Welcome

Dear Network Provider,

On behalf of North Shore-LIJ Health Plan, I want to welcome you as a valued provider in our network. To maintain our standards of excellence and foster a positive and successful collaboration, I am enclosing contact information that you should find useful in working with us.

North Shore-LIJ Health Plan fully understands that having a strong, mutually respectful relationship is essential for the successful servicing of our members. We welcome your thoughts and ideas at any time, and look forward to seeing you at our scheduled provider orientation session.

In order to ensure that each of our network providers has a full understanding of the North Shore-LIJ Health Plan’s policies and procedures, we distribute a comprehensive Provider Manual upon full execution of your provider agreement. We also offer twenty-four hour access to member eligibility, authorization, claims and policy/procedure information on our secure provider website at www.nsljhealthplans.com. Our providers are updated regularly through real-time electronic notifications, quarterly electronic provider newsletters and, when needed, through formal postal mailings. To keep your provider file complete, we need to be informed of any operational or staffing changes within your practice. Our Provider Services staff can be reached at (888) 831-8429 to answer your questions and direct you to additional resources from North Shore-LIJ Health Plan.

We look forward to a long and successful collaboration with you, and thank you in advance for your cooperation. Together we will provide our members with the excellent quality of care they have come to expect.

Sincerely,

Sunny Chiu
Assistant Vice President, Provider Network Services
North Shore-LIJ Health Plan
# The North Shore-LIJ Health Plan
## Managed Long Term Care (“MLTC”) Provider Manual

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Section 1: About North Shore-LIJ Health Plan

1-1 Introduction to North Shore-LIJ Health Plan

What is North Shore-LIJ Health Plan?

- North Shore-LIJ Health Plan is a wholly-owned subsidiary of the North Shore-Long Island Jewish Health System, Inc. (NSLIJ).
- North Shore-LIJ Health Plan is the nation’s third-largest, non-profit, secular healthcare system. We care for people through every stage of life, at one of our 16 acute care hospitals, an array of post-acute and long-term care facilities and more than 200 ambulatory care centers throughout the New York metropolitan area.
- North Shore-LIJ Health Plan, a New York State Managed Long Term Care (MLTC) partially capitated Medicaid program, has been established to coordinate healthcare services for chronically ill adults wishing to remain in their own home and communities as long as possible.
- Members are free to choose their own providers and services typically covered under Medicaid.
- North Shore-LIJ Health Plan provides and coordinates long-term care services that are typically covered by Medicaid for Medicaid members.
- North Shore-LIJ Health Plan provides access to services 24 hours a day, 7 days a week, and 365 days a year, to ensure that members receive the care they need.

Who is eligible to enroll in the North Shore-LIJ Health Plan MLTC Program?

To become a member of the North Shore-LIJ Health Plan MLTC Program you must:
- Be 18 years of age or older;
- Be a resident of Kings, Nassau, New York, Queens, Richmond or Suffolk County;
- Be Medicaid eligible;
- Be able to return to or remain at home without risk to health or safety as determined by a North Shore-LIJ Health Plan care manager;
- Require long-term care services for more than 120 days;
- Agree to receive your covered services through North Shore-LIJ Health Plan.
1-2 Code of Ethical Conduct

North Shore-LIJ Health Plan maintains a code of ethical conduct, prepared with the advice and assistance of legal counsel and approved by the Board of Directors. The code is a formal statement of the corporation’s commitment to the standards and rules of ethical business conduct. It applies to employees, directors, officers, contractors and others with whom North Shore-LIJ Health Plan does business. In addition to being committed to upholding the rules set forth in the code, North Shore-LIJ Health Plan is committed to conducting all activities in accordance with applicable laws and regulations.

You may obtain a copy of the North Shore-LIJ Health Plan Code of Ethical Conduct on our website, www.nsljhealthplans.com. You may also request a copy from North Shore-LIJ Health Plan’s Provider Relations department.

1-3 Prohibition on Restricting Provider Discussion with Members

As mandated by New York State Public Health Law, North Shore-LIJ Health Plan will not, by contract, written policy or written procedure, prohibit or restrict any provider from:

- Disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, any information that such provider deems appropriate regarding a condition or a course of treatment of an enrollee, including the availability of other therapies, consultations or tests, or the provisions, terms or requirements of North Shore-LIJ Health Plan’s products as they relate to the enrollee, where applicable, regardless of benefit coverage limitations.

- Filing a complaint or making a report or comment to an appropriate governmental body regarding the policies or practices of North Shore-LIJ Health Plan when the provider believes that the policies or practices have a negative impact on the quality of, or access to, patient care.

- Advocating to North Shore-LIJ Health Plan on behalf of the enrollee for approval or coverage of a particular treatment or for the provision of health care services.

In addition, nothing in North Shore-LIJ Health Plan’s agreements with providers is intended to, or shall be deemed to, transfer liability for North Shore-LIJ Health Plan’s own acts or omissions, by indemnification or otherwise, to a provider.
1-4 Privacy and Confidentiality

North Shore-LIJ Health Plan has established procedures for compliance with all federal and state statutes, regulations and accreditation standards governing the use, protection and dissemination of medical records and protected health information, including medical records, claims, benefits, surveys and administrative data. North Shore-LIJ Health Plan utilizes protected health information and data to assist in the delivery of health care, to compensate providers, and to measure and improve care.

North Shore-LIJ Health Plan recognizes that an individual who submits, or authorizes his or her health care provider to submit, medical or dental claims information for processing and payment has an expectation that such information, to the extent it identifies the individual, will not be disclosed in any manner that violates federal or state law or regulation.

North Shore-LIJ Health Plan affords members the opportunity to authorize or deny the release of identifiable protected health information. By law, a member must provide a special authorization for North Shore-LIJ Health Plan to release protected health information, including mental health, alcohol and substance abuse, abortion, sexually transmitted diseases, genetic testing and HIV/AIDS-related information. Members may authorize the release of some or all of their protected health information by completing an authorization form.

For those members who lack the ability to give authorization, North Shore-LIJ Health Plan will obtain authorization from a legally designated, qualified person, such as the member's legal guardian or person with the member's power of attorney.

You may obtain a copy of North Shore-LIJ Health Plan's Provider Notice of Privacy Practices on our website, www.nsljhealthplans.com. You may also request a copy from North Shore-LIJ Health Plan's Provider Relations department.
Section 2: Members

2-1 How Can a Provider Verify the Eligibility of a North Shore-LIJ Health Plan Member?

- Every enrolled member receives a North Shore-LIJ Health Plan ID card in the mail. Please refer to Appendix A-1 for example of the front and back of member ID card.

- North Shore-LIJ Health Plan also provides member eligibility information through the Plan's provider website: www.nsljhealthplans.com

- Providers may also access Electronic Medicaid Eligibility Verification System (EMEVs) to verify member eligibility.

2-2 Member Rights and Responsibilities

The rights and responsibilities of a North Shore-LIJ Health Plan member are outlined in the Member Handbook, which is provided after the member has been confirmed for enrollment.

**What are a member’s rights?**

North Shore-LIJ Health Plan members have the right to:

- Receive medically necessary care.

- Have timely access to care and services.

- Expect that their medical records will be kept confidential, and that only those with a member's written authorization, unless otherwise allowed by law, will be able to view medical records.

- Obtain information on available treatment options and alternatives, presented in a manner and language appropriate to their condition and ability to understand (oral translation services are free of charge).

- Get information necessary to give informed consent before the start of treatment or services.

- Be treated with respect and recognition of their dignity and right to privacy. (See our Notice of Privacy Practices on how we protect member information.)

- Obtain a copy of their medical records and ask that the records be amended or corrected.
Take part in decisions about their health care, and have those decisions reflect their ethical, cultural and spiritual beliefs. They also have the right to refuse treatment.

Be free from any form of restraint or seclusion used for convenience or as a means of coercion, discipline or retaliation.

Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.

Be told where, when and how to get the services they need from the MLTC plan, including how to obtain covered benefits from out-of-network providers if those benefits are not available from in-network providers.

Voice concerns or appeals about North Shore-LIJ Health Plan or about their care to their care manager.

Complain to the New York State Department of Health or the local Department of Social Services, and, in the event that they feel they were treated unfairly, use the New York State Fair Hearing System and/or make a New York State External Appeal.

Appoint a relative or friend to make decisions about care and treatment on their behalf if they are unable to do so.

What are a member’s responsibilities?

North Shore-LIJ Health Plan members have the responsibility to:

- Participate in care and care decisions.
- Understand North Shore-LIJ Health Plan’s benefits and plan guidelines.
- Supply accurate and complete information about their health, including information about unexpected changes in their health (to the extent possible), so that North Shore-LIJ Health Plan and their providers can provide appropriate care.
- Notify North Shore-LIJ Health Plan of any changes in their address, telephone number or eligibility status.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow the plans and instructions for care that they have agreed upon with their providers.
- Be responsible for their actions if they refuse treatment or do not follow their provider’s instructions.
2-3 Member Co-payments

North Shore-LIJ Health Plan members do not have co-payments for services they receive. Therefore, with the exception of the Net Available Monthly Income (NAMI) for skilled nursing facility residents, providers are prohibited from charging, collecting a deposit or co-payment from, seeking compensation, remuneration or reimbursement from, or having any recourse against any enrollee/member or person acting on his behalf for covered services furnished in accordance with their contract with North Shore-LIJ Health Plan.

2-4 Non-English Speaking Members

North Shore-LIJ Health Plan accommodates the diversity of its membership with a staff that speaks several languages. In addition, North Shore-LIJ Health Plan contracts with a language assistance line to ensure that we can properly communicate with all members. Contracted providers are also expected to meet the language needs of North Shore-LIJ Health Plan members. If a member needs assistance, please have him/her call (855) 421-3066.

2-5 Impaired Members

In compliance with Americans with Disabilities Act (ADA) requirements, North Shore-LIJ Health Plan accommodates visually impaired and hearing impaired members. Contracted providers are also expected to meet the needs of North Shore-LIJ Health Plan members irrespective of disabilities. If you need assistance, please contact (855) 421-3066 or, if a member is hearing impaired and requires TTY line assistance, please call (855) 871-1665.
Section 3: Care Management Team (CMT)

3-1 Care Management

Care management is a process that ensures consistent oversight, coordination and support to members and their families in accessing managed long-term care covered services, as well as non-covered services. The mutually agreed upon care plan is reviewed and revised over time in response to the changing needs of the member. North Shore-LIJ Health Plan is dedicated to the provision of services that will enable members to remain safe and secure in their own homes.

What are the objectives of the care management team?

- To coordinate member services beginning with pre-enrollment and through active enrollment.
- To establish effective systems to ensure consistent oversight of care and services across all service settings.
- To establish protocols for routine and event monitoring, e.g., during hospitalization or short/long-term nursing home placement, after a new diagnosis or major social or environmental change, or in case of increasing frequency of falls, pain management concerns or a change in cognitive status.
- To establish standards for documentation and practice.
- To apply cost containment controls when clinically appropriate and with consideration for member/family preference.

Members, families and caregivers are instructed to contact the Care Management Team (CMT) directly if they have any questions, concerns, compliments or complaints related to providers. Providers should advise members, families or caregivers to contact the North Shore-LIJ Health Plan CMT for service issues, e.g., aide change. Providers should also contact the member’s CMT for such issues.

3-2 Coordination of Services

North Shore-LIJ Health Plan provides and coordinates services designed to keep members living in their own homes for as long as possible. North Shore-LIJ Health Plan does this by providing a comprehensive team approach in the delivery of long-term care services. The CMT, which is composed of a nurse, social worker and health plan services coordinator, is responsible for coordinating the long-term care services needed by members. Every member has his/her own CMT, and the CMT works with the member and his or her family/caregiver to provide an optimal and safe care plan.
What are the roles of the nurse?

- Develops the initial plan of care based on the initial needs assessment.
- Secures necessary home care services with providers or vendors.
- Monitors change of health/service status.
- Contacts primary care providers to coordinate service delivery.
- Coordinates the physician orders with providers.
- Provides a referral to an out-of-network provider pursuant to a treatment plan approved by North Shore-LIJ Health Plan when the North Shore-LIJ Health Plan’s network does not include an available provider with the appropriate training and experience to meet the member's needs.

What are the roles of the social worker?

- Maintains contact with the member, family or caregiver prior to enrollment.
- Assumes role of care management when indicated.
- Refers the member, family or caregiver to temporary community services as needed.

What are the roles of the Health Plan services coordinator?

- Assists with telephone contacts.
- Arranges for commencement of initial services.
- Collaborates with clinician/clinical team to maintain proper documentation, workflow and procedures.

The North Shore-LIJ Health Plan CMT coordinates the services members receive, and communicate with the doctors and other health care providers on an ongoing basis. The CMT will schedule appointments for members, provide for transportation to and from appointments, and arrange to meet members’ needs. Members develop a unique and strong relationship with their CMT, while the team acts as an advocate and liaison between providers and members. The CMT should be contacted whenever opportunities for improvement are identified. The CMT will contact provider staff when barriers are recognized and will work with provider staff to optimize care and satisfaction. In addition, each CMT has a network of resources within North Shore-LIJ Health Plan to assist it in overseeing provider performance and member outcomes, including direct supervisors, provider relations and contract administration support staff, and quality assurance supports.
What are service authorizations?

Service authorizations are established by the CMT with input from the member, family, physician and other persons involved in the care of the member. Authorizations for medically necessary, covered services will ensure that they are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which they are furnished.

What services require prior authorization?

The following services require prior authorization by North Shore-LIJ Health Plan or its designee (DentaQuest and Davis Vision):

- Adult Day Health Care Services
- Audiology Services
- Chore or Housekeeping Services
- Dental
- Home Care Services, including nursing care, social work services, rehabilitation therapies, nutritional counseling, and home health aide services
- Home Delivered Meals
- Home Safety Modifications
- Medical and Surgical Supplies
- Medical Equipment
- Nursing Home Care
- Nutritional Supplements
- Optometry
- Outpatient Rehabilitation Therapy
- Personal Emergency Response System (PERS)
- Podiatry (required if the services are not covered by Medicare)
- Private Duty Nursing
- Respiratory Therapy and Oxygen
- Social Day Care
- Transportation
What are the procedures for authorizing services?

- Once services are approved, a member of the CMT determines the appropriate provider to coordinate services.
- Upon verbal acceptance of the case by a provider, the CMT will prepare a written authorization detailing the type, frequency and duration of service, and expected date of commencement.
- Authorizations will be mailed or faxed to the provider to confirm approval and made available to North Shore-LIJ Health Plan’s claims adjudicator.
- Providers should initiate providing services only upon receipt of written authorization to ensure payment. Written authorizations should be received by providers within 24 hours following a verbal approval, or the next business day.

What are the procedures for making home health care determinations following an inpatient admission?

Effective January 1, 2010, subdivision 3 of PHL §4903 was amended to change the timeframe for utilization review determinations of home health care services following an inpatient hospital admission. Typically, the request for these home health care services follow an inpatient stay is for skilled services and reimbursable by Medicare.

If a service is Medicare qualified, it is the provider’s responsibility to determine if the member is Medicare eligible. If the Member is Medicare eligible and the service is Medicare qualified, the provider must bill Medicare and North Shore-LIJ Health Plan will be responsible for the co-payment of covered services from days 21-100 for skilled nursing home services.

North Shore-LIJ Health Plan will furnish utilization review determinations of home health care services following a Medicare denial or exhaustion of a Medicare benefit following an inpatient hospital admission, i.e., in a general hospital that provides inpatient care or inpatient services in an Article 28 rehabilitation facility, as follows:

- Within one (1) business day of receipt of the necessary information, or
- Within 72 hours of receipt of the necessary information if the day after the request for services falls on a weekend or holiday.

If a request for home health care services and all necessary information is provided to North Shore-LIJ Health Plan prior to a member’s inpatient hospital discharge, North Shore-LIJ Health Plan will make arrangements to coordinate benefits with Medicare. If there is no Medicare, North Shore-LIJ Health Plan shall not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the determination is pending. An appeal of a denial for home health services following a discharge from a hospital admission will be treated as an expedited appeal under PHL §4904(2).
### 3-3 Covered and Non-Covered Services

The table below summarizes the services covered by the North Shore-LIJ Health Plan MLTCP. It should be noted that North Shore-LIJ Health Plan covers Medicaid eligible services only. The provider is required to bill Medicare as the primary payer when the services are eligible for Medicare coverage.

The North Shore-LIJ Health Plan CMT will coordinate all medical services for the member, including covered and non-covered services.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Non-Covered Services</th>
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<tbody>
<tr>
<td>Care Management</td>
<td>Inpatient and Outpatient Hospital Care</td>
</tr>
<tr>
<td>Home Care, including Nursing, Home Health Aide, Occupational, Physical and Speech Therapies</td>
<td>Laboratory and Radiology Services</td>
</tr>
<tr>
<td>Consumer-directed Personal Assistance Program</td>
<td>Prescription and Non-prescription Drugs</td>
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<tr>
<td>Non-Emergency Transportation to receive medically necessary services</td>
<td>Physician Services</td>
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<tr>
<td>Podiatry (foot care)</td>
<td>Psychiatry and Mental Health Services</td>
</tr>
<tr>
<td>Optometry (including Eyeglasses)</td>
<td>Alcohol and Substance Abuse Services</td>
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<tr>
<td>Audiology, Hearing Aids and Batteries</td>
<td>Chronic Renal Dialysis</td>
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<tr>
<td>Dental Care</td>
<td>Emergency Transportation</td>
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<tr>
<td>Prosthetics and Orthotics</td>
<td>Family Planning Services</td>
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<td>Medical Equipment</td>
<td>Services Covered by Office for People with Developmental Disabilities</td>
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<tr>
<td>Nutrition</td>
<td></td>
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<tr>
<td>Personal Emergency Response System</td>
<td></td>
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<tr>
<td>Social/Environmental Supports (such as chore services or home modifications)</td>
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<tr>
<td>Nursing Home Care</td>
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<tr>
<td>Respiratory Therapy</td>
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<tr>
<td>Rehabilitation Therapies</td>
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<td>Medical Social Services</td>
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<tr>
<td>Adult Day Health Care</td>
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<td>Social Day Care</td>
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<tr>
<td>Home-delivered Meals and/or meals in a group setting (such as a day center)</td>
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North Shore-LIJ Health Plan has delegated utilization management and claims payment for optometry (including eyeglasses) and dental care services to Davis Vision and DentaQuest respectively.
3-4 Member Assessments

North Shore-LIJ Health Plan strives to build a strong relationship with our members that starts before enrollment. Providers partner with us in growing this relationship by supplying services to maximize care and satisfaction, and by communicating any changes in the member's status promptly to the North Shore-LIJ Health Plan CMT.

What does the initial assessment entail?

An enrollment nurse goes to the prospective enrollee's home to conduct an assessment to evaluate the member's medical, cognitive and functional status, and also to evaluate the home environment. Based on the assessment, a plan of care/service plan (PCSP) is developed. A Uniform Assessment System for New York (UAS –NY), Nursing Assessment and PCSP is also prepared by the enrollment nurse and CMT and becomes part of the member's medical record. The PCSP is communicated and agreed to by the enrollee, family and/or caregiver.

The CMT contacts providers to arrange for required services based on the member's needs. Such arrangement begins the strong and unique relationship between the member/member's family/caregiver, the provider and North Shore-LIJ Health Plan.

It is the responsibility of the North Shore-LIJ Health Plan CMT to assess or re-assess the need for a personal care aide, home health aide and housekeeper services, and to evaluate the member's capabilities. The provider is responsible for servicing the member as authorized by North Shore-LIJ Health Plan. The provider must follow the PCSP written on the Home Care Service Guidelines form, which states the services and hours required for home health aides or personal care aides at the member's home. The provider is responsible to open the case and supervise the home health aides or personal care aides according to NYSDOH policies and procedures. The provider should communicate any recommendations or revisions required to the service plan directly to the North Shore-LIJ Health Plan CMT.

What do ongoing assessments entail?

Monthly telephone calls are made to each member by the CMT. The purpose of the calls is to ascertain if the member's needs are being met, distinguish changes in functionality, identify opportunities for improvement and maximize satisfaction. These calls assist in determining whether changes are needed in the PCSP. The CMT nurses and/or social workers may also conduct home visits, as needed, to assist members in maximizing care and functionality.
What is the Uniform Assessment System for New York (UAS-NY)?

The electronic system, Uniform Assessment System for New York (UAS-NY), will be based on a uniform data set and will standardize and automate needs assessments for home and community based programs in New York. Every one hundred eighty (180) days, a formal assessment is conducted by a nurse during a visit to the member's home. As in the initial visit, the nurse conducts an assessment of the member's medical, cognitive and functional status, as well as the home environment. Based on the assessment, a PCSP is developed. The PCSP is communicated and agreed to by the member, his/her family/caregiver and the designated CMT. The CMT staff will then contact providers to meet the identified needs. If additional visits are required or if there is a change in health status, an updated UAS will be completed by an in-home nurse assessor.

3-5 Transitional Care for a New Member

Upon entering our program, new members being treated by out-of-network providers shall be transitioned to in-network providers within sixty (60) days from the date of enrollment. North Shore-LIJ Health Plan shall ensure that the transition shall be seamless. New members who are being treated by an out-of-network dentist shall be allowed to continue seeing that dentist until their current treatment regimen is completed and then transitioned to an in-network provider.

3-6 Obtaining Services While Out-of-area

If a member relocates out of the North Shore-LIJ Health Plan's service area, he/she shall be disenrolled from North Shore-LIJ Health Plan. If a member temporarily travels outside the service area, North Shore-LIJ Health Plan shall be responsible for coordinating MLTC covered services and non-MLTC covered services.
Section 4: Providers

4-1 Provider Network and Provider Services

The North Shore-LIJ Health Plan Provider Relations department maintains and supports its provider network to ensure adequate access to and availability of providers. The department is responsible for provider recruitment, contracting, credentialing and re-credentialing. Once the provider joins the network, the Provider Relations staff members schedule orientations to educate him/her about North Shore-LIJ Health Plan programs, policies and procedures, and provide any necessary updates regarding plan information. The Provider Services staff members are responsible for:

- Assisting providers with prior authorization and referral protocols.
- Assisting providers with claims payment procedures.
- Assisting providers in the review and resolution of reconsiderations and/or provider appeals.
- Fielding and responding to provider questions and complaints.
- Scheduling orientation of providers and subcontractors regarding program goals.
- Arranging provider training to improve integration and coordination of care.

Provider Relations staff members review and update all contracts, as needed, and investigate and resolve all provider-related complaints. If you have any questions, please contact the North Shore-LIJ Health Plan Provider Services line at (888) 831-8429.

4-2 Provider Updates

The North Shore-LIJ Health Plan Provider Relations department contacts individual providers as needed to maximize care and service to members and oversee contractual requirements. The Provider Relations staff members contact providers by telephone, and send periodic emails to inform the network of important changes in plan policies and procedures and to keep providers updated. Provider newsletters and notices are published and mailed to providers on a regular basis. Providers also have 24-hour access to alerts and policy/procedure changes on our secure provider website; for registration and access, please visit www.nsljhealthplans.com.
4-3 Provider Credentialing and Re-credentialing

The North Shore-LIJ Health Plan Provider Relations department must follow and complete certain procedures before a provider is considered as part of the North Shore-LIJ Health Plan provider network.

1. The provider must complete and return a provider application with the required supporting documents, e.g., copies of current Certificate of Liability, license/certification.

2. The complete application package must be reviewed by the medical director for approval.

3. After all required documentation is received, the provider package must be presented to the Quality Assurance Committee (QAC) for approval.

After the initial credentialing, all contracted providers are re-credentialed at least every two years. The re-credentialing requires the providers to send updated information. The North Shore-LIJ Health Plan re-credentialing process also involves a review of provider performance indicators, which may include the following:

- Member/family complaints;
- Information from quality improvement activities; and
- Member satisfaction surveys.

If the re-credentialing is denied, the provider will be notified in writing of North Shore-LIJ Health Plan’s decision and informed of his/her right to appeal that decision. North Shore-LIJ Health Plan may, at its option, terminate the Provider Agreement upon thirty (30) days written notice to the provider.

Effective October 1, 2009, newly licensed health care professionals (HCPs), or HCPs relocating from another state who are joining the group practice of in-network providers, will be allowed to participate in North Shore-LIJ Health Plan’s provider network only if they meet the participation and credentialing criteria outlined below.

- North Shore-LIJ Health Plan will make a determination within ninety (90) days of receipt of a completed application. If no determination is made at that time, an HCP joining a group practice will be considered provisionally credentialed until a final determination is made.

- If the final determination is a denial, the HCP will revert to a non-participating status. The group practice wishing to include the newly licensed or relocated HCP must agree to refund any payments made by North Shore-LIJ Health Plan for in-network services delivered by the provisionally credentialed HCP that exceed any out-of-network benefit. In addition the provider group must agree to hold the member harmless from payment of any services denied during the provisional period.
If North Shore-LIJ Health Plan offers a member transitional care and the transitional care is provided by a provisionally credentialed provider who is ultimately denied credentialing by North Shore-LIJ Health Plan, other medical group providers will assume responsibility for the member's care. Medical groups are encouraged to provide full disclosure to members about a provider's provisional status so that they can determine whether to have a fully credentialed provider in charge of their care.

4-4 Provider Rights and Responsibilities

**What are the provider’s rights?**

North Shore-LIJ Health Plan’s participating providers can act within the scope of their license, as permitted by law, to advise or advocate for members, and possess external appeal rights regarding the following:

a) Determination of health status or plan of care options; and

b) Filing a complaint or making a report or comment to an appropriate governmental body regarding North Shore-LIJ Health Plan’s policies if the provider believes that the policies negatively impact the quality of care or access to care.

Note that effective January 1, 2010, PHL §4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations.

**What are the provider’s responsibilities?**

North Shore-LIJ Health Plan’s participating providers shall provide services that conform to medical and surgical practice standards that are accepted in the community. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control. North Shore-LIJ Health Plan’s participating providers’ responsibilities include but are not limited to:

a) Obtaining physician orders for covered services, including but not limited to personal care aide, home care and skilled nursing services, as required, and providing quality of care within scope of practice (as defined by federal and state laws and regulation and in accordance with North Shore-LIJ Health Plan’s access, quality and participation standards);

b) Adhering to North Shore-LIJ Health Plan clinical guidelines;

c) Complying with all North Shore-LIJ Health Plan administrative, patient referral, quality assurance, utilization management and reimbursement procedures;
d) Providing written reports to care managers following authorizations for service evaluations and after rendering services to members;

e) Providing optimal care to members without regard to race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status or source of payment, and promoting the rights of members as protected by law;

f) Complying with the Americans with Disabilities Act (ADA) guidelines set forth by the New York Department of Health (NYSDOH), e.g., regarding wheelchair access;

g) Complying with non-disclosure and confidentiality rules and maintaining standards for documentation and confidentiality of medical records, as per section 4-10 of this manual;

h) Billing Medicare if a service is Medicare qualified and if the member is Medicare eligible. North Shore-LIJ Health Plan will be responsible for the co-payment of covered service. Providers shall not under any circumstances, including non-payment by or insolvency of North Shore-LIJ Health Plan, bill, seek or accept payment from North Shore-LIJ Health Plan members for covered services;

i) Being the treating provider for North Shore-LIJ Health Plan members in cases where office space is shared with non-participating providers;

j) Allowing North Shore-LIJ Health Plan staff access to clinical data in order to facilitate review of medical records, concurrent review, audits and site visits for credentialing;

k) Submitting “clean” encounter data in a timely fashion, using appropriate claim forms;

l) Notifying North Shore-LIJ Health Plan of any change to, or addition or deletion of, office hours, associates or billing address (written notification should be sent in writing immediately but after no more than three (3) calendar days);

m) Notifying North Shore-LIJ Health Plan immediately but within no more than three (3) calendar days of the following:

   ■ Medical license, DEA certification (if applicable) or operating certificate is revoked or restricted, or any reportable action is taken by a city, state or federal agency.

   ■ Ability to practice medicine is restricted or impaired in any way, or license to practice is revoked, suspended, restricted, requires a practice monitor or is limited in any way.

   ■ Malpractice coverage lapses or malpractice carrier or coverage amounts change.

   ■ A malpractice claim is made.

   ■ A new associate joins a group practice.

n) Updating time-sensitive documents, such as license registration, and malpractice insurance, and sending copies to North Shore-LIJ Health Plan to keep individual files current at all times;
Continuing an on-going course of care and treatment for a member for a transitional period of up to ninety (90) days when the provider leaves North Shore-LIJ Health Plan;

Cooperating and participating in all North Shore-LIJ Health Plan peer-review functions, including quality assurance, utilization review, administrative and grievance procedures as established by North Shore-LIJ Health Plan;

Complying with all final determinations rendered by North Shore-LIJ Health Plan peer review programs, or external arbitrators for grievance procedures, consistent with the terms and conditions of the provider’s agreement with North Shore-LIJ Health Plan; and

Notifying North Shore-LIJ Health Plan in writing of any change in office address, telephone number or office hours. A minimum of thirty (30) calendar days advance notice is requested.

North Shore-LIJ Health Plan encourages providers to discuss with members end-of-life care and the appointment of an agent to assume the responsibility of making health care decisions when the member is unable to do so. Information for members about advance care planning is available at www.nslijhealthplans.com.

What are the responsibilities of North Shore-LIJ Health Plan to providers?

North Shore-LIJ Health Plan recognizes its obligation to assure participating providers of the following:

Comprehensive plan training and orientation programs.

Timely and ongoing communication from knowledgeable staff.

Timely payment for covered services rendered to members.

Timely responses to questions or concerns.

Assistance with complex member issues.

Timely resolution of grievances and appeals.

Constructive feedback on performance and utilization.

4-5 Provider Non-Disclosure and Confidentiality

A member’s protected health information (PHI) is privileged under the contractual relationship between North Shore-LIJ Health Plan and the member, and between North Shore-LIJ Health Plan and the provider. PHI is derived in whole or in part using personally identifiable information which is not otherwise publicly available, and includes enrollment with North Shore-LIJ Health Plan, medical records and/or payment for the provision of health services. Such PHI must be safeguarded and held in strict confidence, so as to comply with applicable privacy provisions of state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA).
North Shore-LIJ Health Plan members sign an authorization at the time of enrollment that allows North Shore-LIJ Health Plan to review, release and use their respective PHI. In addition, at the time of the initial encounter with each North Shore-LIJ Health Plan member, direct medical care providers are required to obtain the member’s written consent to disclose PHI to North Shore-LIJ Health Plan or provide the member with a copy of their Privacy Notice indicating that their PHI will be shared with North Shore-LIJ Health Plan and other entities. This written consent or the member’s written acknowledgment of the provider’s Privacy Notice, is to be maintained in the provider’s records and is subject to audit by North Shore-LIJ Health Plan. All providers should take all reasonable measures to protect the privacy and confidentiality of the member’s non-public personal information at all times, and to prevent its use by or disclosure to any non-affiliated third party. All providers should remain aware that PHI about the provision of substance abuse services, and PHI that identifies the presence of HIV-related illness, is governed by a special set of confidentiality rules. Release of these records requires a special authorization and should not be made to anyone other than the patient except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of North Shore-LIJ Health Plan member’s PHI, please call (888) 831-8429.

What are the provider’s responsibilities regarding non-disclosure and return of trade secrets and intellectual property?

Providers, as well as a provider’s employees, agents, or independent contractors (all of whom shall be deemed to be the providers for the purposes of this section) may not disclose to third parties North Shore-LIJ Health Plan’s trade secrets or intellectual property, regardless of whether such information is marked or designated confidential, without prior written consent of North Shore-LIJ Health Plan. In addition, providers must take commercially reasonable steps to safeguard North Shore-LIJ Health Plan’s trade secrets and intellectual property to prevent its unauthorized or improper use or copying.

Upon termination of the Provider Agreement for any reason, the provider agrees to return (or destroy, at the option of North Shore-LIJ Health Plan) any and all material that could be considered North Shore-LIJ Health Plan’s trade secrets and intellectual property to North Shore-LIJ Health Plan or North Shore-LIJ Health Plan’s designee.

4-6 Termination of Provider Agreement

Termination by North Shore-LIJ Health Plan

North Shore-LIJ Health Plan may, at its option, terminate this Provider Agreement immediately and without notice to the provider in the event of: (a) conduct by the provider or provider’s employee or agent which in the sole judgment of North Shore-LIJ Health Plan poses an imminent harm to member(s); (b) circumstances that result in the provider being legally unable to deliver the covered services specified herein; (c) a determination by North Shore-LIJ Health Plan that the provider or provider’s employee or agent has engaged in fraud,
willful misconduct or grossly negligent acts; (d) a determination to suspend, terminate or deny approval to
the provider to participate in the New York State Medicaid Program or the Medicare Program; (e) a determi-
nation by New York State Department of Health or North Shore-LIJ Health Plan, in its sole discretion, that the
provider has not performed adequately (which includes, but is not limited to, egregious patient harm, signifi-
cant substantiated complaints, submitting claims to North Shore-LIJ Health Plan for services not delivered,
and refusal to participate in North Shore-LIJ Health Plan's quality improvement program); or (f) the provider
rejecting an amendment to the Provider Agreement.  (Refer to Section 4 of the Provider Agreement)

**Termination by provider**

In the event that North Shore-LIJ Health Plan defaults in the performance of any material duty or obligation
hereunder, the provider may, at its option, give North Shore-LIJ Health Plan written notice identifying the
alleged default or breach, and if North Shore-LIJ Health Plan does not cure such default or breach within
thirty (30) days of such notice, the provider may, at its option, terminate this Agreement upon thirty (30)
days prior written notice (refer to Section 4 of the Provider Agreement).

In the event a provider is no longer interested in participating with North Shore-LIJ Health Plan, he/she
should call the North Shore-LIJ Health Plan Provider Services line at (888) 831-8429.

**4-7 Provider Participation in North Shore-LIJ Health Plan Operations**

North Shore-LIJ Health Plan values its relationship with providers and the unique perspectives that both
parties bring to maximizing care and ensuring efficient operations. Ongoing communications are maintained
between Provider Relations Department staff members and providers. Our staff members also reach out to
providers regarding updates to policy or operational procedures to ensure timely and efficient services.

Formal input and participation by North Shore-LIJ Health Plan providers may include internal committee
involvement.  Selected providers may be requested to participate in Quality and Utilization Management
(QUM) Committee and other committee activities hosted by North Shore-LIJ Health Plan.

North Shore-LIJ Health Plan appreciates provider input and conducts periodic surveys of provider
satisfaction. Provider data is completed and returned in a confidential manner.  The data is aggregated
with no individual identifiers noted. Results are used to determine system and operational improvements
to maximize clinical outcomes and operational effectiveness. Examples of actions taken as a result of
satisfaction surveys may include changes to staff meeting times to later in the morning to make staff
more accessible to early morning provider calls; the installation of a new telephone system that allows
direct dialing to staff; a weekly internal communication procedure among the office managers, on-call staff
and our answering service; and the ability to patch through provider after-hours calls quickly in cases of
emergency.
4-8 Network Evaluation

The adequacy of the current provider network is reviewed and analyzed on an annual and ongoing basis. Our mission is to provide the appropriate service, in the appropriate manner, at the appropriate time with the appropriate provider.

North Shore-LIJ Health Plan monitors service outcomes by documenting best practices and noting when service delivery does not match standards or is not delivered within the timeframes specified. Tracking and trending of utilization and services provides an opportunity for CMT staff members to report positive efforts by providers and their staff. Data are logged, analyzed and used to identify best practices as well as provider and access issues, potential inadequacy of the network and a need to add providers.

4-9 Provider Billing Codes

As a condition of payments, providers shall submit their claims using the codes provided in Appendix A-4. Any changes or updates to coding shall apply to date of service occurring on the latter of (a) the effective date of such changes or updates or (b) forty-five (45) calendar days following the date on which CMS or SDOH publishes such changes or updates to coding.

4-10 Medical Record Guidelines

Each provider shall:

- Keep a separate medical record for each member.
- Ensure that the medical record verifies that case manager coordinates care.
- Ensure access to medical records by North Shore-LIJ Health Plan and other regulatory agencies.
- Retain medical records for six (6) years following the member's date of service.

Medical records should be kept in a manner that is current, detailed, organized, complies with all state and federal laws and regulations and is accessible by the treating provider and North Shore-LIJ Health Plan. Providers must maintain medical records and provide such medical, financial and administrative information to North Shore-LIJ Health Plan as is reasonably required to ensure compliance with applicable laws, rules and regulations and for purposes of program management. Records must be made available to North Shore-LIJ Health Plan staff for review when requested; copies of patient charts must be made available to North Shore-LIJ Health Plan without cost, per the provider's participation agreement.
4-11 Provider Audit

North Shore-LIJ Health Plan shall perform periodic reviews of provider records documenting evidence of service delivery to determine accuracy and pattern of error and to guard against malfeasance.

Documents collected may include but are not limited to:

- Medical record notes
- Attendance sheets
- Activity records
- Time slips
- Sign in logs
- DME delivery tickets
- Trip verifications
- Progress notes
- Care plans

Audits shall be based on a sampling of claims for a specific period. Provider selection shall be based on utilization.

General methodology includes the following:

- Providers shall make available, within thirty (30) days advance notice, requested documents identified by invoice number, member names or dates of services.
- Providers shall make available service documents for review by North Shore-LIJ Health Plan staff.
- North Shore-LIJ Health Plan shall develop a report of findings, including errors, if found.
- Providers showing an error rate in excess of five percent (5%) shall be notified and a corrective action plan shall be requested.
- Failure to take corrective action shall result in termination from the North Shore-LIJ Health Plan's network with notification to the regulatory agencies.
- Cases of suspected fraud, abuse or malfeasance shall be referred to the appropriate agencies for investigation.
4-12 Provider Directory
Providers can consult the North Shore-LIJ Health Plan participating Provider Directory by checking the website at www.nslijhealthplans.com or contacting Provider Services at (888) 831-8429.

4-13 Disputes Resolution
North Shore-LIJ Health Plan shall work with providers who have disputes on claims payment and service authorizations. See section 5-4: Claims Appeals for Payments/Review and Consideration.
Section 5: Billing Reimbursement Procedures

5-1 Claims Submission Procedures

North Shore-LIJ Health Plan is committed to providing the highest level of service in claims processing in an accurate and efficient manner. North Shore-LIJ Health Plan also fully adheres to the New York State Insurance Department’s prompt payment requirement.

How can a provider submit claims electronically?

North Shore-LIJ Health Plan utilizes MD On-line, Inc., a leading provider of electronic data interchange (EDI) and a clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 and UB 04 receive a status report indicating which claims were accepted, rejected and/or pending, and the amount paid on the claim once it has been finalized.

Claims submitted electronically must include:

1. North Shore-LIJ Health Plan Payer ID Number 17516
2. Member’s CIN ID number
3. National Provider Identifier (NPI) should reside in:
   - 837 Professional (CMS)-Loop 2310B Rendering Provider Secondary ID, Segment/Element NM109. NM 108 must qualify with an xx (NPI)
   - 837 Institutional (UB04)-Loop 201 AA Billing Provider, Segment/Element NM 109. NM 108 must qualify with an xx (NPI)

To sign up for electronic billing, providers must contact their software vendor and request that their North Shore-LIJ Health Plan claims be submitted through MD On-line, Inc. Providers can also direct their current clearinghouse to forward claims to MD On-line, Inc. Please contact MD On-line, Inc. at (888) 499-5465 for information on how to set up electronic billing.

If you have any questions regarding claims issues, please call (888) 831-8429. Representatives are available Monday through Friday, from 9 am to 5 pm.
How can a provider submit paper claims?

All paper claims should be submitted to:

North Shore-LIJ Health Plan, Inc.
Attn: Claim Department
P.O. Box 958435
Lake Mary, FL 32795-8435

All paper claims should include the NPI, as well as North Shore-LIJ Health Plan's assigned Provider ID number. The North Shore-LIJ Health Plan Provider ID number is a unique provider number for each provider for each practice site (it is not required for electronic claims).

What is the timeframe for claims submissions?

In-network and out-of-network providers must file claims within ninety (90) days of the date of service. We encourage you to submit your claims as soon as possible for prompt processing and payment.

What are the authorization requirements?

All North Shore-LIJ Health Plan in-network and out-of-network providers are required to receive prior authorization for covered services. Except for emergency services and treatment of urgent medical conditions, providers are required to receive authorization prior to providing services to North Shore-LIJ Health Plan members. Please contact North Shore-LIJ Health Plan's CMT at (855) 421-3066 for questions related to care management and service authorizations.

Is balance billing permitted?

All payments for services provided to North Shore-LIJ Health Plan's members constitute payment in full. Providers may not balance bill members for the difference between their actual charges and the amounts paid by North Shore-LIJ Health Plan; any such billing is in violation of the Provider Agreement with North Shore-LIJ Health Plan and applicable New York State Law. Where appropriate, North Shore-LIJ Health Plan will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

How can a provider submit a claim when North Shore-LIJ Health Plan is not a primary payer?

North Shore-LIJ Health Plan is always the payer of last resort and is the secondary payer to Medicare and/or third party payers. If Medicare covers any services, Medicare shall be billed first. If the member has any additional insurance that covers any of the services, the additional insurer shall be billed after Medicare.
Once the Explanation of Payment (EOP) is obtained from Medicare or any insurance other than Medicare or Medicaid, providers may submit a claim for co-payments to North Shore-LIJ Health Plan, along with a copy of the EOP.

5-2 Provider Information

Providers are responsible for contacting North Shore-LIJ Health Plan to report any changes in their organization. It is essential that North Shore-LIJ Health Plan maintains an accurate provider database in order to ensure proper payment of claims, as well as to comply with provider reporting requirements mandated by governmental and regulatory authorities and provide the most up-to-date information on provider choices to our members. Provider must notify North Shore-LIJ Health Plan with changes to any of the following:

- Provider’s name and Tax ID number (s)
- Provider’s address, zip code, telephone or fax number
- Provider’s billing address
- Languages spoken in the provider’s office
- National Provider Identification Number (if applicable)
- Office hours
- Ownership of organization (provider must notify North Shore-LIJ Health Plan if his/her organization is sold or closes)

Providers should call North Shore-LIJ Health Plan Provider Services at (888) 831-8429 with any questions and fax all updates to the Provider Services Department at (516) 472-3920.

5-3 Fraud, Waste and Abuse

It is the policy of North Shore-LIJ Health Plan to comply with all federal and state laws regarding fraud, waste and abuse. North Shore-LIJ Health Plan is committed to implementing and enforcing procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal and state health care programs, and to provide protection for those who report, in good faith, actual or suspected wrongdoing.

Potential fraud or misconduct related to the Medicare program is reported to U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG). Potential fraud, waste, and abuse related to the NY state-funded programs, are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).
What is the definition of fraud, waste and abuse?

**Fraud**: making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts. It includes any act that constitutes fraud under applicable federal or state Law.

Examples of fraud may include:
- Billing for services that were not furnished and/or supplies not provided;
- Altering claims forms and/or receipts to receive a higher payment amount; and
- Deliberately misrepresenting services, resulting in unnecessary costs.

**Waste**: over-utilization of services, misuse of resources or other practices that, directly or indirectly, result in unnecessary costs.

**Abuse**: practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Examples of abuse may include:
- Misusing codes on a claim,
- Charging excessively for services or supplies, and
- Billing for items or services that should not be paid for or were not medically necessary.

**Fraud and abuse can expose providers to criminal and civil liability.**

What is the Fraud, Waste and Abuse compliance policy?

North Shore-LIJ Health Plan maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, North Shore-LIJ Health Plan will:
- Demonstrate to providers its commitment to responsible corporate conduct.
- Maintain an environment that encourages employees, members and providers to report potential problems.
- Ensure appropriate investigation of possible misconduct from employees, members and providers.
North Shore-LIJ Health Plan has adopted various fraud prevention and detection programs whose purpose is to protect the member, the government, and/or North Shore-LIJ Health Plan from paying more for a service than they are obligated to pay. In addition, North Shore-LIJ Health Plan has delegated the claims adjudication process to Healthfirst. Healthfirst has established a Special Investigations Unit (SIU), which ensures that Healthfirst is in compliance with all applicable state and federal regulations. The Healthfirst SIU may assist North Shore-LIJ Health Plan in investigating alleged fraud events.

The following is a summary of federal and New York statutes relating to false claims:

**What is the Federal False Claims Act (FFCA) (31USC §§3729-3733)?**

Under the FFCA, private citizens (i.e., whistle-blowers) can help reduce fraud for the government. This Act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies or contracts (the act does not cover tax fraud). For the purposes of this act, “knowingly” means that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both federal and state FCA apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment,
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government,
- Conspires with others to get a false or fraudulent claim paid by the federal government,
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the federal government.

Examples of the type of conduct that may violate the FCA include when a company or person:

- Knowingly submits premium claims to the Medicaid program for members not actually served by North Shore-LIJ Health Plan;
- Knowingly fails to provide members with access to services for which North Shore-LIJ Health Plan has received premium payments; and
- Knowingly submits inaccurate, misleading or incomplete cost reports.

Those who defraud the government can be required to pay triple the damages done to the government, a fine (between $5,000 and $10,000) for every false claim, the claimant's costs and attorneys' fees. If the
government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

What are the protections for whistle-blowers?

Whistle-blower protection is provided by federal acts and related state and federal laws that shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle-blower. If an employer retaliates in any way, whistle-blower protection might entitle the employee to file a charge with a government agency, sue the employer or both. If you suspect fraud, waste or abuse is taking place, there are various ways you can report such incidents.

For internal reporting, please contact:
North Shore-LIJ Health Plan Confidential Compliance Helpline
(800) 894-3226
www.northshorelij.ethicspoint.com

You also have the right to report these incidents externally. If you suspect Fraud, Waste or Abuse involving New York's Medicaid Program, call the fraud hotline toll free at 1-877-87 FRAUD (1-877-873-7283) to make an anonymous report.

To report suspected fraud, waste or abuse involving Medicare or any other health care program involving only federal funds, you can call the toll-free hotline established by the Federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

What is the Federal Program Fraud Civil Remedies Act (FPFCRA) (31 U.S.C. 3801-3812)?

The FPFCRA provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double the amount of each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula. For more information about this act, please visit https://www.federalregister.gov/articles/2009/06/04/E9-12170/program-fraud-civil-remedies-act.
What is New York False Claims Act (NYFCA) (State Finance Law, §§187-194)?
The NYFCA closely tracks the FFCA. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000-$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false-claim filer may have to pay the government's legal fees. The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government does not participate in the suit and 15-25% if the government participates in the suit.

What is Social Services Law, Section 145-b – False Statements?
It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five (5) years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

What is Social Services Law, Section 145-c – Sanctions?
If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement or intending to do so, the needs of the individual or that of his or her family shall not be taken into account for the purpose of determining his or her needs or that of his or her family (i) for a period of six months upon the first occasion of any such offense, (ii) for a period of twelve months upon the second occasion of any such offense or upon an offense which resulted in the wrongful receipt of benefits in an amount of between at least one thousand dollars and no more than three thousand nine hundred dollars, (iii) for a period of eighteen months upon the third occasion of any such offense or upon an offense which results in the wrongful receipt of benefits in an amount in excess of three thousand nine hundred dollars, and (iv) five years for any subsequent occasion of any such offense.

For additional information about NYFCA and Social Services Laws on False Statements and Sanctions, please visit http://www.omig.state.ny.us/data/images/stories/relevant_fca_statutes_122209.pdf.

What is Social Services Law, Section 145 – Penalties?
Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
What is Social Services Law, Section 366-b – Penalties for Fraudulent Practices?

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor. In addition, any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

What is the process when health care fraud is suspected?

North Shore-LIJ Health Plan, in collaboration with Healthfirst, conducts annual focused audits of high-volume and high-risk service providers. Results of audits are presented to North Shore-LIJ Health Plan’s Compliance Committee and shared with providers. Plans of corrections or quality improvement activities are developed to enhance operational practice and increase member satisfaction.

If, after a review of all documentation provided, North Shore-LIJ Health Plan believes that the services billed are unsupported, payments will be considered overpayments, and North Shore-LIJ Health Plan will determine the total overpayment and ask providers to refund the monies paid. In addition, education will be provided to ensure further billings are submitted according to established guidelines. The results of these audits are presented at the Health Plan’s Compliance Committee. Failure to cooperate may result in the non-renewal of your contract with North Shore-LIJ Health Plan and/or additional reporting to state and/or federal authorities.

What is the role of the Audit, Fraud, Abuse and Compliance Committee (AFACC)?

North Shore-LIJ Health Plan’s AFACC is responsible for:

- Reviewing and updating its annual compliance plan, which describes the responsibilities of the Compliance Officer, employees and contractors to act in a lawful and ethical manner.

- Reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers.

- In cases of confirmed fraud, making recommendations to the North Shore-LIJ Health Plan Board of Directors, which may include but are not limited to termination of the Provider Agreement according to its own terms, reporting to any other applicable regulatory or law enforcement agencies and recovery of overpayments.

- Monitoring the plan’s reporting obligations and ensuring that the required reports are accurate and submitted in a timely manner.
Developing written policies, procedures and standards of conduct that articulate the plan’s commitment to adhere to all applicable federal and state standards.

Conducting appropriate staff training activities in an atmosphere of open communication.

Establishing provisions for internal monitoring and auditing.

Establishing provisions for prompt responses to offenses, with provisions for corrective action initiatives where appropriate.

North Shore-LIJ Health Plan staff members and providers are expected to fully comply with applicable standards, recognize and avoid actions and relationships that might violate those standards and seek counsel in situations raising legal and ethical concerns. AFACC meets at least four (4) times a year and is comprised of the following individuals with such designated authority:

- President
- Compliance Officer
- General Counsel
- Medical Director
- Vice President of Clinical Operations
- Community Board Representative

**What are examples of fraud and abuse?**

In order to assist you in understanding and/or identifying what may constitute fraud, waste and/or abuse, here are examples of fabrication and falsification of claims. In the outright fabrication of claims or portions of claim, a fraud perpetrator uses legitimate patient names and insurance information to:

- Concoct entirely fictitious claims.
- Add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed.
- Submit claims for services not rendered.
- Submit, in the course of billing for actual authorized services, additional charges for services that were never performed.
- Submit claims for equipment and supplies never delivered, or continue to submit claims for rented equipment after it has been picked up.

In the outright falsification of claims or portion of claims, a fraud perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment. This may involve:
Performing medically unnecessary services solely in order to bill and be paid for doing so.

Falsifying the dates on which services were provided, so that they fall within an eligibility period of the member.

Falsifying the identity of the provider of services, so as to obtain payment for services rendered by a non-covered and/or non-licensed provider.

Upcoding the services rendered to obtain greater reimbursement to the medical provider than that warranted by the true procedure or diagnosis.

Upcoding evaluation and management services to indicate a greater complexity of medical decision making than was actually rendered.

In addition, a fraud perpetrator may:

Submit, for the purpose of unbundling, a claim reporting multiple procedure codes that are an inherent part of performing a comprehensive procedure.

Submit unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Submit claims under two tax identification numbers to bypass duplicate claim edits in the claims processing system.

Obtain current membership information from operatives working in the billing offices of legitimate providers and submit claims by fictitious providers, usually on the CMS 1500 claim form. (The CMS 1500 form is the standard claim form used by a non-institutional provider or vendor to bill Medicare and Medicaid carriers.)

**How can a provider report fraudulent, wasteful and abusive activities?**

North Shore-LIJ Health Plan maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. As part of our commitment to this policy, North Shore-LIJ Health Plan wants to ensure that our providers understand that we shall address any alleged inappropriate activity. Providers may confidentially report a potential violation of our compliance policies or any applicable regulations by contacting the internal North Shore-LIJ Health Plan Compliance Department:

**North Shore-LIJ Health Plan**
Attn: Compliance Director and Privacy Officer
3333 New Hyde Park Road
New Hyde Park, NY 11042

By Phone: (516) 465-3267
By email: mchaber@nshs.edu
Anonymous reports of such activity can be made 24 hours, seven days a week, by contacting the North Shore-LIJ Health Plan Confidential Compliance HelpLine:

Compliance Helpline: (800) 894-3226
Compliance Website: www.northshorelij.ethicspoint.com

All individuals are protected from intimidation and retaliation for good faith participation in the North Shore-LIJ Compliance Program. Failure to report a compliance issue may be grounds for disciplinary action.

5-4 Claims Appeals for Payments/Review and Reconsideration

**How can a provider submit a claim review and reconsideration request?**

Providers who are dissatisfied with a claim determination can submit a written request for review and reconsideration request within forty-five (45) days from the paid date on the provider's Explanation of Payment (EOP). Requests should include the basis for reconsideration, a copy of the claim and EOP, as well as all relevant documentation including, but not limited to, contract rate appendices or fee schedules. Providers shall have no right to contest claims that are submitted more than ninety (90) days after the date of service.

Providers should submit all written requests for claim appeals for payments to the following location:

North Shore-LIJ Health Plan, Inc.
Attn: Claims Department
PO. Box 958434
Lake Mary, FL  32795-8434

**How can a provider submit a request for an appeal of a claim determination?**

Providers who are dissatisfied with the outcome of the review and reconsideration may submit a written request for a formal appeal within sixty (60) calendar days from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

North Shore-LIJ Health Plan, Inc.
Attn: Appeals and Grievances Department
PO. Box 958434
Lake Mary, FL  32795-8434
Providers should provide a written statement explaining why they disagree with North Shore-LIJ Health Plan’s decision regarding the review and reconsideration, and submit a copy of that determination. Providers should also specify the name, address and telephone number of the individual who may be contacted regarding the appeal, and include any additional relevant documentation to support their position. North Shore-LIJ Health Plan will not accept appeals from providers that are not made in writing or that fail to address the reason for the appeal.

North Shore-LIJ Health Plan will send a letter to the provider acknowledging the request for an appeal within fifteen (15) business days of receipt. This acknowledgment letter will request any additional information that may be necessary in order for North Shore-LIJ Health Plan to render a decision. If additional information is requested, the provider must submit the information within thirty (30) calendar days. If a provider fails to submit the additional requested information, the file will be closed and a denial letter will be issued to the provider.

Upon the receipt of all the necessary information, North Shore-LIJ Health Plan will issue a decision, in writing, within thirty (30) calendar days. If medical records are necessary to resolve a claim determination, excluding those claims which are denied for failure to obtain prior authorization, the supporting clinical documentation will be reviewed by staff in the North Shore-LIJ Health Plan Quality Management Department and/or North Shore-LIJ Health Plan Medical Director.

North Shore-LIJ Health Plan will not consider appeals that are not filed according to the procedures set forth above. If a provider files an appeal after the (60) calendar day time frame, the request will be deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if an appeal is not filed within the time period allowed.

5-5 Overpayment Recovery

North Shore-LIJ Health Plan periodically reviews payments made to providers to ensure the accuracy of claim payments pursuant to the terms of the Provider Agreement and appendices, or as part of its continuing utilization review and fraud control programs. In doing so, North Shore-LIJ Health Plan may identify instances when overpayments have been made to a provider. When this happens, North Shore-LIJ Health Plan provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

North Shore-LIJ Health Plan will not pursue overpayment recovery efforts after more than twenty-four (24) months after the date of the original payment to a provider unless the overpayment is:

1. Reasonably believed to be due to fraud, intentional misconduct or abusive billing;
2. Required by or initiated by the request of a self-insured plan; or
3. Required by state or federal government program.
In addition, North Shore-LIJ Health Plan may at times apply the procedures described in this section in order to recoup duplication claims payments, but reserves the right to use other procedures to recoup such payments. In addition, if a provider asserts that North Shore-LIJ Health Plan has underpaid any claim(s), North Shore-LIJ Health Plan may offset any underpayments with past overpayments made as far back as the claimed underpayment.

If North Shore-LIJ Health Plan determines that an overpayment has occurred, North Shore-LIJ Health Plan will give the provider thirty (30) days written notice of a request for repayment. This notice will include the member's name, service dates, payment amounts, proposed adjustments and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding or remit payment as outlined below.

**What should a provider do if he/she agrees that North Shore-LIJ Health Plan has made an overpayment?**

Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g. North Shore-LIJ Health Plan) within forty-five (45) days from the date the overpayment notice was mailed by North Shore-LIJ Health Plan. Providers should include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

**What should a provider do if he/she disagrees that North Shore-LIJ Health Plan has made an overpayment?**

If a provider disagrees with North Shore-LIJ Health Plan’s determination concerning the overpayment, he/she must submit a written request for an appeal within sixty (60) days from the date the overpayment notice was mailed by North Shore-LIJ Health Plan, including all supporting documentation in accordance with the provider appeal procedure described in Section 5-4. If, upon reviewing the provider’s supporting documentation, North Shore-LIJ Health Plan determines that the overpayment determination should be upheld, the provider may seek dispute resolution. North Shore-LIJ Health Plan will proceed to offset the amount of the overpayment prior to the final determination made pursuant to the dispute resolution process.

**What will happen if a provider fails to respond to the notice of overpayment?**

If a provider fails to dispute a request for repayment concerning an overpayment determination made by North Shore-LIJ Health Plan within sixty (60) days from the date the overpayment notice was mailed by North Shore-LIJ Health Plan, the provider will have acknowledged and accepted the amount demanded by North Shore-LIJ Health Plan. Subject to the provider's right to dispute resolution, North Shore-LIJ Health Plan may offset the amount outstanding against current and future claim remittance(s) for recoupment of prior overpayments.
What will happen if an offset results in a negative balance?

If an overpayment offset result in a negative balance, the provider will not receive an explanation of payment until the entire offset amount has been recovered. The provider will receive a weekly negative balance letter that states the current negative amount and any claim activity that has taken place since the previous check cycle period. Once the amount owed by the provider has been recovered, the provider will resume receiving EOPs.

5-6 Adverse Reimbursement Change

If the provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, North Shore-LIJ Health Plan must provide notice to the provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a negative impact on the aggregate level of payment to provider. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

5-7 Provider External Appeals

Effective January 1, 2010, Public Health Law §4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of North Shore-LIJ Health Plan; North Shore-LIJ Health Plan is responsible for the full cost of an appeal that is overturned; and the provider and North Shore-LIJ Health Plan must evenly divide the cost of a concurrent adverse determination that is overturned in part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the North Shore-LIJ Health Plan. The provider is required to complete the external appeal application (see Appendix A-6 for External Appeals Application and Instructions), and the designation applies when the appeal of the final adverse determination is claimed by the provider on behalf of the member. The Superintendent of Insurance has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.
Public Health Law §4917 was also amended to prohibit providers from seeking payment, except applicable co-payments, from a member for services determined to be not medically necessary by the external appeal agent when a provider requests an external appeal of a concurrent adverse determination or when a provider requests the external appeal as the member's designee.
Section 6: Complaints/Grievances, Appeals and Compliments

North Shore-LIJ Health Plan strives to achieve member satisfaction at all times. Broad systems have been implemented to accept, investigate, make a determination about and handle appeals for all grievances, and to report compliments. North Shore-LIJ Health Plan offers assistance to members and their representatives in all phases of the grievance and appeal process.

6-1 Complaints/Grievances

- The regulatory definition of grievances as “any expression of dissatisfaction regarding care and treatment that does not amount to change in scope or duration of service” includes all issues previously thought of as complaints.
- A grievance can be written or verbal.
- A grievance can be filed by the member, family/caregiver, friend or provider on behalf of the member.
- A grievance can be made to one of the CMT members (nurse, social worker or service clerk) or any other North Shore-LIJ Health Plan staff member.
- Grievances are tracked by a formal mechanism.
- Attempts are made to rectify grievances immediately or within required time frames, based on the nature of the issue.
- The initial determination notice includes an explanation of the reasons for the decision.
- A member who is dissatisfied with an initial grievance determination may request a second review by filing a grievance appeal.
- A report of all grievances is submitted to the Department of Health on a quarterly basis.

6-2 Appeals

- An appeal can be written or verbal.
- An appeal can be filed by the member, family/caregiver, friend or provider on behalf of the member.
- The request for an appeal must be received within sixty (60) days after the receipt of the notice of grievance decision.
Appeals are tracked by a formal mechanism.

Appeal decisions are made within required time frames, based on the nature of the issue.

Appeal determinations are made by someone other than the person making the initial determination.

The appeal determination notice includes an explanation of the reasons for the decision, including the clinical rationale, as appropriate.

A report of appeals is submitted to the Department of Health on a quarterly basis.

**6-3 Compliments**

- A compliment can be written or verbal.
- A compliment can be filed by the member, family/caregiver, friend or provider on behalf of the member.
- A compliment can be made about a North Shore-LIJ Health Plan employee or provider.
- Provider compliments are included in the Provider Report Card Process.

**6-4 Quality Review and Oversight**

- Records of grievances, appeals and compliments are stored, tracked and reviewed by the Quality Assurance Manager or designee.
- Providers may be asked to investigate individual or aggregate grievances and may be asked to define action improvement plans, as necessary.
- Results of activities are reported to the Quality Utilization and Management (QUM) Committee to determine ongoing issues, trends and opportunities for improvement. Recommendations may also be made to limit a provider’s participation in the network.
- Results of the review and analysis are also reported to the Quality Management Committee.
Section 7: Quality Assurance, Performance Improvement Plan (QAPIP) and Compliance

7-1 Quality Overview
The goal of the Quality Assurance/Program Improvement (QAPI) process is to systematically monitor, evaluate and improve the quality and appropriateness of care provided or coordinated to maximize member satisfaction. The following areas are reviewed annually:

- Quality and quantity of services;
- Management of care, including availability, access and continuity, and early identification of problems;
- Identification and correction of operational and clinical practice issues; and
- Outcomes in clinical and non-clinical areas.

North Shore-LIJ Health Plan supports and fulfills these functions through several cross-functional committees. All committee meetings are recorded and minutes are reported to the Board of Directors at its quarterly meetings.

7-2 QAPI Work Plan Assessment Activities
An annual work plan is designed to conduct activities in support of the QAPIP. Activities include a review of all departments and selected operations to comply with regulatory requirements and business and operational goals. Sources of data include record reviews, grievances, incidents, hospitalizations and nursing home admission data, high risk/high volume utilization data and other customer service and provider performance data reports. Data is reported to the QUC and to the board appointed QMC.

7-3 Provider Quality Report Cards
North Shore-LIJ Health Plan utilizes an annual provider performance report to provide feedback to providers regarding overall performance. Information sources include grievances, utilization data, staff and member feedback. Providers are judged against their peers in network services and against internal benchmarks, when available. North Shore-LIJ Health Plan will distribute this annual performance report card to providers as appropriate.
Section 8: How Providers Can Refer Members to North Shore-LIJ Health Plan

8-1 North Shore-LIJ Health Plan/Provider Partnership

North Shore-LIJ Health Plan envisions each provider as its partner in providing the highest possible quality of care. North Shore-LIJ Health Plan staff works with providers to ensure the right services are provided in the right place for the right amount of time based on a member’s needs. Selected providers also participate in quality improvement and other initiatives designed to maximize member outcomes and satisfaction. When providers identify prospective members they feel will both qualify for and benefit from the unique services North Shore-LIJ Health Plan provides, we ask that they contact us.

8-2 Instructions for Providers Making Referrals

A referral to North Shore-LIJ Health Plan is a phone call away.

- Call the Intake Team at (855) 421-3066.
- Fax North Shore-LIJ Health Plan’s Referral Form to (516) 881-7152.

Upon referral, the intake assessment begins.

What is the role of a health plan intake/enrollment specialist?

- Completes/submits a new Medicaid application or a recertification application for client, as needed.
- Contacts client within 24-48 hours to schedule a home visit.
- Explains covered services and coordinated non-covered services.
- Answers all questions.
- Completes voluntary enrollment upon client authorization.
What is the role of an a health plan services coordinator?
- Works with multidisciplinary Care Management Team to understand the services requested in the care treatment plan.
- Arranges and monitors all services delivered to and received by the members.
- Updates systems with approvals.
- Answers all questions.

What is the role of an enrollment nurse?
- Conducts home visit, with significant other present.
- Conducts a functional, performance, environmental and cognitive assessment.
- Prepares an initial plan of care with client/family input.
- Communicates/Confirms with primary care provider (medications, diagnosis and recommended plan of care).
- Communicates the outcome to referring source.
Appendices

A-1 Examples of North Shore-LIJ Health Plan ID Cards

Member Name
Member ID # XXXXXXX
Effective Date XX/XX/XXXX
A Managed Long Term Care Plan approved by the State of New York

www.nslijhealthplans.com

Please carry this card at all times. For a complete list of covered and non-covered services, please see your Member Handbook. For any care-related questions or needs, please contact your care manager at the member services number below.

Important Telephone Numbers:
North Shore-LIJ Health Plan
Member Services: 1-855-421-3066
(Available 24 Hours) (TTY 1-855-871-1665)
For Dental Services: 1-855-398-8406
For Vision Services: 1-800-999-5431

Member ID Card FRONT

Member ID Card BACK
A-2 Sample Service Plan Letter

<<Date>>

<<First Name>><<Last Name>>
<<Address 1>>
<<Address 2>>
<<City>>, <<State>> <<Zip>>

Member: <<MEM NAME>>
Member ID#: <<MEM ID>>

RE: Service Plan

Dear <<First Name>><<Last Name>>:

This is to inform you that North Shore-LIJ Health Plan has approved the services listed below. This represents your Service Plan for your approved services for the period of DD/MM/YYYY to DD/MM/YYYY.

If you have any additional questions, please contact your Care Management Team at <<(855) 421-3066>> <<Monday – Friday 9:00 a.m. to 5:00 p.m.>>.

Sincerely,

cc: Provider
Facility
PCP
Member

Authorized Service(s) and/or Item(s):

Requesting Provider: <<rp_full_name>>
Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>> Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>
Service Description: <<re_procedure_code1>>
Authorization Number: <<re_authorization_number>>

Requesting Provider: <<rp_full_name>>
Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>> Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>
Service Description: <<re_procedure_code1>>
Authorization Number: <<re_authorization_number>>


**A-3 Sample Service Plan Update Letter**

<<Date>>

<<First Name>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<City>>, <<State>> <<Zip>>

Member: <<MEM NAME>>
Member ID#: <<MEM ID>>

RE: Service Plan Update

Dear <<First Name>> <<Last Name>>:

This letter is to inform you that we have reviewed your request for service(s) and/or item(s). Based on our Care Management Team's review of this request, it has been decided that the service(s) and/or item(s) listed below are medically necessary. Therefore, the service(s) and/or item(s) listed below are approved and will begin on the requested date.

If you have any additional questions, please contact your Care Management Team at <<(855) 421-3066>> <<Monday – Friday 9:00 a.m. to 5:00 p.m.>>.

Sincerely,

cc: Provider
    Facility
    PCP
    Member

**Authorized Service(s) and/or Item(s):**

Requesting Provider: <<rp_full_name>>
Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>> Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>
Service Description: <<re_procedure_code1>>
Authorization Number: <<re_authorization_number>>

Requesting Provider: <<rp_full_name>>
Requested Date(s) or Service(s): <<re_referral_start_date>>-<<re_referral_end_date>> Service(s)/Procedure(s)/Units(s): <<re_units_authorized1>>
Service Description: <<re_procedure_code1>>
Authorization Number: <<re_authorization_number>>
## A-4 Provider Billing Codes

As a condition of payments, providers shall submit their claims using the codes provided as follows:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Code Type</th>
<th>Procedure Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADC</td>
<td>HCPCS</td>
<td>S5102</td>
<td>Day Care Services, Adult; Per Diem</td>
</tr>
<tr>
<td>ADC</td>
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<td>T2003</td>
<td>Non-emergency Transportation; Encounter/Trip</td>
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<td>HCPCS</td>
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<td>Hearing</td>
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<td>HCPCS</td>
<td>E0100-E8002</td>
<td>Durable Medical Equipment</td>
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<td>HCPCS</td>
<td>K0001-K0899</td>
<td>Durable Medical Equipment</td>
</tr>
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<td>HCPCS</td>
<td>L0112-L9900</td>
<td>Orthotic &amp; Prosthetic</td>
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<tr>
<td>Environmental Supports</td>
<td>Home Grown</td>
<td>XXXXX</td>
<td>Various environmental support services</td>
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<td>Hearing &amp; Speech</td>
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<td>Meals</td>
<td>HCPCS</td>
<td>S5170</td>
<td>Home Delivered Meals, Including Preparation; Per Meal</td>
</tr>
<tr>
<td>Home Health</td>
<td>HCPCS</td>
<td>S9123</td>
<td>Nursing Care, in the Home; by Registered Nurse, Per Hour</td>
</tr>
<tr>
<td>Home Health</td>
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<td>S9124</td>
<td>Nursing Care, in the Home; by Licensed Practical Nurse, Per Hour</td>
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<td>S9127</td>
<td>Social Work Visit, in the Home; Per Diem</td>
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<td>Speech Therapy, in the Home, Per Diem</td>
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<td>Occupational Therapy, in the Home, Per Diem</td>
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<td>S9131</td>
<td>Physical Therapy, in the Home, Per Diem</td>
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<td>HCPCS</td>
<td>T1001</td>
<td>Nursing Assessment/Evaluation</td>
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<td>Home Health Aide - Hourly</td>
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<td>Nutritional Counseling/Dietitian - Visit</td>
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<td>97004, 97110</td>
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<td>Unusual Physician Travel</td>
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<td>Homemaker Service, NOS; Per Diem</td>
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<td>Personal Care</td>
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<td>Home Health Aide or Certified Nurse Assistant, Providing Care in the Home; Per Hour</td>
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<td>Personal Care Services, Per 15 Minutes</td>
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<td>HCPCS</td>
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<td>Personal Care Services, Per Diem</td>
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<td>HCPCS</td>
<td>T1021</td>
<td>Home Health Aide or Certified Nurse Assistant Per Visit</td>
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<td>HCPCS</td>
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<td>Personal Emergency Response System; Installation and Testing</td>
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<td>Personal Emergency Response System; Service Fee, Per Month</td>
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<td>Non-emergency Transportation; Taxi - within Common Medical Marketing Area</td>
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<td>Transportation</td>
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<td>A0100-TN</td>
<td>Non-emergency Transportation; Taxi – outside Common Medical Marketing Area</td>
</tr>
<tr>
<td>Transportation</td>
<td>HCPCS</td>
<td>A0130</td>
<td>Non-emergency Transportation; Wheelchair Van – within Common Medical Marketing Area</td>
</tr>
<tr>
<td>Transportation</td>
<td>HCPCS</td>
<td>A0130-TN</td>
<td>Non-emergency Transportation; Wheelchair Van – outside Common Medical Marketing Area</td>
</tr>
<tr>
<td>Transportation</td>
<td>HCPCS</td>
<td>A0170</td>
<td>Transportation Ancillary: Parking Fees, Tolls, Other</td>
</tr>
</tbody>
</table>
A-5 Required Data Elements and Claim Forms

Prior to being adjudicated, all claims are reviewed within the North Shore-LIJ Health Plan Claims Department for completeness and correctness of the data elements required for processing payments, reporting and data entry into the North Shore-LIJ Health Plan utilization systems. If the following information is missing from the claim, the claim is not “clean” and will be rejected:

<table>
<thead>
<tr>
<th>Data Element</th>
<th>CMS 1500</th>
<th>UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Subscriber Name/Address</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>North Shore-LIJ Health Plan Member ID Number Client Identification Number (CIN)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)/other insured's information</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Date(s) of Service</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ICD-9 Diagnosis Code(s) including 4th and 5th Digit When Required</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CPT-4 Procedure Code(s)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HCPCS Code(s)</td>
<td>X</td>
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<tr>
<td>Service Code Modifier (if applicable)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Place of Service</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Service Units</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Charges per Service and Total Charges</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provider Name</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provider Address/Phone Number</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>National Provider Identifier -NPI (North Shore-LIJ Health Plan does not accept legacy Provider ID numbers submitted on HIPPA standard Transactions)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tax ID Number</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>North Shore-LIJ Health Plan Provider Number - For Paper Claims Only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>North Shore-LIJ Health Plan Payer ID Number 17516 - For EDI Claims Only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital/Facility Name and Address</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Type of Bill</td>
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<td></td>
</tr>
<tr>
<td>Admission Date and Type</td>
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<td></td>
</tr>
<tr>
<td>Patient Discharge Status Code</td>
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<td></td>
</tr>
<tr>
<td>Condition Code(s)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Occurrence Codes and Dates</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Value Code(s)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Revenue Code(s) and corresponding CPT/HCPCS Codes when billing outpatient services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Principal, Admitting, and Other ICD-9 Diagnosis Codes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Present on Admission (POA) Indicator (if applicable)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Attending Physician Name and NPI</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>North Shore-LIJ Health Plan Authorization Number</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

CMS 1500 forms and UB-04s can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and facilities billing on behalf of employed providers.
A-6 Provider External Appeals Application

NEW YORK STATE EXTERNAL APPEAL APPLICATION
New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental/investigational (including a clinical trial or rare disease treatment) or out-of-network, complete and send this application to the above address within 4 months of the plan's final adverse determination if you are the patient or the patient's designee, or within 45 days if you are a provider appealing on your own behalf. For help call (800) 400-8882 or e-mail externalappealquestions@dfs.ny.gov.

TO BE COMPLETED BY ALL APPLICANTS

1. Applicant Name: ___________________________________________________________________

(Please check one)  ☐ Insured/Patient   ☐ Patient's Designee   ☐ Provider

2. Patient Name: ___________________________________________________________________

3. Patient Address: ___________________________________________________________________

City__________________________________State__________Zip________________

4. Patient Phone Number: Home:(_______)-_________________Work:(_______)-__________________

5. Patient E-mail (if patient submits application and wants contact by e-mail):

____________________________________________________________________________________

6. Name of the Patient's Health Plan: _______________________________________________________

7. Name of the Patient's Physician: ___________________________________________________________

8. Physician Address: ___________________________________________________________________

City__________________________________State__________Zip________________

9. Physician Phone Number: (______)________________________________________________________

Physician Fax Number: (______)__________________________________________________________

10. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination?

(Please check one.)  ☐ Yes   ☐ No   ☐ Don't know

11. Reason for Health Plan Denial: (Please check one.)

☐ Not medically necessary       ☐ Experimental/investigational (other)
☐ Experimental/investigational (clinical trial)    ☐ Experimental/investigational (rare disease)
☐ Out-of-network and the health plan proposed an alternate in-network service

12. Describe the service and the date(s) of service and attach all information you want considered.  

____________________________________________________________________________________
13. External Appeal Eligibility: (Please check one.)

- Attached is the final adverse determination from the first level of appeal with the health plan.
- Attached is the health plan's letter waiving an internal appeal.
- The patient requested an expedited internal appeal at the same time as this external appeal.
- The health plan did not comply with internal appeal requirements for the patient's appeal.

14. If the patient has not received the service, this appeal may be expedited. An expedited decision will be made within 72 hours instead of 30 days, even if the patient or the patient's physician does not provide needed medical information to the external appeal agent. If this is a request for an expedited appeal check one of the following:

- The denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.
- The 30 day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health, and the patient's physician will complete the attached Physician Attestation (pages 4-6) and send it to the Department of Financial Services.

15. If this is an appeal of experimental/investigational services (including a clinical trial or rare disease treatment) or an out-of-network denial, the patient's physician who prescribed the treatment must complete the Physician Attestation (pages 4-6) and send it to the Department of Financial Services. See special rules for rare diseases on page 6.

(Please check one.)
- I gave the form to my physician.
- I did not give the form to my physician.

16. External Appeal Fee: You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)

- I enclosed a check or money order made out to the health plan.
- I faxed my application and will mail the fee to the Department of Financial Services within 3 days.
- The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.
- The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.
- The health plan does not charge a fee for an external appeal or the fee is not required.

17. I am sending this application to the Department of Financial Services by: (Please check one.)

- Certified or registered mail to New York State External Appeal, PO Box 7209, Albany, NY 12224-0209.
- Fax to 1-800-332-2729. If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for NYS External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.
NEW YORK STATE EXTERNAL APPEAL APPLICATION (page 3)

TO BE COMPLETED IF APPLICANT IS THE PATIENT'S DESIGNEE

18. Complete this only if a designee submits this external appeal on the patient's behalf. The patient may be asked to confirm that a designee was authorized.

Name of Designee: __________________________________________________________________________

Relationship to Patient: ____________________________________________________________________

Address: ____________________________________________________________________________________

City__________________________________________________State__________Zip_________________

Phone Number: (______)_______________________________________________________________________

Fax Number: (______)_________________________________________________________________________

Designee E-mail (if designee wants contact by e-mail): _____________________________________________

TO BE COMPLETED IF APPLICANT IS THE PATIENT'S PROVIDER

19. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This item should be completed by providers appealing on their own behalf, or appealing as the patient's designee. The health plan's initial denial and final adverse determination from the first level of appeal must be attached.

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a co-payment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Name: _____________________________________________________________________________

Person or Firm Representing Provider (if applicable): ______________________________________________

Contact Person for Correspondence: _____________________________________________________________

Address for Correspondence: __________________________________________________________________

City___________________________________________State_____________Zip____________________

Phone Number: (______)__________________________ Fax Number: (______)_________________________

E-mail (if you want contact by e-mail): ___________________________________________________________

Provider Signature:__________________________________________________________________________
PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NYS EXTERNAL APPEAL

The patient, the patient’s designee, and the patient’s provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient’s health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent’s decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

____________________________________________________________________________________
Signature of Patient Date
(Or the patient’s representative who can consent to the release of the patient’s medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Print Name: ________________________________________________________________________

Patient’s Health Plan ID#: ___________________________________________________________
The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal.

- For an experimental/investigational denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items 1-10 and 14.
- For a clinical trial denial, the patient's physician must complete items 1-9, 11 and 14.
- For an out-of-network denial, the patient's physician must complete items 1-9, 10 and 14.
- For a rare disease denial, a physician, other than the treating physician, must complete items 1-9, 12 and 14.
- For an expedited appeal, the patient's physician must complete items 1-9, 13 and 14.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882 or e-mail externalappealquestions@dfs.ny.gov.

1. Name of Physician completing this form: ___________________________________________________

To appeal an experimental/investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.

2. Physician Address: _____________________________________________________________________

   City________________________________ State_________ Zip_________________

3. Contact Person: ______________________________________________________________________

4. Phone Number: (______)____________________ Fax Number: (______)____________________

5. Physician E-mail (if you want contact by e-mail): __________________________________________

6. Name of Patient: ______________________________________________________________________

7. Patient Address: _______________________________________________________________________

   City________________________________ State_________ Zip_________________

8. Patient Phone Number: __________________________________________________________________

9. Patient Health Plan Name and ID Number: ________________________________________________

10. Complete this item for an external appeal of an experimental/investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient's clinical trial participation or rare disease.
**PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL (page 2)**

For an experimental/investigational denial: As the patient's physician I attest: (Select a or b without altering.)

a. ___Standard health services or procedures have been ineffective or would be medically inappropriate.  

   OR  

b. ___There does not exist a more beneficial standard health service or procedure covered by the health plan.

AND that I recommended a health service or pharmaceutical product that, based on the following two documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. (Complete c and d below.)

For an out-of-network denial: As the patient's physician I attest that the out-of-network health service (identify service)

is materially different from the alternate in-network health service recommended by the health plan, and based on the following two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. (Complete c and d below.)

c. List the documents relied upon in the space below and attach a copy of the documents.

   Document #1 Title: ________________________________

   Publication Name: _______________________________________________________________________

   Issue Number: __________________________________________ Date: _____________________

   Document #2 Title: ________________________________

   Publication Name: _______________________________________________________________________

   Issue Number: __________________________________________ Date: _____________________

d. The medical and scientific evidence listed above meets one of the following criteria. *(Note peer reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)* (Check the applicable items below and on the following page for each of the documents.)

   ☐ Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpt a Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;

   Document #1 ☐  Document #2 ☐
11. Complete this item only for a denial of a patient's participation in a clinical trial.

a. ___There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. (Although not required, it is recommended you enclose the clinical trial protocols and related information.)

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.
12. Complete this item only for a rare disease treatment denial.

As a physician, other than the patient’s treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service. I do____ do not____ (check one) have a material financial or professional relationship with the provider of the service AND (select a or b without altering):

a. ___The patient’s rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

OR

b. ___The patient’s rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

13. Complete this item only for an expedited appeal.

If the patient has not yet received the treatment, and the 30 day timeframe will seriously jeopardize the patient’s life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient’s health, the patient’s physician may request the appeal to be expedited.

The external appeal agent must make an expedited decision within 72 hours, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. You must send any information to the agent immediately in order for it to be considered. (Please check one.)

___YES, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at:________________________________________________

___NO, this appeal does not need to be expedited.

14. Complete this item for an external appeal of a health plan’s denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal.

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician Name (Please Print Clearly): ________________________________________________

________________________________________
Signature of Physician (Date)
External Appeal Instructions & Application

Consumers have the right to an external appeal when health care services are denied by an HMO or insurer (health plan) as not medically necessary, experimental/investigational, a clinical trial, a rare disease treatment, or out-of-network. Providers have their own right to an external appeal when these health care services are denied concurrently or retrospectively. To request an external appeal, complete the attached application and send it to the New York State Department of Financial Services within four (4) months of the date of the health plan’s final adverse determination.

What Is An External Appeal?
It is a request you make to the New York State Insurance Department when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan’s denial.

When Do I Request An External Appeal?
You must send an external appeal application to the Insurance Department within 45 days from the date of the final adverse determination from the first level of appeal with the health plan OR the health plan’s letter waiving the internal appeal process. If your application is not sent to the Insurance Department within 45 days (with an additional 8 days allowed for mailing), you will not be eligible for an external appeal.

What If A Health Plan Offers A Second Level Of Internal Appeal?
You do not have to request a second level of internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 45 days of the health plan’s first level appeal determination.

What If Services Are Denied As Experimental/Investigational, A Clinical Trial, Or A Rare Disease?
The patient must have a life-threatening or disabling condition or disease and the patient’s physician (who for rare diseases may not be the treating physician) must complete and send pages 3-5 of the application to the Insurance Department.

What If Services Are Denied As Out-Of-Network?
The patient must be covered under an HMO or managed care insurance contract and a pre-authorization request must be denied because the requested service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The patient’s physician must complete and send pages 3-5 of the application to the Insurance Department.

When Will An External Appeal Agent Make A Decision?
In 3 days for expedited appeals or 30 days for standard appeals. The external appeal agent’s decision is binding on the patient and the patient’s health plan.
**How Do I Request An Expedited (fast-tracked) External Appeal?**

The patient’s physician must complete pages 3-5 of the application and attest that the patient has not received the treatment and a delay would pose a serious threat to the patient’s health. Once an appeal is expedited, a decision will be made in 3 days, even if all of the patient’s medical information has not been submitted.

**When Can I Send Information To The External Appeal Agent?**

The patient, the patient’s designee, and where appropriate the patient’s provider, will be notified when an external appeal agent is assigned to the appeal. You must send any information to the agent immediately. Once the agent makes a decision, additional information will not be considered.

**Do I Pay A Fee For An External Appeal?**

Some health plans charge $50.00, which is waived for patients who appeal and are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to the patient. The fee will be returned to you if the external appeal agent overturns the health plan’s denial.

**What If A Patient Has Medicare Or Medicaid Coverage?**

Patients covered under Medicare are not eligible for an external appeal and should call 1-800-MEDICARE or visit [www.medicare.gov](http://www.medicare.gov). Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 1-800-342-3334 or visit [www.otda.state.ny.us/oah](http://www.otda.state.ny.us/oah) for fair hearing information.

**What Are My External Appeal Rights If I Am A Health Care Provider?**

You have your own right to an external appeal of a concurrent or retrospective final adverse determination. Regardless of whether you appeal on your own behalf, or as the patient’s designee, you may not pursue reimbursement from the patient for the health care service if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance, or deductible.

FOR QUESTIONS OR HELP WITH AN APPLICATION CALL THE NEW YORK STATE INSURANCE DEPARTMENT AT 1-800-400-8882 OR VISIT OUR WEBSITE [www.ins.state.ny.us](http://www.ins.state.ny.us).
A-7 REFERRAL INQUIRY FORM

FAX TO: 1-(516) 881-7152 or CALL: 1-(855) 421-3066

REFERRER INFORMATION

Date: ___________________ Name/Title: _____________________________________________________________
Organization: ____________________________________________________________
Tel (______) __________________ Fax (______) ___________ Email: ________________________________
Address_________________________________________________________________________________
City __________________________________________ State__ NY__ Zip__________________________

CLIENT INFORMATION

Name: Last__________________________________ Initial_______ First______________________________
Address________________________________________ Apt.#_____________________________
City__________________________________________________ State_______ Zip_____________________
Tel (______) ____________________________________________________________
*Date of Birth (Must be 18)_______________________________  □ Female   □ Male
Primary Language:  □ English  □ Spanish  □ Other:__________________________________________________
Lives Alone:  □ Yes □ No      May we contact potential client?  □ Yes □ No
Was client informed of Referral to NSLIJ Health Plan? □ Yes □ No
Emergency Contact Name:________________________________________ Relationship__________
Tel: Home (_____) __________________ Work (_____) __________________ Cell (_____) __________________
*Medicaid No.________________________________________ Medicare No.____________________ SSN__________
*If no Medicaid, does client want to apply? □ Yes □ No
Current Services in the Home? □ Yes □ No
If Yes, Vendor:________________________________________________________________________
Problems/Diagnoses: □ Dementia □ Diabetes □ Hypertension □ High Cholesterol □ Osteoarthritis
□ Other:_______________________________________________________________________________

PRIMARY CARE PROVIDER INFORMATION

Name___________________________________________Tel (________)____________________________
Address_________________________________________________________________________________
City________________________________________ State_______ Zip__________________________
Blank Inside Back Cover
Telephone Number

Business Hours are Monday through Friday
8:30 AM through 5:00 PM

All North Shore-LIJ Health Plan Staff can be reached at one number

Call: (888) 831-8429