Enrollee Services at the toll-free number on the back of the enrollee ID card. An Enrollee Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Enrollee Service representative does not resolve the problem to the enrollee's satisfaction, the enrollee has the right to file a grievance.

A grievance is an oral or written expression of dissatisfaction about any matter ***other than as adverse benefit determination*.** Grievances may include, but not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's right regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by AmeriHealth Caritas DC to make an authorization decision. The enrollee may file a grievance at any time in writing or by telephone at the information below. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the enrollee.

A grievance may be filed about issues such as the quality of the care the enrollee receives from AmeriHealth Caritas DC or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas DC or any service or item that did not meet accepted standards for health care during a course of treatment.

To file a grievance:
Call:
Enrollee Services: 844-214-2470 (TTY 711)
Enrollee Services Hours of Operation: Monday – Friday, 8 a.m. - 6 p.m.

Write to:
AmeriHealth Caritas District of Columbia
Healthy DC Plan
Enrollee Services Grievances Department
200 Stevens Drive Philadelphia, PA 19113

If the enrollee needs assistance in filing his/her grievance or needs the help of an interpreter, the enrollee may call Enrollee Services and, if needed, interpretation services will be made available to the enrollee free of charge.

AmeriHealth Caritas DC will send the enrollee an acknowledgement letter within two business days of receiving the grievance. AmeriHealth Caritas DC will make reasonable efforts to provide oral notice and send a decision letter within 90 days of receiving the request. In some cases, AmeriHealth Caritas DC or the enrollee may need additional time to obtain more information. The enrollee may request up to 14 more days and AmeriHealth Caritas DC may also have an additional 14 days if additional information is needed and the delay is in the enrollee's best interest. If AmeriHealth Caritas DC needs more time, but the extension was not requested by the enrollee, the following will be performed:

- Reasonable efforts will be made to give the enrollee prompt verbal notice of the delay.
- Within two (2) calendar days of the decision, the enrollee will be provided written notice of the reason for the decision to extend the timeframe and the enrollee will be informed of the right to file a grievance if he/she disagrees with that decision.

If the enrollee does not agree with the decision resulting from a grievance, he/she or an "authorized representative" (i.e. his/her doctor, a family member or friend) may file an appeal within 60 calendar days of receiving the decision.

APPEALS PROCESS

NOTICE OF ADVERSE BENEFIT DETERMINATION

An adverse benefit determination is defined as follows:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner as defined by the District; or
- The failure of the health plan to act within the timeframes for resolution and notification of a grievance or appeal.

A denial of services is an adverse decision in response to an enrollee's or provider's request for the initiation, continuation or modification of treatment. The failure to make a decision on a request for treatment within the mandated constitutes a denial for services. A denial includes a complete or partial disapproval of treatment requests, a decision to authorize coverage for treatment that is different from the requested treatment, or a decision to alter the requested amount, duration, or scope of treatment. A denial also constitutes an approval that is conditioned upon acceptance of services in an alternative or different amount, duration, scope, or setting from that requested by the provider or enrollee. An approval of a requested service that includes a requirement for a concurrent review by AmeriHealth Caritas DC during the authorized period does not constitute a denial. All denials are considered adverse benefit determinations for purposes of grievances and appeals.

If the enrollee does not agree with AmeriHealth Caritas DC's determination as outlined in the Notice of Adverse Benefit Determination, he/she may file an appeal. The enrollee may ask an "authorized representative" (i.e. his/her doctor, a family member or friend) to file the appeal for them. Or, the provider may file the appeal, with the enrollee's written consent.

The enrollee, or an authorized representative with written consent, may ask for an independent external reviewafter exhausting the AmeriHealth Caritas DC one-level appeal process and within four months from the date of the appeal resolution notice to uphold the adverse determination. Additional information on requesting an independent external review is available in this section of the Provider Manual.

STANDARD APPEAL

AmeriHealth Caritas DC will review a decision about the enrollee's care when a standard appeal is requested. The enrollee must file an appeal within 180 calendar days of the date on the notice of adverse benefit determination.

To file an appeal, the enrollee or authorized representative may:

Write to:

AmeriHealth Caritas District of Columbia Healthy DC Plan
Attention: Appeal Coordinator
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

Call:
Enrollee Services (on behalf of an enrollee and with written consent):
844-214-2470 (TTY 711)
Enrollee Services Hours of Operation:
Monday – Friday, 8 a.m. - 6 p.m.

The review begins the day AmeriHealth Caritas DC receives the request. AmeriHealth Caritas DC will send a written acknowledgement to the enrollee within two business days of receipt of the appeal. AmeriHealth Caritas DC will send written notice of resolution to the enrollee no later than 30 calendar days for pre-service requests and 60 calendar days for post-service requests after receiving the appeal. A standard non-formulary pharmacy appeal is resolved within 72 hours.

Before AmeriHealth Caritas DC makes a decision, the enrollee and/or the person helping the enrollee with the appeal may give information to AmeriHealth Caritas DC. The new information may be in writing or by phone.

In some cases, AmeriHealth Caritas DC, or the enrollee may need additional time to obtain more information. The timeframe for a standard resolution of an appeal may be extended by fourteen (14) days if:

a) The enrollee requests the extension; or
b) AmeriHealth Caritas DC needs additional information and the delay is in the enrollees' best interest. Reasonable efforts will be made to give the enrollee prompt verbal notice of the delay and a written notice is sent to the enrollee within two (2) calendar days explaining why an extension is needed and of their right to file a grievance if he or she disagrees with the decision to extend the time allowed for issuing an authorized decision.

The enrollee may review his/her file any time while AmeriHealth Caritas DC is reviewing the appeal. The enrollee and his/her authorized representative may look at the case file. The enrollee's estate representative may review the file after the enrollee's death. The file may include medical records and/or other papers.

AmeriHealth Caritas DC will send the enrollee or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas DC made its decision and the date the decision was made.

EXPEDITED APPEAL

If the time for a standard resolution could jeopardize the enrollee's life, health or ability to attain, maintain or regain function, an enrollee, or his/her authorized representative may request an expedited appeal orally or in writing. Note: Expedited appeals are for health care services only – not denied claims.

To request an expedited appeal, the enrollee or his/her authorized representative may call Enrollee Services. AmeriHealth Caritas DC will not take punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal.

AmeriHealth Caritas DC will send a written decision for an expedited appeal within 72 hours and will make a reasonable effort to provide oral notice of the resolution. If the request for an expedited appeal is denied, the appeal will immediately be moved into the standard appeal timeframe. The enrollee will be contacted by telephone as soon as possible and notified in writing within two calendar days of the application of the standard appeal timeframe.

INDEPENDENT EXTERNAL REVIEW PROCESS

District of Columbia law makes available to Healthy DC Plan enrollees an independent external review of adverse determination decisions made by AmeriHealth Caritas DC. The external review will be performed by a third-party Independent Review Organization (IRO) who is not associated with AmeriHealth Caritas DC. External review is performed on a standard or expedited timetable, depending on which is requested, and on whether medical circumstances meet the criteria for expedited review.

- A request for external review may not be made until an enrollee has exhausted our internal appeal process.
- A request for standard external review must be submitted in writing to AmeriHealth Caritas DC within four months of receiving our notice of final determination that the services in question are not approved. The enrollee or authorized representative can submit this request by faxing **844-214-2475** or writing to:

  AmeriHealth Caritas District of Columbia
  Healthy DC Plan
  Attention: External Review Request
  Enrollee Appeal Department
  200 Stevens Drive
  Philadelphia, PA 19113-1570
- Within five business days of receipt, AmeriHealth Caritas DC will complete a review of the request to determine if it meets the eligibility requirements for external review.
- If the request for external review is accepted, an IRO will be assigned. The IRO will communicate its determination within 45 calendar days for standard external review requests and within 72 hours for expedited external review requests from the date they received the initial request.
- The IRO's external review decision is binding.

If you have any questions or concerns regarding the independent external review process, please contact Enrollee Services at 844-214-2470 (TTY 711).

If an enrollee is not satisfied with the help provided by Enrollee Services, they may contact the District of Columbia Office of Health Care Ombudsman and Bill of Rights for help **at 202-724-7491 (OFFICE)** or **1-877-685-6391** (TOLL-FREE) (TTY 711) or via email at healthcareombudsman@dc.gov.

CONTINUATION OF BENEFITS

An enrollee may continue to receive services while waiting for the AmeriHealth Caritas DC appeal or the independent external review decision if all of the following apply:

- The appeal is filed on or before ten calendar days of the date of the Notice of Adverse Benefit.
- Determination or the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.
- The enrollee requested the services to continue.

The enrollee's services continue to be covered until one of the following occurs:

- The enrollee decides not to continue the appeal.
- Ten calendar days have passed, from the date of the notice of resolution of the appeal, unless the enrollee has requested a Fair Hearing within that timeframe.
- The time covered by the authorization is ended or the limitations on the services are met.
- The independent review organization issues a hearing decision adverse to the enrollee.

If the independent review organization agrees with the enrollee, AmeriHealth Caritas DC will pay for the covered services that were rendered to the enrollee while waiting for the decision. If the independent review organization agrees with the enrollee and the enrollee did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas DC will issue an authorization for the covered services no later than 72 hours from the date it receives notice of reversal to restart services as soon as possible and AmeriHealth Caritas DC will pay for the covered services.

PROVIDER MEDICAL APPEALS

A provider requesting an administrative or medical appeal, for the reversal of a medical denial, may also submit an appeal in writing to:

AmeriHealth District of Columbia
Attn: Provider Appeals Department P.O. Box 7359
London, KY 40742

As a reminder, a provider may also file an appeal on an enrollee's behalf, with the enrollee's written consent. To file an appeal as an authorized representative on behalf of an enrollee, a provider may call the Provider Appeals telephone line at 1-877-759-6254.

Note Regarding All Appeals: The purpose of this appeal process is to address medical determinations regarding health care services. This process is not intended to address denied claims or other issues. For information on filing an informal provider complaint regarding administrative functions please refer to the "Provider and Network Information" section of this Provider Manual. For information on disputing a claim, please refer to the "Claims Submission Protocols and Standards" section of this Provider Manual.

SECTION VII
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM

VII. Quality Assurance and Performance Improvement Program

AmeriHealth Caritas DC's Quality Assurance and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to enrollees. The AmeriHealth Caritas DC Board of Directors provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into AmeriHealth Caritas DC's operations. Operational responsibility for the development, implementation, monitoring and evaluation of the QAPI program is delegated by the AmeriHealth Caritas DC Board of Directors through the regional president to the AmeriHealth Caritas DC Market President and Quality Assessment Performance Improvement Committee (QAPIC).

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas DC enrollees by providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to enrollees through the credentialing/re-credentialing process.
- Reducing health care disparities by measuring, analyzing and re-designing of services and programs to meet the health care needs of our diverse membership.
- Optimizing Utilization Management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensuring that enrollee benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over-utilization
- Utilizing Enrollee and Network Provider satisfaction and experience information when implementing quality activities
- Evaluating Disease and Complex Care Management to ensure program effectiveness
- Identifying, enhancing and developing activities that promote enrollee safety

AmeriHealth Caritas DC develops goals and strategies considering applicable District and Federal laws and regulations and other regulatory requirements, NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. AmeriHealth Caritas DC also uses performance measures such as HEDIS®, CAHPS®, consumer and practitioner surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT COMMITTEE

The QAPIC oversees AmeriHealth Caritas DC's efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Caritas DC enrollees, and evaluates the effectiveness of the QAPI program. Additional committees and council support the QAPI program and report into the QAPIC:

Provider Advisory Council – Solicits input from provider and community stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies.

Enrollee Wellness Advisory Council – Provides a forum for enrollee participation and input to AmeriHealth Caritas DC programs and policies to promote collaboration, maintain an enrollee focus and enhance the delivery of services to diverse AmeriHealth Caritas DC communities.

Quality of Service Committee – Monitors performance and quality improvement activities related to AmeriHealth Caritas DC services; reviews, approves and monitors action plans created in response to identified variances.

Pharmacy and Therapeutics Committee – Monitors drug utilization patterns, formulary composition, pharmacy benefits management procedures and quality concerns.

Credentialing Committee – Reviews practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas DC Network.

Culturally and Linguistically Appropriate Service (CLAS) Committee – Provides direction for AmeriHealth Caritas DC activities that are relevant to the U.S. Department of Health and Human Services Office of Minority Health's National CLAS standards and to NCQA's Multicultural Healthcare Standards to ensure that AmeriHealth Caritas DC enrollees are served in a way that is responsive to their cultural and linguistic needs.

PRACTITIONER INVOLVEMENT

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at 1-888-369-0247or their Provider Network Account Executive.

QAPI ACTIVITIES

The QAPI program is designed to monitor and evaluate the quality of care and service provided to enrollees. Practitioners and other providers agree to allow AmeriHealth Caritas DC to use their performance data as needed for the organization's QI activities to improve the quality of care and services, and the overall enrollee experience. On-going QAPI activities include:

PERFORMANCE IMPROVEMENT PROJECTS

AmeriHealth Caritas DC develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

ENSURING APPROPRIATE UTILIZATION OF RESOURCES

AmeriHealth Caritas DC will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

CHRONIC CARE IMPROVEMENT PROGRAMS

AmeriHealth Caritas DC Chronic Care Improvement Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

MEASURING ENROLLEE AND PROVIDER SATISFACTION

AmeriHealth Caritas DC uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess enrollee satisfaction. AmeriHealth Caritas DC also conducts Provider Satisfaction studies annually. Survey results, along with analysis and trends on dissatisfaction and enrollee opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

PARTICIPANT AND PROVIDER DISSATISFACTION

Dissatisfactions or complaints/grievances from enrollees and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

ENROLLEE SAFETY PROGRAMS

The QAPI department is responsible for coordinating activities to promote enrollee safety. Initiatives focus on promoting enrollee knowledge about medications, home safety and hospital safety. Enrollees are screened for potential safety issues during the initial assessment.

NCQA HEDIS® REPORTING MEASURES

The AmeriHealth Caritas DC Quality Management Department is responsible for the collection and reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®) standardized performance measures that assess the quality of health care – much like a report card. These measures, adopted by NCQA in 1993 and used by over 90% of all health plans in United States, are reported annually and consist of the following categories:

- Effectiveness of Care
- Accessibility/Availability of Care
- Experience of Care
- Utilization (Use of Services)

Adherence to these HEDIS guidelines:

- Ensures health plans are offering quality preventive care and services.
- Provides a comparison to other plans.
- Identifies opportunities for quality improvement.
- Measures the plan's progress from year to year.

AmeriHealth Caritas DC appreciates provider cooperation with medical record reviews and participation in the provider survey as part of our HEDIS data collection processes.

All plan policies referenced throughout this Provider Manual are available for health care professional/ provider review upon request.

PREVENTIVE HEALTH AND CLINICAL GUIDELINES

The QAPIC is responsible for approving all preventive health and clinical practice guidelines. Guidelines are developed using criteria established by nationally recognized professional organizations and with input from the

AmeriHealth Caritas DC Provider Advisory Council. Guidelines are distributed via the Plan's website, with hard copies available upon request. ~~Current guidelines are listed in Tables 2 and 3, below:

Table 2: Preventive Health Guidelines

Preventive Health	
• Pregnancy • Well Child Age Birth-10 yrs. • Adolescent Age 11-20 yrs. • Adult Age 21-44 yrs. • Adult Age 45-64 yrs. • Adult Age 65+ yrs.	• Childhood Immunizations • Adolescent Immunizations • Adult Immunizations • Tobacco control • Early and Periodic, Screening, Diagnosis, Treatment • (EPSDT) Schedule/HealthCheck

Table 3: Clinical Guidelines

Condition	Clinical Evidence-Based Guideline
Acute Pharyngitis in Children	Michigan Quality Improvement Consortium. Acute pharyngitis in children 2 – 18 years old. Southfield (MI): Michigan Quality Improvement Consortium; 2013 Jan. 1 p. http://www.guideline.gov/content.aspx?id=47107
Adult Depression	Practice Guideline for the Treatment of Adult Depression in Primary Care. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 Sep. 129 p. http://www.guideline.gov/content.aspx?id=47315&search=adult+depression
Asthma	From the Global Strategy for Asthma Management and Prevention, Global Initiative for Asthma (GINA) 2014. • http://www.ginasthma.org/Guidelines/guidelines-resources.html • Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, National Institute of Health (NIH) 2007. • http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report
Attention Deficit Hyperactivity Disorder	American Academy of Pediatrics Clinical Practice Guideline for Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents. 2011. • http://www.amerihealthdc.com/pdf/provider/resources/clinical/guidelines/american-academy-adhd-cpg.pdf
Childhood Obesity	Childhood Overweight and Obesity, CDC Guidelines. • http://www.cdc.gov/obesity/childhood/index.html
Cholesterol	National Heart, Lung, and Blood Institute: National Cholesterol Education Program — Third Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), 2004. • http://www.nhlbi.nih.gov/health-pro/guidelines/current/cholesterol-guidelines

Condition	Clinical Evidence-Based Guideline
COPD	Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2015 • http://amerihealthcaritasdc.com/provider/resources/cpg/copd.aspx • http://www.ginasthma.org/Guidelines/guidelines-resources.html
Diabetes	American Diabetes Association: Clinical Practice Recommendations 2012 • http://care.diabetesjournals.org/content/35/Supplement_1/S4
Hemophilia	Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation – MASAC Recommendations Concerning Products Licensed for the Treatment of Hemophilia and Other Bleeding Disorders, 2014. • http://www.hemophilia.org/NHFWeb/MainPgs/MainNHF.aspx?menuid=57&contentid=693
Heart Failure	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults • http://circ.ahajournals.org/content/119/14/1977.full.pdf
Human immunodeficiency virus (HIV)	District of Columbia HIV Medical Case Management Guidelines, 2nd Edition, 2014. • http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/MCM%202ND%20EDITION%202014.pdf
Hypertension	2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014 • http://www.guideline.gov/content.aspx?id=48192
Sickle Cell	NHBLI • http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf
Asthma	GINA • http://www.ginasthma.org/Guidelines/guidelines-resources.html
Depression	Practice Guideline for the Treatment of Patients with Major Depressive Disorder • http://psychiatryonline.com/pracGuide/PracticePDFs/PG_Depression3rdEd.pdf
Management of Acute Lower Back Pain	Institute for Clinical Systems Improvement. Adult Acute and Subacute Low Back Pain. Updated November 2012. • https://www.icsi.org/_asset/bjvqrj/LBP.pdf
Maternity and breastfeeding	Institute for Clinical Systems Improvement. Routine Prenatal Care. Updated July 2012. • https://www.icsi.org/_asset/13n9y4/Prenatal-Interactive0712.pdf Primary Care Interventions to Promote Breastfeeding, U.S. Preventive Services Task Force (USPST), October 2008. • http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrfd.htm The American Academy of Pediatrics and American College of Obstetricians and Gynecologists; Guidelines for Perinatal Care, 7th ed. October, 2012. • http://www.mqic.org/pdf/MQIC_2010_Routine_Prenatal_

Condition	Clinical Evidence-Based Guideline
Sexually Transmitted Diseases	Centers for Disease Control and Prevention (CDC). Chlamydial Infections. In: Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR Recomm Rep 2010 Dec 17; 59(RR-12):44 – 9. • http://www.guideline.gov/content.aspx?id=25577&search=sexually+transmitted+diseases
Sickle Cell Disease	National Heart, Lung and Blood Institute. Division of Blood Diseases and Resources. The Management of Sickle Cell Disease, June 2002. • http://www.nhlbi.nih.gov/files/docs/guidelines/sc_mngt.pdf
Substance Use Disorders	Va/DoD Clinical Practice Guideline for Management of Substance Use Disorders, Washington (DC): Department of Veteran Affairs, Department of Defense; 2009 Aug. 158 p.; and Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition, American Psychiatric Association, August 2006 (psych.org). • http://www.healthquality.va.gov/guidelines/MH/sud/ • http://psychiatryonline.org/guidelines

AVAILABILITY AND ACCESSIBILITY AUDITS

Compliance with AmeriHealth Caritas DC's access and availability standards is monitored annually to ensure sufficient numbers of network providers are available to meet enrollee needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Quality of Service Committee (QSC) evaluates the report annually. AmeriHealth Caritas DC also conducts an annual assessment of primary care providers', behavioral health practitioners' and specialists' compliance with appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QSC for review and recommendations.

MEDICAL RECORD REQUIREMENTS

Medical records of network providers are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality and organization of records at all times.

Providers are required by contract to make medical records accessible to the D.C. Department of Health Care Finance (DHCF), the D.C. Department of Health (DOH), the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designees in order to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each enrollee's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are signed by the author.

- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each enrollee.
- Patient’s chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan’s Preventive Health Guidelines.
- An immunization record is up to date (for enrollees 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.

MEDICAL RECORD AUDITS

AmeriHealth Caritas DC conducts medical record audits to assess the provision and documentation of high quality primary care according to established standards. Compliance with these standards will be audited by periodic review and chart samplings of the participating primary care offices. Health care practitioners/providers must achieve an average score of 90 percent or higher on the medical records review. AmeriHealth Caritas DC will assist health care practitioners/providers scoring less than 90 percent through corrective action plans and re-evaluation.

ADVERSE ACTION REPORTING

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas DC sends information on reportable events, (as outlined in the NPDB Guidebook) to the NPDB and to the State Board of Medical or Dental Examiners, as appropriate, in the state where AmeriHealth Caritas DC is located.

All review outcomes, including actionable information, are incorporated in the provider credentialing file and database.

MANDATORY REPORTING REQUIREMENTS

AmeriHealth Caritas DC providers are required to comply with the reporting of specific conditions and diseases in accordance with the D.C. Code § 7-131, 132 (2006), Title 22 of the D.C. Code of Municipal Regulations, the District's Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act (2002) and D.C. Code § 7-871.3 (2006). Specific reporting requirements include but are not limited to:

- Child or adult enrollees with vaccine-preventable diseases.
- Infants, toddlers and school-age children experiencing developmental delays, as evidenced by developmental assessments or inter-periodic exams.
- Enrollees with sexually transmitted and other communicable diseases, including HIV.
- Enrollees diagnosed with or suspected of being infected with tuberculosis must be reported within 24 hours of identification.
- Laboratories and/or providers must report results of all blood lead screening tests to the District of Columbia Department of Health Care Finance (DHCF), District Department of Environment Division of Childhood Lead Prevention Program and AmeriHealth Caritas DC within 72 hours of identification.

Additionally, AmeriHealth Caritas DC providers are required to comply with the reporting requirements of District registries and programs, including but not limited to the District of Columbia Cancer Registry and Department of Health Immunization Registry.

POTENTIAL QUALITY OF CARE CONCERNS

Potential quality of care concerns are fully investigated by AmeriHealth Caritas DC.

The Medical Director's outcome determination of the quality of care concern may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from AmeriHealth Caritas DC's network.

If the concern is referred to the QAPIC, follow-up actions are conducted based on the QAPIC's recommendation(s), which may include sanctioning the practitioner/provider.

If the QAPIC investigation involves a reportable action, the appropriate practitioner/provider's case information will be reported to the National Provider Data Bank (NPDB) and District regulatory agencies, as required.

The QAPIC reserves the right to impose any of the following actions, based on its discretion:

- Requiring the practitioner/provider to submit of a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by AmeriHealth Caritas DC to ensure that adverse events do not continue. This requirement will be documented in writing. A corrective action plan may also include provisions that

the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.

- Implementing formal sanctions, including termination from the AmeriHealth Caritas DC network if the offense is deemed an immediate threat to the well-being of AmeriHealth Caritas DC enrollees. AmeriHealth Caritas DC reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

At the conclusion of the investigation of the QAPIC, the practitioner/provider will be notified by letter of the concern of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

REPORTING & MANAGING UNUSUAL OCCURRENCES

CRITICAL INCIDENTS, SENTINEL EVENTS AND NEVER EVENTS

AmeriHealth Caritas DC monitors the quality and appropriateness of care provided to its enrollees by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of AmeriHealth Caritas DC. This includes critical incidents, sentinel events and never events, as defined below. The phrase "or risk thereof" includes any process variation for which an occurrence (as in a 'near miss') or recurrence would carry a significant chance of a serious adverse outcome.

Important definitions include:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes an enrollee death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.
- **Critical Incident** – Retrospective identification of an unexpected occurrence that causes an enrollee death or serious physical or psychological injury, or risk thereof, that includes permanent loss of function. Critical incidents differ from sentinel events only in terms of the timeframe in which they are identified.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above.

AmeriHealth Caritas DC's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences;
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes and strategies for prevention.

MANAGING UNUSUAL OCCURRENCES

Providers are expected to report unusual occurrences, including all instances as described above and including near misses, events that require the intervention of law enforcement or security, and/or any event during which an AmeriHealth Caritas DC enrollee displays behavior or symptoms leading to the reasonable belief that additional engagement by AmeriHealth Caritas DC is necessary or prudent to improve the enrollee's wellbeing. All such events must be reported to AmeriHealth Caritas DC in real time. AmeriHealth Caritas DC recognizes that the safety of the involved enrollee is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the enrollee prior to reporting. All unusual occurrences must be reported to AmeriHealth Caritas DC within 24 hours of occurrence. Reports may be made to the AmeriHealth Caritas DC Clinical Quality Performance Specialist by calling 1-855-217-2219.

AmeriHealth Caritas DC will not take punitive action or retaliate against any person for reporting an unusual occurrence. The practitioners involved will be offered the opportunity to present factors leading to the unusual occurrence and to respond to any questions arising from the review of the unusual occurrence.

Once an AmeriHealth Caritas DC staff enrollee identifies or is notified of an unusual occurrence, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Director, Quality Management is notified of the event via an incident report, telephone, email or personal visit as soon as reasonably possible after identification of the occurrence.
2. The Director, Quality Management will collaborate with the Chief Medical Officer and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All unusual occurrences require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance. A multidisciplinary team led by the Chief Medical Officer will perform all root cause analysis.
5. As appropriate, issues are identified for correction and corrective action plans are developed to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the actions.
6. Confirmed critical incidents and sentinel events will be reported to the D.C. Department of Health Care Finance (DHCF), Division of Quality and Health Outcomes and the Contract Administrator within 24 hours of occurrence or as soon as a determination is made that the occurrence is a critical incident or sentinel event. Additionally, AmeriHealth Caritas DC will report all critical incidents and sentinel events, as well as actions taken, to the D.C. DHCF and the Contract Administrator on a quarterly basis.
7. As appropriate, other agencies will also be notified of confirmed critical incidents and sentinel events.
8. As appropriate, information from the investigation of unusual occurrences will be provided to the Credentialing Committee to support the re-credentialing process.

REPORTING PROVIDER PREVENTABLE CONDITIONS

Please refer to the "Claims Submission Protocols and Standards" section of this Provider Manual for more information regarding the AmeriHealth Caritas DC reimbursement policy on provider preventable conditions and how to report such conditions via the claims process.

CREDENTIALING PROGRAM

AmeriHealth Caritas DC's Quality Assessment and Performance Improvement Program (QAPI) provides oversight of the Credentialing Program. The activities described below are additional functions of the Credentialing Program. For more information on the credentialing and re-credentialing processes, please refer to the "Provider and Network Information" section of this Provider Manual.

PROVIDER SANCTIONING POLICY

It is the goal of AmeriHealth Caritas DC to assure enrollees receive quality health care services. In the event that health care services rendered to an enrollee by a network provider represent a serious deviation from, or repeated non-compliance with, AmeriHealth Caritas DC's quality standards, and/or recognized treatment patterns of the organized medical community, the network provider may be subject to AmeriHealth Caritas DC's formal sanctioning process.

Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

FORMAL SANCTIONING PROCESS

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas DC will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas DC on the proposed action.

SECTION VIII

CULTURAL COMPETENCY PROGRAM AND REQUIREMENTS

VIII. CULTURAL COMPETENCY PROGRAM AND REQUIREMENTS

INTRODUCTION

Embedded in all AmeriHealth Caritas DC efforts are a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community, by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas DC routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 enrollees of AmeriHealth Caritas DC's population. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Our Cultural Competency Program, led by a cross-departmental workgroup, has been built upon the following 14 national standards for Culturally and Linguistically Appropriate Services (CLAS) as set forth by the U.S. Department of Health and Human Services. AmeriHealth Caritas DC:

- Ensures each enrollee experiences culturally and linguistically competent care that considers the values, preferences and expressed needs of the enrollee.
- Has built a staff that adequately mirrors the diversity of the enrollee service area.
- Provides on-going education and training in culturally and linguistically appropriate service delivery to staff at all levels and across all disciplines.
- Offers language assistance services, including bilingual staff and interpreter services, at no cost to the enrollee with Limited English Proficiency (LEP).
- Assures the competency of language assistance services and ensures that friends and family are not providing interpretation services (except upon request by and with informed consent of the enrollee).
- Informs the enrollee, in a language they can understand, that they have the right to free language services and that these services are readily available.
- Ensures that written materials routinely provided in English to enrollees, applicants, and the public are also available in commonly encountered languages other than English.
- Developed, implemented and promoted a written strategic action plan to ensure culturally and linguistically appropriate services.
- Assesses CLAS-related activities and incorporates mechanisms to measure the success of these activities into our internal audits, performance improvement programs, enrollee satisfaction surveys and outcomes-based evaluations.
- Ensures that data on an enrollee's race, ethnicity, and spoken and written language are collected in health records, integrated into our management information systems and updated on a regular basis.
- Maintains a current demographic and cultural profile and needs assessment of our service area. This demographic and cultural profile is used in planning services that respond to the cultural and linguistic characteristics of our service area.
- Committed to both community and enrollee involvement in designing and implementing CLAS-related activities by our Community Advisory Committee.
- Provides grievance and appeals processes are culturally and linguistically sensitive with respect to identifying, preventing, and resolving cross-cultural conflicts or complaints by enrollees.

- Publicizes information regarding our progress and success in implementing CLAS standards and also provides public notice regarding the availability of this information.

Providers may request more information on the Cultural Competency Program by contacting Provider Services at 1-888-369-0247.

CULTURAL AND LINGUISTIC REQUIREMENTS

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible to make arrangements for language services for enrollees, upon request, who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such enrollees.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to ensuring equal access to benefits and services for LEP, LLP and sensory impaired enrollees is to ensure that you, our Network Provider, can effectively communicate with these enrollees. Plan providers are obligated to offer translation services to LEP and LLP enrollees upon request and to make reasonable efforts to accommodate enrollees with other sensory impairments free of charge.

Providers should discourage enrollees from using family or friends as oral translators. Enrollees should be advised that translation services from AmeriHealth Caritas DC are available. Providers are required to:

- Provide written and oral language assistance at no cost to plan enrollees with limited English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Provide enrollees verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read enrollee signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where an enrollee has been made aware of his/her right to receive free interpretation services and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

When an enrollee uses AmeriHealth Caritas DC's interpretation services, the provider must sign, date and complete documentation of such in the medical record in a timely manner.

AmeriHealth Caritas DC contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at 202-408-2237 or toll-free at 1-888-656-2383.

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired enrollee should contact AmeriHealth Caritas DC Healthy DC Plan Enrollee Services at 1-844-214-2470 (TTY 711) and a representative will help locate a professional interpreter to communicate in the enrollee's primary language.

Additionally under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan Providers are strongly encouraged to:

Provide effective, understandable, and respectful care to all enrollees in a manner compatible with the enrollee's cultural health beliefs and practices of preferred language/format;

- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area;
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services;
- Establish written policies to provide interpretive services for plan enrollees upon request; and,
- Routinely document preferred language or format, such as Braille, audio, or large type, in all enrollee medical records.

SECTION IX
CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

IX. CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

CLAIMS SUBMISSION

All claims for services rendered must be submitted to AmeriHealth District of Columbia within 180 days from the date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed on the CMS-1500 or UB-04. The following mandatory information is required on all claims:

- Enrollee's (patient's) name
- Enrollee's ID number
- Enrollee's date of birth and address
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs)
- Information advising if enrollee's condition is related to employment, auto accident or liability suit
- Date(s) of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM diagnosis codes, coded to the correct 4th or 5th digit
- Authorization or referral number, as applicable
- Name of referring physician, if appropriate
- HCPCS procedures, services or supplies codes
- CPT procedure codes with appropriate modifiers
- CMS place of service code
- Charges (per line and total)
- Days and units
- Physician/supplier Federal Tax Identification Number or Social Security Number
- National Practitioner Identifier (NPI) and Taxonomy
- Physician/supplier billing name, address, zip code, and telephone number
- Name and address of the facility where services were rendered
- NDC's required for physician administered injectables that are eligible for rebate
- Invoice date
- Signature

NOTE: Please utilize our billing manual for more information at www.amerihealthcaritasdc.com.

GENERAL PROCEDURES FOR CLAIM SUBMISSION

AmeriHealth Caritas DC is required by District and Federal regulations to capture specific data regarding services rendered to its enrollees. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be rejected by AmeriHealth Caritas DC for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas DC enrollees must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas DC are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.

- Verification of enrollee eligibility for services under AmeriHealth Caritas DC during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible enrollee.
- Verification that an authorization or referral has been given for services that require prior authorization or referral by AmeriHealth Caritas DC.

AmeriHealth Caritas DC accepts paper and electronic claims. Plan providers and practitioners are encouraged to submit claims electronically for faster turn-around.

For more detailed billing information and line-by-line instructions, please refer to the Claims and Billing Manual in the provider area of our website at www.amerihealthcaritasdc.com.

ELECTRONIC CLAIMS SUBMISSION (EDI)

AmeriHealth Caritas DC encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or one of our EDI clearinghouses, Optum/Change Healthcare or Availity, Inc.

There are many different products that may be used to bill electronically. As long as you have the capability to send EDI claims to one of our clearinghouses, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may:

- Contact your EDI software vendor or:
    - Optum/Change Healthcare at 1-800-527-8133, Monday through Friday from 7a.m. to 5:30 p.m. CT.
    - Availity Client Services at 1-800-AVAILITY (282-4548), Monday through Friday from 8 a.m. to 8 p.m. ET.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

AmeriHealth Caritas District of Columbia
EDI Payer ID#: 77002

PAPER CLAIM MAILING INSTRUCTIONS

Please submit paper claims to the address below:

AmeriHealth Carias District of Columbia Healthy DC Plan
Attn: Healthy DC Plan Claims
P.O. Box 7341
London, KY 40752

CLAIM FILING DEADLINES

All original paper and electronic claims must be submitted to AmeriHealth Caritas DC within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to capitated and fee-for-service claims. Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or enrollee data.

Note: **Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.**

Rejected claims are defined as claims with missing or invalid data elements, such as the provider tax identification number or enrollee ID number, that are returned to the provider or EDI source without registration in the claim processing system. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

Denied claims are registered in the claim processing system but do not meet requirements for payment under AmeriHealth Caritas DC guidelines. They should be re-submitted as a corrected claim. Where an initial claim is submitted within the timely filing period but is denied and resubmitted subsequent to the end of the timely filing period, the resubmitted claim shall be considered timely filed provided it is received within 365 days of the denial of the initial claim.

PROMPT PAYMENT ACT OF 2002

AmeriHealth Caritas DC is contractually obligated to meet the following prompt payment guidelines according to the provisions of the D.C. Prompt Payment Act of 2002:

- Pay or deny ninety percent (90%) of all clean claims within 30 days of receipt and ninety-nine percent (99%) of clean claims within ninety days of receipt.

  Note: A clean claim is defined as having no material defect or impropriety, including any lack of reasonably required substantiating documentation or information which may prevent timely payment.

- In the event that a clean claim is not paid within 30 days of receipt, and AmeriHealth Caritas DC does not notify the provider within said 30 days of any missing information required to pay the claim, AmeriHealth Caritas DC will implement measures to determine and pay interest penalties in accordance with the provisions of the Prompt Payment Act of 2002, as follows:
  - One and a half percent (1.5%) from the 31st day through the 60th day;
  - Two percent (2%) from the 61st day through the 120th day; and,
  - Two and one half percent (2.5%) after the 120th day.

IMPORTANT BILLING REMINDERS – ENCOUNTER REPORTING

VISIT REPORTING

CMS defines an encounter as "an interaction between an individual and the health care system." Encounters occur whenever an AmeriHealth Caritas DC enrollee is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury. An encounter is any health care service provided to an AmeriHealth Caritas DC enrollee. Encounters must result in the creation and submission of an encounter record (CMS-1500 or UB-04 form or electronic submission) to AmeriHealth Caritas DC. The information provided on these records represents the encounter data AmeriHealth Caritas DC reports to the District's Medicaid programs, according to mandatory reporting requirements.

COMPLETION OF ENCOUNTER DATA

PCPs must complete and submit a CMS-1500 or UB-04 form or file an electronic claim every time an AmeriHealth Caritas DC enrollee receives services from the provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows the Plan to gather statistical information regarding the medical services provided to enrollees, which better support our statutory reporting requirements.
- It allows the Plan to identify the severity of illnesses of our enrollees.

AmeriHealth Caritas DC accepts encounter submissions via paper or electronically (EDI). For more information on electronic claim submission, please refer to the billing information available on our plan website at www.amerihealthcaritasdc.com or contact EDI Technical Support via email at EDI.DC@amerihealthcaritasdc.com.

In order to support timely statutory reporting requirements, PCPs must submit encounters within thirty (30) days of the visit.

AmeriHealth Caritas DC monitors encounter data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to re-submit corrected information to AmeriHealth Caritas DC Network providers may also be subject to sanctioning by AmeriHealth Caritas DC for failure to submit accurate encounter data in a timely manner.

PRIMARY CARE AND DEPRESSION MANAGEMENT

AmeriHealth Caritas DC requires that PCPs submit a claim or encounter when screening, diagnosing, and treating a Plan enrollee for depression. Capitated practitioners are required to submit an encounter and will not be reimbursed above the capitation fee. Non-capitated practitioners will be reimbursed when an appropriately coded claim is submitted.

The depression diagnosis does not have to be the primary diagnosis.

PCPs may submit these diagnoses codes with the standard medical evaluation and management CPT codes, or with the 90862-medication management code.

CLAIMS INQUIRY

If a provider does not receive payment for a claim within 45 days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the AmeriHealth Caritas DC website at www.amerihealthcaritasdc.com/provider/resources/navinet to access the NaviNet provider portal, a free, web-based, multi-payer solution for electronic transactions and information.
- Using the self-service Interactive Voice Response (IVR) by calling 202-408-2237 or toll-free at 1-888-656-2383 and selecting the appropriate prompts.
- Calling Provider Services at 1-888-369-0247.

BALANCE BILLING ENROLLEES

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas DC to participating Plan providers must be accepted as payment in full for services rendered. Enrollees may not be balanced billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims dispute processes to resolve any outstanding claims payment issues.

REQUESTS FOR ADJUSTMENTS

Requests for adjustments may be submitted electronically, by phone, or by mail.

By phone:
Provider Claim Services
1-888-369-0247
(Select the prompts for the correct department and then select the prompt for claim issues.)

By mail:

If you prefer to write, please be sure to mark each claim submitted “corrected” or “re-submission” and address the letter to:

AmeriHealth Caritas District of Columbia
Attn: Healthy DC Plan Claims
P.O. Box 7341
London, KY 40752

CLAIM DISPUTES (NON-FEDERALLY QUALIFIED HEALTH CENTERS AND LOOKALIKES)

If a claim or a portion of a claim is denied for any reason or underpaid, the provider may dispute the claim within 60 days from the date of the denial or payment. A telephone inquiry regarding payment or denial of a claim does not constitute dispute of the claim. Claim disputes must be submitted in writing, along with supporting documentation to:

AmeriHealth Caritas DC Healthy DC Plan
Attn: Formal Disputes
P.O. Box 7445
London, KY40742-7445

Providers may also submit claim disputes and supporting documentation via the NaviNet provider portal by accessing the Dashboards and Forms section and completing the Provider Claim Dispute Level 1 form.

If a provider is not satisfied with the resolution of a dispute, they may seek a second-level review. A request for a second level review must be sent in writing within 30 calendar days of receiving AmeriHealth Caritas DC's response to the initial review. We will send an acknowledgement letter within five business days of receiving your appeal. You will receive a response letter regarding your appeal within 30 calendar days of AmeriHealth Caritas receiving your appeal. If the claims denial is overturned, you will receive payment within 30 calendar days of the decision.

CLAIM DISPUTES (FEDERALLY QUALIFIED HEALTH CENTERS AND LOOKALIKES)

Administrative Claims Dispute

The following AmeriHealth Caritas DC administrative claim dispute (appeal) process applies to the federally qualified health centers (FQHCs) and FQHC lookalikes in our network:

1. A claim dispute (appeal) is a provider's request to AmeriHealth Caritas DC to take another look at a previously denied claim.
2. All first-level claim disputes must be submitted within 90 business days of the denial or payment.
3. Providers must submit a written request for an appeal with the specific reason for the appeal and the appropriate supporting documentation (including a copy of the claim and Explanation of Benefits [EOB]).
4. AmeriHealth Caritas DC will send an acknowledgment letter within five business days of receiving an appeal.
5. Second-level appeals must be sent in writing within 30 calendar days of receiving AmeriHealth Caritas DC's response letter. We will send an acknowledgement letter within five business days of receiving your appeal. You will receive a response letter regarding your appeal within 30 calendar days of AmeriHealth Caritas receiving your appeal.
6. If the claims denial is overturned, you will receive payment within 30 calendar days of the decision.

Provider Medical/Clinical Claim Appeal

The following AmeriHealth Caritas DC provider claim appeals process applies to providers requesting claims to be reviewed for clinical, medical necessity reason:

1. A provider claim appeal is a provider's request to AmeriHealth Caritas DC to take another look at a previously denied claim for medical necessity.
2. All first-level appeals must be submitted within 60 business days of the denial or payment.
3. Providers must submit a written request for an appeal with the complete medical records pertaining to the date of service in question. This type of appeal must always contain complete medical records pertaining to the case and the services that were not previously paid.
4. We will send an acknowledgement letter within five business days of receiving your appeal. You will receive a response letter regarding your appeal within 30 calendar days of AmeriHealth Caritas receiving your appeal.
5. If the claims denial is overturned, you will receive payment within 30 calendar days of the decision.

Regarding All Claims Disputes

Available forms (these forms can be found on our provider website):

1. Administrative Claims Appeal Form, first and second levels and binding arbitration
2. Medical/Clinical Claim Appeal Form, first levels

When to use each form:

1. The Administrative Claims Appeal Form should be used when you are still within timely filing limitations for the claim:
    a. You submit a corrected claim. ***Please note:*** *Corrected professional claims may be resubmitted electronically using the appropriate bill type to indicate a corrected claim. Adjusted claims must be identified in the bill type*. *Please include the original claim number.*
    b. You submit proof of timely filing (such as a clearinghouse acceptance form, a certified mail receipt, or information in your practice management system showing the patient registered with other insurance and that you billed AmeriHealth Caritas DC as soon as you confirmed the coverage was with us).
    c. You submit another carrier's EOB.
    d. Your claim was denied for lack of authorization, and you have proof in your practice management system that prior authorization was obtained.
    e. The claim was administratively denied in error.
    f. The claim was not processed in network and the provider is in network.
    g. The claim was processed under an incorrect tax identification number (TIN) or using incorrect rates.
    h. You are attaching additional information requested by AmeriHealth Caritas DC.
    i. You are sending a refund, or you need payment stopped.

2. The Medical/Clinical Appeal Form should be used in situations that require a medical necessity decision after a review of medical records. These situations include denied inpatient days, pre-service clinical denials, authorization not obtained for services requiring a prior authorization, services denied for lack of medical necessity, and emergency room care for diagnosis codes not on the auto-pay list. This type of appeal must always contain complete medical records pertaining to the case and the services that were not previously paid. For example, an emergency room summary sheet is not a complete record. It will not provide all of the information necessary to allow more than an emergency room triage fee to be paid; in many cases, an emergency room summary sheet does not contain enough information to prove the Emergency Medical Treatment and Labor Act (EMTALA) was even met (which could cause the triage fee originally paid to be retracted).

Where to send each form:

1. The Administrative Claims Appeal Form can be mailed to AmeriHealth Caritas DC:

    AmeriHealth Caritas District of Columbia Healthy DC Plan
    Attn: Formal Disputes
    P.O. Box 7445
    London, KY 40742-7445

2. The Medical/Clinical Appeal Form can be mailed to AmeriHealth Caritas DC:

    AmeriHealth Caritas District of Columbia
    Attn: Provider Appeals Department
    P.O. Box 7359
    London, KY 40742

BINDING ARBITRATION

In the event the dispute cannot be resolved through the Second-level appeals process, provider may elect binding arbitration by giving written notice, within 30 days of the Second-level appeals decision, of the election to seek binding arbitration. We will send an acknowledgement letter within 30 days of receiving the election. The dispute shall be determined by binding arbitration pursuant to the American Health Lawyers Association's (AHLA) Alternative Dispute Resolution Service or such other alternative dispute resolution service as the parties may mutually agree. Any such arbitration proceeding shall occur in Washington, D.C., or in such place as-mutually agreed to by the parties before one arbitrator who is a member of the AHLA Alternative Dispute Resolution Service and who is familiar with issues related to payment for provider services by health care plans. The dispute shall be determined by one arbitrator chosen by the parties and if the parties cannot agree on one arbitrator, each party shall select one arbitrator and the two arbitrators shall select a third arbitrator and the third arbitrator shall hear and decide the matter individually. The parties shall equally share the cost of the arbitrator. Each party shall bear the expense of its own attorney's fees and expenses. Discovery in arbitration shall be restricted to the exchange of documents necessary for the arbitrator to understand and fairly decide the case without interrogatories or depositions.

The arbitrator shall apply the law of the District of Columbia and issue a written, reasoned decision setting forth the basis of award within 30 days of the conclusion of the arbitration. The arbitrator's decision and award shall be final and binding and may be entered in any court having jurisdiction thereof. In no event shall any arbitrator proceeding initiated pursuant to this Section extend beyond one hundred and eighty (180) days from the date the arbitration is initiated. The parties and the arbitrators shall keep confidential and not disclose to any third parties any information obtained in connection with the arbitration process, including the resolution of the dispute.

PROSPECTIVE CLAIMS EDITING POLICY

AmeriHealth Caritas DC claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider's contract, and/or an enrollee's eligibility to receive covered health care services.

REFUNDS FOR IMPROPER PAYMENT OR OVERPAYMENT OF CLAIMS

If a Plan provider identifies improper payment or overpayment of claims from the AmeriHealth Caritas DC Medicaid program, the improperly paid or overpaid funds must be returned to the Plan within 60 calendar days of identification. Providers are required to return the identified funds to AmeriHealth Caritas DC by submitting a refund check directly to the appropriate claims processing department:

AmeriHealth Caritas DC Healthy DC Plan
Attn: Provider Refunds
P.O. Box 7341 London, KY 40742

Note: Please include the enrollee's name and ID, date of service and claim ID.

THIRD PARTY LIABILITY/SUBROGATION

In the event of an accidental injury (personal or automobile) where a third party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas DC contract, AmeriHealth Caritas DC will be entitled to recover any funds up to the amount owed by the third party payer.

ADDITIONAL INFORMATION FOR ELECTRONIC BILLING

INVALID ELECTRONIC CLAIM RECORD REJECTIONS/DENIALS

All claim records sent to AmeriHealth Caritas DC must first pass clearinghouse HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted with all necessary and valid data elements within the required filing deadline of 365 days from the date the initial claim was rejected. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the clearinghouse or your EDI software vendor in order to identify and re-submit these claims accurately.

MONITORING REPORTS FOR ELECTRONIC CLAIMS

The clearinghouse will produce an Acceptance Report* and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers using clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. In order to verify satisfactory receipt and acceptance of submitted records, please review both the clearinghouse Acceptance Report and the R059 Plan Claim Status Report.

*Acceptance Report verifies acceptance of each claim at the clearinghouse.

**R059 Plan Claim Status Report is a list of claims that passed the clearinghouse's validation edits. However, when the claims
were submitted to the Plan, they encountered provider or enrollee eligibility edits.

PLAN SPECIFIC ELECTRONIC EDIT REQUIREMENTS

AmeriHealth Caritas DC currently has two specific edits for professional and institutional claims sent electronically.

- 837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- 837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Statement date must be not be earlier than the date of service.

Plan-assigned individual practitioner ID number is strongly encouraged.

ELECTRONIC BILLING EXCLUSIONS

Certain claims are excluded from electronic billing and must be submitted by paper. These exclusions fall into two groups:

Excluded Claim Categories
Claim records requiring supportive documentation (but not including secondary claims with COB information).
Claim records for medical, administrative or claim appeals.
Excluded Provider Categories
Providers not transmitting directly through a clearinghouse or providers sending to vendors not transmitting through one of our clearinghouses.
Pharmacists (through Emdeon).

(These exclusions apply to inpatient and outpatient claim types.)

COMMON REJECTIONS

Invalid Electronic Claim Records – *Common Rejections from Emdeon*
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.).
Claims without enrollee ID numbers.
Invalid Electronic Claim Records – *Common Rejections from AmeriHealth Caritas DC (EDI Edits within the Claim System*)
Claims received with invalid provider numbers (including NPI and Taxonomy, Plan ID, as applicable).
Claims received with invalid enrollee ID numbers.
Claims received with invalid enrollee date of birth.

RE-SUBMITTED CORRECTED CLAIMS

Providers using electronic data interchange (EDI) can submit "institutional" and "professional" corrected claims* electronically to AmeriHealth Caritas DC.

*A "corrected claim" is defined as a re-submission of a claim with a specific change you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

Your EDI clearinghouse or vendor needs to remember the following:

- Use “6” for adjustment of prior claims or “7” for replacement of a prior claim utilizing bill type or frequency type in loop 2300, CLM05-03 (837P or 837I).
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; do not use dashes or spaces.
- Also, when submitting a corrected claim:
- Do use this indicator for claims that were previously processed (approved or denied).
- Do include the Plan’s claim number in order to submit your claim with the 6 or 7.
- Do not use this indicator for claims that contained errors and were not processed (rejected up front).
- Do not submit corrected claims electronically and via paper at the same time.

For more information, please contact the AmeriHealth Caritas DC EDI Technical Support department via email at EDI.DC@amerihealthcaritasdc.com.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

EFT simplifies the payment process by:

- Providing fast, easy, and secure payments
- Reducing paper
- Eliminating checks lost in the mail
- Not requiring you to change your preferred banking partner

To sign up to receive EFT from AmeriHealth Caritas DC, enroll through our EFT partner, ECHO Health: https://enrollments.echohealthinc.com/efteradirect/enroll. If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 1-888-834-3511.

You can download ERAs from the ECHO provider portal at **www.providerpayments.com.**

ELECTRONIC BILLING INQUIRIES

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically	Contact your EDI software vendor or: • Optum/Change Healthcare at **1-800-527-8133**, Monday through Friday from 7a.m. to 5:30 p.m. CT. • Availity Client Services at **1-800-AVAILITY (282-4548**), Monday through Friday from 8 a.m. to 8 p.m. ET.
If you have general EDI questions	Contact EDI Technical Support:EDI.DC@amerihealthcaritasdc.com
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports	Contact your EDI software vendor or: • Optum/Change Healthcare at **1-800-527-8133**, Monday through Friday from 7a.m. to 5:30 p.m. CT. • Availity Client Services at **1-800-AVAILITY (282-4548**), Monday through Friday from 8 a.m. to 8 p.m. ET.
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)	Contact Provider Claim Services: 1-888-369-0247
If you have questions about claims that are reported on the remittance advice	Contact Provider Claim Services: 1-888-369-0247
If you need to know your provider NPI number…	Contact Provider Services: 1-888-369-0247
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information OR For questions about changing or verifying provider information	Contact Provider Services: 1-888-369-0247
If you would like information on the 835 remittance advice	Contact your EDI vendor: • Optum/Change Healthcare at **1-800-527-8133**, Monday through Friday from 7a.m. to 5:30 p.m. CT. • Availity Client Services at **1-800-AVAILITY (282-4548**), Monday through Friday from 8 a.m. to 8 p.m. ET.
Check the status of your claim	Review the status of your submitted claims on NaviNet at www.navinet.net.

Sign-up for the Provider Portal	Go to www.navinet.net or contact NaviNet Customer Service: 1-888-482-8057
Sign-up for Electronic Funds Transfer	Go to https://enrollments.echohealthinc.com/efteradirect/enroll or contact ECHO Health: 1-888-834-3511

PROVIDER PREVENTABLE CONDITIONS

AmeriHealth Caritas DC will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, AmeriHealth Caritas DC does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

A. Foreign Object Retained After Surgery
B. Air Embolism
C. Blood Incompatibility
D. Catheter Associated Urinary Tract Infection
E. Pressure Ulcers (Decubitus Ulcers)
F. Vascular Catheter Associated Infection
G. Mediastinitis After Coronary Artery Bypass Graft (CABG)
H. Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
I. Manifestations of Poor Glycemic Control
J. Surgical Site Infection Following Certain Orthopedic Procedures
K. Surgical Site Infection Following Bariatric Surgery for Obesity
L. Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for
    a. Pediatric and Obstetric Populations

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, AmeriHealth Caritas DC will not reimburse providers for any of the following never events in any inpatient or outpatient setting:

- Surgery Performed on the Wrong Body Part
- Surgery Performed on the Wrong Patient
- Wrong Surgical Procedure Performed on a Patient

MANDATORY REPORTING OF PROVIDER PREVENTABLE CONDITIONS

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular enrollee existed prior to the initiation of treatment for that enrollee by the provider. This situation may be reported on the

claim with a “Present on Admission” indicator.

- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; AmeriHealth Caritas DC will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the Y diagnosis codes, such as Y65.51, Y65.52 or Y65.53in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury or Y codes on the claim in field 67 A – Q. Examples of ICD-10 and “Y” diagnosis codes include:

1. Wrong surgery on correct patient Y65.51;
2. Surgery on the wrong patient, Y65.52;
3. Surgery on wrong site Y65.53
4. If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the
    a. Patient Status Code 20 “Expired”.

INPATIENT CLAIMS

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired.

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the enrollee’s medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

INDICATING PRESENT ON ADMISSION (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the “Present on Admission” (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300; segment K3, data element K301.

Valid POA Indicators Include:

A. “Y” = Yes = present at the time of inpatient admission
B. “N” = No = not present at the time of inpatient admission
C. “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient
    a. admission
D. “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present
    a. at time of inpatient admission or not “null” = Exempt from POA reporting

SURGICAL REIMBURSEMENT POLICIES

PRE-OPERATIVE TEST REQUIREMENTS

It is the surgeon's responsibility to provide information to the enrollee on the hospital's requirements for pre-operative physical examination, laboratory and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.

MULTIPLE PROCEDURES

Multiple surgical or invasive procedures are paid at a reduced rate. The secondary procedure is paid at fifty percent (50%) of the allowable charge. Subsequent procedures will be paid at twenty-five percent (25%) of the allowable charge or per provision of the individual practitioner's contract.

INCIDENTAL SURGERY

Incidental procedures are not reimbursed as separate charges when they are performed in conjunction with other surgical procedures. The following are a few examples of incidental procedures:

- Procedures to create surgical entry
- Exploratory laparotomy
- Incidental appendectomy

ASSISTANT SURGEONS

AmeriHealth Caritas DC follows Medicare guidelines for reimbursement of assistant surgeon services. According to the Medicare Fee Schedule, the following assistant surgeon services are not reimbursed when billed with the assistant surgeon modifier (80):

- Procedures where assistant surgeons are not allowed.
- Procedures that do not require an assistant surgeon or are not surgical in nature.
- Global obstetrical deliveries.

Additionally, the assistant surgeon component will be denied on claims where the primary surgeon and assist surgeon are listed as the same provider. Services provided by a second assistant surgeon are also not reimbursable for most surgical procedures.

GLOBAL SURGICAL REIMBURSEMENT

Pre-and post-operative visits are considered to be part of the surgical fee. Visits do not fall within the Medicare surgical global guidelines; therefore, payment for visits will be denied.

SECTION X
BEHAVIORAL HEALTH CARE

X. BEHAVIORAL HEALTH CARE

The information contained in this section of the Provider Manual applies to providers who are contracted with AmeriHealth Caritas DC to provide covered behavioral health care services. Please note that, in general, the responsibilities, expectations, and processes outlined in this Provider Manual pertain to all provides, including behavioral health providers, unless otherwise indicated in this section or specified via subsequent communications. For more information, please contact AmeriHealth Caritas DC's Provider Services at 1-888-369-0247.

MEDICAID PROGRAM BEHAVIORAL HEALTH SERVICES

The following behavioral health services are included in the AmeriHealth Caritas DC Medicaid program's benefit package:

- Diagnostic and assessment services
- Physician and mid-level practitioner visits
- Individual counseling, group counseling, family counseling and Federally Qualified Health Center (FQHC) services Medication/Somatic treatment
- Crisis services
- Inpatient hospitalization and emergency services
- Day Services
- Intensive day treatment
- Patient Psychiatric Residential Treatment Facility (PRTF) services for enrollees under 22 years of age
- Mental health services for children, as included in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) during holidays, school vacations or sick days from school
- Case management services
- Education on how to access mental health services

ADDITIONAL BEHAVIORAL HEALTH SERVICES

AmeriHealth Caritas DC covers behavioral health services available to Healthy DC Plan enrollees. However, specialized mental health services provided by the Department of Behavioral Health and all substance abuse related services, with the exception of inpatient detoxification services at a hospital, are not covered by AmeriHealth Caritas DC. These services are available to all Healthy DC Plan enrollees via the resources listed below.

AmeriHealth Caritas DC PCPs are expected to assist enrollees with accessing substance abuse and mental health services, as needed. The AmeriHealth Caritas DC Rapid Response team is also available to enrollees and providers to support care coordination and access to services. Enrollees and providers may request Rapid Response support by calling 1-877-759-6224.

Department of Behavioral Health
(For specialized mental health services)
Available 24 hours a day, 7 days a week by calling 1-888-793-4357
www.dmh.dc.gov
Specialized Mental Health Services include:

- Community-Based Interventions (CBI)
- Multi-systemic Therapy (MST)
- Assertive Community Treatment (ACT)
- Community Support
- Crisis Intervention, including mobile crisis services
- Case Management

Addiction, Prevention and Recovery Administration (APRA)
(For drug and alcohol services*)
www.doh.dc.gov/apra

Assessment and Referral Center (ARC)
Hours of Operation: 7am - 6pm
For same day service, arrive before 3:30pm
75 P Street NE (enter on Florida Avenue near the P Street intersection)
Washington, DC 20002
Telephone (202) 727-8473
Fax: (202) 727-8411

Regional Addiction Prevention (RAP), Inc.
Hours of Operation: Monday-Friday 8:00am - 8:00pm
1949 4th Street NE
Washington, DC 20002
Ward 5
Telephone: (202) 462-7500
Fax: (202) 526-8916

Family & Medical Counseling Services
Hours of Operation: Monday-Thursday 9:00am-4:00pm; Friday 9:00am-1:00pm
2041 Martin Luther King Jr Ave SE, Suite 303
Washington, DC 20020
Ward 8
Telephone: (202) 889-7900
Fax: (202) 610-3095

MBI Health Services
Hours of Operation: Monday-Friday 9:00am-5:00pm
2041 Martin Luther King Jr Ave SE, Suite M8
Washington, DC 20020
Ward 8
Telephone: (202) 388-9203

*Inpatient detoxification services are covered by AmeriHealth Caritas DC

ACCESS TO BEHAVIORAL HEALTH CARE

AmeriHealth Caritas DC and AmeriHealth Caritas DC providers must meet standard guidelines as outlined in this publication to help ensure that Plan enrollees have timely access to behavioral health care.

AmeriHealth Caritas DC endorses and promotes comprehensive and consistent access standards for enrollees to assure enrollee accessibility to health care services. AmeriHealth Caritas DC establishes mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for enrollees.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for enrollees should comply with the access standards defined below.

The standards below apply to behavioral health care services and behavioral health providers; please refer to the "Provider and Network Information" section of this Provider Manual for the standards that apply to medical care services and medical providers.

Access to Behavioral Health Care	
Emergency Psychiatric or Mental Health Care *(An active crisis where the enrollee or others are at risk, or where there is an expected risk in the next 24 hours.)*	Within One (1) Hour of the Need Being Presented to the Provider
Urgent Psychiatric or Mental Health Care	Within the Same Day of the Need Being Presented to the Plan or Provider
Behavioral Health Telephone Crisis Triage	Within Fifteen (15) Minutes Over the Telephone *Must be Available on a 24-Hour Basis, Seven Days a Week.*
Psychiatric Intervention or Face-to-Face Assessment	Within Ninety (90) Minutes of Completion of Telephone Assessment, As Needed *Must be Available on a 24-Hour Basis, Seven Days a Week.*
Hospital Discharge Follow-Up Care with an Outpatient Provider *(Care following discharge from a Psychiatric Inpatient Facility or Psychiatric Residential Treatment Facility.)*	Initial Assessment Within Seven Calendar Days of Discharge to the Community *Must include assessment and provision of prescriptions if needed.* Plus Subsequent Appointment Within Thirty (30) Calendar Days of Discharge from an Acute Care Facility
Community Based Interventions Screening for Children/Youth Admitted to an Acute Care Facility	Within 48 Hours of Admission by Contacting the Department of Behavioral Health Child/Youth Care Manager
Routine Behavioral Health Appointments	Within Seven Calendar Days of Request
Initial Service in the Follow-Up Care Based on Results of an Assessment	Within Ten (10) Business Days of Completion of the Assessment
Waiting Time in a Provider Office	Not to Exceed 45 Minutes
Use of Free Interpreter Services	As Needed Upon Enrollee Request During All Appointments

AFTER-HOURS ACCESSIBILITY

AmeriHealth Caritas DC enrollees must have access to quality, comprehensive health care services 24 hours a day, seven days a week. Behavioral Health Providers must have either an answering machine or an answering service for enrollees during after-hours for non-emergent issues. The answering service must forward calls to the Behavioral Health provider, an on-call provider, and/or instruct the enrollee that the provider will contact the enrollee within 30 minutes. When an answering machine is used after hours, the answering machine must provide the enrollee with a process for reaching a provider after hours. The after-hours coverage must be accessible using the provider's office's daytime telephone number.

For emergent issues, both the answering service and/or answering machine must direct the enrollee to call 911 or go to the nearest emergency room. AmeriHealth Caritas DC will monitor access to after-hours care on an annual basis by conducting a survey of Behavioral Health offices after normal business hours.

INTEGRATING BEHAVIORAL AND PHYSICAL HEALTH CARE

Enrollees with behavioral health disorders may also experience physical health conditions that complicate the treatment and diagnosis of both health conditions. AmeriHealth Caritas DC understands that coordination of care for these enrollees is imperative. AmeriHealth Caritas DC's integrated care management program will seamlessly coordinate enrollee care across the physical and mental health and social service areas.

Plan staff will work with the appropriate primary care and behavioral health providers to develop an integrated Treatment Plan for enrollees in need of physical and behavioral health care coordination. Care Managers will also assure that communication between the two disciplines, providers and organizations, occurs routinely for all enrollees with physical and behavioral health issues. Care Managers will also work to coordinate community resources, as appropriate. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that enrollee needs are continuously reviewed assessed and documented in the Treatment Plan.

For care coordination assistance, behavioral health providers may contact the Rapid Response team at 1-877-759-6224.

BEHAVIORAL HEALTH SERVICES REQUIRING PRIOR AUTHORIZATION

The following is a list of behavioral health services requiring prior authorization review for medical necessity and place of service:

1. Mental Health Partial Hospitalization Program
2. Inpatient Detoxification Admissions
3. Mental Health IP Inpatient Admissions
4. Neuropsychological Testing
5. Psychological Testing
6. Developmental Testing
7. Behavioral Health Day Treatment
8. Residential Treatment
9. Electroconvulsive Therapy

The AmeriHealth Caritas DC Utilization Management (UM) department hours of operation are 8 a.m. to 5:30 p.m., Monday through Friday.

- To contact the Behavioral Health Utilization Management team directly, please call 1-877-464-2911. Prior authorization requests can also be made via NaviNet [www.navinet.com]. For more information on how to use NaviNet, please see the AmeriHealth Caritas DC website www.amerihealthcaritasdc.com. The general Behavioral Health UM Department fax numbers are 202-408-1031 or 1-877-759-6216.

For the initial prior authorization of inpatient stays, electroconvulsive therapy and/or partial hospitalization programs, please submit requests by telephone to the UM department. Requests are also accepted by fax or via NaviNet if they contain all the appropriate information to support a medical necessity review and/or level of care evaluation. AmeriHealth Caritas DC typically authorizes inpatient stays for three (3) to five (5) days at a time and partial hospitalization programs for one (1) week at a time, depending on medical necessity. Requests to extend authorization on these services may also be submitted by telephone to the UM Department. For the initial prior

authorization of outpatient services (after the initial 10 sessions of behavioral health counseling or therapy, excluding outpatient evaluation, medication management and nursing services) or day treatment programs, please submit requests by completing and faxing the Outpatient Treatment Request Form to the UM department. AmeriHealth Caritas DC typically authorizes day treatment for 30 days at a time. Requests to extend authorization on outpatient services may also be submitted by completing and faxing the Outpatient Treatment Request Form to the UM department. For additional information on how to submit a request for prior authorization, please refer to the provider area of our website at www.amerihealthcaritasdc.com.

BEHAVIORAL HEALTH SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

The following is a list of behavioral health services does not require prior authorization review for medical necessity and place of service:

- Outpatient Behavioral Health Counseling and Therapy (individual, family, group)
- Outpatient Evaluation
- Outpatient Medication Management Services
- Outpatient Nursing Services

BILLING FOR BEHAVIORAL HEALTH CARE SERVICES

Behavioral health providers will follow the same billing procedures as medical health care providers. Please refer to the "Claims Submission Protocols and Standards" section of this Provider Manual for more information on how to submit claims for behavioral health care services covered by AmeriHealth Caritas DC.

For more detailed billing information and line-by-line instructions, please refer to the Claims and Billing Manual in the provider area of our website at www.amerihealthcaritasdc.com.

www.amerihealthcaritasdc.com

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