Montefiore Diamond Care Provider Manual

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What is Montefiore Diamond Care and Montefiore HMO, LLC?

- Montefiore Diamond Care is a New York State Managed Long Term Care Plan (MLTCP) capitated Medicaid program. It is a partially capitated program which means that members are free to choose their own medical providers and receive those services through fee for service Medicaid and/or Medicare...

- Montefiore Diamond Care is offered by Montefiore HMO, LLC.

- Montefiore Diamond Care delivers and coordinates services that are typically covered by Medicaid. However, we will also coordinate services covered by Medicare.

- Montefiore Diamond Care provides access to services 24 hours a day, seven days a week, 365 days a year, to ensure that members receive the care they need.

- Providers receiving this manual are participating with Montefiore Diamond Care, one of the products offered by Montefiore HMO, LLC. Providers are contracted with Montefiore HMO, LLC.

Who is eligible to enroll in Montefiore Diamond Care?

To become a member of Montefiore Diamond Care a patient must:
- Be 21 years old of age or older
- Be a resident of the Bronx or Westchester counties
- Be Medicaid eligible
- Be able to live safely at home with the support of Montefiore Diamond Care or in a nursing home
- Require long-term care services for a continuous 120 days or more
- Agree to receive all covered services through Montefiore Diamond Care
2-1: How to Identify a Montefiore Diamond Care Member

Every enrolled member receives a Montefiore Diamond Care ID card in the mail. See example below.

**FRONT**

<table>
<thead>
<tr>
<th>Montefiore Diamond Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Smith</td>
<td>Plan ID: AB12345X</td>
</tr>
</tbody>
</table>

*Montefiore Diamond Care, a managed long term care plan approved by the State of New York*

**BACK**

**Member Services:** 1-855-55-MONTE (1-855-556-6683)
TTY: 711
24 hours/7 day

*Services billable to Medicare and/or fee-for-service Medicaid include:* Medical visits, pharmacy, hospitalizations, mental health and substance use programs, laboratory and radiology services.

*For pre-authorization, call:* 1-855-55-MONTE
*For claims inquiries, call:* 1-855-796-6683
Member Rights and Responsibilities

Pre-Enrollment Process – Each potential member:

- Receives information about the program and services and his or her rights from the Enrollment Team
- Receives a copy of the Member Handbook
- Authorizes receipt of information

Rights of a Montefiore Diamond Care Member

- To access comprehensive treatment with consideration, dignity, respect, confidentiality and without discrimination
- To participate fully in all decisions that relate to treatment and care
- To choose one’s own primary care doctor
- To access emergency health services when and where the need arises without prior authorization from Montefiore Diamond Care
- To receive information disclosure before enrollment, at enrollment and when there is a change in services in a manner that is accurate, easily understood and supports informed decisions
- To initiate disenrollment from the program at any time
- To enjoy a fair and responsive process for resolving differences, including a rigorous internal review of complaints

Responsibilities of Members

- To participate in care and decisions related to their care
- To support the Montefiore Diamond Care program
- To provide information requested by Montefiore Diamond Care staff to facilitate the preparation of a Care Plan

2-2: Member Copayments

As part of the Medicaid program, members may have copayments for prescriptions. However, Montefiore Diamond Care members do not have copayments for services they receive from the Plan. Therefore, members may not be asked to provide payment. All claims submissions and requests for payment should be made through Montefiore Diamond Care’s Claims Reimbursement process or discussed with Montefiore Diamond Care Provider Services.
2-3: Non-English-Speaking Members

Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

Montefiore Diamond Care celebrates the diversity of its membership, and our staff speaks several languages. In addition, Montefiore Diamond Care contracts with a language assistance line to ensure we can properly communicate with all members.

Contracted providers are also expected to meet the language needs of Montefiore Diamond Care members. If you need assistance, please call 1-855-55-MONTE (1-855-556-6683).

2-4: Members with Disabilities

In compliance with Americans with Disabilities Act (ADA) requirements, Montefiore Diamond Care accommodates members with visual, auditory, speech, cognitive and mobility impairments. Contracted providers are also expected to meet the needs of Montefiore Diamond Care members. If you need assistance, please contact 1-855-55-MONTE (1-855-556-6683).

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. Montefiore Diamond Care is dedicated to the provision of services that will enable members to remain safe and secure in their own homes.

The objectives of care management are to:

- Ensure primary accountability for case management, beginning
with pre-enrollment and continuing through transition and enrollment

- Establish effective systems to ensure consistent oversight of care and services across all service settings

- Establish protocols for routine and event monitoring (e.g., hospitalization, short or long-term nursing home placement, new diagnosis, major social or environmental change, increasing frequency of falls, pain management concerns or change in cognitive status)

- Establish standards for documentation and practice

- Apply cost containment controls when clinically appropriate and with consideration for member/family preference
Contact with Members and Families or Caregivers

Members, families and caregivers are instructed to contact the Care Management Team (CMT) if they have any questions, concerns or complaints related to providers. They should not contact providers directly.

Members, families or caregivers who contact providers for service issues (e.g., aide change) should be told to contact the Montefiore Diamond Care CMT, and the provider staff should inform the member’s CMT about the inquiry.

3-2: Coordination of Services

Montefiore Diamond Care provides and coordinates services designed to keep members living in their own homes for as long as possible. Montefiore Diamond Care does this by providing a comprehensive team approach in the delivery of long-term care services. The Care Management Team (CMT)—consisting of either a nurse or a social worker and service coordinator—who are responsible for coordinating the Medicaid and Medicare services needed by members. Every member has his or her own CMT, and the CMT works with the member and his or her family or caregiver to provide an optimal and safe care plan.

Each of the following team members performs a valuable and integrated service designed to introduce Montefiore Diamond Care's comprehensive care management:

- **Nurse or Social Worker**
  - Develops the *Initial Care Plan* based on the initial needs assessment
  - Secures necessary home care services with providers (vendors)
  - Monitors change of health/service status
  - Contacts primary care providers to coordinate service delivery
  - Maintains contact with enrollee and family or caregiver prior to enrollment
  - Refers members to temporary community services as needed

- **Service Coordinator**
  - Assists with telephone contacts
  - Arranges for initial services

The Montefiore Diamond Care CMT coordinates the services members receive and communicates with the doctors and other healthcare providers on an ongoing basis. CMTs will schedule appointments for members, provide for transportation to and from appointments and arrange to meet members’ needs.

Montefiore Diamond Care members develop a unique and strong relationship with the CMT, and the team acts as an advocate and liaison between both providers and members. CMTs should be contacted whenever opportunities for improvement are identified. CMTs will contact provider
staff when barriers are recognized and will work to optimize care and satisfaction. In addition, each CMT has a network of resources within Montefiore Diamond Care to assist it in meeting members’ needs. These resources include access to supervisors, provider relations coordinators, contract administrators and the quality assurance supervisor to oversee provider performance and member outcomes.

**Service Authorizations**

Service Authorizations are care decisions made by the CMT with input from the member, family, physician and other persons involved in the care of the member. Service Authorizations ensure that covered services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished, subject to the following:

- The services must be medically necessary
- The services are authorized to maintain the member’s health and safety

**Steps for authorizing services:**

- Once services are approved, a member of the CMT determines the appropriate provider to provide services
- Upon verbal acceptance of the case by a provider, the CMT member prepares a written authorization detailing the type, frequency, amount of service duration and expected date of commencement
- Authorizations are faxed and subsequently mailed to the provider to confirm approval and made available to Montefiore Diamond Care’s claims processor
- To ensure payment, providers should initiate services only upon receipt of written authorization. Written authorizations should be received by providers within 24 hours following a verbal approval, or the next business day.

Providers Seeking Authorizations: Except for emergency services and treatment of urgent medical conditions, providers are required to receive authorization prior to providing services to Montefiore Diamond Care members. The only services in which the provider does not need to seek authorization are:

- Dentistry
- Optometry
- Audiology (exam)
- Podiatry

Contact Montefiore Diamond Care's Care Management Team at 1-855-55-MONTE (1-855-556-6683) for questions related to service authorizations.
3-2a: Sample Service Authorization Letter

200 Corporate Boulevard South
Yonkers, New York 10701
1-855-556-6683

APPROVAL NOTICE

<SelectionDate>

<RecipientFirstName><RecipientLastName>
<RecipientAddressLine1>
<RecipientAddressLine2>
<RecipientCity>, <RecipientState> <RecipientZip>

Enrollee ID: <MemberID>
Coverage type: <TypeOfPlan>
Service: <TypeOfService>
Provider: <FacilityName>
Plan Reference Number: <AuthorizationNumber>

Dear < MemberFullName>

You are getting this notice because your health plan has approved your <TypeOfService>.

On <RequestDate> you or your provider asked Montefiore Diamond Care for the service listed above.

(Insert if <ProviderNetworkStatus> is ‘IN NETWORK’) Montefiore Diamond Care has decided this service is medically necessary.

(Insert if <ProviderNetworkStatus> is ‘OUT OF NETWORK’) Montefiore Diamond Care has decided this service is approved to be provided by an out-of-network provider.

This means from < ActualAdmissionDate> (If NULL, <AuthorizedAdmissionDate>) to <ExtendedServiceDate>, your health care service is approved for: <TotalDaysApproved> Days

(Insert if <TypeOfReview> is ‘PROSPECTIVE’ or ‘CONCURRENT’)
We will review your care again <NextReviewDate>

(Insert if <ProviderNetworkStatus> is 'IN NETWORK')
<FacilityName> is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

(Insert if <ProviderNetworkStatus> is 'OUT OF NETWORK')
<FacilityName> is an out of network provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This approval (authorization) is based on medical necessity and applies only to the specific provider and service(s) shown above. Neither the approval nor this letter guarantee payment. You must be a Montefiore Diamond Care member at the time of service. Payment is subject to all terms, limits and exclusions of your plan at the time you receive the services.

If you would like to speak to Montefiore Diamond Care about this decision, please call 1-855-556-6683 (TTY/TDD: 711) Monday-Friday 8:30am to 5:00pm.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

<SignatureFile>

<SignatureNameTitle>
Medical Director
Geriatric Medicine
Montefiore Diamond Care

CC: Physician: <AdmittingProvider>
Facility/Vendor: <FacilityName>
3-2b: Sample Service Authorization Nursing Home Letter

Montefiore Diamond Care

200 Corporate Boulevard South
Yonkers, New York 10701
1-855-556-6683

APPROVAL NOTICE

<SelectionDate>

<RecipientFirstName><RecipientLastName>
<RecipientAddressLine1>
<RecipientAddressLine2>
<RecipientCity>, <RecipientState> <RecipientZip>

Enrollee ID: <MemberID>
Coverage type: <TypeOfPlan>
Service: <TypeOfService>
Provider: <ServicingProvider>
Plan Reference Number: <AuthorizationNumber>

Dear <MemberFullName>:

You are getting this notice because your health plan has approved your <TypeOfService>.

On <RequestDate> you or your provider asked Montefiore Diamond Care for the service listed above.

(Insert if <ProviderNetworkStatus> is 'IN NETWORK')
Montefiore Diamond Care has decided this service is medically necessary.

(Insert if <ProviderNetworkStatus> is 'OUT OF NETWORK')
Montefiore Diamond Care has decided this service is approved to be provided by an out-of-network provider.

This means from <ReferralStartDate> to <ExtendedServiceDate>, your health care service is approved for:

<table>
<thead>
<tr>
<th>Procedure or Service</th>
<th>Description</th>
<th>Quantity</th>
<th>Unit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;TotalProcedureCode&gt;</td>
<td>&lt;TotalProcedureCodeDescription&gt;</td>
<td>&lt;TotalQuantityApproved&gt;</td>
<td>&lt;TotalUnitType&gt;</td>
</tr>
<tr>
<td>&lt;TotalProcedureCode&gt;</td>
<td>&lt;TotalProcedureCodeDescription&gt;</td>
<td>&lt;TotalQuantityApproved&gt;</td>
<td>&lt;TotalUnitType&gt;</td>
</tr>
<tr>
<td>&lt;TotalProcedureCode&gt;</td>
<td>&lt;TotalProcedureCodeDescription&gt;</td>
<td>&lt;TotalQuantityApproved&gt;</td>
<td>&lt;TotalUnitType&gt;</td>
</tr>
</tbody>
</table>

(Insert if <TypeOfReview> is ‘PROSPECTIVE’ or ‘CONCURRENT’, and <NextReviewDate> is not blank)
We will review your care again <NextReviewDate>

Montefiore Diamond Care Provider Manual
(Insert if <TypeOfReview> is ‘PROSPECTIVE’ and <ProviderNetworkStatus> is ‘IN NETWORK’)
<ServicingProvider> is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

(Insert if <TypeOfReview> is ‘PROSPECTIVE’ and <ProviderNetworkStatus> is ‘OUT OF NETWORK’)
<ServicingProvider> is an out of network provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This approval (authorization) is based on medical necessity and applies only to the specific provider and service(s) shown above. Neither the approval nor this letter guarantee payment. You must be a Montefiore Diamond Care member at the time of service. Payment is subject to all terms, limits and exclusions of your plan at the time you receive the services.

If you would like to speak to Montefiore Diamond Care about this decision, please call 1-855-556-6683 (TTY/TDD: 711) Monday-Friday 8:30am to 5:00pm.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

<SignatureFile>

<SignatureNameTitle>
Medical Director
Geriatric Medicine
Montefiore Diamond Care

CC: Physician: <ReferToProvider>
    Facility/Vendor: <FacilityName>
3.2c: Home Healthcare Determinations

Effective January 1, 2010, subdivision 3 of PHL 4903 was amended to change the time frame for utilization review determinations of home healthcare following an inpatient hospital admission. Typically, the request for these home healthcare services following 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 Montefiore Diamond Care will be responsible for the copay of covered services.

Montefiore Diamond Care will furnish utilization review determinations of home healthcare services following a Medicare denial or exhaustion of a Medicare benefit following an inpatient hospital admission—that is, in a general hospital that provides inpatient care or inpatient services in an Article 28 rehabilitation facility, as follows:

- Within one 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 healthcare services and all necessary information is provided to Montefiore Diamond Care prior to a member’s hospital discharge, Montefiore Diamond Care will make arrangements to coordinate benefits with the Medicare plan. If no Medicare insurance plan is in place, Montefiore Diamond Care will 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.

3-2d: Reports of Services Rendered

Providers are required to provide written reports to care managers following authorizations for service evaluations and after services provided to members. Payments may be deferred due to delays in receipt of required reports.
Montefiore Diamond Care Provider Manual

### 3-3: Covered and Non-Covered Services for Montefiore Diamond Care Members

The following benefits are fully covered when specified in your service plan.

**Montefiore Diamond Care Covered Services:**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care Management</td>
<td>• Care management is a process that ensures consistent oversight, coordination and support to members and their families in accessing MLTCP covered services as well as non-covered services.</td>
</tr>
<tr>
<td>• Nursing Home Care</td>
<td>• Short- or long-term stays, including permanent placement, provided in a New York State (NYS) licensed skilled care residential facility. Care is provided to members through Montefiore Diamond Care network facilities.</td>
</tr>
<tr>
<td>(Residential Health Care Facility)</td>
<td></td>
</tr>
<tr>
<td>• Home Care</td>
<td>a. Intermittent, part-time nursing services. Nursing services must be provided by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing services include care rendered directly to the member and instructions to a caregiver in the procedures necessary for the member’s treatment or health maintenance.</td>
</tr>
<tr>
<td></td>
<td>b. Personal care services in addition to vital signs, administering pre-drawn insulin, passive range of motion exercises, housekeeping services.</td>
</tr>
<tr>
<td></td>
<td>c. Information, referral and assistance obtaining or maintaining benefits to help the member remain in the community.</td>
</tr>
<tr>
<td>• Adult Day Health Care</td>
<td>Care and services provided in a healthcare facility, including medical, nursing, nutrition and social services; rehabilitation therapy; leisure time activities or other services.</td>
</tr>
<tr>
<td>• Personal Care</td>
<td>• Assistance with one or more activities of daily life, such as walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environment support function tasks.</td>
</tr>
<tr>
<td>• Consumer Directed Personal Assistance Service (CDPAS)</td>
<td>• Allows the member or person acting on the member’s behalf to assume full responsibility for hiring, training, supervising, arranging backup coverage when necessary, keeping payroll records and, if necessary, terminating the employment of the person providing personal care services.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| • Durable Medical Equipment (DME)                    | **a. Medical/Surgical Supplies**  
Items for medical use, other than drugs, used to treat a specific medical condition, such as diabetic supplies, wound dressings and other prescribed therapeutic supplies.                                                                 |
|                                                      | **b. Medical Equipment**  
Adaptive devices and equipment prescribed by a medical provider.                                                                                                                                   |
|                                                      | **c. Enteral and Parenteral Nutritional Supplements***  
Liquid nutritional supplements as prescribed.                                                                                                                                                    |
|                                                      | **d. Prosthetics**  
Artificial substitute or replacement of a limb.                                                                                                                                                    |
|                                                      | **e. Orthotics**  
Appliances and devices used to support or correct the function of a movable part of the body.                                                                                                        |
|                                                      | **f. Orthotic Footwear**  
Limitations may apply.                                                                                                                                                                             |
| • Personal Emergency Response System                 | An electronic device that enables members to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center. |
| • Non-emergency Medical-Related Transportation       | Travel by ambulance, ambulette, taxi or livery service to obtain necessary covered medical care and services.                                                                                      |
| • Podiatry                                           | Services by a podiatrist, which include routine foot care performed as a necessary and integral part of medical care, such as in the diagnosis and treatment of diabetes, ulcers and infections. |
| • Dentistry                                          | Includes but not limited to routine exams, preventive and therapeutic dental care, dentures and supplies.                                                                                             |
| • Optometry/Eyeglasses                               | Includes the services of an optometrist and an ophthalmic dispenser, eyeglasses, medically necessary contact lenses and other low-vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member’s condition. |
### Covered Services

<table>
<thead>
<tr>
<th><strong>Covered Services</strong></th>
<th><strong>Definition</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient Rehabilitation Therapies:</td>
<td></td>
</tr>
<tr>
<td>a. Physical Therapy (PT)*</td>
<td>a. Rehabilitative healthcare that uses specially designed exercises and equipment to help patients regain or improve their physical abilities.</td>
</tr>
<tr>
<td>b. Occupational Therapy (OT)*</td>
<td>b. Rehabilitative healthcare that uses specially designed exercises and equipment to help patients regain or improve their abilities to perform activities of daily living.</td>
</tr>
<tr>
<td>c. Speech Therapy (ST)*</td>
<td>c. Rehabilitation services for the restoration of the member to his or her functional level in speech or language.</td>
</tr>
<tr>
<td>* Montefiore Diamond Care Plan will cover medically necessary PT, OT and ST visits that are ordered by a physician or other licensed healthcare professional.</td>
<td></td>
</tr>
<tr>
<td>• Audiology</td>
<td></td>
</tr>
<tr>
<td>• Hearing aids and batteries</td>
<td>Audiology services include examination, testing, hearing aid evaluation and prescription. Hearing aid services include selecting, fitting, repairs, replacement, special fittings and batteries.</td>
</tr>
<tr>
<td>• Respiratory Therapy</td>
<td>The provision of preventive, maintenance and rehabilitative airway-related techniques and procedures, including oxygen and other inhalation therapies prescribed by a physician and provided by a qualified company/respiratory therapist.</td>
</tr>
<tr>
<td>• Nutrition</td>
<td>Provided by a Montefiore Diamond Care registered dietician (RD) or diet technician (DT). The RD or DT makes specific recommendations for service to the Care Manager and the member.</td>
</tr>
<tr>
<td>• Private Duty Nursing</td>
<td>Part-time or continuous care from a nurse in the member’s place of residence, based on medical needs.</td>
</tr>
<tr>
<td>• Home Delivered or Congregate Meals</td>
<td>Meals delivered for members without cooking facilities or other special circumstances.</td>
</tr>
<tr>
<td>• Social Day Care</td>
<td>Care and services provided in a facility that provides socialization, supervision, monitoring and nutrition.</td>
</tr>
<tr>
<td>• Social and Environmental Supports</td>
<td>Services and items include, but are not limited to, home maintenance tasks, homemaker/care services, housing improvement and respite care.</td>
</tr>
</tbody>
</table>
Effective January 1, 2016, covered services may be delivered by telehealth. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver covered services.

Benefits cannot be transferred from the member to any other person or organization.

The following services are not covered by Montefiore Diamond Care.

**Montefiore Diamond Care Non-Covered Services:**

<table>
<thead>
<tr>
<th>Non-Covered Services</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Care Services</strong></td>
<td>A hospital or other institutional bed for receiving care, including room, board and general nursing.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Care Services</strong></td>
<td>Care received in a clinic, medical office or other site affiliated with a hospital but not occupying a regular hospital bed.</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td>Preventive care, primary medical care and specialty services that fall within a physician’s scope of practice.</td>
</tr>
<tr>
<td><strong>Laboratory and Radioisotope Services</strong></td>
<td>Tests and procedures ordered by a qualified medical professional.</td>
</tr>
<tr>
<td><strong>Emergency Transportation</strong></td>
<td>Transportation by ambulance as a result of an emergency condition.</td>
</tr>
<tr>
<td><strong>Rural Health Clinic Services</strong></td>
<td>Federally Qualified Health Centers providing affordable, quality primary care services.</td>
</tr>
<tr>
<td><strong>Chronic Renal Dialysis</strong></td>
<td>Method used to treat advanced and permanent kidney failure, provided by a renal dialysis center.</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>Medical specialty concerned with the prevention, diagnosis and treatment of mental illness.</td>
</tr>
<tr>
<td><strong>Alcohol and Substance Abuse Services</strong></td>
<td>Treatment to end the excessive use of a substance such as alcohol or drugs.</td>
</tr>
<tr>
<td><strong>Office for People With Developmental Disabilities (OPWDD) Services</strong></td>
<td>Long-term therapy services provided by treatment facilities certified by OPWDD, comprehensive Medicaid Case Management services, and home- and community-based waiver program services for the developmentally disabled.</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>Contraceptive and birth control services.</td>
</tr>
<tr>
<td><strong>Prescription and Nonprescription Drugs; Compounded Prescriptions</strong></td>
<td>Medications prescribed and/or recommended by a physician. Prescriptions prepared by a pharmacist.</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally-ill with a life expectancy of twelve (12) months or less.</td>
</tr>
<tr>
<td><strong>All other services listed in the Title XIX State Plan</strong></td>
<td>Services paid by Medicaid fee-for-service.</td>
</tr>
</tbody>
</table>

1 Non-covered services will be paid for by Medicare, Medicaid fee-for-service or third party insurance, if applicable. We will coordinate these services for all members.
3-4: Member Assessments

Montefiore Diamond Care builds a strong relationship with the Montefiore Diamond Care members that starts before enrollment and is a relationship that grows deeper over time. Providers partner with the plan in growing this relationship by supplying services to maximize care and satisfaction and by communicating any changes in the member’s status promptly to a Montefiore Diamond Care Care Management Team (CMT).

The Initial Assessment

An Intake Nurse goes to the prospective Montefiore Diamond Care 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 Care/Service Plan is developed. The Care Plan/Service Plan is communicated and agreed to by the enrollee, family and/or caregiver.

The new enrollee’s CMT contacts providers based on the member’s needs to arrange for required services. This begins the strong and unique relationship between the member/member’s family/caregiver, the provider and Montefiore Diamond Care.

It is the responsibility of Montefiore Diamond Care CMT to assess or reassess the need for a personal care aide, home health aide and to evaluate the member’s resources. The provider is responsible for servicing the member according to the services authorized by Montefiore Diamond Care. The provider must follow the Care Plan. The provider is responsible to open the case and supervise the home health aides or personal care aides according to contract or New York State Department of Health and Mental Hygiene (NYSDOHMH) policies and procedures. The provider should communicate any recommendations or revisions required to the service plan directly to the Montefiore Diamond Care CMT.

Ongoing Assessments

Outgoing 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. Results of these calls assist in determining changes in services or the Care Plan. Team nurses and/or social workers may also conduct home visits, as needed, to assist members in maximizing care and functionality and to deal with clinical and social issues.
**Semiannual Assessments**

Every 180 days or after a hospitalization or incident of care, 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 Care Plan is developed. The Care Plan/Service Plan is communicated and agreed to by the enrollee and his or her family/caregiver and to the designated CMT. CMT staff will then contact providers to meet the identified needs.
4-1: Contracting and Provider Relations

The Montefiore Diamond Care Provider Relations Department maintains and supports the plan’s provider network. Once providers join the network, Provider Relations staff schedule provider orientations to educate providers about Montefiore Diamond Care programs, policies and procedures, and any other updates on plan information. The Provider Relations staff members work closely with the Claims and Quality Management Departments in the review and resolution of complaints, provider reconsiderations and/or provider appeals. The Contracting Department is responsible for provider recruitment and contracting.

Provider Relations staff review and update all contracts, as needed, and investigate and resolve all provider-related complaints. If you have any questions, please contact the Montefiore Diamond Care Provider Relations line at 855-796-6683.

4-2: Provider e-Newsletter and Notices

Montefiore Diamond Care contacts individual providers as needed to maximize care and service to members and oversee contractual requirements. Staff contact providers by telephone, and send periodic emails and e-newsletters, to inform the network of important changes in plan policies and procedures and to keep providers updated.

4-3: Provider Credentialing and Recredentialing

There are a few steps that Montefiore Diamond Care must complete before considering a provider as a permanent part of its network. First, the provider must complete and return a completed provider application with the required supporting documents—for example, copies of current Certificate of Liability, license/certification, credentialing application (if applicable). The complete application package is reviewed. After all required documentation is received, the provider package is presented to the Quality Management Committee for approval.

After the initial credentialing, all contracted providers are recredentialed every three years, which requires that providers send updated information. The Montefiore Diamond Care recredentialing process also involves a review of provider performance indicators, which may include, but not limited to the following:

- Member/family complaints
- Information from quality improvement activities
- Member satisfaction surveys
- Requesting and reviewing any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last time the Montefiore Diamond Care credentialied the Participating Provider

If the recredentialing is denied, the provider is notified in writing of Montefiore Diamond Care’s decision and informed of his or her right to appeal that decision. Montefiore Diamond Care may, at its option, terminate the Provider Agreement upon 120 days' written notice to
Effective October 1, 2009, newly licensed healthcare professionals (HCPs), or HCPs relocating from another state who are joining the group practice of in-network providers, will be allowed to participate in Montefiore Diamond Care’s provider network only if they meet the participation and credentialing criteria outlined below.

Montefiore Diamond Care will make a determination within 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 denial, the HCP will revert to non-participating status. The group practice wishing to include the newly licensed or relocated HCP must agree to refund any payments made by Montefiore Diamond Care 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 Montefiore Diamond Care offers a member transitional care and the transitional care is provided by a provisionally credentialed provider who is ultimately denied credentialing by Montefiore Diamond Care, 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 then determine whether to have a fully credentialed provider in charge of their care.

4-4: Provider Rights and Responsibilities and Dual Eligible Members

Provider Rights
Montefiore Diamond Care’s participating providers can act within the lawful scope of their license to advise or advocate for members, and possess external appeal rights as follows:

a) Health Status or Care Plan options (including sufficient information to enable the member to decide among various care plan options);

b) Filing a complaint or making a report or comment to an appropriate governmental body regarding Montefiore Diamond Care’s policies if the provider believes that the policies negatively impact the quality of care or access to care; and

c) Effective January 1, 2010, Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations (see Section 5-7).
**Provider Responsibilities**
Montefiore Diamond Care’s participating providers' responsibilities include, but are not limited to, providing quality care:

a) Provide care within scope of practice (as defined by Montefiore Diamond Care) and in accordance with Montefiore Diamond Care access, quality and participation standards.

b) Provide optimal care to members without regard to age, race, sex, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status.

c) Comply with the Americans with Disabilities Act (ADA) guidelines set forth by the New York Department of Health and Mental Hygiene—for example, wheelchair access.
**Dual Eligible Members**
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 Montefiore Diamond Care will be responsible for the copay of covered service.

**Montefiore Diamond Care’s Responsibilities to Providers**
Montefiore Diamond Care recognizes its obligation to assure participating providers the following:

a) Comprehensive plan training and orientation programs  
b) Timely and ongoing communication from knowledgeable staff  
c) Timely payment for covered services rendered to members  
d) Timely responses to questions or concerns  
e) Assistance with complex member issues  
f) Timely resolution of complaints and appeals  
g) Constructive feedback on performance and utilization

**4-5: Provider Non-Disclosure and Confidentiality**

**Required Provider Provisions**
All providers will ensure the following:

Pertinent contracts, books, documents, papers and records of their operations are available to the Department, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.

The New York State Office of the Attorney General (OAG), the Department, OMIG and the State Comptroller (OSC) have the right to audit, investigate, or review the provider and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq and to bring criminal prosecutions.

The provider shall provide the New York State Office of the Attorney General, the Department, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider’s, or the provider’s subcontractor’s, premises, physical fatalities, equipment, books, records, contracts, computer or other electronic systems relating to Montefiore Diamond Care performance under this Agreement for the purposes of audit, inspection, evaluation and copying. The provider shall give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider.

Montefiore Diamond Care Provider Manual
The provider is required to promptly report to Montefiore Diamond Care after they identify any overpayment related to performance under this agreement.

**The Health Insurance Portability and Accountability Act (HIPAA)**

The HIPAA Privacy Rule requires providers to take reasonable steps to protect and safeguard the Protected Health Information (PHI) of members/patients. A member’s PHI is subject to the protections established by the Privacy Rule and under the contractual relationship between Montefiore Diamond Care and the member, and between Montefiore Diamond Care and the provider. PHI includes information regarding enrollment with Montefiore Diamond Care, medical records, claims submitted for payment etc. 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). Ways in which a provider can protect member/patient PHI include ensuring that only authorized provider office employees have access to member/patient charts; including limited information on member/patient sign-in sheets; restricting non-employees from being in areas of the office that contain member/patient records.

**Member Authorization & Consent**

Authorization must be obtained from the member/patient or qualified person before any personal health information can be released to an outside organization or agency, unless release of that information is legally required or permitted. Montefiore Diamond Care members sign an authorization at the time of enrollment that allows Montefiore Diamond Care to review, release and use their respective PHI. In addition, at the time of the initial encounter with each Montefiore Diamond Care member, direct medical care providers are required to obtain the member’s written consent to disclose personal health information to Montefiore Diamond Care, and provide the member with a copy of the Privacy Notice indicating that the member’s PHI will be shared with Montefiore Diamond Care and other entities. This written consent and written acknowledgment of the provider’s Privacy Notice is to be maintained in the provider’s records and is subject to audit up to and through ten (10) years by Montefiore Diamond Care. All providers should take all reasonable measures to protect the privacy and confidentiality of the member’s nonpublic personal information at all times, and to prevent the 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 those that identify the presence of HIV-related illness, are governed by a special set of confidentiality rules. Release of these records requires special authorization. They should not be released to anyone other than the patient except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of Montefiore Diamond Care members’ information, please call 1-855-55-MONTE (1-855-556-6683).*

Montefiore Diamond Care Provider Manual
Confidentiality of HIV-Related Information

HIV-related information is any information that shows a person:

1. Had an HIV-related test (such as an HIV antibody test, PCR test, CD4 test for HIV, viral load test or other test);
2. Has HIV-infection, HIV-related illness, or AIDS;
3. Has been exposed to HIV; or
4. Has one of these conditions, including information on the individual's contacts.

All providers must develop policies and procedures to assure the confidentiality of HIV-related information. Such policies and procedures shall assure that such information is disclosed to employees or contractors only when appropriate. Such policies and procedures shall cover:

- Maintaining the confidentiality of HIV-related information
- Providing initial employee education and annual in-service education of employees
- Maintaining a list of job titles and the specific employee functions within those titles for which employees are authorized to access such information
- Limiting access to trained staff (including contractors)
- Ensuring that records (including electronic storage) are accessed on a need-to-know basis
- Handling requests by other parties for confidential HIV-related information
- Prohibiting employees/agents/contractors from discriminating against persons having or suspected of having HIV infection
- Reviewing of the policies and procedures on at least an annual basis

Members’ Access to Medical Records

The HIPAA Privacy Rule provides Montefiore Diamond Care members with the right to access, review, copy and request amendments to their medical records held by providers. A Montefiore Diamond Care member or other individuals authorized by the member may submit a written request to his or her provider for a copy of such medical records. Additionally, a member or other individuals authorized by the member may challenge the accuracy of the information in the medical records. Providers should have appropriate policies and procedures in place to address such requests for medical records.
Non-Disclosure

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

Return of Trade Secret and Intellectual Property

Upon termination of the Provider’s Agreement for any reason, the provider promises to return (or destroy, at the request of Montefiore Diamond Care) any and all material that falls under Montefiore Diamond Care trade secrets and intellectual property to Montefiore Diamond Care or Montefiore Diamond Care’s designee.

4-5 a: Notice of Privacy Practices

Notice of Privacy Practices
Montefiore Diamond Care, LLC

This Notice describes how medical information about you may be used and disclosed, how you can get access to this information and your rights as a health plan enrollee. Please review it carefully.

The effective date of this Notice is September 1, 2019

At Montefiore Diamond Care your privacy is very important to us, and we are committed to protecting health information that identifies you (“Health Information”). This Notice will tell you about the ways we may use and disclose Health Information. We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you, give you this Notice of our legal duties and privacy practices with respect to your Health Information, and follow the terms of our Notice that are currently in effect. We are giving you this notice because our records show that we provide managed long-term care benefits to you.

Changes to this Notice
We are required to follow the terms of this notice until we replace it, and we reserve the right to change the terms of this notice at any time. If we make changes, we will revise it and send a new Privacy Notice to all persons to whom we are required to give the new notice. We reserve the right to make the new changes apply to your medical information maintained by us before and after the effective date of the new notice.

How We Use or Share Information

In this notice, when we talk about “information” or “health information,” we mean information we receive directly or indirectly from you through enrollment forms such as your name, address and other demographic data; information from your transactions with us or our providers, such as medical history, healthcare treatment, prescriptions, healthcare claims and encounters, health service requests, and appeal or complaint information; or financial information pertaining to your eligibility for governmental health programs or pertaining to your payment of premiums.

Permissible Uses and Disclosures Without Your Consent or Authorization

Montefiore Diamond Care Provider Manual
The following are ways we may use or share information about you:

Healthcare Providers’ Treatment Purposes: We may disclose your health information to your doctor, at the doctor’s request, for your treatment; use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment; or share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor. We may use or share your information with others to help manage your healthcare. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.

Information regarding the care management services provided to you will be stored in Montefiore Health System’s electronic medical record system and will be available to healthcare providers and staff members at Montefiore who may be involved in your medical care.

Healthcare Operations: We may use and disclose your health information to conduct quality assessment and improvement activities to others who help us manage, plan or develop our business operations; to business associates authorized to perform data aggregation services; and to participate in case management or care coordination. We will not share your information with these outside groups unless they agree to keep it protected.

In some situations we may disclose your health information to another covered entity for the limited healthcare operations activities and healthcare fraud and abuse compliance activities of the entity that receives your health information.

Healthcare Services: We may use or share your information to give you information about alternative medical treatments and programs or about health-related products and services that you may be interested in. For example, we might send you information about asthma, diabetes control or smoking cessation programs. We do not sell your information to outside groups who may want to sell their products or services to you, such as a catalog company. We may disclose your health information to our business associates to assist us with these activities.

As Required by Law: State and federal laws may require us to release your health information to others. We may be required to report information to state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, New York State and City Departments of Health, Local Districts of Social Service and New York State Attorney General.

We may also use and disclose your health information as follows:
- To report information to public health agencies if we believe there is a serious health or safety threat;
- To provide information to a court or administrative agency (for example, pursuant to a court order, subpoena or child protective order);
- To report information to a government authority regarding child abuse, neglect or domestic violence; report information for law enforcement purposes;
- To share information for public health activities;
- To share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others;
- For research purposes in limited circumstances;
- To a coroner, medical examiner or funeral director about a deceased person;
- To an organ procurement organization in limited circumstances; and
- To prevent serious threat to your health or safety or the health or safety of others.
PERMISSIBLE USES AND DISCLOSURES WITH YOUR CONSENT OR AUTHORIZATION
If one of the above reasons does not apply, we must get your written permission to use or disclose your health information. If you give us written permission to use or disclose your personal health information and change your mind, you may revoke your written permission at any time. Your revocation will be effective for all your medical information we maintain, unless we have taken action in reliance on your authorization.

YOUR HIPAA RIGHTS
The following are your rights with respect to your health information that we maintain. You may make a written request to us to do one or more of the following concerning your health information.

• You have the right to request a copy of this notice to be mailed to you if you received this notice through means other than by U.S. Mail.

• You have the right to request copies of your health information. In limited situations, we do not have to agree to your request (i.e., information contained in psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil criminal or administrative action or proceeding; and information subject to certain federal laws governing biological products and clinical laboratories). In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

• You have the right to ask us to restrict how we use or disclose your information for treatment, payment or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your healthcare or payment for your healthcare. While we may honor your request, we are not required to agree to these restrictions, unless you or someone other than the health plan paid in full for the treatment.

• You have the right to submit special instructions to us regarding how we send plan information to you that contains protected health information. For example, you may request that we send your information by a specific means (such as U.S. Mail or fax) or to a specified address if you believe that you would be harmed if we send your information to you by other means (for example, in situations involving domestic disputes or violence). We will accommodate your reasonable requests as explained above. Even though you requested that we communicate with you through alternative means, we may provide the contract holder with cost information.

• You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A “designated record set” is the group of records that we use in order to make decisions about you, including enrollment, payment, claims adjudication and case management records.

• You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. Your written request must include a reason for your request. If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you. Denied requests to amend will be communicated to you in writing with an explanation for the denial. You have a right to file a written statement of disagreement.
You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. We are not required to provide you with an accounting of the following disclosures:

- Disclosures made for treatment, payment and healthcare operations purposes;
- Disclosures made to you, your personal representative or pursuant to your authorization;
- Disclosures made incident to a use or disclosure otherwise permitted;
- Disclosures made to persons involved in your care or other notification purposes;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions, law enforcement officials or health oversight agencies; or
- Disclosures made as part of a limited data set for research, public health or healthcare operations purposes.

You have the right to be notified of a breach of your Health Information. If there is improper access, use or disclosure of your Health Information that meets the legal definition of a "Breach" of your Health Information, we will notify you in writing.

YOUR ENROLLEE RIGHTS

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand; you can get oral translation services free of charge.
- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to get care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, gender identity or expression, physical appearance, marital status or religion.
- You have the right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
• You have the right to appoint someone to speak for you about your care and treatment.

• You have the right to seek assistance from the Participant Ombudsman program.

EXERCISING YOUR HIPAA RIGHTS
If you would like to exercise the HIPAA rights described in this notice, please contact our Compliance Office (below), Monday through Friday, from 9:00 am to 5:00 pm, by phone or in writing. We will provide you with the necessary information and forms for you to complete and return to our office. In some cases, we may charge you a cost-based fee to carry out your request. If you have any questions about this notice or about how we use or share information, please contact the Compliance Office at:

Montefiore Diamond Care Compliance Office
200 Corporate Boulevard South
Yonkers, New York 10701
Phone: 1-914-378-6200
Email: cmocompliance@montefiore.org

EXERCISING YOUR ENROLLEE RIGHTS
If you would like to exercise your enrollee rights, please contact the Member Services Call Center at 1-855-55-MONTE (1-855-556-6683) and they will assist you with your request.

COMPLAINTS
If you believe that we have violated your privacy or enrollee rights, you have the right to file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by calling the Montefiore Compliance Hotline which is available 24 hours per day, 365 days per year. All calls are confidential, and you may make calls anonymously.
We will not take action against you for filing a complaint with us or with the U.S. Department of Health and Human Services.

Montefiore Compliance Hotline: 1-800-662-8595
Website: www.montefiore.alertline.com
Montefiore Diamond Care Compliance Office
200 Corporate Boulevard South
Yonkers, New York 10701

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building, Suite 3312
New York, New York 10278
OCR Hotlines—Voice: 212-264-3313; TDD: 212-264-2355
Email: ocrmail@hhs.gov
Website: http://www.hhs.gov/ocr/
4-6: Termination of Provider Agreement

Termination by Montefiore Diamond Care

Montefiore Diamond Care may, at its option, terminate this agreement immediately and without notice to provider in the event of: (i) the provider is suspended or terminated from participation in the Medicaid Program; (ii) termination of the SDOH Agreement for any reason; (iii) in the event of imminent patient harm or a determination by Montefiore Diamond Care that the provider has engaged in fraud or abusive billing.

Termination by Providers

In the event a provider is no longer interested in participating with Montefiore Diamond Care, the agreement may be terminated without cause by giving 120 days’ prior written notice to Montefiore Diamond Care.

4-7: Provider Participation in Montefiore Diamond Care Operations

Montefiore Diamond Care values its relationship with providers and the unique perspectives that both parties bring to maximizing care and efficient operations. Informal access is available on an ongoing basis through communications with the Provider Relations Department and other plan staff. Plan staff also reach out to providers regarding updates to policy or operational procedures to ensure timely and efficient services. Examples of formal input and participation by Montefiore Diamond Care providers include internal committee involvement and completion of Provider Satisfaction Surveys.

Committee Participation

Selected providers may be requested to participate in committee activities. An example of this involvement occurs with Montefiore Diamond Care’s ad hoc Quality Improvement Teams. Participation is requested based on the event or issues to be explored.

Provider Satisfaction Survey Participation

While provider input is welcome at all times, Montefiore Diamond Care conducts periodic surveys of provider satisfaction. Results are used to determine system and operational improvements to maximize clinical outcomes and operational effectiveness. Provider data are collected and returned in a confidential manner. The data are aggregated with no individual identifiers noted.

4-8: Network Evaluation

The adequacy of the current provider network is reviewed and analyzed on an annual and ongoing basis. Our mission of service provision is to provide the appropriate service, in the appropriate manner, at the appropriate time with the appropriate provider.
Montefiore Diamond Care monitors service outcomes by documentation of best practices or when service delivery does not match standards or is not delivered within the timeframes specified.

Tracking and trending of utilization and services provide an opportunity for Care Management Team members to report positive efforts by providers and their staff. Data are logged, and then analyzed and used to identify best practices as well as provider and access issues, potential inadequacy of the network, and a need to expand the providers of service.

**5: Billing Reimbursement Procedures**

Montefiore Diamond Care is committed to provide the highest level of service in claims processing, including rapid reimbursement. Montefiore Diamond Care also adheres to the New York State Department of Financial Services' prompt payment requirement.

**5-1a: Claims Submission Procedures**

**Submitting Claims Electronically**

Montefiore Diamond Care utilizes the Change Healthcare clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 and/or UB 04 receive a notification indicating the claim’s status (accepted, rejected and/or pending) and a detailed, line item report with the amount paid on the claim once it is finalized. Claims submitted electronically must include:

1. Montefiore Diamond Care Payer ID Number (46161)
2. Montefiore Diamond Care Member’s CIN ID number
3. A 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 should contact Provider Relations as well as contact their software vendor and request that their Montefiore Diamond Care claims be submitted through Change Healthcare. Providers can also direct their current clearinghouse to forward claims to Change Healthcare. Please contact Change Healthcare at 800-845-6592 for information on how to set up electronic billing.

If you have any questions regarding claims issues, please call (914) 377-4400. Representatives are available Monday–Friday, 9:00 am–5:00 pm.
Submitting Paper Claims
All paper claims should be submitted to:

Montefiore Diamond Care  
PO Box 1070  
Yonkers NY 10703

All paper claims should include the National Provider Identifier (NPI) as well as the Montefiore Diamond Care-assigned Provider ID Number (the latter is not required for electronic claims).

Timely Claim Submission
In-network providers must submit clean claims to Montefiore Diamond Care not more than 90 days after the date of service for the claim or 60 days from receipt of payment from a third-party payor that is primary to Montefiore Diamond Care.

Billing Montefiore Diamond Care
All payments by Montefiore Diamond Care for services provided to its members constitute payment in full.

Providers may not balance bill members for the difference between their actual charges and the reimbursed amounts; any such billing is violation of the provider’s contract with Montefiore Diamond Care and applicable New York State Law.

Where appropriate, Montefiore Diamond Care will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
To setup EFT/ERA, please contact 914-377-4477. The Team can provide additional information and answer any questions regarding EFT/ERA setup.
The following information is required on a CMS-1500 form (medical and professional claims) for claims processing

The following information is required on a CMS-1500 form for claims processing. If this information is not provided, claims processing may be delayed. Please note that all fields on a CMS-1500 form must be completed. Be sure to include all pertinent Coordination of Benefits (COB), Referral and Type of Service information.

<table>
<thead>
<tr>
<th>Required Information</th>
<th>CMS-1500 Line Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td>1a</td>
<td>Member’s insurance ID number</td>
</tr>
<tr>
<td>Patient Name</td>
<td>2</td>
<td>Enter member’s name as shown on insurance ID card</td>
</tr>
<tr>
<td>Other Insurance Coverage</td>
<td>9a</td>
<td>Enter other insured’s policy or group number (for COB)</td>
</tr>
<tr>
<td>Condition Related To?</td>
<td>10</td>
<td>Indicate service related to Employment, Auto, or Other Accident Related</td>
</tr>
<tr>
<td>Insurance Plan Name</td>
<td>11c</td>
<td>Enter member’s insurance carrier (i.e., HIP)</td>
</tr>
<tr>
<td>Date of Service</td>
<td>24a</td>
<td>Date on which service was provided</td>
</tr>
<tr>
<td>Place of Service</td>
<td>24b</td>
<td>Place where services have been rendered</td>
</tr>
<tr>
<td>Services/Procedures</td>
<td>24d</td>
<td>Enter procedures, service or supplies</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>24e</td>
<td>Enter diagnosis code</td>
</tr>
<tr>
<td>Number of Days and Units</td>
<td>24g</td>
<td>Enter days and units</td>
</tr>
<tr>
<td>Provider FTIN</td>
<td>25</td>
<td>Federal tax identification number</td>
</tr>
<tr>
<td>Total Charge</td>
<td>28</td>
<td>Sum of all itemized charges or fees</td>
</tr>
<tr>
<td>Signature of Physician or Supplier</td>
<td>31</td>
<td>Signature of physician or supplier</td>
</tr>
<tr>
<td>Name/Address Service Rendered</td>
<td>32</td>
<td>Enter name and address of where services were rendered</td>
</tr>
<tr>
<td>Physicians, Suppliers, Billing Name Address</td>
<td>33</td>
<td>Address of provider/supplier requesting claim reimbursement</td>
</tr>
</tbody>
</table>

Refer to the sample copy of the CMS-1500 Form on the following page.
5-1: Requests for Review and Reconsideration of a Claim
At times, a provider may be dissatisfied with a decision made by Montefiore Diamond Care regarding a claim determination. Providers may be dissatisfied for reasons including, but not limited to, incorrectly processed or denied claims, the untimely submission of claims or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Montefiore Diamond Care must submit a written request for review and reconsideration with all supporting documentation to Montefiore Diamond Care within 90 calendar days from the paid date on the provider’s Explanation of Payment (EOP). Written requests, including attachments, must be mailed to:

Montefiore Diamond Care
PO Box 1070
Yonkers NY 10703

All written requests for review and reconsideration should include a written statement explaining why you disagree with Montefiore Diamond Care’s determination as to the amount or denial of payment and the following information and supporting documentation:

- Provider’s name, address and telephone number
- Provider’s identification number
- Member’s name and Montefiore Diamond Care identification number
- Date(s) of service
- Montefiore Diamond Care claim number
- A copy of the original claim or corrected claim if applicable
- A copy of the Montefiore Diamond Care EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare) along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g., copy of Montefiore Diamond Care member ID card)
- Evidence of timely filing
  - R059 Report (insurance Carrier Rejection report) or Emdeon Vision “Claim for Review”/“Claim Summary Report”
  - Please note: Montefiore Diamond Care does not accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing
- Copy of the approval number issued by the Care Management Team
- Montefiore Diamond Care will investigate all written requests for review and reconsideration and respond within 30 calendar days from the date of receipt of the provider’s request for review and reconsideration with a written explanation stating that either the claim has been reprocessed or the initial denial has been upheld.
Montefiore Diamond Care will not review or reconsider claims determinations that are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the 90-calendar-day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, regardless of the merits of the underlying dispute, if the request for review and reconsideration is not filed timely. In such cases providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Center at 855-796-6683.

5-2: Provider Information

Providers are responsible for contacting Montefiore Diamond Care to report any changes in their practice. It is essential that Montefiore Diamond Care maintain an accurate provider database in order to ensure proper payment of claims, to comply with provider reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Providers must notify Montefiore Diamond Care of any of the following changes:

- Provider’s name and tax identification 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
- If the practice is closed to new patients

Providers should call Montefiore Diamond Care’s Provider Services at 855-556-6683 or 914-377-4400 with any questions.

5-3: Fraud, Waste and Abuse

It is the policy of Montefiore Diamond Care to comply with all federal and state laws regarding fraud, waste and abuse; to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal and state healthcare 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 the U.S. Department of Health and Human Services’ Office of Inspector General (HHS OIG) and to the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to New York State–funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

The Montefiore Diamond Care Compliance Program
Montefiore Diamond Care maintains a strict policy of **zero tolerance** toward fraud and abuse and other inappropriate activities. Providers, their employees, employees of Montefiore Diamond Care and members of Montefiore Diamond Care 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, Montefiore Diamond Care provides this information to providers to achieve the following goals:

- Demonstrate to providers its commitment to responsible corporate conduct
- Maintain an environment that encourages employees and providers to report potential problems
- Ensure appropriate investigation of possible misconduct by the company and its providers

**Definitions**

**Abuse:** Practices by providers that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

**Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him- or herself or another person. It includes any act that constitutes fraud under applicable federal or state law.

**Waste:** The extravagant, careless or needless expenditure of funds resulting from deficient practices, systems, controls or decisions.

**Relevant Statutes and Regulations**

**False Claims Act**
Using the False Claims Act, private citizens (i.e., whistle-blowers) can help reduce fraud against the government. The 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 policy, “knowing and/or knowingly” means that a person has actual knowledge of the information, acts in a 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 the federal and New York False Claims Act 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.

**What Money Can Be Recovered?**
Those who defraud the government can end up paying double the damages done to the government, a fine (between $5,000 and $10,000) for every false claim, and 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 a percentage of the recovered funds.

**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 that fraud, waste or abuse is taking place against New York’s Medicaid program, call the State’s fraud hotline toll free at 1-877-87-FRAUD (1-877-873-7283) to make an anonymous report.

To report information about fraud, waste or abuse involving Medicare or any other healthcare 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, go to https://oig.hhs.gov.

The following are the applicable false claim act regulations for further reference:
False Claims Act (31 U.S.C. §§ 3729-3733)

The civil False Claims Act (FCA) protects the federal government from being overcharged. According to the FCA, it is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.

Federal Program Fraud Civil Remedies Act (31 U.S.C. 3801-3812)

For a copy of this citation, please visit https://www.federalregister.gov/articles/2009/06/04/E9-12170/program-fraud-civil-remedies-act

The Act provides federal administrative remedies for false claims and statements, including those made to federally-funded healthcare 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 damages for 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.

The New York False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $6,000 to $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 to 30 percent of the proceeds if the government does not participate in the suit and 15 to 25 percent if the government participates in the suit.
Social Services Law §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 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.

Social Services Law §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 person’s family’s needs are not taken into account for six months if a first offense, 12 months if a second offense (or a first offense if benefits received are over $3,900), and five years for four or more offenses.

Social Services Law §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.

Social Services Law §366-b, Penalties for Fraudulent Practices
Any person who obtains or attempts to obtain, for him- or herself 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.

Any person who, with intent to defraud, presents for payment any 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.
Responsible Parties—Healthcare Fraud
As necessary, Montefiore Diamond Care conducts annual focused audits on select vendors. Results of audits are shared with vendors. Plans of corrections or quality improvement activities are developed to enhance operational practice and support member satisfaction.

If, after a review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments, and Montefiore Diamond Care will determine the total overpayment and ask the selected provider 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 to the Montefiore Diamond Care Audit, Fraud, Abuse and Compliance Committee (AFAC). Failure to cooperate may result in the nonrenewal of your contract with Montefiore Diamond Care and/or additional reporting to state and/or federal authorities.

How to Report Fraudulent, Wasteful and Abusive Activities
Montefiore Diamond Care maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. As part of our commitment to this “zero-tolerance” policy, Montefiore Diamond Care wants to ensure that our providers understand that we expect them to bring any alleged inappropriate activity that involves Montefiore Diamond Care to our attention.

Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following department:

Montefiore Diamond Care Privacy
Office 200 Corporate Boulevard
South Yonkers, New York 10701
1-914-378-6200

Montefiore Diamond Care Audit, Fraud, Abuse and Compliance Committee (AFAC)
The AFAC Committee is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers; has the authority to make recommendations to the Montefiore Diamond Care Board of Directors regarding the allegation including, but not limited to, termination of the provider agreement according to the guidelines described in the provider contract and any other applicable regulatory or law enforcement agencies; and is responsible for recovery of overpayments.

In addition, the AFAC Committee reviews and updates its annual compliance plan. The plan describes the responsibilities of the Compliance Officer, employees and contractors to act in a lawful and ethical manner. Each is 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.

Common Methods of Fraud and Abuse
In order to assist you with understanding and/or identifying what may constitute fraud, waste and/or abuse, some typical examples are provided below for your reference.
**Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or to add to otherwise legitimate claims, fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered.
  - A provider who, in the course of billing for actual authorized services, submits additional charges for services that were never performed.
  - A Durable Medical Equipment provider submitting claims for equipment and supplies never delivered or continuing to submit claims for rented equipment after it has been picked up.

**Falsification of Claims:** In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so.
- A provider falsifies the dates on which services were provided, so that they fall within a given eligibility period of the member.
- A provider falsifies the identity of the provider of services, so as to obtain payment for services rendered by a non-covered and/or non-licensed provider.
  1. For example, submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy.
- A provider upcodes the services rendered to obtain greater reimbursement.
- Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision making than was actually rendered; encounters that required straightforward decision making are reported as having required highly complex decision making.

Other examples of fraudulent claims practices include:

**Unbundling:** Provider submits a claim reporting comprehensive procedure code with multiple incidental procedure codes that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

**Fragmentation:** Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

**Duplicate Claim Submissions:** Submitting claims under two tax identification numbers to bypass duplicate claim edits in the claims processing system.
Fictitious Providers: Perpetrators obtain member demographics from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

Reporting of fraudulent, wasteful and abusive activities
Montefiore Diamond Care maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. As part of our commitment to this “zero-tolerance” policy, Montefiore Diamond Care wants to ensure that our providers understand that we expect them to bring any alleged inappropriate activity that involves Montefiore Diamond Care to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following department:

Montefiore Diamond Care Privacy Office
200 Corporate Boulevard South
Yonkers, New York 10701
Phone: 914-378-6200

5-4: Claims Appeals/Review and Reconciliation Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a written request for a formal appeal within 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:

Montefiore Diamond Care
Provider Claim Appeals
PO Box 1070
Yonkers, NY 10703

Providers should provide a written statement explaining why they disagree with the Montefiore Diamond Care 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 the provider’s position. Montefiore Diamond Care will not accept appeals that are not made in writing and fail to address the reason for the appeal.

For appeals on payment rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation including, but not limited to, contract rate sheets or fee schedules.
Montefiore Diamond Care 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 is deemed ineligible and will be dismissed. Providers will not be paid for any services, regardless of the merits of the underlying dispute, if an appeal is not filed within timely filing requirements.

**5-5: Overpayment Recovery Appeals Process**

Montefiore Diamond Care periodically reviews payments made to providers to ensure the accuracy of claim payments pursuant to the terms of the provider’s contract, or as part of its continuing utilization review and fraud control programs. In doing so, Montefiore Diamond Care may identify instances when we have overpaid a provider for certain services. When this happens, Montefiore Diamond Care provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

Montefiore Diamond Care will not pursue overpayment recovery efforts for claims older than 24 months after the date of the original payment to a provider unless the overpayment is (1) based upon a reasonable belief of fraud, intentional misconduct or abusive billing; (2) required or initiated at the request of a self-insured plan; or (3) required by state or federal government program. The above restrictions shall not apply to any overpayment recovery efforts made by Montefiore Diamond Care prior to August 1, 2013, when notice has been provided to the provider of such recovery efforts.

In addition, we may at times apply the procedures described in this section to recoup duplicate claims payments, but reserve the right to use other procedures to do so. In addition, if a provider asserts that Montefiore Diamond Care has underpaid any claim(s), Montefiore Diamond Care may offset any underpayments that may be owed against past overpayments made by Montefiore Diamond Care dating as far back as the claimed underpayment.

**We Will Provide Notice of Overpayments Before We Seek Recovery**

If Montefiore Diamond Care has determined that an overpayment has occurred, Montefiore Diamond Care will provide 60 days’ written notice to the provider of the overpayment and request 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.

**If You Agree That We Have Overpaid You**

Upon receipt of a request for repayment, providers may voluntarily submit a refund check made payable to Montefiore Diamond Care within 60 days from the date the overpayment notice was mailed by Montefiore Diamond Care. 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.

The participating provider agrees that where Montefiore Diamond Care has previously recovered overpayments, by whatever mechanism utilized by Montefiore Diamond Care, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by the agencies listed in your contract with the Plan.

The participating provider agrees that where Montefiore Diamond Care has recovered overpayments, Montefiore Diamond Care shall retain said recoveries, except where such recoveries are made on behalf of OMIG or the Department, or pursuant to a combined audit as provided in your contract with the Plan.

Montefiore Diamond Care shall require and have a mechanism in place for its Participating or Non-Participating Providers to report to Montefiore Diamond Care when the Participating or Non-Participating Provider has received an overpayment, to return the overpayment within 60 days of the date of the identification of the overpayment, and to notify Montefiore Diamond Care in writing of the reason for the overpayment.

OMIG or the Department shall have the right to request that Montefiore Diamond Care recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its Participating Provider consistent with the requirements of Insurance Law § 3224-b. In such cases OMIG or the Department may charge the Participating Provider a collection fee as set forth in State Finance Law, in an amount to be determined by OMIG or the Department in its sole discretion. Montefiore Diamond Care shall remit, on a monthly basis, to the Department all amounts collected from the Participating Provider. Upon collection of the full amount owed to the Medicaid program, the Montefiore Diamond Care may retain the collection fee to account for reasonable costs incurred to collect the debt. Montefiore Diamond Care shall report the amounts recovered in its Quarterly Provider Investigative Report in accordance with Your agreement with the Plan. OMIG will only request that Montefiore Diamond Care recover an overpayment, payment or other damage where there has been a final determination. For purposes of this section, a final determination is defined as:

i.) a Notice of Agency Action issues by OMIG pursuant to 18 NYCRR Part 515; ii.) a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516;

ii.) a Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517;

iii.) a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or
v.) an Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519: however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG’s request pending a decision.

Consistent with 18 NYCRR § 517.6(g) OMIG may enter into an agreement with Montefiore Diamond Care to conduct a combined audit or investigation of Montefiore Diamond Care’s Participating Provider, Non-Participating Provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between Montefiore Diamond Care and OMIG as provided for in the combined audit or investigation agreement. In no event shall Montefiore Diamond Care share in any recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.
If You Disagree That We Overpaid You
If a provider disagrees with Montefiore Diamond Care determination concerning overpayment, the provider must submit a written request for an appeal within 60 days of the date the overpayment notice was mailed by Montefiore Diamond Care and include all supporting documentation in accordance with the provider appeal procedure described in Section 5.4. If, upon reviewing all supporting documentation submitted by a provider, Montefiore Diamond Care determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. Montefiore Diamond Care will proceed to offset the amount of the overpayment prior to the final determination made pursuant to binding arbitration.

If You Fail to Respond to Our Notice of Overpayments
If a provider fails to dispute a request for repayment concerning an overpayment determination made by Montefiore Diamond Care within 60 days from the date the overpayment notice was mailed by Montefiore Diamond Care, the provider will have acknowledged and accepted the amount demanded by Montefiore Diamond Care and, subject to the provider’s right to arbitration pursuant to the provider agreement, Montefiore Diamond Care will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by Montefiore Diamond Care.

If an Offset Results in a Negative Balance
If an overpayment offset results in a negative balance for the provider, the provider will not receive an explanation of payment for future claims 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 check cycle period. Once the entire negative amount has been recovered, the provider will resume receiving EOPs.

5-6: Adverse Reimbursement Change
An adverse reimbursement change is defined by the New York State Public Health Law as one that “could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional.”

Section44-6-c of the Public Health Law 4406-c requires written notice to providers of adverse reimbursement changes to the provider’s contract and allows the provider to terminate the contract, as follows:

Montefiore Diamond Care will provide written notice at least 90 days prior to an adverse reimbursement change to the provider contract.

If the provider objects to the change, he or she may, within 30 days of the date of the notice, give written notice to Montefiore Diamond Care to terminate the contract effective upon the implementation of the reimbursement change.
The following statutory exceptions apply to the notice requirement:

The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the state or federal government or by the American Medical Association’s Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and

The change is provided for in the contract between the managed care organization (MCO) and the provider or the independent practice association (IPA) and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a healthcare professional relative to this provision.

**5-7: Provider External Appeals**

**Provider External Appeal Rights**
Public Health Law 4914 extends 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 Montefiore Diamond Care, Montefiore Diamond Care is responsible for the full cost of an appeal that is overturned, and the provider and Montefiore Diamond Care 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 MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application (see attached External Appeals Application and Instructions) and the designee. The New York Staff person investigating the member complaints (also known as the Superintendent) 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 time frame will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

**Hold Harmless**
Section 4917 of the Public Health Law states that a provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable copays, from a member for services determined to be not medically necessary by the external appeal agent. Thus, members are held harmless in such cases.
NEW YORK STATE EXTERNAL APPEAL APPLICATION
Complete and send this application within 4 months of the plan’s final adverse determination for health services if you are the patient or the patient’s designee, or within 60 days if you are a provider appealing on your own behalf to DFS. Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210 or Fax to: (800) 332-2729. For help, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov.

1. Applicant Name:
2. Patient Name:

Date of Birth: Gender: □ Male □ Female □ Non-Specified
3. Patient Address:
Street:
City: State: Zip Code:
4. Patient Phone Number: Primary: ( ) Secondary: ( )
5. Patient Email Address:
6. Patient Health Plan: ID #:
7. Patient’s Physician/Prescriber:
8. Physician/Prescriber Address:
Street:
City: State: Zip Code:
9. Physician/Prescriber Phone #: ( ) Fax: ( )

10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?
□ Yes
□ No
□ Don’t know

11. To be completed if the applicant is the patient’s designee
Complete this section only if a designee is submitting this appeal on a patient’s behalf. If the patient’s provider is the designee complete section 14 instead of this section.
Name of Designee:
Relationship to Patient:
Address:
Street:
City: State: Zip Code:
Phone Number: ( ) Fax: ( )
Designee Email Address:

12. Reason for Health Plan Denial - check only one and attach a completed physician’s attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:
□ Not medically necessary □ Experimental/investigational for a clinical trial
□ Experimental/ investigational □ Experimental/investigational for a rare disease
□ Out-of-network and the health plan proposed
an alternate in-network service □ Out-of-network referral
□ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)

13. This appeal may be expedited. Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.
If Expedited

Montefiore Diamond Care Provider Manual
check one:

☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.

☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient’s life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient’s health, and patient’s physician will complete the Physician Attestation and send it to the Department of Financial Services.

☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient’s prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.

If Standard

check one:  ☐ Standard Formulary Exception (72 hours) ☐ Standard Appeal for all other appeals (30 days)

*** If expedited you must call 888-990-3991 when the application is faxed***

14. To be completed if applicant is patient’s provider

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

☐ Provider filing own behalf ☐ Provider filing as designee on behalf of patient

Provider Name:
Person or Firm Representing Provider (if applicable):
Contact Person for Correspondence:
Address for Correspondence:
Street:
City: State: Zip Code:
Phone Number: ( ) Fax: ( )
Email Address:

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 copayment, coinsurance 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 Signature:
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15. Description and date(s) of Service: (Attach any additional information you want considered):

16. External Appeal Eligibility (Check one):

☐ Attached is final adverse determination from the health plan.

☐ Attached is the health plan’s letter waiving an internal appeal.

☐ Patient requests expedited internal appeal at same time as the external appeal.
Health plan did not comply with internal appeal requirements for patient appeal.

17. 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:

☐ Enclosed is a check or money order made out to the health plan.

☐ Application was faxed and fee will be mailed to the Department within 3 days.

☐ Patient is covered under Medicaid or Child Health Plus.

☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.

☐ Health plan does not charge a fee for an external appeal or fee is not required.

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE 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. When an external appeal is filed, a 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 use 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.

If the patient or the patient’s designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient’s healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:
Print Name:
Relationship to patient, if applicable:
Patient Name: Age:
Patient’s Health Plan ID#:
Date: (required)
PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

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. The patient’s prescriber may also request an expedited formulary exception appeal. 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.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY, 12210 or Fax to: (800) 332-2729.

Type of Review Requested:

☐ Standard Appeal (30 days), or for a nonformulary drug (72 hours)
☐ Expedited Appeal (72 hours), or for a nonformulary drug (24 hours)

If Expedited check one:

☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.
☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient’s life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient’s health.
☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.

If Expedited complete both:

☐ 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 (or 24 hours for a non-formulary drug) 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: ( )

• For an expedited appeal, the patient’s physician, or for a non-formulary drug, the patient’s prescribing physician or other prescriber, must complete the box below and item **14. You must send information to the agent immediately in order for it to be considered.**
• 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 service denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient’s physician must complete items **1-10 and 14.**
• For an out-of-network referral denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient’s physician must complete items **1-9, 13 and 14.**
• For a rare disease denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14.**

1. Name of Physician (or Prescriber) completing this form:
To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient’s treating physician.

2. Physician (or Prescriber) Address:
   Street:
   City: State: Zip Code:
3. Contact Person:
4. Phone Number: ( ) Fax: ( )
5. Physician (or Prescriber) Email:
6. Name of Patient:
7. Patient Address:
8. Patient Phone Number:
9. Patient Health Plan Name and ID Number:

10. Experimental/Investigational Denial or Out-of-Network Service Denial
(Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

a. For an Experimental/Investigational Denial:
As the patient’s physician I attest that (select one without altering):

OR
☐ Standard health services or procedures have been ineffective or would be medically inappropriate.
☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.

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

b. For an Out-of-Network Service Denial
☐ As the patient’s physician I attest that the following 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.

c. List the documents relied upon and attach a copy of the documents:
Document #1 Title:
Publication Name: Issue Number: Date:
Document #2 Title:
Publication Name Issue Number: Date:

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d. Supporting Documents
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 documents:

Peer-reviewed medical literature, including literature relating to therapies reviewed and

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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, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;

Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

☐ Peer-reviewed abstracts accepted for presentation at major medical association meetings;

☐ Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;

The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network’s Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard’s Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;

Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

11. Clinical Trial Denial
☐ There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.
Although not required, it is recommended you enclose 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 non-governmental 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 NIH.
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12. Rare Disease Treatment Denial
If provision of the service requires approval of an Institutional Review Board, include or attach the approval.
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 ☐ I do not have a material financial or professional relationship with the provider of the service (check one).
Check one:
☐ 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.
☐ The patient’s rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial
As the patient’s attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.

Name of out-of-network provider:
Address of out-of-network provider:
Training and experience of out-of-network provider:
(e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).

14. Physician (or Prescriber) Signature
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.

Signature of Physician (or Prescriber): Date:
Physician (or Prescriber) Name:
EXTERNAL APPEAL INSTRUCTIONS & APPLICATION

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION
Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application
• The Type of Review must be completed if an expedited appeal is being requested. External Appeals can only be expedited if the denial falls into one of these categories. If you already received the services your appeal cannot be expedited.
• Number 11 indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
• Number 12 is to be used to describe the services requested. You can attach a separate document with this information.
• Number 14 relates to the fee that a health plan may charge for the external appeal. The final adverse determination will indicate if the health plan charges a fee.
• Number 15 is required if the provider is submitting the application on their own behalf or behalf of the patient.
• Number 16 is only required if the patient has designated someone other than the provider to act on their behalf.
• Patient Consent to the Release of Records for NYS External Appeal – this document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased the document must be signed by the patient’s healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician’s Attestation
• The first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient’s life, health or ability to regain maximum function, or the delay would pose an imminent or serious threat to the patient’s health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
• Number 10 is required for Experimental/Investigational and Out-of-Network Service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections
a, c and d are required when appealing an experimental/investigational denial.

- Subsections b, c and d are required for Out-of-Network Service denials.
- Subsection c. must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient’s condition. Two articles are required. This section MUST be completed in full, “See attached” will not suffice. The documents that are acceptable for submission are described in subsection d. There is no requirement that the two documents be from different categories.
- Number 11 is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- Number 12 is required for the Experimental/Investigational denials for treatment of a rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient’s attending physician. They must disclose any relationship with the patient’s attending physician and indicate which definition of “rare disease” applies to the patient’s condition.
- Number 13 must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider’s curriculum vitae, Board certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- Number 14 must be signed by a Physician. Physician is defined in NYS Education law as an MD or DO. Attestations signed by any other provider will not be accepted.
6: Grievances, Appeals and Complaints

Montefiore Diamond Care strives to achieve member satisfaction at all times. Systems have been implemented to accept, investigate, make a determination, handle appeals and grievances, and report complaints. Montefiore Diamond Care offers assistance to members and their representatives in all phases of the grievance and appeal process.

6-1: Complaints and Grievances

- The regulatory definition of a grievance is any expression of dissatisfaction regarding care and treatment that does not amount to change in scope or duration of service, including all issues previously thought of as complaints.
- A grievance can be written or verbal.
- A grievance can be filed by the member, family member/caregiver, friend or provider on behalf of the member.
- A grievance can be made to a Care Management Team member (nurse, social worker or service coordinator) or any other Montefiore Diamond Care staff member.
- Grievances are tracked by a formal mechanism.
- A complaint may be filed orally or in writing with us. The person who receives the complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.
  - If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
  - For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.
- Our answer will describe what we found when we reviewed your complaint and our decision about your complaint. 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 complaint appeal must be filed in writing. It must be filed within 60 business days of receipt of the initial decision about your complaint. Once we receive the appeal, you will receive a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.
- For standard appeals, we will make the appeal decision within 30 business days after receiving all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will
use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

- There will be no punitive action taken against a provider who requests an expedited resolution.
- 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 member/caregiver, friend or provider on behalf of the member.
- The appeal must be filed within 60 days of the postmarked date of the letter notifying the member of the action.
- Appeals can be Standard or Expedited.
- There will be no punitive action taken against a provider who requests an expedited resolution.
- Appeals are tracked by a formal mechanism.
- Appeal decisions are made within required time frames, based on the urgency 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 and information regarding filing external appeal or Fair Hearing information as appropriate.
- If we did not decide the appeal totally in our member’s favor, they may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on the appeal.
- If the appeal involved the restriction, reduction, suspension or termination of authorized services the member was currently receiving, and they have requested a Fair Hearing, the member will continue to receive these services while they are waiting for the Fair Hearing decision. The request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.
- Our member’s benefits will continue until they withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.
• If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

• Although our member may request to continue services while they are waiting for the Fair Hearing decision, if the Fair Hearing is not decided in their favor they may be responsible for paying for the services that were the subject of the Fair Hearing.

• A report of appeals is submitted to the Department of Health on a quarterly basis.
6-3: Complaints

- A complaint can be written or verbal.
- A complaint can be filed by the member, family member/caregiver, friend or provider on behalf of the member.
- A complaint can be made about a Montefiore Diamond Care employee or provider.
- Provider complaints are included in the Provider Report Card process (see Section 7-3 below).

6-4: Quality Review and Oversight

- Records of complaints, appeals and complaints are stored, tracked and reviewed by the Clinical Director, Network Management or his or her designee.
- Providers may be asked to investigate individual or aggregate complaints and may be asked to develop action improvement plans, as necessary.
- Results of activities are reported to the Quality Management Committee to determine ongoing issues, trends and opportunities for improvement. Recommendations may also be made to limit a provider's participation in the network.
7-1: Quality Assurance Performance Improvement (QAPI) Plan

The goal of the QAPI plan is to systematically monitor, evaluate and improve the quality and appropriateness of care administered by providers or coordinated by the Montefiore Diamond Care and maximize member satisfaction. The following areas are reviewed annually:

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

Montefiore Diamond Care supports and carries out these functions through several cross-functional committees. Examples of these committees include an internal Quality Utilization Committee and a board-appointed Quality Management Committee. All committee meetings are recorded, and minutes are reported to the Board of Directors at its quarterly meetings.

7-2: Quality Assurance Performance Improvement (QAPI) Work Plan

An annual work plan is designed to conduct activities in support of the QAPI Plan. 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, complaints, incidents, hospitalizations and nursing home admission data, high-risk/high-volume utilization data, and other customer service and provider performance data reports. Data are reported to the board-appointed Quality Management Committee.
Montefiore Diamond Care views each provider as a partner in care and works with each one accordingly. Montefiore Diamond Care staff work 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.

Participating Providers are prohibited from displaying Montefiore Diamond Care’s outreach materials in their offices.

Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State’s Enrollment broker for education on all plan options. Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type.