FYB
For Your Benefit

PROVIDER MANUAL

For Your Benefit Inc.
1668 S. Garfield Ave, Alhambra, CA 91801 | (877) 282-8272

(092023v6)

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SECTION 1 **INTRODUCTION**

PURPOSE OF THIS MANUAL

This Operations Manual is intended to provide providers and their staff with information necessary for serving and coordinating the care of For Your Benefit (FYB) medical group patients.
Amendments to guidelines contained in this handbook are recommended to the FYB Board of Trustees by the FYB Quality Assessment/Utilization Review Committee or by the FYB Chief Executive Officer (CEO). Upon passage by the Board of Trustees, all amendments are distributed through the FYB newsletter to FYB providers and are effective thirty days after such distribution.

FOR YOUR BENEFIT

The primary purpose of the For Your Benefit (FYB) is to provide quality medical care and be culturally sensitive to meet the needs of our community.
FYB operates as a Restricted Health Plan licensed by the Department of Managed Health Care, and as such, FYB contracts with health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 as amended.

FYB MISSION STATEMENT

The mission of For Your Benefit is to provide quality Healthcare services in a timely and culturally sensitive manner and to work in cooperation with community organizations and government agencies to create vibrant, healthy, physical, and social environments in the communities that we serve.
In support of its mission, For Your Benefit is committed to:

1. Leveraging the services of Network Medical Management to support FYB's contracted IPAs, community health care institutions, hospitals, managed care health plans, ambulatory care services, ancillary providers, and an array of community health programs, and
2. Providing a value-based delivery model, promoting and strengthening the provider network of FYB, providing managed care contracting opportunities for participating FYB providers, and maintaining an open panel of needed community providers screened by an appropriate credentialing process.

FYB has several standing Committees. Committee members are appointed by the Board of Trustees. For information regarding FYB committees, contact the FYB Operations Director or Chief Executive Officer. FYB committees include:

- Quality Management/Utilization Management Committee
- Finance Committee
- Compliance Committee

SECTION 2 **CONTACTING FYB**

Office: 1668 S. Garfield Ave., Alhambra, CA 91801
Phone: (877) 282-8272
Email: ProviderRelationsDept@NetworkMedicalManagemement.com
Fax: (626) 943-6375

Please contact FYB Provider Relations for matters relating to:

- Notification of changes to your provider information, including changes in office locations, tax ID number, billing address, or telephone numbers
- Questions about FYB policies, guidelines, or information in this Handbook
- Requesting login information for the FYB's Provider Portal
- Inquiries about electronic health records (EHR) implementation

Operations Management		EMAIL
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UM Delegation Oversight	Phyllis Hsieh, Manager	PHsieh@networkmedicalmanagement.com
QUALITY MANAGEMENT	Rayna Hurdle, Manager	RHurdle@networkmedicalmanagement.com

NOTIFICATION OF PROVIDER STATUS AND PRACTICE CHANGES

Please notify FYB in writing regarding changes of address, phone numbers, and related information with as much advance notice as possible. Providers must provide FYB with adequate advance written notice for any changes in status and practice changes. Please fax or mail written notices to FYB at the fax number or address listed under the "Contacting FYB" section.

NOTIFICATION OF CONTRACT TERMINATION OR RESIGNATION FROM FYB

Providers who want to terminate their FYB Provider Agreement **must provide FYB with adequate advance written notice as documented in the contract agreement conditions before the effective date of the termination**. This includes physicians who are retiring or closing their practices. The adequate advance notice allows FYB to notify contracted health plans of a Provider's termination from FYB's network and will allow health plans to notify their Members and to assist them in transitioning care to another in-network physician or to ensure that those who may be eligible to continue receiving care from the terminating provider for a designated period are notified per state law. Notice of resignation or termination of your Provider Agreement must be faxed or mailed to FYB at the fax number or address listed under the "Contacting FYB" section.

CONTACTING FYB CONTRACTED HEALTH PLANS FOR PATIENT ELIGIBILITY

Member eligibility should always be verified by all Providers before providing medical services. A patient's insurance ID card is not necessarily proof of eligibility, and benefits/copayments may vary. All health plans also offer online eligibility verification on their Websites. The following is a list of FYB contracted health plans. For information on new health plans added from time to time, you may contact NMM's Customer Service Department at (626) 282-0288.

Providers may contact the health plans directly for information on accessing online eligibility and benefits.

Verify Member Eligibility and Benefits	Website	Phone
Anthem Blue Cross	www.anthem.com	888-230-7338
Brand New Day	www.bndhmo.com	866-255-4795
Central Health Plan	www.centralhealthplan.com	866-314-2427
Clever Care Health Plan	www.clevercarehealthplan.com	833-388-8168
SCAN Health Plan	www.scanhealthplan.com	800-559-3500

SECTION 3 **FYB PROVIDER RESPONSIBILITIES**

RESPONSIBILITIES OF FYB PRIMARY CARE PHYSICIAN (PCP)

Members of FYB contracted health plans are required to select a primary care physician from FYB's network of primary physicians. Primary insurance members may select different PCPs from dependents on the same policy.

The FYB PCP is responsible for:

- Providing covered services to patients as medically necessary
- Assuring reasonable access and availability to primary care services
- Making referrals to in-network or out-of-network providers when medically necessary
- Providing 24-hour coverage for medical advice and/or access to care for patients
- Communicating authorization decisions (approvals and denials) to patients

Members may require services that go beyond the scope of their PCP. When this occurs, the PCP refers the patient to an appropriate FYB provider. If FYB does not have providers under the needed specialty, the PCP must request prior authorization from FYB's Utilization Management Department for an out-of-network specialist using an FYB **Treatment Authorization Request (TAR) form**. In the case of an emergency, authorization requests should be obtained on the next working day following the emergency.

RESPONSIBILITIES OF FYB SPECIALIST PHYSICIAN (SPECIALIST)

Patients may be referred to an FYB Specialist provider (Specialist) by an FYB PCP or another FYB Specialist. When a member has been referred to a Specialist, the Specialist is responsible for diagnosing the patient's condition and managing treatment of the condition as necessary.

FYB Specialist providers are responsible for:

- Providing covered services to patients as medically necessary
- Informing the patient's PCP of the patient's condition with a consultation report
- Obtaining concurrence from the patient's PCP and/or prior authorization from FYB's Utilization Management Department for medically necessary services as needed
- Notify the patient's PCP when the member requires services from other specialists or ancillary providers for further diagnosis or specialized treatment, or if the patient requires admission into a hospital
- Providing 24-hour coverage for medical advice and/or access to care for patients

When an FYB PCP or provider identifies the need to refer a patient to another in-network provider, giving clinical notes to the referring provider is recommended. If FYB does not have an appropriate provider under the needed specialty, a prior authorization must be requested from FYB's Utilization Management Department for out-of-network services using an FYB **Treatment Authorization Request form**. In the case of an emergency, authorization requests should be obtained on the next working day following the emergency.

__Important Note__: OB/GYN specialists may provide care to female patients without a referral from a PCP; consistent with California law.

RESPONSIBILITIES OF ALL FYB PROVIDERS

1. **Verifying Member Eligibility**
   Verification of member eligibility and benefits must be completed before rendering medical services. As member eligibility and medical benefits (i.e. copayments, coinsurance, etc.) are subject to change, both must be verified before providing medical services to the Member. Providers should contact the patient's respective health plan/insurance company directly for the most accurate information. All health plans offer online eligibility verification on their website. Providers may contact the health plans for information on accessing online eligibility and benefits or may contact the respective health plan's customer service line.

   Please ask Members to present their insurance ID card each time, before their appointment. ID cards will contain information to assist you in verifying the Member's eligibility. An insurance ID card is **NOT** proof of eligibility.

2. **Collecting Copayments**
   Co-payments should be collected from the patient based on the patient's health insurance benefits. It is important to verify member eligibility and benefits before providing medical services. When a claim is paid by FYB, the co-payment is deducted from the payable amount. An FYB Explanation of Benefits (EOB) or Remittance Advice (RA) will accompany each payment and will indicate the applicable copay deduction. Members are obligated to pay any applicable copayment according to their insurance benefits. Any overpayments made by a patient more than the allowed amount must be refunded to the patient.

   Depending on a patient's health benefits, copayments may be waived for preventive services. Providers must check member eligibility and benefits to determine the appropriate copayment when performing preventive services. Providers are expected to review a patient's medical record to determine if and when the patient needs to receive preventive services. Preventive service guidelines are recommended by the United States Preventive Services Task Force (USPSTF). For the most up-to-date information, please go to: http://www.uspreventiveservicestaskforce.org

3. **Notification of Authorization Approvals**
   Decisions to approve a request for service authorization that was requested before, or concurrent with the provision of health care services shall be communicated by the Utilization Management Department to the requesting provider within 24 hours of the decision. It is the responsibility of the requesting provider to communicate to the member the specific health care service(s) that was approved and document when the Member was notified of the approved service. Patients may be notified by telephone, written notice, email, or in person.

4. **Providing and Documenting Language Assistance**
   FYB providers must document in the patient's medical records the language preference of patients who may be Limited English Proficient (LEP). It is the physician's responsibility in notifying and documenting an LEP member's right to language assistance. The following requirements are to be followed at all times:
   - A qualified interpreter should always be offered to Limited English Proficient (LEP) patients as a preferred option.

- If patients decline the use of a qualified interpreter and prefer to use a friend or family member for interpretation, they have the right to do so. When patients decline the services of a qualified interpreter, this must be documented in the patient's medical records.
- Minors should only be used as interpreters in an emergency.

The following is a list of language interpreter services offered through the patient's respective health plans:

Health Plan	To Request Interpretation or Translation Services
Anthem Blue Cross	1-800-677-6669
Brand New Day	1-866-255-4795
Central Health Plan	1-866-314-2427
Clever Care Health Plan	1-833-388-8168
SCAN Health Plan	1-800-559-3500

5. Providing Members with Grievance and Appeals Information

If a Member is dissatisfied with a decision or action made by FYB, their Health Plan, or FYB providers must inform the Member of their right to file a grievance and offer to provide the Member with a copy of their Health Plan Member Grievance and Appeal forms. Grievance forms are available on the Health Plan's website.

6. Training Requirements for Providers and Staff

FYB requires that all providers and their respective staff complete the following training and attest to having completed the training on an annual basis. The training listed below is required by the Centers for Medicare and Medicaid Services (CMS) for all providers and entities involved with the administration of care to Members enrolled under Part C Medicare Advantage Plans (MA) and Part D Medicare Prescription Drug Plans (PDP):

- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, Waste, and Abuse (FWA)
- Workplace Harassment
- Cultural Competency
- Any training as required by contracted health plans, e.g. Model of Care (MOC)

FYB provides training materials and an attestation form on our website. To access the training materials, please go to: https://www.networkmedicalmanagement.com/providers/provider-resources

Providers and their staff only need to complete compliance training (see list of required training above) once a year. If the provider has already completed the required training through a different organization (i.e. health plan, medical group, etc.), an attestation indicating the completion of such training must be submitted to FYB to satisfy this requirement. All attestations must be submitted to FYB using one of the following methods:

By Fax: (626) 943-6375
By Email: ProviderRelations.Dept@NetworkMedicalManagement.com

7. **Participation in all FYB Contracted Health Plans**
   FYB requires that all contracted providers participate in all FYB contracted Health Plans (refer to Section 1 Introduction of this Handbook). Should a physician wish to close their panel from accepting new Members for one FYB contracted Health Plan, the physician's panel will be considered closed for all FYB contracted Health Plans.

8. **Advance Directive**
   Patients are not obligated to complete an Advance Directive if they do not wish to. If they choose to complete an Advance Directive, it is important that patients, and their physicians, receive a copy to place in their medical records.

SECTION 4 **CREDENTIALING AND RE-CREDENTIALING**

FYB is committed to providing quality care to its members. On behalf of FYB, Network Medical Management (NMM), FYB's Management Services Organization, uses a rigorous process to evaluate providers. This process thoroughly evaluates a provider's experience, licensing, sanction activity, and quality of care.

Procedure

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Department reviews each initial application with all supporting verifications and documentation before submission to the Credentialing Committee.
2. Initial Application: Network Medical Management uses an online credentialing portal, aka "Provider Hub", for the submission of credentialing applications. These applications will require the provider to provide information on:
    a. Reasons for inability to perform the essential functions as a provider, with or without accommodation
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitations of privileges or disciplinary activities
    e. Attestation by the applicant of the correctness and completeness of the application. Attestations will cover seven (7) years for initial providers and three (3) years for re-credentialed providers
3. Completed application for Primary Care Physicians and Specialists: Each applicant will be required to complete an application. In addition, the applicant will provide:
    a. Curriculum Vitae (CV)
    b. A copy of current State Medical or Dental License(s) (pocket license)
    c. A copy of a valid DEA certificate (if applicable)
    d. Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
    e. Board Certification Certificates (if applicable)
    f. Certificates of Degree Completion (i.e., medical or dental school)
    g. Internships and Residency certificates of completion
    h. A copy of the Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
    i. Addendum A (Provider Rights)
    j. Addendum B (as applicable)
    k. HIV Designation Form
    l. Delegation of Service Agreements (mid-levels) (as applicable)
    m. Forms of identification issued by state or federal agency
    n. Social Security Card
    o. National Provider Identifier
    p. Request for Taxpayer Identification Number (W-9)
4. Incomplete application: The Credentialing Department will send three follow-up requests for missing information (e.g., any incomplete application, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement, or is dated more than three months before receipt). If the requested information is not received after the third request, the application will be considered inactive.

5. Primary source verification: Upon receipt of a completed application, Network Medical management will obtain and verify the information. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Medical Director and Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.
6. Providers' rights (Due Process). Providers shall have:
    a. The right to review the information submitted in support of their credentialing application. Exception: Applicants are not to review references, recommendations, or other information that is peer review- protected
    b. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to Network Medical Management by the applicant
    c. The right to correct information provided to Network Medical Management which the applicant considers to be erroneous
    d. The right to be informed upon request of the status of his/her credentialing/re-credentialing application
7. Re-applying: Providers denied by the Board of Directors will not be eligible to reapply for membership for at least two (2) years.
8. Length of appointment: Providers will be credentialed for an initial period of not to exceed three years (36 months).
9. Errors and Omissions: The providers will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the provider along with a letter of explanation.
10. All documents received will be date stamped and initialed.

Recredentialing:

The re-credentialing process is also completed within NMM's online credentialing portal, aka "Provider Hub". Six months before the credentials expiration date, providers will receive an email from our automated credentialing system. Upon receiving the email, please follow the instructions to log in and complete
the re-credentialing application. Be sure to attach/upload the following documents as may be required for the provider type:

- Midlevel practitioners (NPs/PA): supervising/collaborating physician agreement.
- Physicians without hospital privileges: Identify the admitting physician or hospitalist group, and the name(s) of the hospitals where patients will be admitted.
- All Providers: Current copy of malpractice insurance certificate.

All questions regarding credentialing and/or re-credentialing should be directed to the Credentialing Department at (877) 282-0288.

SECTION 5 **HEALTH SERVICES**

UTILIZATION MANAGEMENT PROGRAM

Utilization management (UM) involves evaluation of the medical necessity of services and the appropriateness of the selected level of care and procedures according to established criteria or guidelines. Resources must be effectively managed. Utilization metrics are used to determine how much care is being utilized by a network's members. Typically, utilization is measured per thousand members so that it can be compared and analyzed across providers and practices. Some common utilization metrics are:

- ER/K: Emergency room visits per thousand members
- UC/K: Urgent care visits per thousand members
- Admits/K: Admissions per thousand members
- Bed days/K: Inpatient days per thousand members

The key to successful utilization is proactive identification and medical management of those members who are at risk for inappropriate utilization of the most costly points of care. It is important to determine if these Members can be more appropriately treated in less acute settings and/or with targeted care management programs. In addition to the aforementioned list, utilization can also be measured through referral metrics on referral patterns to providers and through encounter submission data which tracks the frequency with which providers see the network's Members.

Along with Network Medical Management's Utilization Management Committee, FYB Utilization Management and Quality Management Committees will regularly monitor and assess the performance of its participants (e.g., Medical Director, Utilization Management and Quality Management Committee Members, Case Managers) involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the ability to consistently apply specified utilization management criteria (e.g., Federal and State guidelines, health plan guidelines, MCG [formerly Milliman Care Guidelines], and Health Care Management Guidelines). The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the appropriateness of care resources, and promote the delivery of high-quality, medically necessary, and efficient care.

UM policies and procedures are available upon request. Please contact the UM Department at (626) 282-3749.

A. Specialty Referral Data

Specialty referral data on contracted providers is collected and tabulated every quarter by Network Medical Management on behalf of FYB. Providers whose referral patterns differ significantly from the average will be identified and reviewed by the Utilization Management Committee. Potential outliers will be reviewed for differences in case mix, appropriateness of referrals, and evidence of knowledge or skill gaps. A statistical report will be generated for each provider indicating referral performance relative to the mean and standard deviation of the group.

B. Hospital Admission/Re-admission

Outliers for hospital admissions and/or re-admissions may be due to intensive treatment for members

or underutilization reflective of barriers to care, case mix differences, or lack of access to effective preventive health care. Outliers will be identified using MCR guidelines.

C. Emergency Room Visits

High outliers for emergency room visits may be reflective of poor access to primary care, management issues, or be due to case mix differences. A combination of high emergency room use or low institutional use may raise concerns about barriers to primary care and secondary care. Providers with statistics higher than MCR guidelines or industry benchmarks will be flagged for possible access issues.

D. Feedback and Corrective Action

Providers reviewed by the FYB Utilization Management and Quality Management Committees will receive specific feedback and/or on-going education. Provider Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committees.

E. Referral to Non-contracted Provider

All Members must be referred to a contracted and credentialed provider through FYB. If a provider cannot be located for a particular health service, the referring provider must contact Network Medical Management's Utilization Management Department for further guidance. Providers who inappropriately refer a Member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

F. Service Coordination

Network Medical Management is responsible for coordinating the following services on behalf of FYB:

- Acupuncture
- AIDS and AIDS-related conditions waiver program
- California Children Services (CCS)
- Chiropractic services
- Dental
- Direct observation therapy for the treatment of tuberculosis
- Drug and alcohol treatment
- Kidney transplants
- Lead poisoning case management
- Local education agency assessment services
- Mental health
- Prayer or spiritual healing
- Community-Based Adult Services (CBAS)
- Regional centers
- Vision
- Developmentally Disabled-Continuous Nursing Care (DD-CNC)
- Family Planning, Access, Care and Treatment Program (Family PACT)

- Transportation services
- Women Infants and Children (WIC)
- Pediatric Palliative Care Waiver (PPC)

Decision Making

Utilization Management (UM) decision-making is based only on the appropriateness of care and service and the existence of coverage. For Your Benefit (FYB) does not specifically reward practitioners or other individuals for issuing denials of coverage or care. No financial incentives are involved in UM decisions that result in underutilization.

PROCESS FOR SUBMITTING A REFERRAL REQUEST

An authorization referral request must be submitted with all pertinent information to Network Medical Management for authorization before the provider performs any treatment and/or services. Incomplete medical information may cause a delay in the referral request. Providers can submit authorization referral requests 24 hours a day / 7 days a week. Providers can submit retro requests up to 90 days after the date of service. Authorization approval, modification, deferred, or denial determinations will be made based on medical necessity and will reflect the appropriate application of approved guidelines.

The request will be reviewed and completed accurately and timely within Industry Collaboration Effort (ICE), health plan, and/or regulatory agency compliance standards as follows:

- Urgent within 72 hours/three (3) calendar days (to be used if the 5-day turn-around time would seriously jeopardize the life, health, and or ability to regain maximum function)
- Routine within five (5) business days
- Standing Referral – may be subject to a treatment plan that may limit the number of visits to the specialist, limit the time for which the visits are authorized, or require the specialist to provide

regular reports to the primary care physicians.

Requests include:

- Member demographics
- Member diagnosis(s)
- Required treatment(s)/testing
- Requested frequency and period/duration of treatment
- Relevant history and physical, medical records, laboratory, and radiology results.

For cases that need to be expedited (i.e., non-emergency services needed within 24 hours), providers should submit the request via the Network Medical Management Web Portal and contact Network Medical Management's Customer Service Department at (626) 282-0288.

Authorization Process

Providers wishing to submit an authorization referral request may fax the FYB Authorization Request Form (ARF) or login to the Network Medical Management Web Portal at **https://www.nmm.cc/provider-portal** and follow the steps included in the Web Portal User Guide provided at the time of orientation.

After authorization is submitted, the following process will occur:

1. If the requested medical treatment, service, and/or procedure is covered by the health plan and meet the established criteria, the request will be approved for ninety (90) days. An approval letter is sent to the Member via the U.S. Postal Services (USPS) and a fax is sent to the requesting provider, or it is posted on the provider's portal.
2. If additional information is required, Network Medical Management's Authorization Coordinator will contact the requesting provider and/or specialist by fax or telephone to obtain specific information as appropriate. If the case is pended for additional medical information it will be held for 14-45 days depending on the Member's health plan.
3. Once an approved decision is made, the provider will be notified within 24 hours of the decision via fax and or posted to the portal.

4. If the authorization is denied, the reason for the denial, an alternative treatment, and the Utilization Management criteria will be included in the letter. The Medical Director and/or designee shall be available by telephone to discuss the case.
5. The letters denying or modifying requested services are sent to the Member via USPS and fax or posted to the portal to the requesting provider and the Member's primary care provider within two (2) working days of the determination. Only a Medical Director or designee physician may make an adverse determination.

In some cases, a provider can re-submit an authorization with new supporting documentation. Providers should attach additional supporting documentation to the authorization via the Network Medical Management Web Portal. If the provider is unable to upload the information, supporting documentation should be submitted via fax.

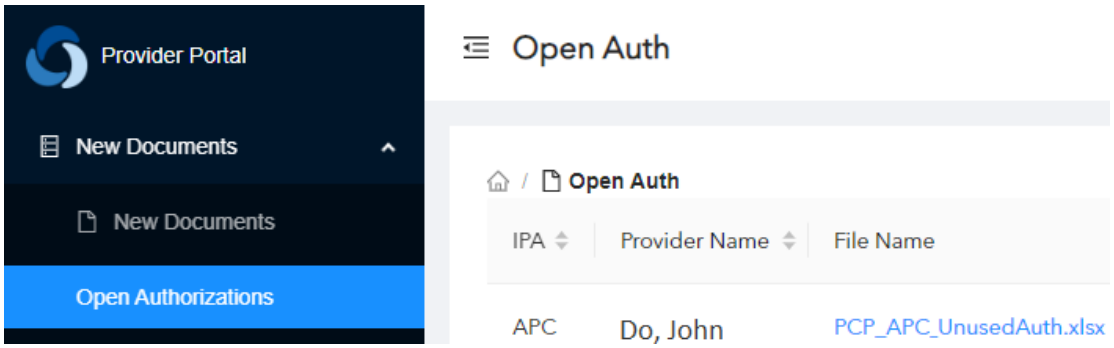
Treatment Authorization Request (TAR)
All Treatment Authorization Requests should be submitted through the web portal. However, a Treatment Authorization form is also available. Attach any medical information to support the request.

Fax routine and retro requests **and** supporting clinical information to the UM Dept. at **(415) 390-6754**.

Fax urgent requests **and** supporting clinical information to the UM Dept. at (**415) 663-5197.**

Standardized Prescription Drug Prior Authorization Form (Form No.61-211)
All providers must utilize the uniform Prescription Drug Prior Authorization Request form (Form No. 61-211)

Specialty Referral Tracking
The PCP and Specialist may track their Member's open referrals to ensure the Member is receiving the required care and to ensure the PCP office obtains the specialist consultation notes. On your provider portal, a list of open authorizations for your Member is provided. The list consists of authorizations that are 90 days old in which there is no claim on file. The office staff is to contact your Member to determine if this authorization should be closed, if the Member has been seen, or if the services are scheduled for a later date.



Turn Around Time Decision Standards

Routine/Non-Urgent Requests	Up to 14 calendar days
Urgent Requests	Up to 72 hours
Retro Requests	Up to 30 calendar days

Standing Referrals

PCPs may allow standing referrals where a member requires continuing specialty care over a prolonged period (e.g., a Member has a life-threatening, degenerative, or disabling condition that requires coordination of care by a specialist instead of PCP). PCPs and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period during which the visits are authorized and the plan for each visit

Specialist Physician Referrals

When a PCP refers a member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, when authorized by the medical group.

Second Opinions

Second opinions are covered even if the service is determined not to be covered. PCPs must provide referrals to another network physician when a second opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. If the recommendation of the first and second physicians differ regarding the need for surgery (or other major procedure), a third opinion is also covered. Second-opinion referrals are for consultation only and do not imply referral for ongoing treatment.

Transplants

Transplant evaluation and services must be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety. See https://www.cms.gov///MedicareApprovedFacilitie/index.html.

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the preferred provider. The referral, as well as denial or acceptance of the referral needs, are to be documented in the Member's medical record by both the referring provider and preferred provider. Specialists must provide the referring PCP with relevant reports on care rendered in a timely manner.

Specialist Requirements/Responsibilities

- Document all work-up and treatments done and include them with your request for authorization
- If the Member was seen, please forward your consult and/or progress notes to the Member's Primary Care Physician.

Primary Care Physician Responsibilities – As a standard requirement, PCPs must document that they have received/read the specialist consultation notes and document any outreach to the Member and/or specialist provider. PCPs are responsible for coordinating care and addressing Member needs.

- **If a Member missed their appointment, please follow up with the Member.**
- Document all work-up and treatments done including authorization requests.

Hospice/Palliative Care - For the geriatric population and/or the terminally ill: assessment and Member wishes must be documented.

- End-of-life discussions related to advanced directives, palliative care, and or hospice.

Referrals to Out-Of-Network Providers

All Members must be referred to a contracted and credentialed provider through FYB. If a provider cannot be located for a particular health service, the referring provider must contact the Utilization Management Department for further guidance. Providers who inappropriately refer a Member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

Prior authorization is required to refer Members to an out-of-network provider. Authorization Request Forms (ARF) must be submitted for all services from non-contracted FYB providers including non-contracted FYB behavioral health providers as these require prior authorization from the Utilization Management Department.

RECOMMENDED RECORDS AND CLINICAL GUIDELINES

The following section lists recommended records and clinical guidelines for specialty referrals. For each specialty (listed alphabetically) there are documents/information which FYB may require to evaluate medical necessity:

Allergy

- Clinical notes describing the Member's signs and symptoms and conservative management attempted; e.g., nasal steroids
- Consult notes (if obtained) by ENT

Bariatric Surgery

- Completion of bariatric screening tool, to include Member's height, weight, BMI, and attempts at weight reduction
- Psych and Cardiac consults

Cardiac consultation is appropriate for:

- Evaluation of Member who is high-risk and who remains symptomatic or uncontrolled after provider (PCP) initiation of and titration of therapy
- Evaluation of Members with unstable cardiac conditions, including unstable angina
- Sustained or complex non-sustained ventricular arrhythmia
- Sustained or severely symptomatic supra-ventricular arrhythmia
- Severe cardiomyopathy
- Angina despite maximal medication or markedly abnormal stress test
- Evaluation and surveillance of complex or cyanotic congenital disease
- Severe valvular disease
- Symptomatic
- Associated with LVD
- Atrial fibrillation (AF), if Member is a candidate for cardioversion or chronic AF with inability to control rate or patient is symptomatic with usual measures
- Chest pain with an unstable pattern of angina, exercise stress test abnormal at low-level, ischemia with

  L V dysfunction, angina post-M.I., suboptimal response to medications with limiting symptoms
- Palpitations, if Member is having disabling symptoms or has had syncope or near syncope
- Members with new or frequent palpitations, particularly when associated with other symptoms in the face of known CAD or significant LVD or other serious structural heart diseases
- Request for cardiac rehabilitation must be initiated/recommended by a cardiologist

  Information necessary with consultation request may include:
  - o Clinical record documenting risk, condition, and treatment regimen
  - o EKG
  - o Previous (outside) report of cardiac cath, PTCA, CABG, stress test, Echo, Chest x-ray, etc.

Endocrine

- Clinical record documenting medical need for service, Member's signs and symptoms of concern, and treatment tried
- Current lab verifying deficiency/problems; e.g., thyroid panel
- Special diagnosis study reports; e.g., U.S., C.T., etc., which may have been obtained to validate/diagnose the condition

Otolaryngology (ENT)

- Clinical record indicating concern, physical exam findings, signs and symptoms, and conservative treatment tried; e.g., series of antibiotics (date and type), antihistamine, and/or steroid use (oral and/or nasal)
- Any current lab and/or x-ray finding specific to the concern
- Any specialty consult that may have been accomplished; e.g., allergy consultation or FNA report (of neck node)
- Any diagnostic study which indicates pathology; e.g., biopsy, MRI, CT, etc., requiring surgical intervention
- Any outside records/consultations which indicate the need for follow-up

Gastroenterology

- Clinical record documenting signs and symptoms; e.g., anorexia, weight loss, upper abdominal distress persistent after treatment, melena, fecal occult blood, and conservative treatment tried.
- Current lab demonstrating concern; e.g., iron deficiency, anemia.
- Current radiology report demonstrating concern; e.g., Barium Enema
- Current specialty study/exam demonstrating concern; e.g., Barium Enema or UGI series report(s)
- Past specialty study/exam/surgical report demonstrating concern; e.g., previous Colorectal cancer operative report, colonoscopy, or EGD with path report (specifically, previous polyp size and type)

General Surgery

- Clinical record documenting signs and symptoms of condition and treatment tried (if appropriate)
- Current lab demonstrating concern; e.g., CBC with diff
- Current radiology report demonstrating concern; e.g., KUB, U.S.
- Current specialty exam demonstrating concern; e.g., colonoscopy/sigmoidoscopy report with path findings

Genitourinary (G.U.)

- Clinical records indicating the reason for a consult, with treatment tried
- Urinalysis and, where appropriate, C&S (which should have been treated if positive growth)
- P.S.A. report, where appropriate. If elevated, need to include previous PSA result(s) or document if this was the first PSA study
- Any special diagnostic study

Nephrology

- Clinical records indicating concern with signs and symptoms of same and treatment attempted
- Current pertinent lab reports; e.g., BUN, Creatinine
- Reports of any special diagnostic study performed

Neurology

- Clinical record documenting concern, a neurology exam appropriate to the concern, as well as signs and symptoms
- If the referral request is due to ALOC, a mini-mental status exam should be included
- Report of previous (outside) consult/report indicating the need for follow-up or further studies
- Results of any diagnostic study demonstrating concern relative to the issue to be investigated. Neurology consults should be considered before requesting EMG/NCS

Neurosurgery

- Clinical record documenting signs and symptoms of the condition, treatment tried, and neuro exam/deficit, etc.
- Current radiology/imaging reports demonstrating concern; e.g., MRI, CT.
- Consult report (if appropriate) from Neurology or Pain Specialist, suggesting further specialty care

Oncology

- Clinical record describing medical need; e.g., signs and symptoms of concern
- Current lab results
- If hospitalized, previous to consult request, copy of H&P and discharge summary
- Operative report (if the surgical procedure has been accomplished) with a pathology report
- Any staging studies (reports) accomplished

Orthopedics

- Ortho consult is appropriate for:
  - Evaluation of a condition to determine surgical remedy; e.g., osteoarthritis of hip or knee for possible replacement, possible torn ligament or meniscus, for possible orthoscopic procedure
  - Evaluation of and treatment plan advertisement of an orthopedic condition that has not been amenable to or is showing progressive disability despite usual conservative management
  - Evaluation of suspected aseptic neurosis, locked knee, unstable joint, acute or sub-acute effusions
- Provider (PCP) to submit clinical notes, including history of concern and P.E. findings, signs and symptoms expressed by Member and treatment regimen tried
- Current x-ray reports. Member should be instructed to pick up films and take them to consult appointment, once the request has been authorized
- Current labs pertinent to concern, as appropriate
- Any specialty procedure/study report that may have been done in or outside the group/IPA specific to the concern; e.g., MRI, previous operative notes

Pain Management

- Pain Management consults are generally appropriate for:
  - Chronic long-standing back pain
  - Pain unrelieved by conservative measures
- Current clinical notes documenting Member's signs and symptoms and treatment previously tried; e.g., medication use, local injections
- Any consult (if appropriate) from neurology or neurosurgery indicating the need for further specialist consultation
- X-ray or image report defining the concern

Physical and Occupational Therapy

- Current clinical notes documenting Member's condition and treatment previously attempted (e.g., rest, medications)
- Referral should advise therapist(s) of any specific movement limitations or restrictions (i.e., do not hyper-extend joint)

Podiatry

- Clinical record documenting signs and symptoms regarding the concern and conservative management attempted
- Any comorbidities
- X-ray report of feet/foot
- Copies of any previous podiatry provider reports

Pulmonary

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Radiology report; e.g., chest X-ray
- 02 sat results
- Previous consult relative to concern or indicating need for follow-up
- Copy of any specialty diagnostic report demonstrating concern; e.g., chest CT, MRI, pulmonary function exam
- Spirometry
- Request for pulmonary rehabilitation may require Pulmonologist endorsement

Rheumatology

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Lab reports documenting/demonstrating concern; e.g., Rheumatology studies, CBC with differential and platelets, chemistry panel 18, sedimentation rate, C reactive protein, rheumatoid factor, ANA
- X-ray reports documenting/demonstrating concern (if accomplished)
- Specialty reports demonstrating concern; e.g., bone density, MRI

Vascular Surgery

- Clinical record documenting signs and symptoms of concern and treatment attempted
- X-ray/Specialty study report documenting concern; e.g., U.S., previous Angiography
- Copy of previous consult (outside IPA) indicating the need for follow-up

DENIALS

Members and providers will receive written notification of any denial of medical treatment, service, and/or procedure.

1. All denials for service will be handled on time and will be entered into the system for tracking purposes.
2. Utilization review criteria are applied consistently and the assessment information is documented by the Medical Director or designee. Approval, modification, deferred or denial determinations will be based on medical necessity, benefit coverage, and approved criteria and guidelines.
3. All expedited appeals will be processed in compliance with the timeframe required by the Centers for Medicare and Medicaid Services (CMS) and following health plans' processes.
4. Only providers may make an adverse determination; they will use clinical reasoning and approved criteria and/or clinical guidelines to determine medical necessity.
5. The requesting provider may at any time contact FYB Medical Director or designee during normal working hours to discuss the determination of medical appropriateness.
6. Common reasons for denials:
    a. The provider is not contracted
    b. The service does not meet utilization review criteria or benefits
    c. The Member is not eligible
    d. The service is not a covered benefit (this includes "Carve-Out" plans)
    e. The Member's benefits for that service have been exhausted

TTY numbers available

Procedures and Criteria are disseminated to Members and providers upon request by calling NMM's Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 9 AM and 5 PM. For Members with impaired hearing, Members can call our TTY telephone at 877-735-2929, Monday Through Friday between the hours of 8:30 am to 5:00 pm. A requesting provider may call Network Medical Management to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext.6195. This phone line is open **24 hours per day / 7 days per week**. All calls will be returned within 24 hours.

APPEALS

Member Appeals

The policy of Network Medical Management is to refer all Member appeals to the appropriate health plan. The health plan will contact Network Medical Management for appropriate information needed to resolve the Member's issue. Network Medical Management will contact the provider to obtain the requested information, which must be submitted within the timeframe guidelines mandated by each health plan. Provider shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

Provider Appeal

The Utilization Management Committee will review all denial and appeal determinations regularly. If the provider chooses to appeal the determination for a denial of a requested service, the appropriate medical information is gathered by the Utilization Management Coordinator for review by the Medical Director and/or the Utilization Management Committee. Requesting providers must resubmit new authorization with supporting documentation with the reason for appeal. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management
Committee meeting. All expedited appeals are reviewed by the Medical Director or designee immediately, and all expedited appeal responses are made within seventy-two (72) hours. Determinations to modify, reverse, or uphold the original decision will be completed and processed within five (5) days of the appeal. Reversals of denials for requests for expedited appeals are processed immediately. The requesting provider shall receive written notification of the outcome.

PROCEDURES RECOMMENDED FOR OUTPATIENT SETTING

The following procedures are recommended to be performed in an outpatient ambulatory surgery setting. This is not an exclusive list of procedures. Exceptions require prior authorization.

A. Gastroenterology
- Liver Biopsy
- Colonoscopy (screening)
- ERCP (Endoscopic Retrograde Cholangiopancreatography)
- Sigmoidoscopy
- Esophagogastroduodenoscopy (EGD)
- Esophagoscopy

B. Gynecology
- Marsupialization of Bartholin Cyst
- Treatment of Condylomata Acuminata
- Cryotherapy (alone or with a biopsy and/or dilation & curettage)
- Dilation and Curettage
- Examination under Anesthesia
- Culdoscopy
- Hymenotomy
- Hysterosalpingogram
- Therapeutic Abortion (first trimester)
- Dilation and Evacuation (second trimester)
- Laparoscopy, diagnostic, or sterilization
- Removal of IUD
- Hysteroscopy
- Culdocentesis (office)
- Amniocentesis or Amniogram
- Perineorrhaphy (minor)
- Cervical Amputation
- Cervical Conization

C. General Surgery
- Breast Biopsy (if a two-stage procedure for a possible malignancy)
- Cervical Node Biopsy
- Lipoma Excision
- Muscle Biopsy
- Rectal Polypectomy
- Excision of Sebaceous Cyst
- Excision of Skin Lesion with Primary Closure
- Excision Bakers cyst
- Excision Breast Masse(s)
- Excision Draining Sinus Tract
- Excision Neuroma
- Foreign Body Removal
- I & D abscesses
- Varicose Vein Ligation (without stripping)
- Minor hemorrhoidectomy
- Hernia Repair (infant)

- Paracentesis

D. Plastic Surgery
- Blepharoplasty (upper/lower or combined)
- Mammoplasty (augmentation, revision) after mastectomy for cancer, unless a major case requires postoperative hospital days.
- Small Skin Graft
- Dupuytren's Contracture
- Many Tendon Repairs
- Fingertip Injury Revisions
- Excision Lesions (minor)
- Excision Ganglion (wrist)
- Acute Nerve Repair (hand)
- Other Minor Hand Procedures
- Staged Reconstructive Procedures
- Scar Revision

E. Ophthalmology
- Argon Laser Prescription
- Chalazion
- Discussion
- Ectropion and Entropion
- Insertion of the glass tube into the lacrimal duct
- Lacrimal Duct probing
- Pterygium
- Strabismus

F. Otolaryngology
- Myringotomy (with or without tubes)
- Antral Puncture (with or without irrigation)
- Inferior Turbinate Fracture
- Nose, Closed Reduction
- Type I: Tympanoplasty with the removal of attic and oval window cholesteatoma sacs
- Nasal reconstruction
- Otoplasty unilateral, bilateral (Depending on age: young children may require hospitalization overnight)
- Cervical node biopsy
- Esophagoscopy
- Frenulectomy
- I and D abscess (simple)
- Otoscopy (with or without removal of foreign body)
- Removal of foreign body from nose or ear
- Removal of scars, moles, or basal cell CA
- Wiring simple joint fracture

G. Orthopedic Surgery
- Ganglion Excision
- Carpal tunnel decompression
- Excision of foreign body
- Tenotomy
- Manipulation of joints, individual consideration,

depending upon the joint involved and indication for the procedure
- Removal of bursae (Olecranon)
- Dupuytren's Contracture
- Many Tendon Repairs

H. Urology
- Circumcision (pediatric and adult)
- Dorsal slit
- Meatotomy
- Urethra dilation
- Vasectomy
- Cystoscopy
- Fulguration of venereal warts
- Excision and biopsy of the scrotal lesion
- Cystoscopy and retrograde
- Prostatic biopsy

I. Endoscopy
- Culdoscopy
- Diagnostic cystoscopy
- Gynecological laparoscopy
- Otoscopy
- Proctosigmoidoscopy
- Fiberoptic sigmoidoscopy and fiber optic colonoscopy (diagnostic only)
- Gastroscopy

J. Thoracic or Vascular
- Esophageal dilation
- Excisional surgery: chest wall lesion
- Lymph node biopsy
- Mediastinoscopy
- Thoracentesis

K. Pulmonology
- Bronchoscopy

PROCEDURES RECOMMENDED FOR SAME-DAY SURGERIES

Prior authorization is required from FYB

A. Gynecology
- Mini Lap (tubal ligation)
- Bartholin Cystectomy
- Vaginal Tubal Ligation

B. General Surgery
- Pilonidal Cystectomy
- Excision of Thyroglossal Duct Cyst
- Varicose vein ligation with stripping
- Hernia repair (Inguinal and Femoral)
- Umbilical Herniorrhaphy

C. Ophthalmology
- Correction of eye muscle impairment
- Cataract extraction
- Iridectomy
- Phacoemulsification
- Prolapsed iris, etc.
- Reconstruction of lacrimal duct

D. Urology
- Cystoscopy with fulguration of small bladder tumors
- Installation of chemotherapy in the ureter and bladder locally

E. Otolaryngology
- Ethmoidectomy (intranasal)
- Tonsillectomies
- Adenoidectomies
- T and A
- Tympanoplasty
- Sinus surgery

F. Neurosurgery
- Morton's neuroma
- Neuroma

G. Cardiology
- Pacemaker generator change
- Pacemaker programming
- Cardiac catheterization (if findings negative)

H. Orthopedics/Podiatry
- Morton's neuroma
- Hammertoes with tenotomies and resection of bone (This procedure is recommended for outpatient surgery except when performed on both feet at the same time, or when the patient is elderly and cannot ambulate on crutches or walker without physical therapy training)
- Arthroscopy
- Bunionectomy

I. Endoscopy
- Observation bronchoscopy (flexible, for patients under 40 years of age)
- Triple upper endoscopy

NO AUTHORIZATION REQUIRED / AUTO-PAYABLE SERVICES

NMM is compliant with the California Senate Bill (SB) 138 which was effective January 1, 2015, and allows health plan Members 12 years and older the right to request health care and benefits information, such as Explanation of Benefits, request for additional information or medical records, to be sent to an alternate address. California SSCC law allows the Member to invoke the right when it involves a "sensitive service." The "sensitive service" outlined in SB 138 includes services and treatment for mental health, pregnancy, sexually transmitted diseases, sexual assault, drug or alcohol treatment, HIV, and counseling.

Procedure:
A. The following services do not require prior authorization per State, Federal, or Health Plan regulations:

- ➢ Preventive Health Services including immunizations
- ➢ Annual well-women care
- ➢ Laboratory Services when referred by member's contracted provider
- ➢ Emergency-related services
- ➢ 911-Ambulance/Paramedic Calls
- ➢ Out of Network Renal Dialysis services for up to 3 months or until coordination is provided for in-network.
- ➢ Emergency services (medical screening & stabilization) including emergency behavioral health care
- ➢ Crisis stabilization, including behavioral health
- ➢ Urgent Care Services
- ➢ Communicable Disease Services
- ➢ Sexually Transmitted Disease (STD) services for both within and outside the provider network
- ➢ Sensitive Services for Minors
- ➢ Sensitive and confidential services and treatment (including, but not limited to, services relating to sexual assault, pregnancy, and pregnancy-related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment)
- ➢ Basic Prenatal Care, including OB/GYN in-network referrals and consults
- ➢ Family Planning Services provided to members of childbearing age to delay or prevent pregnancy through any family planning providers.
- ➢ Acute Care Hospitals—For services provided in a licensed acute care hospital, NMM will not deny payment of a claim on the basis that the contracting entity did not provide authorization for health care services that were provided in a licensed acute care hospital and that were related to services that were previously authorized if all of the following conditions are met:
  - It was medically necessary to provide the services at the time.
  - The services were provided after the delegate's normal business hours.
  - The delegate does not maintain a system that provides for the availability of a delegate representative or an alternative means of contact through an electronic system, including voicemail or electronic mail, whereby the delegate can respond to a request for authorization within 30 minutes of the time that a request was made.
  - Does not apply to investigational or experimental therapies or other noncovered services.

INPATIENT CASE MANAGEMENT

A. Availability

Network Medical Management's Case Management Department provides 24/7 on-call coverage for contracted providers. Providers needing to reach Case Management after hours or on weekends should call (877) 282-8272 or (626) 216-1441. The answering service will contact the appropriate on-call provider for any problem that may arise after hours, including emergency room authorizations or after-hour patient calls. If a Member feels they have a serious medical condition, they will be instructed to hang up and dial 911 or to go to the nearest emergency room.

B. Hospital Admissions

Non-business hours

All non-emergency hospital admissions must be authorized. Hospitals calling after hours to report a hospitalization will be put in contact with the designated Case Manager who will coordinate the Member's care accordingly. The answering service has access to contact the Case Manager after hours and on weekends. The provider should notify Network Medical Management of any admissions by calling (877) 282-8272 or (626) 216-1441 in the event they are contacted by the hospital regarding a hospitalization.

Business Hours

Providers requesting to admit a Member into the hospital should contact Network Medical Management's Case Management Department. The provider may need to submit an authorization request for hospital admission.

C. Hospitalists

To coordinate hospital admissions, Network Medical Management may provide hospitalists on-call. The Case Management Department will be contacted by the admitting hospital for notification purposes. The Case Manager will contact the hospitalist assigned to coordinate the Member's care. Network Medical Management encourages providers to contact its Case Management Department if they receive notification of admission or if they require assistance in directing the Member to the appropriate hospital. Case Management is available 24 hours a day, 7 days a week at (877) 282-8272 or (626) 216-1441. Admission face sheets and in-patient medical records can be faxed to Case Management at (415) 390-5735.

D. Discharge Planning

Case Management is available to assist providers in discharge planning and the post-acute hospital phase. During the treatment planning phase, options for post-acute services are identified early in the patient's hospitalization. If the patient discharged is from another facility, the assigned Case Manager coordinates with the hospital staff to assure a smooth transition out of the acute care facility.

The Case Manager can assist by:

- Identifying and authorizing services that can benefit the patient after acute hospitalization.
- Working with the hospital Discharge Planner to arrange for Skilled Nursing Facility placement or home health care at home.

Inpatient CM policies and procedures are available upon request. Please contact the Inpatient CM Department at (626) 282-3749.

AMBULATORY CARE MANAGEMENT

Purpose

The Case Management (CM) Program, in collaboration with network providers, meets individual patient needs through communication and the use of available resources, intending to deliver quality cost-effective care and positive health outcomes.

Scope

NMM's care management program provides individualized assistance to Members experiencing complex, acute, or catastrophic illnesses. The focus is on early identification of and engagement with high-risk Members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs, and improve health and functional status, resulting in favorable outcomes.

The program scope includes Basic Case Management (BCM), Complex Case Management (CCM) as delegated, Pediatric Case Management, High-Risk Pregnancy Case Management, CM Triage for Coordination of Care (COC), and SNP dual eligible Case Management.

Ambulatory CM policies and procedures are available upon request. Please contact the Ambulatory CM Department at (626) 282-3749.

Case Management Program Goals, Objectives, and Functions

NMM's program goals are to achieve, in collaboration with providers, the following:

> ***Quality health outcomes*** - identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.
>
> ***Cost-effectiveness*** - NMM is committed to measuring the effectiveness of the care management program. NMM seeks clinical and cost information feedback from internal encounter data and Health Plans to assist in enhancing the performance of medical management programs.
>
> ***Resource efficiency*** – NMM's care management team works with internal and external stakeholders (Health Plans) to improve the efficiency and effectiveness of the medical group's care management activities.

The goal of Case Management is to assist Members navigate the health care system and obtain necessary services in an optimal setting for any critical medical event or diagnosis they experience. The focus is on reducing future inpatient admissions and coaching self-care management. Collaborating with the Member, the PCP, and/or Providers, the Case Manager assists in identifying educational and care options that are acceptable to the Member and family. Motivational Interviewing and Coaching for behavioral changes are techniques used in the process to increase adherence to treatment plans leading to successful outcomes. CM involvement is short-term with a ninety (90) day Care Plan (CP) Goal. The processes of assessment, planning, facilitation, and advocacy for options and services are incorporated into the overall case management approach.

Access to Case Management and Complex Case Management (CCM)

Referral Criteria

Conditions, diseases, or high-risk groups most frequently managed include, but are not limited to the following:

- Over-, under-, or inappropriate utilization of services
- Multiple/frequent ER visits or acute inpatient admissions
- Multiple Referrals and/or Providers in and out of network
- Multiple/severe disabilities
- Chronic Diseases w/ co-morbidities
- Permanent or temporary alteration of functional status
- Medical/psychosocial/functional complications
- Non-adherence to treatment or medication regimens, or missed appointments
- High-cost injury or illness
- Lack of family or social support or financial resources
- Exhaustion of benefits - for example, a Member with medical necessity for a specialized hospital bed, but the Member's durable medical equipment (DME) benefit is exhausted.

Source of referrals

NMM utilizes the following sources to identify Members for case management:

- Health Risk Assessment
- Claims or encounter data.
- Hospital discharge data.
- Pharmacy data, if applicable.
- Data collected through the UM management referral/authorization process, if applicable.
- Data supplied by purchasers, if applicable.
- Data supplied by Members or caregivers, if applicable
- Data supplied by practitioners
- Data received from health plans and internal sources are analyzed by the UM, team and triaged for possible referral for CM services.

The referral avenues for Members to be considered for CM or CCM referrals include the following sources:

- NMM's Post Acute Care Unit
- Medical management program referral, including disease management program, UM program, or referral that comes from other organizations' programs or vendors.
- Discharge planner referral
- Member or caregiver referral
- Primary Care Physician referral via Provider Portal or AmbulatoryCare@NetworkMedicalManagement.com

HEALTH SERVICES CONTACT INFORMATION

Phone Numbers

UM Customer Service: (626) 282-3749

Acute & SNF Admissions:

Office Hours – (415) 216-0088

After-Hours/Weekend – (626) 216-1441 or (626) 282-0288 x0

Fax Numbers

Routine and Retro Services: (415) 390-6754

Urgent Services: (415) 663-5197

Acute & SNF Facesheet & Clinical Notes: (415) 390-5735

E-Mail

Ambulatory Care: AmbulatoryCare@NetworkMedicalManagement.com

Delegation Oversight: DOversight@networkmedicalmanagement.com

Inpatient Services: CaseManagementDept@NetworkMedicalManagement.com

Quality Management: QualityManagementDept@NetworkMedicalManagement.com

Outpatient Services: UtilizationManagementDept@NetworkMedicalManagement.com

SECTION 6 **CLAIMS PROCEDURES**

TIMELY FILING GUIDELINES

Claims must be submitted to FYB within the timely filing timeframe specified in the Provider Agreement for contracted providers 365 days for non-contracted providers for Medicare members and 180 days for Commercial and Medi-Cal members.

FILING ELECTRONIC CLAIMS

FYB highly recommends billers submit claims electronically. If providers are submitting claims electronically, they may do so through the following methods:

- Web Portal – https://www.networkmedicalmanagement.com/providers/provider-portal (Preferred submission method)
- Office Ally (clearing house)
    - **NMM01**: Allied Pacific IPA
    - **AHIPA**: Accountable Health Care IPA
    - **NMM04**: Alpha Care Medical Group

OR

FILING PAPER CLAIMS

All paper claims for FYB must be submitted on a **CMS 1500 Form** or UB04 as appropriate to:

For Your Benefit, Inc.
Attention: Claims Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

CHECKING CLAIMS STATUS

Claims status can be checked on-line by using FYB's online provider portal. For more information on using our provider portal, please contact our Portal Team at (626) 943-6146 or by email at Portal.Help@networkmedicalmanagement.com.

CLAIM PAYMENT TIMELINES

The first date stamp on a claim begins the counting of days. The counting of days ends when the check is in the mail.

CMS/Medicare Plans

- Clean claims from non-contracted providers are to be paid or denied within thirty (30) calendar days of receipt.
- Clean claims from contracted providers and unclean claims from non-contracted providers are to be paid or denied within sixty (60) calendar days of receipt.

- 90% of Paid and Contested claims must be completed within 30 calendar days of receipt for Medi-Cal members. 95% of claims must be completed within 45 working days.
- Paid, Contested, and Denied claims must be completed within 45 working days for Commercial members.

CLAIM SUBMISSIONS

All claims should be submitted on a CMS 1500 Form or UB04 as appropriate. Important elements that are necessary for billing include:

1. Patient's name, and address.
2. Patient ID number (including suffix #, i.e. 01, 02, 03, etc.)
3. Date of birth
4. Date of service
5. Provider's name, address, NPI, tax ID number, and provider signature.
6. Usual charges
7. ICD-10 diagnosis codes
8. Modifiers (if applicable)
9. J Codes (if applicable)
10. Authorization number if the procedure(s) need(s) an Authorization
11. Rendering Provider ID #/NPI
12. Federal Tax ID Number
13. CPT procedure codes
14. Place of service codes
15. Completion of item 11. If there is insurance primary to Medicare, the insured's policy or group number should be entered. If there is no insurance primary to Medicare, then "none" should be entered.

Reference to the following link for the elements that should be used for claim processing:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf

The ensuing pages list "place of service" codes and some CPT codes.
If you use computer-generated forms, such forms must carry the same information. Provider signature should be on all paper claim forms.

CLAIMS FOR REFERRED SERVICES

For electronic claims, the FYB specialist physician must indicate the name of the referring FYB physician on the electronic claim.
For paper claims, the FYB specialist physician must indicate the name of the referring FYB physician on the claim.

CLAIMS FOR AUTHORIZED SERVICES

Be sure that a claim for authorized services includes the following:

a) The procedure code(s) that was authorized on the Authorization Request Form (ARF) matches the code on the claim form,
b) The reference number for the authorization,
c) And, when submitting a paper claim, attach a copy of the approved ARF.

CLAIMS RESUBMISSION POLICY

To avoid duplicate claims, please first check the status of your claims either on our provider portal or by calling our Claims Department at (415)216-0088 to confirm receipt.

Paper Claims Processing Fee
It is strongly encouraged that all providers submit claims electronically through EDI (Electronic Data Interchange).
If a provider has already signed up for the Electronic Remittance Advice (ERA) service, it will reflect such a charge on it.
The paper claim processing fee will be waived for the following situations:

- Paper claim submission with supporting documents including medical note, timely proof, cost invoice, and primary EOB
- Payment for an overturned PDR

ELECTRONIC FUND TRANSFERS (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA) SERVICES

FYB recommends all providers that receive claims payment through Electronic Fund Transfers (EFT). Payments made by FYB to the providers will automatically deposited into the bank account upon completion of the EFT process. Please submit a completed EFT enrollment form, a voided check, and a W-9 form to the Provider Relations Department by email at ProviderRelationsDept@networkmedicalmanagement.com.
Along with Claim submission (837P) and electronic payment EFT, providers will automatically receive the Electronic Remittance Advice (ERA) service, also known as 835 files via the provider's clearing house to replace the hardcopy claims payment information and replace paper EOBs.

REFUNDS

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

PLACE OF SERVICE CODES

CODES	DEFINITION
02	Telehealth
11	Office
12	Patient Home
19	Off Campus- Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus- Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility

32	Nursing Home/Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
51	Inpatient Psychiatric Facility
52	Psych Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate care Facility/Individuals with Intellectual Disabilities
55	Residential Treatment Center/Substance Abuse
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

For a full list of Place of Service codes, please refer to the link below:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

I. CLAIMS SUBMISSION INSTRUCTIONS

A. Sending Claims to FYB. Claims for services provided to Members assigned to For Your Benefit must be sent to the following:

Via Mail: **For your Benefit, Inc.**
Attention: Claims Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

B. Claims status can be checked on-line by using FYB's online provider portal. For more information on using our provider portal, please contact our Portal Team at (626) 943-6146 or by email at Portal.Help@networkmedicalmanagement.com. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information, and claims documentation required by FYB:

Claims are to be submitted on a CMS-1500/UB-4 form or their respective successor forms and shall include patient name, date of service, gender, date of birth, Member ID number, authorization number, type of service provided, valid CPT codes, pricing and reports as necessary or requested, within ninety (90) days from the date of service or the date specified in the Provider Agreement.

C. Claim Receipt Verification. For verification of claim receipt by FYB, please do the following:

a. Call the Claims department at (626) 282-0288

II. PROVIDER DISPUTES

Dispute Resolution Process for Non-Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to FYB and/or the Member's applicable health Plan challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

   a. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from FYB to a contracted provider the following must be provided: a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect. Overpayment notice shall be issued (i) within three hundred sixty-five (365) calendar days of the date of payment, or at any time, in the event of fraud and/or misrepresentation.

   b. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

   c. If the contracted provider dispute involves a member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and a member's written authorization for the provider to represent said Members.

B. Sending a Contracted Provider Dispute to FYB. Contracted provider disputes submitted to FYB must include the information listed in Section II. A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the **Provider Dispute Resolution Unit** at the following:

Via Mail:
For Your Benefit, Inc.
Attn: Provider Dispute Resolution Unit
1600 Corporate Center Dr.
Monterey Park, CA 91754
Fax: (626) 656-6323

C. Period for Submission of Provider Disputes.

   a. Contracted provider disputes must be received by FYB within three hundred sixty-five (365) calendar days from FYB's action that led to the dispute (or the most recent action if there are multiple actions), or

b. In the case of inaction, contracted provider disputes must be received by FYB within three hundred sixty-five (365) calendar days after the time for contesting or denying a claim (or most recent action if there are multiple claims) has expired.

c. Contracted provider disputes that do not include all required information as set forth above in Section II. A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to FYB within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. FYB will acknowledge receipt of all contracted provider disputes as follows:

a. Electronic contracted provider disputes will be acknowledged by FYB within two (2) Working Days of the Date of Receipt by FYB.

b. Paper contracted provider disputes will be acknowledged by FYB within fifteen (15) Working Days of the Date of Receipt by FYB.

E. Contact FYB Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to FYB at (877) 282-8272.

F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing, or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

a. Sort provider disputes by a similar issue

b. Provide a cover sheet for each batch

c. Number each cover sheet

a. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

i. Period for Resolution and Written Determination of Contracted Provider Dispute. FYB will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

ii. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, FYB will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

DISPUTE RESOLUTION PROCESS FOR NON-CONTRACTED PROVIDERS

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to FYB challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

   a. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from FYB to the provider the following must be provided: a clear identification of the disputed item, the Date of Service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

   b. If the non-contracted provider dispute involves a member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service, the provider's position on the dispute, and a member's written authorization for the provider to represent said Members.

B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as outlined in sections II.B., II.C., II.D., IIE., and IIF. above.

A. Medicare Provider Dispute Resolution Process:

   a. Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) expanded its current provider payment dispute resolution process for disputes between non-contracted and deemed providers and Private Fee for Service Plans to include disputes between non-contracted providers and all:

   b. Applies to only Non-Contracted Providers

   c. Includes decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare.

   d. Effective September 18, 2020 - A CMS PDR DOES NOT INCLUDE:

      i. Payment denials by payers that result in zero payments being made to a non-contracted provider.

      ii. Payment disputes for contracted providers.

      iii. Local and National Coverage Determinations.

      iv. Medical necessity determinations.

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

e. Submission of a first-level Provider Dispute must be filed within a minimum of 120 calendar days after the notice of initial determination (i.e., EOBs/ RAs/ Letters).

f. Payers may allow an additional 5 calendar days for mail delivery.

g. The payer may extend the time limit for filing a provider dispute if good cause is shown.

h. If documentation has not been submitted for review of the Provider Dispute, the payer may request that required documentation be submitted.

i. Requests can be made via phone or in writing.

j. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the payer conducts the review based on the information in the file.

k. In the event the documentation is received after the 14-calendar day deadline, the payer must consider the evidence before making and issuing the final determination.

B. The payer's decision on the Payment Dispute must be within 30 calendar days from the date the Payment Dispute is first received by the payer.

a. Must be in writing.

b. Include facts and rationale about the resolution

c. Inform provider about their right to the MAO-Health Plan or designee, Provider Dispute Resolution (Second Level) review process.

d. 30 Calendar Day TAT based on:

i. A decision in the provider's favor = Mail Date of Payment/Letter

ii. The decision upheld = Letter Mail Date

e. The non-contracted provider may submit a second-level written request to the applicable MAO-Health Plan or designee for a second-level review, by email, fax, or mail within 180 calendar days of written notice from the payer.

f. The Second Level request may be filed if:

i. 30 calendar days have elapsed from the date the payer received the payment dispute, and the payer has not responded.

g. The MAO-Health Plan or designee may request documentation from the payer who processed the first-level provider dispute.

A. Claims Overpayments

a. FYB processes overpayment recovery following CMS regulations or contractual

agreements. By law, Providers are required to report and return the overpayment to FYB within sixty (60) calendar days after the date the overpayment was first identified. Overpayments occur when too much has been paid to the Provider and a refund to FYB is necessary. For Medicare Advantage health plans, overpayments include but are not limited to the following:

i. Duplicate submission of the same service claim

ii. Billing for excessive services or noncovered services

iii. Payment for excluded or medically unnecessary services

iv. Payment to the incorrect payee

v. Claims-system configuration issues

vi. Pricing errors

vii. Incorrect adjustments

viii. Primary payment when FYB is secondary

B. FYB's look-back period for overpayments will be done following the time frames permitted by CMS unless otherwise stated in the Participating Provider's agreement with FYB. A prior written notification about the overpayment amount, along with the reason and time frame for returning overpaid amounts, is provided to the Provider. If the Provider does not submit a full refund within the time frame indicated in the written notification, FYB will process recoupments against future claims payments.

C. Providers must mail refund checks, along with a copy of the notification or other supporting documentation to:

For your Benefit, Inc.
Attention: Recoveries Department
1600 Corporate Center Dr.
Monterey Park, CA 91754

CLAIMS OVERPAYMENTS CONTINUED:

A. Notice of Overpayment of a Claim. If FYB determines that it has overpaid a claim, FYB will notify the provider in writing through a separate notice identifying the claim, the name of the patient, the Date of Service(s), and a clear explanation of the basis upon which FYB believes the amount paid on the claim was more than the amount due, including interest and penalties on the claim.

B. Contested Notice. If the provider contests FYB's notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send a written notice to FYB stating the basis upon which the provider believes that the claim was not overpaid. FYB will process the contested notice following FYB's contracted provider dispute resolution process described in Section II above.

C. No Contest. If the provider does not contest FYB's notice of overpayment of a claim, the provider must reimburse FYB within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

D. Offsets to payments. Per section D of this Exhibit, the Provider specifically authorizes FYB to offset an uncontested notice of overpayment of a claim against the provider's current claim submission when; (i) the Provider fails to reimburse FYB within the timeframe outlined in Section C, above. If an overpayment of a claim or claims is offset against the provider's current claim or claims according to this section, FYB will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

SECTION 7 **QUALITY MANAGEMENT**

PROCEDURES

Quality Management (QM) promotes the highest quality of medical care and service to Members by performing ongoing evaluations and modifications.

QM Identifies and resolves issues that directly or indirectly affect Member care.

Quality Management Committee Meetings:

- Special studies & trending
- Preventative Health Services
- Development/Implement Clinical
- Practice Guidelines
- Policy and Procedures
- Grievance Resolution
- Access Monitoring
- Culturally and Linguistically Appropriate Services (CLAS)

All Primary Care Physician offices will be audited on a routine basis by Network Medical Management and periodically by all HMO companies.

It is imperative that the PCP office be kept tidy and that all logs are kept current and available for these audits.

For assistance preparing for audits, please contact our Quality Management Department at (626) 282-0288. Network Medical Management will assist you in any way that we can to make sure that you are audit-ready at all times.

GRIEVANCES AND APPEAL PROCESS

The policy of Network Medical Management is to refer all Member grievances and appeals to the appropriate Health Plan, to ensure Members are provided appropriate medical care of the highest possible quality.

The health plan will contact Network Medical Management for appropriate information needed to resolve the Member's issue. Network Medical Management will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan. Provider shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

ACCESS TO CARE STANDARDS

Quality and Health care access standards established by FYB ensure all members have access to healthcare services. FYB makes these standards known to all providers, continuously monitors its provider networks' compliance with these standards, and takes corrective action, as necessary. These standards ensure that the hours of operation of FYB networks are convenient to, and do not discriminate against Members and are no less available than hours offered, and that services are available 24/7 when Medically Necessary. FYB access standards are following California Managed Health Care Coalition, health plans, and NCQA standards.

Access Criterion	FYB Standard
Primary Care Provider (PCP) Accessibility Standards:	
Routine Primary Care Appointment (Non-Urgent)	Within 10 business days of a request
Urgent Care Appointment	Within 48 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
Preventive Care	Within 10 business days of a request- 30 calendar days for Medicare
First Prenatal Visit	Within 10 business days of a request
Post Stabilization Services	30 minutes (DHCS = 30 Minutes) (CMS = 1 hour)
Specialty Care Provider (SPC) Accessibility Standards:	
Routine Specialty Care Appointment (Non-Urgent)	Within 15 business days of a request
Urgent Care Appointment	Within 96 hours of request
Ancillary Care Accessibility Standards:	
Routine Ancillary Care Appointment (Non-Urgent)	Within 15 business days of a request
Behavioral Care Accessibility Standards:	
Routine Behavioral Care Appointment (Non-Urgent)	Within 15 business days of the request (Physicians)
	Within 10 business days of the request (non-Physicians)
Urgent Care Appointment	Within 48 hours of request
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
After-Hours Care Standards:	
After-Hours Care	• Automated systems must **provide emergency 911 instructions**
	• An automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP or covering physician
	• Offer a **call-back** from the PCP, covering physician, or triage/screening clinician **within 30 minutes**
Physician Telephone Responsiveness:	
In-Office Waiting Room Time	Within 30 minutes
Speed of Telephone Answer	Within 30 seconds
Missed Appointments	Within 48 hours to reschedule

NETWORK MEDICAL MANAGEMENT DEFINES THE ACCESS CRITERION AS FOLLOWS:

1. Preventive care: Care or services provided to prevent disease/illness and/or its consequences. For example, an annual physical exam, immunizations, or a disease screening program.
2. Specialty care: Medical care provided by a specialist, such as a cardiologist or a neurologist.
3. Routine primary care: Services that include the diagnosis and treatment of conditions to prevent further complications and/or severity. These are non-acute or non-life or limb threatening.
4. Urgent care: Care given for a condition(s) that could be expected to deteriorate into an emergency or cause prolonged impairment, such as acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5. Post-stabilization services: Contracted providers must provide 24/7 access to providers for prior authorization of Medically Necessary post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by NMM within 30 minutes (DHCS = 30 Minutes) (CMS = 1 hour) or the service is deemed approved. Upon stabilization, additional medical-necessity assessment will be performed to assess the appropriateness of care and assure that care is rendered in the appropriate venue.
6. After-hours non-urgent phone call: Examples include an Rx refill, questions regarding the current treatment plan, or problems identified.
7. After-hours emergency/urgent phone call: A call made for a life-threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
8. Waiting time: the period from the scheduled appointment time until seen by the provider in the exam room (assuming that Member arrives on time). The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
9. Ancillary services: Include, but are not limited to, the provisions of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, home-health service providers, and providers of mental health or substance abuse services.
10. Triage or screening: The assessment of a Member's health concerns and symptoms to determine the urgency of the Member's need for care.

Providers are encouraged to accept walk-in members in case of unforeseen circumstances and should let members know of their office policy for same-day appointments.

HEALTH EDUCATION PROGRAMS

Providers are encouraged to inform Members about Health Education programs offered by FYB and contracted Health Plan organizations which are available in the threshold languages and different formats. The following is a list of health education programs that are available:

- Asthma
- Childhood Obesity
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control
- How to Quit Smoking
- Nutrition
- Parenting
- Prenatal Health (for pregnant women)
- Safety Tips
- STDs and HIV
- Tobacco Cessation
- Weight Problems

NETWORK MEDICAL MANAGEMENT
HEALTH EDUCATION REFERRAL PROCESS

1. Complete Treatment Authorization Request (TAR).
2. Retain a copy of TAR in Medical Records and document the Health Education referral in progress notes.
3. Fax to Utilization Review Department at the number specified on the TAR corresponding to Medical Group.
4. Utilization Review Coordinators will enter the request into the system and give an authorization number.

HEALTH EDUCATION MATERIAL REQUEST FORM

If your office needs Health Education (HE) Materials, please fill out this assessment form and fax it to (626) 943-6383.

Provider Name: _____

Provider Address: _____

Provider Telephone: _____

Provider Fax Number: _____

Provider Health Plan Contracts: _____

1. Would you like more information about health education classes?
   _____Yes _____No

2. Do you have health education materials in your office?
   _____Yes _____No

3. What sources have you used to obtain health materials?
   _____

4. Please Circle Health Education Materials needed in your office and specify the languages.

Advance Directive	Hypertension	Medi-Cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other: _____
Diabetes Mellitus	Smoking Cessation	_____
Family Planning	Weight Management	
GYN Disorders	Women's Health	

Language: (circle one) English Spanish Chinese Other: _____

Completed by: _____ Date:_____

NETWORK MEDICAL MANAGEMENT USE ONLY

Date (HE) Materials sent to Provider: _____ By: _____

MEDICAL RECORD STANDARD

It is the FYB to ensure that the medical record is maintained in a manner that is consistent with the legal requirements, current, protected, relevant, standardized, detailed, organized, available to practitioners at each patient encounter, facilitates coordination and continuity of care, and permits effective, timely, confidential, quality review, care and service. It is the policy of FYB through Network Medical Management to distribute this policy to all practitioners and to ensure its practitioners comply with these standards.

I. The medical records serve as the basis for planning and maintaining the quality of patient care. Medical records that are devoid of pertinent medical information may impact other treating providers' or health professionals' ability to provide appropriate care. Failure to maintain adequate and accurate records relating to the provision of services constitutes unprofessional conduct. (Business & Professions Code 2266)
II. Reimbursement for services may be limited or denied unless documentation supports the charges that the physician is charging for the level of care.
III. Incomplete medical records documentation may interfere with a physician peer's ability to perform peer review to maintain quality health care delivery, and may subject the physician to disciplinary action or severe sanction by outside review agencies.
IV. Medical records are often a physician's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a physician's ability to defend him or herself.
V. It is recommended that each physician office site employ a process for ensuring that pertinent medical information about medical and non-medical services rendered to Members is available at each patient visit and that periodic purging and archiving of medical records information be conducted following all applicable state and federal laws. Network Medical Management has adopted a seven (7) year minimum period from the last medical visit in which to purge and archive medical records. Ten (10) years for Medicare Members. Records of minors must be maintained for at least one (1) year after a minor has reached age 18 but in no event for less than seven (7) years. Member medical information and records must be stored anonymously, and if disposed of must be destroyed in a way such that information is not identifiable. This may mean reformatting, shredding, or another form of destruction, depending on the media involved. It is Network Medical Management's policy that medical records be retained for seven (7) years to retain a record of the patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question. Ten *(10) years for Medicare Members), five (5) years for Medi-Cal) from the end of the current fiscal year in which the date of service occurred; the record or data was created or applied; and when the financial record was created or the Contract is terminated) (For Molina health plan, the medical records must be kept for ten (10) years for all product lines)*
VI. Occasionally an entry may be made in a medical record that is incorrect due to a mistake or clerical error. If such an entry is discovered, it should be corrected. The erroneous entry itself should not be obliterated or erased. Rather, a line should be marked through it to indicate the error, with the current date and initials of the person correcting the entry. Obliteration of the entry with correction fluid so that it may not be read, may raise a question later as to what the entry contained or why it was erroneous and may jeopardize the defense of a medical malpractice case should one be filed. Modifying or altering a medical record for fraudulent purposes is prohibited by law and may result in both disciplinary action by the California Medical Board and criminal action punishable as a misdemeanor. (B&P Code 2262 & Penal Code 471.5)

The clinical record should be maintained and organized in the following manner:

1. An individual medical record is maintained for each patient. Each patient's medical record will be individualized, format standardized, organized, and secure and permit effective confidential Member care, and quality review.
2. Each patient medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease and accuracy of filing, retrieval, availability, and accessibility as well as confidentiality. *Personnel must be periodically trained and have evidence of confidentiality on HIPPA guidelines.*
3. Member identification is on each page, including first and last name, and/or unique patient number established for use on clinical sites. Electronically maintained records and printed records from electronic systems contain patient identification.
4. Biographical/personal data will include name, date of birth, address, employer name/phone, sex, home phone, work phone, principally spoken/written language, marital status, and insurance information which will be kept in the Member's medical record.
5. Member's emergency contact information must be documented in the medical record. This shall include the name and phone number of a relative or friend or a home, work, cellular, or message phone number. If the patient is a minor, the emergency contact must be a parent or guardian. If the patient refused to provide information, "refused" is noted in the medical record.
6. Entries must contain author authentication including title and date.
7. Entries must be legible to someone other than the writer.
8. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
9. Medical records content is securely fastened.
10. There must be evidence that the Advanced Health Directive information has been offered and discussed with adult patients 18 years of age and over.
11. Documentation is to occur within 24 hours of the patient visit.
12. Identifiable chronic problems/significant conditions (inclusive of behavioral health) are listed and must be maintained and dated in the medical record such as on a problem list. A chronic problem is defined as one which is of long duration, shows little change, or is a slow progression. *The absence of chronic problems will be noted on the problem list.*
13. An identifiable current continuous medication is listed with name, strength, route, dosage, duration, dates of initial or refill prescriptions and quantity of all prescribed medications must be noted and maintained in the medical record. Discontinued medication must be noted in the progress notes and stop date will be noted in the medication list.
14. All services provided directly by the PCP, reasons for and results of ancillary services, diagnostic and therapeutic services. *This includes all diagnostic and therapeutic services for which a Member was referred by a practitioner such as home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports.*
15. Allergies and adverse reactions shall be prominently displayed on the front of the medical record or inside cover, including in the problem list and on each visit progress note. If Member has no allergies or adverse reaction, "No Known Allergies" (NKA), or "No known Drug Allergies" (NKDA), this also needs to be noted in the medical record.
16. The history of the present illness must be documented. Physical exam must be documented related to presenting complaint including subjective and objective information.
17. Diagnosis or medical impression, clinical findings, and evaluation must be documented regarding each visit.

18. The plan of treatment must be documented and be consistent with findings and care that is medically appropriate.
19. Follow-up plan and date of a return visit, if indicated is noted specifically in weeks, months, or as needed.
20. Unresolved and/or continuing problems are addressed in subsequent visit(s).
21. Evidence of continuity of care between PCP and providers if applicable via progress note notation indicating review of consultant's reports and actions taken by PCP if necessary or that patient was contacted. Evidence of appropriate use of consultants, if applicable. All requested referral information is to be placed in the Member's medical records. *The medical record shall include identification for all practitioners participating in Member's care and information on services they render.*
22. Evidence of appropriate utilization of labs and other diagnostic studies with reasons for and results of studies. All labs and diagnostic reports should reflect PCP review via initials and date. This includes pertinent inpatient records that must be maintained in the office medical record. These records may include but are not limited to the following: history and physical, surgical procedure reports, ER reports, and/or discharge summaries.
23. Missed/failed appointments, cancellations, and follow-up contacts/outreach efforts are noted in the medical record to ensure appropriate medical care and Member non-compliance monitoring. "No-show", "Rescheduled" or "Canceled" is noted in the medical records as applicable. In addition, Practitioner must document intervention in the medical records.
24. Evidence of compliance with established practice guidelines and related policies and procedures. (e.g., Confidentiality, Missed Appointments, Notification of Test Results, After Hours Calls, Treatment Consent)
25. Documentation shall substantiate medical care rendered.
26. Initial Health Assessment (IHA) must be completed on all Members within 120 days of the effective date of enrollment into the plan or documented within 12 months of prior Member's enrollment. This assessment must include a comprehensive history and physical, assessment to determine health practices, values, behaviors, beliefs, literacy levels, and health educational needs.
27. Individual Health Education Behavioral Assessment (IBEHA) for new Members must be conducted within 120 days of effective enrollment date as part of the initial health assessment. For existing Members, age-appropriate IBEHA is conducted at Member's next non-acute care visit, but no later than the next scheduled health-screening exam. The tool is re-administered at appropriate age intervals.
28. The Member's primary language must be noted in the medical record.
29. Linguistics needs for non or limited English proficient Members will be prominently noted in the medical record. Request for language and/or interpretation services will be documented. The Member's refusal of these services will also be documented. Evidence of documentation on request for and refusal of Language interpretive services.
30. Tracking of record location when out of the filing system will be accomplished by way of a tickler system indicating medical record whereabouts.
31. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporated into the patient's medical record.
32. Adult patients (18 years and older) who inspect their medical records are allowed to provide a written addendum to their records if the patients believes that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
33. Medical records shall be transferred among practitioners when a Member changes to a new PCP (before the Member's first visit with the new PCP). The privacy of the medical record must be

safeguarded in transit. The requested information must be delivered on time (before the Member's first visit with the new PCP) to ensure continuity of care. A practitioner furnishing a referral service must report appropriate information to the referring practitioner/provider on time. Also, the record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Practitioners shall request information from other treating practitioners as necessary to provide care on time. *For Senior Members there is no charge for medical records and information transfer. Release of medical records to the Member must include reasons but not be limited to Member's request and quality improvement activities.*

Disclosure of Medical Information/HIPPA- The expanded definition of "individually identifiable" (includes name, address, phone number, Social Security number, email address, etc.)

- Prohibition of requiring a patient as a condition to receiving Healthcare services to sign an authorization, release, consent, or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
- Medical information is released after Member authorization and following applicable Federal or State law.
- A Member has the right to authorize/deny the release of PHI beyond uses for treatment, payment, or health care operations
- Disclosures and security measures for PHI meet the requirements under HIPPA
- In the event of improper use or disclosure of PHI, steps must be taken to notify the health plan by self-reporting.

Health Maintenance documentation must include the following:

A. Appropriate adult past medical history documentation to include:
   1. Smoking habits
   2. Alcohol use
   3. Substance abuse history
   4. Family planning, reproductive health history
   5. Surgical procedures
   6. Illnesses & serious accidents
   7. Discharge summaries from hospitalized Members
   8. Inpatient hospital admissions
   9. For Members seen multiple times are easily identified and include serious accidents, operations, and illnesses.

B. Appropriate Children/Adolescents' past medical history documentation must include:
   1. Smoking history
   2. Alcohol usage/history of substance abuse for patients over 12 years of age
   3. Surgical procedures
   4. Childhood illnesses
   5. Personal/psychosocial/family history
   6. Completed and current record
   7. Documentation of education and age-appropriate preventive/risk screening services and risk factors following NETWORK MEDICAL MANAGEMENT practice guidelines (including behavioral health practice guidelines, if applicable)

8. For Members seen </= 18 years, past medical history relates to prenatal care, birth, operations, and childhood illnesses.

Pediatric Preventive Services Documentation should include the following:

A. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:
   1. For Members under the age of 18 months, the PCP is responsible to perform an initial health assessment (IHA) within 60 days of enrollment or within periodic timelines established by the American Academy of Pediatrics (AAP) for age two and younger whichever is less.
   2. For Members 18 months of age and older upon enrollment, including all adults, the PCP is responsible for ensuring an initial health assessment (IHA) is performed within 120 days of enrollment.

B. Initial Health Assessment documentation for Medi-Cal (CHDP PM 160 INF) (Staying Healthy Assessment form) Members must include:
   1. Health Developmental history
   2. Unclothed physical examination
   3. Assessment of Nutritional Status
   4. Inspection of ears nose, mouth, throat, teeth, and gums (any referrals if applicable, including but are not limited to dental care, and eye care)
   5. Vision Screening
   6. Hearing Screening
   7. Tuberculosis Testing, Laboratory Testing for anemia, diabetes, and urinary tract infections
   8. Testing for sickle cell trait and Lead Poisoning
   9. Immunizations appropriate to age following recommendations of the Advisory Committee on Immunization Practices of the American Academy of Pediatrics
   10. Health education and anticipatory guidance

C. Periodic Assessments should include:
   1. Persons Eligible for periodic assessments shall receive one assessment during each designated age period. Providers must follow the schedule recommended by the American Academy of Pediatrics.

D. Appropriate Health Education Documentation must include:
   1. Date of health education intervention Type and topic of health education Intervention (i.e. one-on-one class, sub-group).
   2. Patient feedback or comments regarding health Intervention.
   3. Referrals to other classes if applicable.
   4. Follow-up from previous health interventions with explicit notations in the medical record particularly for consultation, abnormal lab, and imaging study results

E. **Community Resource- Documentation in the patient's medical records if receiving services from/through**
   1. **California Children's Services (CCS)**
   2. **Regional Center**
   3. **Women, Infants, and Children (WIC)**

ADVANCED DIRECTIVE

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

FYB providers shall provide to each adult (18 years and older) subscriber (incapacitated included) an Advance Directive Brochure on the first visit or when reasonably feasible. Also, the PMG/IPA will assist Member in their understanding of advance directives. This information may be given to the Member's family or surrogate. The provider (staff) is instructed to follow up to ensure that the information is given directly to the individual at the appropriate time.

Following title 22 of the California Code of Regulations, medical records for adults 18 years and older must include documentation; documentation of discussion; whether the Member has been informed of (advance directive brochure), or has or has not executed an advance directive, such as a durable power of attorney for health care (DPAHC), by the primary care physician. Forms are available at Advance Health Care Directive Registry | California Secretary of State www.sos.ca.gov

Additionally, you may refer to the NMM Web Portal under the section "Provider Recourses" for a copy of an Advanced Directive form.

SECTION 8 **CULTURAL AND LINGUISTIC SERVICES**

OVERVIEW

Culturally and linguistically appropriate services (C&L) areas include:

A. Identification of Limited English Proficient (LEP) and hearing-impaired Members and recording language preferences/American Sign Language in medical records.

B. Posting signs at all Member key points of contact to inform LEP and hearing-impaired Members of the availability of free interpreter services.

C. Ability to access interpreter services through Network Medical Management and/or health plans for medical and non-medical points of contact.

D. Ensuring access to free interpreter services to LEP and hearing-impaired Members on a 24-hour basis which includes an after-hours protocol on how to access interpreter services. This also includes face-to-face and over-the-telephone interpreter services.

E. Offering interpreter services and recording requests/refusal of interpreter services in LEP or hearing-impaired Member's medical records. Minors are prohibited to be used as interpreters except in emergency/life-threatening situations.

F. Attend and/or promote cultural competency training/resources for providers and staff. Ensure qualifications of bilingual staff are kept on file.

G. Making available Member information and health education materials to LEP Members in the threshold languages and alternative formats such as Braille, large print, etc.

H. Having the right of the Members/providers to file a grievance when a C&L is not met and having the availability of the form in the threshold languages and how to obtain it. If Providers need Health Education materials they must contact the Quality Management department at (626) 282-0288 and should fill out the Material Needs Form (page 50).

Practices should contact Network Medical Management's Customer Service Department at (877) 282-8272 or the Member's health plan Customer Service to obtain more information on how to access cultural and linguistic services for Members of FYB which is located on the back of the member's insurance card.

C&L SERVICES – PROVIDER RESPONSIBILITY

The California Department of Health Services (DHS) and Network Medical Management (NMM) and its affiliates expect providers/practitioners to adhere to the following:

24-Hour Access to Interpreters

When the Provider/Practitioner does not speak the Members' language, he/she must ensure 24-hour access to interpreters for Members whose primary language is not English. To access interpreters for FYB Members at no cost to you or the patient call Language Line Services at 1-800-367-9559, access code for Network Medical Management is **2554** or ID **295164,** or utilize free interpretation services provided by the contracted health plan. It is never permissible to ask a family member to interpret.

State and Federal laws state that it is never permissible to turn away or limit the services provided to them because of language barriers. It is also never permitted to subject a Member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the Member.

Documentation

If a patient insists on using a family member as an interpreter, or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost, document this in the Member's medical record.

All counseling and treatment done via an interpreter should be noted in the medical record that such counseling and treatment were done via interpreter services. Provider should document who provided the interpreter service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreters' name, operator code number, and vendor.

Should the Member refuse to utilize the Interpretative Services, the Request/Refusal for Interpretive Services Form must be completed and placed in the Member's medical record.

Facility Signage

DHS requires that Provider offices post important signs in the threshold languages such as the "free interpretation services" poster. Check the health plan's website for downloadable signs in a variety of languages. If you need particular signage and cannot locate it, contact Quality Management Department for assistance at (626) 282-0288 ext.6207.

NMM LANGUAGE LINE SERVICES INFORMATION

Language Line Automated Access offers a fast and efficient way to connect to a professional Interpreter, anytime, anywhere. Language Line Automated is an over-the-phone interpretation service that has more than 140 languages, 24 hours a day. The following is a *Quick Reference Guide* on how to use this free service provided for your office by Network Medical Management. Please ensure that all users in your office know how to use the conference feature on their phones for this service to be used efficiently.

Login Information:
Toll Free Line: 1-800-367-9559
Client ID# 295164
Access Code: 2554

Help Information:
Customer Service Line: 1-800-752-6096 Option 1
E-mail: www.LanguageLine.com

1. Place the non-English speaker on Conference Hold.
   A. If you are placing an outbound call, access the Interpreter first and then place the call to the non-English speaker.
2. Dial Language Line Services at 1-800-367-9559
3. Follow Prompts
   A. Press 1 for Spanish.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.
   B. Press 2 for all other languages.
      - Speak the name of the desired language clearly; (e.g., "Chinese", "Japanese"). *Say only the language name* – do not add any other words. The system will repeat your request and ask that you:
      - Press 1 to confirm the language.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.
4. Enter your 6-digit Client ID# (provided above) on the telephone keypad.
5. Enter your numeric Access Code (provided above) followed by the pound sign (#) on the telephone keypad.
6. Your Interpreter is connected to the call. Brief the Interpreter about the nature of the conversation and provide specific information to be relayed to the non-English speaker.
7. Add a non-English speaker to the line after you have briefed the Interpreter.

INTERPRETIVE SERVICES REQUEST/REFUSAL FORM

Patient Name: _____

Primary Language: _____

- ❑ Yes, I am requesting interpretive services.
  Language: _____
- ❑ I prefer to use my family or friend as an interpreter. (Interpreters must be over 18 years of age)
- ❑ No, I do not require interpretive services.
- ❑ N/A

  Please explain: _____

  _____

  _____

_____ _____

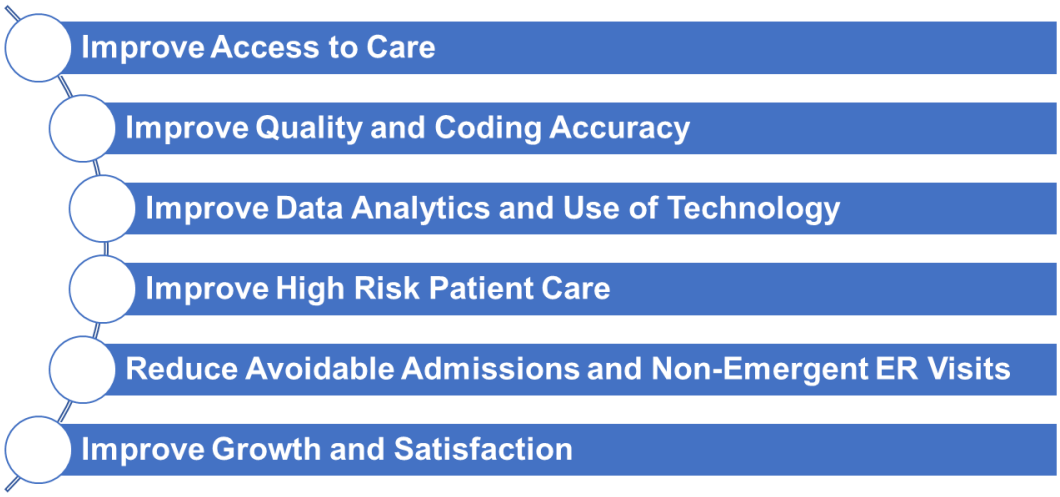
Patient Signature Date

Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

*Please place in the patient's medical record.

SECTION 9 **POPULATION HEALTH/QUALITY INTRODUCTION**

As the healthcare landscape continues to shift from a fee-for-service, volume based-model, to a quality-driven, value-based care model, population health plays a critical part in providing the framework and tools to help providers drive success. Population health management is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The goals of FYB's population health program are to provide the highest quality of care most cost-effectively and to ensure high patient and provider satisfaction. With these goals in mind, our population health program will be grounded and focused on the 6 Pillars of Population Health Performance. The 6 Pillars of Population Health Performance are:



Concerning "Improve Quality and Coding Accuracy," the subsequent sections will provide more detailed information on how quality outcomes are reflected through Health Effective Data and Information Set (HEDIS) measures and how the Member's risk adjustment factor (RAF) reflects the complexity of the Member's health condition through Hierarchical Condition Categories (HCCs). Whether it's capturing HCCs or addressing/closing HEDIS measures, the work that the provider and his/her office staff do is critical to the performance of our population health program.

The subsequent sections provide more details regarding quality HEDIS measures and risk adjustment components.

HEALTH EFFECTIVE DATA & INFORMATION SET OVERVIEW

Health Effective Data & Information Set (HEDIS) is a tool used by more than 1,000 health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of more than 90 measures across 6 domains of care. With data collection and technical specifications, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to identify areas for improvement.

Each health plan implementing HEDIS is required to collect data and report HEDIS results based on the technical specifications of the HEDIS measurement sets. Health plans report their HEDIS rates separately for each product line and provide this reporting on their internal websites and marketing materials. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by The National Committee of Quality Assurance (NCQA).

Consumers also benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's healthcare system. HEDIS data also are the centerpiece of most health plan "report cards".

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans, and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured.

MEASURES AND CATEGORIES

HEDIS data is collected from the providers through encounters and medical record audits. The following are the key measures that will be measured through HEDIS criteria:

Category		MEASURE	MEDICARE	COMMERCIAL	MEDI-CAL
Adult Health	1	Annual Wellness Visit (AWV)	✓		
	2	Care for Older Adults (COA)	✓		
	3	Colorectal Cancer Screening (COL)	✓	✓	
	4	Eye Exam for Patients with Diabetes (EED)	✓	✓	✓
	5	HbA1C Control for Patients with Diabetes (HBD)	✓	✓	✓
	6	Kidney Health Evaluation for Patients with Diabetes (KED)	✓	✓	✓
	7	Blood Pressure Control for Patients with Diabetes (BPD)			✓
	8	Controlling High Blood Pressure (CBP)	✓	✓	✓
	9	Transition of Care (TRC)	✓		
Women's Health	10	Breast Cancer Screening (BCS)	✓	✓	✓
	11	Cervical Cancer Screening (CCS)		✓	✓
	12	Osteoporosis Management in Women Who Had a Fracture (OMW)	✓		
	13	Chlamydia Screening in Women (CHL)		✓	✓
	14	Postpartum Care (PPC)		✓	✓
	15	Prenatal Care (PPC)		✓	✓
Pediatric Health	16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		✓	✓
	17	Immunization for Adolescents (IMA)		✓	✓
	18	Well Child Visits in the First 30 Months of Life (W30)		✓	✓
	19	Childhood Immunization Status (CIS)		✓	✓
	20	Child and Adolescent Well-Care Visits (WCV)		✓	✓
General Health	21	Annual Physical Exam		✓	✓
	22	Initial Health Assessment (IHA)	✓	✓	✓
Medication-Related	23	Statin Therapy	✓	✓	✓
	24	Medication Adherence	✓		

For a complete summary of the most current HEDIS measures, please visit the NCQA website, http://www.ncqa.org/tabid/59/Default.aspx, or reach out to:

Quality Care Improvement Team:
Tel: (626) 282-0288 Ext. 5548
E-mail: QualityImprovement@networkmedicalmanagement.com

HEDIS ENGAGEMENT

All contracted PCPs are required to participate with the IPA network in HEDIS (including STAR measures) program. The IPA network will provide the PCP with gaps in care (GIC) reports, monthly eligibility, and other ad hoc reports provided by the health plans. GIC reports & other ad hoc reports will be provided electronically to the PCP at least quarterly. **All contracted PCPs are required to provide medical records upon request to support Health Plan audits and data reconciliation efforts to close care gaps.**

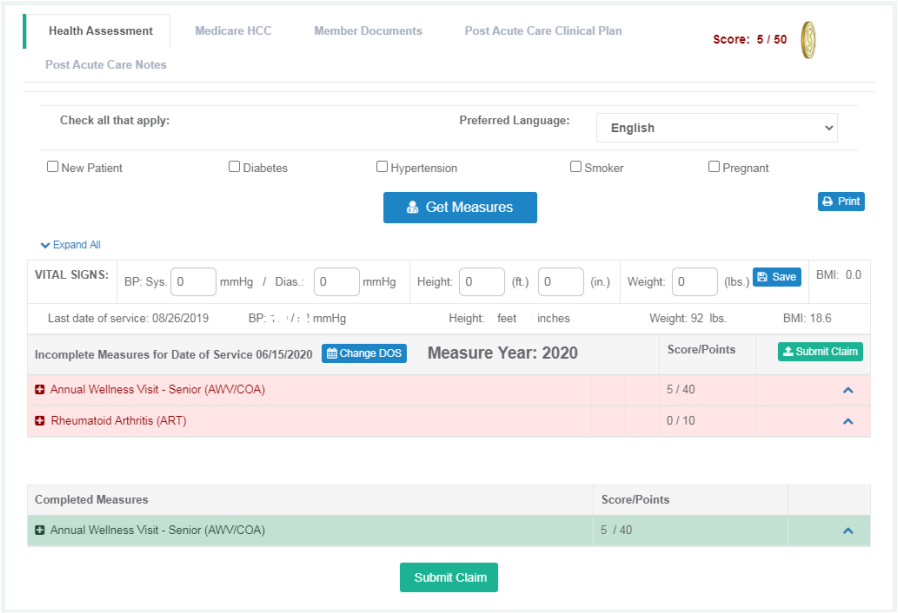
The PCP and IPA network will review the GIC reports to address the following:

1) Patients with true "gap in care"
2) Patients who have had the screening/test but may be new to the IPA and/or PCP. The IPA and PCP will work on collecting supplemental data to report findings to the applicable health plan
3) Patients who are non-compliant with disease or preventative care management

The IPA network will work with the health plans to maximize administrative and encounter data transactions. The IPA network will provide the PCP with references and resources to ensure appropriate CPT, CPT II, and ICD-10 codes are utilized by the PCP when billing. The IPA will monitor the PCP claims encounter data submissions to ensure appropriate service codes are utilized for compliance with HEDIS/STAR measures criteria.

PCP providers can use the NMM Web Portal system to monitor patients with gaps in care. The NMM Web Portal provides indicators (see image example below) for patients who have completed or require specific measures. It integrates data collected from Encounter data, Laboratory data, Radiology data, and Health Plan data. We encourage the PCP office to use the resources provided by the IPA to monitor patients with gaps in care to ensure the IPA is compliant with health plan & State standards for preventative or disease management measures.

The NMM Web Portal can be accessed at:
https://www.networkmedicalmanagement.com/providers/provider-portal

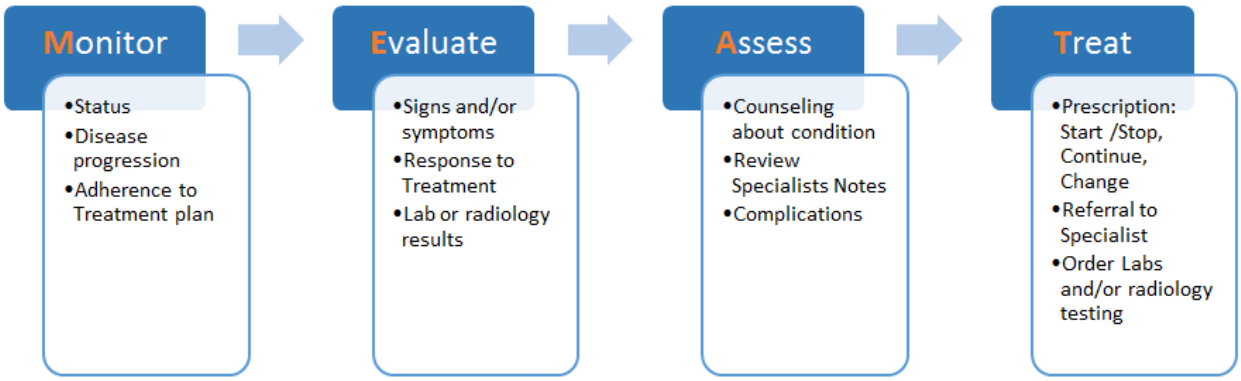


RISK ADJUSTMENT

Documentation Requirements

To ensure the accuracy and integrity of the risk adjustment data submitted to CMS:

- All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit
- Diagnosis must be accurately coded according to ICD-10 CM guidelines
- Assessing all conditions at least once annually
- The reported diagnosis must be supported by **M.E.A.T.**



Risk Adjustment Factor (RAF)

- Risk adjustment is calculated using an actuarial tool developed to predict the cost of healthcare for covered beneficiaries/Members
- A risk adjustment score is determined by using a combination of demographic information (Age, Sex, Status) along with disease information to predict future healthcare costs for Members
- The score is highest for the sickest patients as determined by a combination of factors
- A Risk Score of 1.000 reflects the Medicare incurred expenditures of an average beneficiary/Members

Disease Interactions

- Disease Interactions allow for additive factors based on conditions and disabled status to increase funding
- Additional risk scores are added automatically when certain diseases are coded together
  - ✓ Congestive Heart Failure and Diabetes
  - ✓ Congestive Heart Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Congestive Heart Failure and Arrhythmia
  - ✓ Congestive Heart Failure and Renal
  - ✓ Cardiorespiratory Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Disorders of Immunity and Cancer
  - ✓ Substance Use Disorder and Psychiatric

Hierarchical Condition Categories (HCCs)

- Developed by CMS for Risk adjustment of the Medicare Advantage Program (Medicare Part C)
- Predictive Model using current year data to predict next year's risk

- HCC categories are additive
- Data Derived from:
  - ✓ Inpatient Diagnosis
  - ✓ Outpatient Diagnosis
  - ✓ Provider Office Diagnosis
  - ✓ Clinically trained non-physician provider

Comparison of RAF Score – Documentation and Coding Complexity

All Conditions Coded Complex		Some Conditions Coded Moderate		No Conditions Coded Healthy	
69-year-old female (non-dual)	**0.323**	**69-year-old female (non-dual)**	**0.323**	**69-year-old female (non-dual)**	**0.323**
DM w/chronic complications	0.302	DM w/chronic complications	0.302		0.000
CHF	0.331	CHF	0.331		0.000
COPD	0.335		0.000		0.000
Disease Interaction DM/CHF	0.121	Disease Interaction DM/CHF	0.121		0.000
Disease Interaction CHF/COPD	0.155		0.000		0.000
TOTAL RAF	**1.567**	**TOTAL RAF**	**1.077**	**TOTAL RAF**	**0.323**

***Estimated Score for illustration purposes.**

Documentation Guidelines Available on Web Portal:

- ✓ Atherosclerosis of the Aorta (AAA)
- ✓ Cancer
- ✓ Chronic Obstructive Pulmonary Disease (COPD)
- ✓ Chronic Kidney Disease (CKD)
- ✓ Eligible Progress Note with Chart Mechanics
- ✓ Dementia
- ✓ Rheumatoid Arthritis
- ✓ Senile Purpura

Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care. Primary care physicians are required to maintain a medical record for each member that must include patient records of care provided within the IPA/medical group, as well as

care referred outside the IPA/medical group.
FYB requires medical record reviews to assess both physician office records and institutional medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.
Medical records are reviewed annually against FYB medical record standards. Records are sampled from those submitted for HEDIS review. FYB requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Preventive Health Services
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/ past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with the diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For **Medicare Advantage** members, evidence on the presence or absence of Advance Directives, for adults over age 18 is prominently located in the medical record

Providers must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by FYB, to demonstrate compliance.

To assist FYB in maintaining continuity of care for its members, physicians are required to share medical records of services and supplemental data for care rendered to FYB members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, x-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the physician must provide one copy of these materials, **at no charge,** to the member's new physician or IPA/medical group.

Health Risk Assessment
A Health Risk Assessment Survey is mailed to all new FYB plan members. This survey is designed to identify members who may be among the frail elderly, who require reminders for preventive health services, who may require assistance with activities of daily living, and those with certain chronic diseases. Those whose results show five or more identified risks are forwarded to IPA/medical group Medical Directors quarterly for dissemination to these members' primary care physicians and/or IPA/medical groups' case management programs. For Dual Special Needs Plan members, the Health Risk Assessment results are sent to the IPA/medical group and primary care providers with each completed Health Risk Assessment.

SECTION 10 **INITIAL HEALTH APPOINTMENT**

Effective January 1, 2023, "Initial Health Appointment" (IHA) replaces the previously used term, "Initial Health Assessment" based on APL 22-030 per Department of Health Care Services (DHCS). APL 22-030 supersedes APL 13-017 and Policy Letters (PL) 13-001 and 08-003.
The Initial Health Appointment to include an age-appropriate Individual Health Education Behavioral Assessment (IHEBA) or a Staying Healthy Assessment (SHA) for each Member will **no longer** be a required component of the IHA beginning January 1, 2023.
An IHA must be completed for all Members and periodically re-administered according to requirements in the Population Health Management (PHM) Policy Guide. However, DHCS is preserving the following requirements:

- The IHA must be completed within 120 days of enrollment for new Members and must continue to include a history of the Member's physical and behavioral health, identification of risks, an assessment of the need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.
- For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered per the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL 19-010.
- The provider is accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as Members receive all required screenings on time consistent with USPSTF guidelines.
- DHCS will measure primary care visits as a proxy for the IHA, leveraging Managed Care Accountability Sets (MCAS) measures specific to infant and child/adolescent well-child visits and adult preventive visits. For children, DHCS will measure both primary care visits and childhood screenings, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD

An IHA:

- Must be performed by a Provider within the primary care medical setting.
- Is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

An IHA must include all of the following:

- A history of the Member's physical and mental health;
- Identification of risks;
- An assessment of the need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases

REFERENCES

1) APL 22-030 (ca.gov)
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf
2) Population Health Management Policy Guide
https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

SECTION 11 **COMPLIANCE**

INTRODUCTION AND PURPOSE

For Your Benefit (FYB) developed this Compliance Program manual to meet the requirements set forth by the Centers for Medicare and Medicaid Services ("CMS") to ensure all Workforce Members, directors, contractors (including providers, delegates, and other vendors), and first tier, downstream, and related entities ("FDR") understand their duties to act in a compliant and ethical manner within a managed care setting. In addition, the Compliance Program is intended to apply to FYB's business arrangements with any of its FDRs, including physicians, hospitals, and entities that may be impacted by federal or state laws relating to fraud, waste, and abuse to demonstrate our commitment to compliance.

For Your Benefit (FYB) is committed to adhering to all applicable federal and state standards, including, but not limited to:

- Federal and state false claims acts
- Anti-kickback statute
- Prohibition on inducements to beneficiaries
- Federal Health Insurance Portability and Accountability Act ("HIPAA")
- Code of Federal Regulations
- Sub-regulatory guidance produced by the Centers for Medicare and Medicaid Services ("CMS"), which includes manuals, training materials, and guides, including CMS compliance program guidelines in Chapter 21 of the Medicare Managed Care Manual ("MMCM") and Chapter 9 of the Prescription Drug Benefit Manual ("PDB")
- Applicable civil monetary penalties and exclusions
- Applicable state laws
- Terms and conditions of government contracts

For Your Benefit (FYB) Workforce Members, directors, and all first tier, downstream and related entities are expected to adhere to the CMS program requirements, the Compliance Program and Code of Conduct, and all applicable Policies and Procedures ("P&Ps"). We ensure adherence and implement compliance-related programs through our internal controls, engagement of senior staff, monitoring and auditing, risk assessment, training and education, and proactive identification of possible issues.

To ensure all Workforce Members, directors, contractors, and first-tier, downstream, and related entities learn about and have access to the compliance program, this Compliance Program description will be distributed in the following manners:

- To all new Workforce Members within ninety (90) days of hire
- To all new contractors upon executing the final contractual agreements
- To all directors at their first official Board of Directors meeting
- When requested by the Compliance Department by appropriate persons

Additionally, Program materials are on For Your Benefit's (FYB) Intranet, available to all Workforce Members at any time. To ensure Workforce Members, directors, contractors, and first-tier, downstream, and related entities have received the Compliance Program materials, acknowledgment forms will be signed, gathered, and kept on file.

For Your Benefit (FYB) ensures the mandates and responsibilities of the Compliance Program are met by:

- Providing annual compliance training to each Workforce Member, contractor, director, and first tier, downstream and related entity ("FDRs") and at each new hire orientation.
- Providing a compliance hotline at 844-975-2651 for named or anonymous reporting of suspected or actual non-compliance.
- Developing an email account (Compliance@networkmedicalmanagement.com) for the sole purpose of ensuring Workforce Members, FDRs, contractors, and directors both receive compliance information and have an additional mechanism to communicate with the Compliance Officer.
- Establishing well-publicized disciplinary standards.
- Establishing a fraud, waste, and abuse policy and training program, which may be a part of general compliance training.
- Incorporating For Your Benefit (FYB)'s Compliance Program and Code of Conduct (APPENDIX A).
- Incorporating For Your Benefit (FYB)'s Handbook (APPENDIX B).

DEFINITIONS

Abuse: Providing products or services that are either inconsistent with accepted practices or are unreasonable or unnecessary.

CMS: Center for Medicare and Medicaid Services.

Downstream Entities: Any party to a written agreement below that of a first-tier entity, such as subcontractors.

First Tier Entity: Any party to a written administrative or health care services agreement with a Medicare Advantage plan. Examples include an organization under contract to provide services to plan Members, For Your Benefit (FYB)s, and marketing organizations.

FDR: First tier, downstream and related entities.

Fraud: Intentional submission of false or misleading information to receive payments

FWA: Fraud, waste, and abuse.

HIPAA: The federal Health Insurance Portability and Accountability Act.

Related Entities: Any entity related to For Your Benefit (FYB) by common ownership or control.

Waste: Extravagant, careless, or needless spending resulting from weak practices and poor decisions.

COMPLIANCE PROGRAM ELEMENTS

Written Policies, Procedures, and Code of Conduct

For Your Benefit (FYB) is proud to offer Medicare Advantage services to our contracted health plan Members. We do so while ensuring high standards of conduct that meet our principles and values. Each Workforce Member, director, consultant, and FDR must adhere to these standards, articulated in For Your Benefit (FYB)'s Compliance Program and Code of Conduct (APPENDIX A) and in separate written P&Ps including, but not limited to, For Your Benefit (FYB)'s Fraud, Waste and Abuse P&P. The Compliance Program and Code of Conduct are our standards of conduct and articulate For Your Benefit

(FYB)'s commitment to complying with all federal and state laws and CMS policies and regulations. For Your Benefit (FYB) has P&Ps that describe the operation of the Compliance Program and detail such issues as fraud, waste and abuse, training, and monitoring of FDRs. These policies and this Compliance Program will be distributed to Workforce Members, directors, contractors, and FDRs annually, within ninety (90) days of hire or engagement, and when updated. Distribution will occur by email, fax, hand, or any other effective method.

Compliance Officer and Compliance Committee, Program Oversight

For Your Benefit (FYB) has designated a Compliance Officer ("CO") who reports to the Chief Executive Officer and the Board of Directors. The CO is responsible for overseeing the day-to-day operations of the Compliance Program. The CO will not be a Workforce Member of For Your Benefit (FYB)'s downstream or related entities or contractors. The Compliance Committee (CC) and the Board of Directors meet at least annually to, among other duties, approve all compliance-related P&Ps and documents; review any audits, issues, and investigations; oversee any corrective actions; review compliance, HIPAA, FWA, Code of Conduct and other compliance-related training; and ensure the Compliance Program is operating effectively. The minutes of each CC meeting are maintained by the Compliance Department.

Governing Body

For Your Benefit (FYB)'s Board of Directors ("BOD") is responsible for maintaining knowledge of the content and operation of the Compliance Program and is tasked with overseeing the implementation and oversight of the Compliance Program. To ensure effective communication and awareness, the CO regularly meets with senior management to make certain the Board keeps abreast of the operation and implementation of the Compliance Program. At Board meetings, the CO will accept and incorporate any advice and counsel received regarding the operation of the Compliance Program. While the Board has delegated oversight of the Compliance Program to the CO and the CC, it may not and does not delegate overall responsibility for reviewing the status of the Compliance Program.

For Your Benefit (FYB)'s Board of Directors has approved this Compliance Program Description. The Board will remain informed of any Compliance Program modifications, compliance issues and resolutions, and audit results, among other items. Any documentation regarding material corrective actions will be presented to the Board and discussed. The Audit Program will be discussed, as will the timing and results of all internal and external audits. The minutes of each Board meeting are maintained by the Compliance Department. With these and similar steps, the Board exercises the required oversight concerning the implementation and effectiveness of the Compliance Program.

Senior Management

All senior management, defined as those reporting directly or indirectly to the Chief Executive Officer, is engaged in the operation of the Compliance Program. Senior staff meets regularly to discuss For Your Benefit (FYB) operations, including the Compliance Program. At each meeting, the CO has an opportunity to speak and report the status of the Compliance Program, any risk areas and mitigation as well as any communication from Health Plans.

TRAINING AND EDUCATION

General Compliance and Ethics Training

For Your Benefit (FYB) has established a general compliance and ethics training program that occurs annually and within ninety (90) days of hire. All Workforce Members, FDRs, directors, contractors, and senior management, including the Chief Executive Officer, shall complete or attest to the equivalent completion of training. Compliance training topics include a description of the Compliance Program and

related P&Ps, relevant laws, and regulations, including:

- How Workforce Members can communicate with the Compliance Department and report compliance concerns, anonymously if desired,
- How to identify and react to potential compliance, legal, and/or ethical violations, and
- an overview of the auditing and monitoring process.

Training is either held in person and/or online through a learning management solutions platform. Evidence of completion is documented for each training course confirming an understanding of the content, requirements, and duties presented.

Fraud, Waste, and Abuse Training

Workforce Members, directors, contractors, senior management, and FDRs will also receive training on the topic of FWA. This training will occur annually and within ninety (90) days of hire. FWA training will also occur if a Workforce Member is found to be noncompliant or if a corrective action plan ("CAP") is necessary. Workforce members who continue to not comply shall face disciplinary action, up to and including termination. FDRs who have met the FWA certification requirements through enrollment in the Medicare and Medi-Cal program or accreditation as a Durable Medical Equipment ("DME"), Prosthetics, Orthotics, and Supplies ("DMEPOS") are deemed to have met the requirements but must provide For Your Benefit (FYB) with proof of compliance.

FWA training will address topics such as laws and regulations related to Medi-Cal plans, Medicare Advantage ("MA") plans, and Part D FWA, such as the False Claims Act, Anti-Kickback statute, etc., obligations of FDRs to have in place appropriate FWA P&Ps, processes for For Your Benefit (FYB) and FDR Workforce Members to report suspected FWA, protections for For Your Benefit (FYB)'s and FDR's Workforce Members reporting suspected FWA, and types of FWA that can occur in the settings where For Your Benefit (FYB) and FDR Workforce Members' work.

Privacy and Information Security Training

Workforce Members, directors, contractors, senior management, and FDRs will also receive training on the topics of privacy and information security, i.e., requirements related to HIPAA and other applicable State laws. This training will occur annually and within ninety (90) days of hire and before access to any Protected Health Information ("PHI"). Privacy and information security training will also occur if a Workforce Member is found to be noncompliant or if a corrective action plan ("CAP") is necessary. FDRs who have met the privacy and certification training requirements through training provided by their organization are exempt from completing For Your Benefit (FYB)'s training; however, they must provide For Your Benefit (FYB) with proof of compliance.

COMMUNICATION AND REPORTING ISSUES

For Your Benefit (FYB) has established methods by which Workforce Members, directors, contractors, and FDRs may communicate directly with the Compliance Officer. The most common methods are by email, phone, or in person, but For Your Benefit (FYB) has also developed confidential and anonymous methods:

i. Between Workforce Members, contractors, and the Compliance Department

   Each For Your Benefit (FYB) Workforce Member, contractor, and director may contact the Compliance Officer, at For Your Benefit (FYB)'s compliance hot line 844-975-2651 or email Compliance@networkmedicalmanagement.com. Confidential means of communication are also

available and described below. All Workforce Members, contractors, and directors are directed to contact the Compliance Officer with questions about the Compliance Program or with any concerns or reports about potential FWA, compliance or ethics, privacy, or other violations.

ii. Between FDRs and the Compliance Department

Each FDR Workforce Member may contact the Compliance Officer at For Your Benefit (FYB)'s compliance hotline at 844-975-2651 or email Compliance@networkmedicalmanagement.com. The Compliance Department may contact FDRs at any time to discuss compliance-related issues. FDR Workforce Members should make themselves reasonably available for communicating with For Your Benefit (FYB)'s Compliance Department.

When reporting any compliance issues, FDR Workforce Members may also use confidential means of communication described below. Any FDR Workforce Member is directed to contact the Compliance Officer with questions about the compliance program or with any concerns or reports about potential FWA, compliance, or ethics violations.

iii. Enrollee/Member Education

For Your Benefit (FYB) will educate our Members about reporting potential FWA and compliance issues through For Your Benefit (FYB)'s website content and/or informational materials. Members may also avail themselves of the reporting mechanisms described above in addition to contacting For Your Benefit (FYB)'s member services.

iv. Reporting Issues

All For Your Benefit (FYB) Workforce Members, Directors, contractors, and FDRs are obligated to report and assist in the investigation of any identified or suspected noncompliant or unethical behavior, potential FWA or compliance issues as well as any possible violations of laws, regulations, or For Your Benefit (FYB) policies or procedures. To ensure effective reporting, For Your Benefit (FYB) has created four communication options:

Communication Method	Available To	Contact Information
1. Speak with an immediate supervisor, reporting authority, or an FYB contact, who then communicates to the Compliance Officer	Everyone	Whomever the Workforce Member reports to, the person overseeing the contractor, or the FDR FYB contact.
2. Confidential compliance hotline	Everyone	844-975-2651 (available 24/7)
3. Email	Everyone	The form may be emailed to Compliance@networkmedicalmanagement.com. The Employee may remain anonymous.
4. Directly contacting the Compliance Officer	Everyone	626-556-3478

v. No retaliation for reporting issues; assisting in investigations

Workforce Members, contractors, directors, and FDR Workforce Members must report any potential or suspected legal, ethical, or compliance violations and any incidents of possible or potential FWA. For Your Benefit (FYB) maintains an environment where people feel comfortable in reporting any good faith issues or violations by ensuring that no For Your Benefit (FYB) Workforce Member, director, contractor or FDR retaliates, attempts to retaliate, or intimidates anyone who, in good faith, participated in the Compliance Program by reporting, investigating, or speaking to a supervisor or an investigator concerning a suspected compliance issue or a legal, regulatory or procedural violation. This includes any investigation issues, remedial actions, self-evaluations, and audits. Additionally, laws and regulations protect those who lawfully report possible violations to their employers.

For Your Benefit (FYB) as an organization has a strict non-retaliation policy to make certain each person feels comfortable in raising any good faith violation concerns. As part of this policy, every Workforce Member with supervisory responsibilities must encourage a work environment where ethical concerns are raised and openly discussed without fear of retribution or reprisal. Anyone who is found to have engaged in any such retaliation or intimidation is subject to immediate disciplinary actions, up to and including termination and referral to the appropriate authorities.

Workforce Members, contractors, directors, and FDR Workforce Members are required to assist in any investigation of a suspected legal, ethical, or compliance breach. This assistance may include speaking directly to the Compliance Officer, a Compliance Department member, or supervisor, completing a report or other written document, making themselves available to meet or speak with any investigator, and generally supporting an ongoing investigation.

DISCIPLINARY STANDARDS

As mentioned above, For Your Benefit (FYB) expects to receive any reports of compliance issues, including non-compliant, illegal, or unethical behavior. All Workforce Members, contractors, directors, and FDR Workforce Members will receive training outlining how to report any potential violations and For Your Benefit (FYB)'s policy of non-retaliation. Examples of non-compliant, illegal, or unethical behavior subject to discipline include:

- Failing to perform an obligation detailed in the Compliance Program or related P&Ps, including any conduct resulting in a legal violation.
- Failing to report a suspected or actual compliance or legal violation.
- Failing to reasonably assist or obstruct a compliance investigation.
- Behavior leading to the filing of a false or improper claim in violation of federal or State laws.

Anyone found to be engaged in non-compliant, illegal, or unethical behavior is subject to discipline, which, depending on the severity of the violation, may include an oral or written warning, a personal development plan, suspension, or termination. Disciplinary standards will be well publicized through annual training, P&Ps, communications with FDRs, For Your Benefit (FYB)'s website, newsletters and other documents, and emails. Any enforcement of these standards will be documented and maintained in the Compliance and Human Resources Departments.

ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

For Your Benefit (FYB) has in place a mechanism for routinely monitoring and identifying internal and external compliance risks to test and confirm our adherence to CMS regulations, agreements, policies, and applicable federal and State laws. Internal monitoring includes reviewing the performance of our operational systems while auditing is a formal review of our compliance against a set of standards. External monitoring includes reviewing the performance and operations of FDR services and systems while external auditing includes a formal review of FDR compliance and contractual obligations against a baseline set of standards as dictated in For Your Benefit (FYB)'s Audit Program.

For Your Benefit (FYB) begins our monitoring and auditing process with an audit program overseen by the Compliance Officer and the CC, which identifies and addresses any potential Medicare Part C and Part D risks, and any other risks For Your Benefit (FYB) faces based on all applicable authority. Audits and monitoring will follow based on the results of the audit program, the results of which will be communicated to the CC and the Board. The CC and the Board will discuss the results and record meeting minutes. The following are the procedures by which we will perform internal and external monitoring and auditing:

Identifying risks

For Your Benefit (FYB) will conduct a baseline assessment to gauge potential risk areas. Areas of assessment will include, but may not be limited to:

- UM Operations
- Appeal and Grievance Procedures
- Exclusions
- Claims Processing
- Health Plan Requirements
- FWA
- FDR and Other Contractor Oversight
- Software Security
- HR Requirements
- Regulatory Requirements
- Solvency
- Member Rights
- CAPs Issued by a Governing Body

Audit Program

The audit program may include certain methodologies and vary in audit types (desk or onsite). The audit program will include a process for monitoring and follow-up review of any non-compliant areas. Any corrective action will be led by the Compliance Officer, in conjunction with senior management related to the affected department(s). Results will be communicated to the CC as necessary.

Office of the Inspector General/General Services Agency exclusion

Government payments from both Medi-Cal and Medicare may be issued for any item or service furnished or prescribed by a person excluded by the Office of the Inspector General ("OIG") or the General Services Agency ("GSA"). Monthly, For Your Benefit (FYB) staff will check the OIG and GSA and all other excluded party lists to ensure compliance with exclusions.

Prompt Response to Compliance Issues
Any potential issue regarding FWA or noncompliance for either For Your Benefit (FYB)'s Part C or Part D or any other applicable duties and responsibilities will result in a reasonable and timely inquiry with the implementation of any necessary corrective actions. This process is also used if For Your Benefit (FYB) discovers evidence of misconduct related to the payment or delivery of items or services under its contract with Health Plans. If misconduct related to payment or contractually obligated services delivery is found, the corrective action plan will include communication with Health Plans, rectifying the error (e.g., repaying any overpayments), providing additional training, modifying processes as necessary, and/or disciplinary action as needed.

If a Workforce Member, contractor, director, or FDR Workforce Member suspects Medicare-related FWA or misconduct, he or she may voluntarily contact the Health Plan directly to report the suspicion. If Medicare-related FWA or misconduct impacting one or more beneficiaries is discovered, the Compliance Officer or designee will contact the Health Plan to voluntarily self-report the issue and cooperate with any investigations undertaken by the Health Plan or CMS.

FRAUD, WASTE, AND ABUSE

FWA is unacceptable. Workforce Members, directors, contractors, and FDRs must, at all times, act with efficiency and care. Resources are to be used appropriately and judiciously and services must be rendered in a manner consistent with the contract with the Health Plan, other applicable authorities, and P&Ps. For Your Benefit (FYB) uses the monitoring and auditing measures outlined here as tools and measures to detect and prevent FWA, as well as the following procedures:

- Anyone who suspects FWA must report the situation immediately, with any supporting documents, to his or her supervisor, Plan contact, or Compliance Officer (see contact methods above). The suspected individual should not be contacted by the person suspecting the noncompliance.
- If communication is made to a supervisor or a Plan contact is informed, that person must contact the Compliance Officer immediately by email or phone number.
- The Compliance Department will document the report, begin investigating the claim, make a report to the CC and the Board, as necessary, and conduct follow-up reviews as necessary.
- Corrective actions may include identifying the root cause of the issue, contacting the Health Plan, conducting additional training, repayment, or similar error correction, adding additional procedures, or modifying existing procedures, and follow-up reviews.

Examples of FWA one may encounter in a workplace include, but are not limited to:
- Over and underutilization activities
- Mishandling a member's appeal
- Forwarding or processing a fraudulent claim
- Misrepresenting or falsifying information
- Duplicating co-pays or imposing excessive co-pays
- Manipulating data regarding members

RELEVANT LAWS

The False Claim Act, Anti-Kickback Statute, Physician Self-Referral (Stark Law), HIPAA, and criminal codes are also used to address any FWA.

i. The False Claims Act

The False Claims Act protects the government from being overcharged or selling substandard goods or services. Civil liability is imposed on anyone who knowingly submits, or causes the submission, a false or fraudulent claim to the federal government.

ii. The Anti-Kickback Statute

The Anti-Kickback statute makes it a criminal offense, with some exceptions, to knowingly and willfully offer, pay, solicit, or receive any payment to induce or reward referrals of items or services that can be reimbursed by Medicare or Medi-Cal.

iii. Physician Self-Referral (Stark Law)

The Stark Law prohibits a physician from referring certain health services to an entity where that physician or immediate family member has an ownership or investment interest, or which he or she has a compensation arrangement with applicable exceptions.

iv. Health Insurance Portability and Accountability Act of 1996

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandated industry-wide standards for the privacy of healthcare information and strengthened efforts to combat FWA by establishing the Health Care Fraud and Abuse Control Program.

v. Criminal Codes

The Federal criminal statute prohibits anyone from knowingly or willfully executing, or attempting, a scheme to defraud any federal health care benefit program or obtain by pretenses or promises any money or property owned by or under the control of any federal health care benefit program. Penalties for violating the criminal statute may include fines, imprisonment, or both.

PROVIDER TRAINING ATTESTATION

I have received a Newly Contracted Provider Training that includes an overview of the provider manual, web portal, policies, and procedures. A copy of the "STATE OF CALIFORNIA PATIENT RIGHTS AND RESPONSIBILITIES" and "BE INFORMED" notice was provided. I am aware that a copy of the provider manual is available on the web portal and that it is my responsibility to maintain and add any additional information/updates provided in the future.

As a contracted provider with For Your Benefit, you attest to the following statements:

- Your organization has in place an effective compliance program that meets the Center for Medicare & Medicaid Services (CMS) standards to detect, prevent, and report instances of Fraud, Waste, and Abuse ("FWA"), other non-compliance, or Health Insurance Portability and Accountability Act ("HIPAA") Privacy or Security issues.
- Providers and all staff who see managed care beneficiaries comply with CMS training requirements (42 CFR 422.503 and CFR 423.504). Training is completed within 90 days for initial new hires and annually thereafter, additionally, a record confirming the training has occurred must be retained for 10 years.
- As a regulatory requirement, an annual review is completed of UM protocols & policies, updates, clinical criteria, and other programs outlined below. I understand that the trainings are subject to audit and may change periodically.

COMPLIANCE TRAINING

- CMS Fraud, Waste & Abuse (FWA) & General Compliance (*False Claims Act, OIG & SAM Listing)*
- Cultural Competency Training
- HIPAA Privacy Training
- Standard of Conduct
- Model of Care Training (MOC) (*Each contracted health plan has a unique MOC training that must be completed)*

UM PROTOCOLS & POLICIES TRAINING:

▪ Access to Care Standards	▪ General UM Provider Updates *sent via fax and/or available within your provider web portal account*
▪ Advance Directives	
▪ Balance Billing Guidelines (Medi-Cal)	
▪ Behavioral Health Treatment (BHT)	▪ Health Home Process
▪ California Children's Service Program (CCS)	▪ Hospice / Palliative Care
▪ California Immunization Registry Program (CAIR)	▪ Initial Health Assessment Guidelines
▪ Childhood Disability and Prevention Program (CHDP)	▪ Language Assistance Program (LAP) *PDF Insert*
▪ Comprehensive Perinatal Service Program (CSPS)	▪ Screening, Brief Intervention, and Referral to Treatment (SBIRT) *Alcohol and Substance Abuse*
▪ Contracted provider responsibilities (PCP&SPC)	
▪ Contracted specialist requirements	▪ Specialty Referral Tracking
▪ Early Start/Early Intervention Developmental Disabilities and Regional Centers	▪ Standing Referral Requirements
	▪ Sterilization PM330 and DHCS Education Booklet requirement
▪ Family Planning Services *(Women, Infant and Children's (WIC) Program & Health Plan Supplemental Benefits)*	▪ Vaccine for Children Program (VFC)

Our program training materials are located on NMM's website
https://www.networkmedicalmanagement.com/providers/provider-resources

By signing below, I attest to being the authorized representative for the practice and have received and reviewed the training materials for the topics indicated above.

Vendor Name / Organization Name _____ Tax ID _____ NPI _____

Print Name, Title _____ Signature _____ Date _____

Please return this form to: ProviderRelationsDept@NetworkMedicalManagement.com | Fax: (626) 943-6375

SECTION 12 **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PATIENTS MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

The primary purpose of For Your Benefit (FYB) is to provide quality Healthcare services in a timely and culturally sensitive manner and to work with the cooperation of the community and government agencies to create a vibrant healthy, physical, and social environment.

At For Your Benefit (FYB), we respect the confidentiality of your health information and will protect your information responsibly and professionally. We are required by law to maintain the privacy of your health information and to provide you with this notice. We must follow the terms of this notice while it is in effect.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights concerning your health information and how you can exercise those rights.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information created or received by FYB that identifies an individual applying for or enrolled in a health benefits program in which FYB is a provider, the person's participation in the program, the person's past, present, or future physical or mental health condition, the provision of health care to that person, or payment for the provision of health care to that person. PHI does not include publicly available information or information that is available or reported in a summarized or aggregate fashion that does not identify any person.

HOW FYB MAY USE OR SHARE INFORMATION

The following are ways we may use or share PHI:

- FYB may use the information to help pay patients' medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share patients' information with doctors or hospitals to help them provide medical care. For example, if a patient is in the hospital, we may give them access to any medical records sent to us by the patient's doctor.
- We may use or share patient information with others to help manage the patient's health care. For example, we might talk to the patient's doctor to suggest a disease management or wellness program that could help improve the patient's health.
- We may share patient information with others who help us conduct our business operations. For example, we may contract with a disease management company to offer services to improve the patient's health status. **We will not share your information with these outside companies unless they have proper securities in place and agree to keep the provided information protected.**
- We may use or share patient information for certain types of public health or disaster relief efforts.
- We may use or share patient information to send reminders if the individual has an appointment with your doctor.
- We may use or share patient information to give information about alternative medical treatments and programs or about health-related products and services that the patient may be interested in.

For example, we might send the patient information about smoking cessation or weight loss programs.
- We may use or share patient information with an employee benefit plan through which the patient receives health benefits. **We will not share detailed health information with the patient's benefit plan unless they have proper security in place and agree to keep it protected.**

There are also state and federal laws that may require us to release patient health information to others. We may be required to provide information for the following reasons:

- We may report information to state and federal agencies that regulate us such as the US Department of Health and Human Services and the California Department of Managed Health Care.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking prescription drug and medical device problems.
- We may report information to public health agencies if we believe there is a serious health or safety threat.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions).
- We may provide information to a court or administrative agency (for example, under a court order, search warrant, or subpoena).
- We may report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness, or missing person.
- We may report information to a government authority regarding child abuse, neglect, or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with a funeral director as necessary to carry out their duties.
- We may use or share information for the procurement, banking, or transplantation of organs, eyes, or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

If one of the above reasons does not apply, ***we must get a patient's written permission to use or disclose their health information***. If the patient provides written permission and changes their mind, the patient may revoke their written permission at any time.

WHAT ARE THE PATIENT'S RIGHTS

The following are patients' rights concerning their health information. If a patient would like to exercise the following rights, please contact the ***FYB Compliance Officer, c/o For Your Benefit, 1668 S. Garfield Ave., Alhambra, CA 91801, Phone: 626-943-6286.***

- ***Patients have the right to ask us to restrict*** how we use or disclose information for treatment, payment, or healthcare operations. Patients also have the right to ask us to restrict the information that we have been asked to give to family members or to others who are involved in their health

care or for payment for your health care. Please note that while we will try to honor the patient's request, we are not required to agree to these restrictions.

- ***Patients have the right to ask to receive confidential communications*** of information. For example, if a patient believes that they would be harmed if we send information to their current mailing address (for example, in situations involving domestic disputes or violence), patients can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate reasonable requests.

- ***Patients have the right to review or obtain copies of their protected health information records, with some limited exceptions***. Usually, the records include enrollment, billing, claims payment, and case or medical management records. Requests to review and/or obtain a copy of protected health information records must be made in writing. A fee for the costs of producing, copying, and mailing a patient's requested information may be applicable, and patients should be notified of the cost in advance.

- ***However*, patients do not have the right to access certain types of information and we may decide not to provide patients with copies of the following information:**
    - Contained in psychotherapy notes;
    - Compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding; and
    - Information is subject to certain federal laws governing biological products and clinical laboratories.

  In certain situations, we may deny the request to inspect or obtain a copy of the information. If we deny a patient's request, we will notify the patient in writing and may provide the patient with a right to have the denial reviewed.

  FYB will deny requests to inspect or obtain a copy of the information if there is reasonable doubt or question to the following:
    - Identity of the person presenting the authorization
    - Status of the individual as the duly appointed representative of a minor, a deceased, or an incompetent patient
    - Legal age or status as an emancipated minor
    - Patient's capacity to understand the meaning of the authorization to disclose PHI
    - The authenticity of the patient's signature
    - Current validity of the authorization

- ***Patients have the right to ask us to make changes*** to the information we maintain in their records. These changes are known as amendments. We may require that the patient's request be in writing and that the patient provide a reason for the request. We will respond to the request no later than 60 calendar days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify the patient of the delay and the date by which we will complete action on the patient's request.

  If we make the amendment, we will notify the patient that it was made. In addition, we will provide the amendment to any person that we know who has received the patient's health information.

We will also provide the amendment to other persons identified and authorized by the patient.

If we deny a patient's request to amend, we will notify the patient in writing of the reason for the denial. The denial will explain the patient's right to file a written statement of disagreement. We have a right to respond to the patient's statement. However, the patient has the right to request that their written request, our written denial, and statement of disagreement be included with the patient's information for any future disclosures.

- ***Patients have the right to request and receive an accounting of certain disclosures*** of PHI made by us during the six years before the request. Please note that we are not required to provide patients with an accounting of the following information:

  - Any information collected before April 14, 2003.
  - Information disclosed or used for treatment, payment, and health care operations purposes.
  - Information disclosed to the patient or according to their authorization.
  - Information that is incident to a use or disclosure otherwise permitted.
  - Information disclosed for a facility's directory or to persons involved in the patient's care or other notification purposes.
  - Information that was disclosed for national security or intelligence purposes.
  - Information that was disclosed to correctional institutions, law enforcement officials, or health oversight agencies.
  - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We may require that the patient's request be in writing. We will act on the patient's request for an accounting within 60 days. We may need additional time to act on the patient's request. If so, we may take up to an additional 30 days. The patient's first accounting will be free. We will continue to provide the patient with one free accounting upon request every 12 months. If the patient requests additional accounting within 12 months of receiving the free accounting, we may charge a fee. We will inform the patient in advance of the fee and provide the patient with an opportunity to withdraw or modify the request.

CAPACITY TO AUTHORIZE: WHO CAN SUBMIT REQUESTS FOR HEALTH INFORMATION

FYB requires a written, signed, current, and valid authorization to release Protected Health Information (PHI) as follows:

Member Category	Required Signature
Adult Member	The Member or a duly authorized representative, such as a court-appointed guardian or attorney. Proof of authorized representation is required, such as notarized power of attorney.
Deceased Member	Next of kin or executor/administrator of the estate.
Un-emancipated Minor	A parent or legally appointed guardian /attorney (proof of relationship required)
Emancipated Minor	Same as Adult Member above.
Members for Psychiatric, Drug, and Alcohol Treatment	Same as Adult Member above.

Members for AIDS/HIV or other Sexually Transmitted Disease Treatment	Same as Adult Member above.
Members for Abnormal Birth, Fetal Death, or Other Deformity Treatment	Same as Adult Member above.

Written authorization is required for all uses and disclosures. Written authorization must contain detailed, specific information directing the release of member information. Authorizations must include the following information:

- Name and address of FYB
- Name of the member
- Person or organization, including complete address, to whom the information is to be released
- Information to be released
- Purpose of Disclosure
- Signature of the member or duly authorized representative
- Date signed
- Signature of witness (if applicable)

EXERCISING PATIENT'S RIGHTS

Patients have a right to receive a copy of this notice upon request at any time. Patients can also view a copy of the notice on our website at https://www.networkmedicalmanagement.com/. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to patients upon request and post it on our website.

If a patient has any questions about this notice or about how we use or share information, please contact FYB Compliance Officer at 626-943-6286. The office is open Monday through Friday from 8:30 am to 5:00 pm PST. Patients can also send us questions by e-mail to: **MemberServicesHC@networkmedicalmanagement.com.**

If a patient believes their privacy rights have been violated, they may file a complaint to ***FYB Compliance Officer, c/o For Your Benefit, 1668 S. Garfield Ave., Alhambra, CA 91801.*** If the patient is not satisfied with how this office handles a complaint, the patient may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

The patient may also address a complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at: **http://www.hhs.gov/about/agencies/regional-offices/#**
All complaints must be submitted in writing. **WE WILL NOT TAKE ANY ACTION AGAINST ANY PATIENTS FOR FILING A COMPLAINT**.
We reserve the right to change our practices and to make the new provisions effective for all individually identifiable health information that we maintain.