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Chapter 1: Overview and Contact Numbers

1. Overview

This manual outlines the responsibilities of contracted providers for VNS CHOICE Medicare plans. These plans include VNS CHOICE Medicare Option 1, VNS CHOICE Option 2 and VNS CHOICE Managed Long Term Care (MLTC) Plus.

2. Useful Telephone Numbers

VNS CHOICE has created a single point of contact with extended business hours for its Providers. Providers can reach VNS CHOICE for any reason, including pre-certification, by dialing (866) 783-0222. VNS CHOICE business hours are from 8:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday, except legal holidays. Additionally, there is a VNS CHOICE Staff Member on-call 24 hours per day, 7 days per week to meet your needs. VNS CHOICE telephone numbers are:

Appeals and Grievances.....	1-866-791-2212
Appeals and Grievances (Fax).....	1-212-290-0012
Behavioral Health & Substance Abuse Pre-Authorizations.....	1-866-783-0222
Billing/Claim Inquiries.....	1-866-783-0222
General Information.....	1-866-VNS-0047 (1-866-867-0047)
Medical Management	1-866-783-0222
Medical Management (Fax -includes pre-authorizations)	1-866-791-2214
Member Eligibility	1-866-783-0222
Member Services	1-866-783-1444
CVS Caremark (Includes Specialty Division)	1-866-783-0222
CVS Caremark (Fax)	1-800-373-0238
Provider Disputes.....	1-866-783-0222
Provider Disputes (Fax).....	1-212-290-0012
Provider Services (and pre-authorizations).....	1-866-783-0222
TTY Number.....	1-888-844-5530

3. Useful Addresses:

Nursing Home Providers send claims to:

VNS CHOICE Medicare Claims Department
Attn: Claims Dept
1250 Broadway, 11th Floor
New York, NY 10001

For Behavioral Health and Substance Abuse Services send claims to:

ValueOptions
PO 1380
Latham, NY 12110

All Other Providers send claims to:

VNS CHOICE Medicare Claims Department
P.O. Box 4498
Scranton, PA 18505

For Covered Part D vaccines send claims to:

Caremark Medicare Vaccine Processing
PO BOX 52193
Phoenix, AZ 85072-2193

Provider Dispute Resolution:

VNS CHOICE
Attn: Provider Dispute Resolution
1250 Broadway, 11th Floor
New York, NY 10001

Prior Authorizations or Transitional Care Requests:

VNS CHOICE
Medical Management Department
1250 Broadway 3rd Floor
New York, NY 10001

Website:

www.vnschoice.org

4. Member Information

a. Selecting a Physician

- 1) All VNS CHOICE Members choose a Participating Primary Care Physician (PCP).
- 2) If a member does not select a PCP within 30 days of enrollment, one is assigned by the plan.
- 3) PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Geriatrics and Nurse Practitioners in Adult Medicine or Gynecology.
- 4) Under special circumstances and with VNS CHOICE approval, Specialists may also serve as PCPs.
- 5) Members may change their designated PCP at any time by contacting Member Services at the number listed under “Useful Telephone Numbers”.

The PCP serves to create a “Medical Home” for the Member. The PCP works with VNS CHOICE staff to coordinate all care the Member receives. PCPs provide and authorize Covered Services for Members. The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resources.

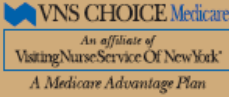

A Participating Specialist may serve as the Member’s PCP if:

- 1) The Participating Specialist satisfies the credentialing requirements for a PCP.
- 2) VNS CHOICE approves the request.
- 3) The Participating Specialist agrees to fulfill the role.

b. Member Eligibility and Identification

You may obtain information on VNS CHOICE Member eligibility by calling the Member Eligibility contact telephone number listed in the beginning of this section Monday through Friday from 8:00a.m. – 9:00p.m. Eastern Time.

Each VNS CHOICE Member is given an identification card. Members should present their cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.

 <p>VNS CHOICE Medicare Option 1</p> <p>Lillian D. Wald Member ID: VNS0700012345 Rx ID: VNS0700012345 Effective Date: 01/01/2007 Payor Number: 80840 H5549-001</p>	<p><i>Medical Benefits</i> PCP: Dr. John O. Smith PCP ID: 123456789 PCP Phone Number: 718-987-6543</p> <p><i>Pharmacy Benefits</i> RxBin: 610468 RxPCN: VNS RxGRP: 5600300</p> <p>Member Services: 1-866-783-1444 TTY/TDD: 1-888-844-5530 www.vnschoice.org</p> 
<p>Medical Benefits Provider Services and Precertification: 1-866-783-0222 or www.vnschoice.org/provider Claims: VNS CHOICE, PO Box 4498, Scranton, PA 18505 REFERRALS NOT REQUIRED. For services that require precertification call the number above. In an emergency call the local hotline (e.g. 911) or go to the nearest emergency facility. Notify Member Services promptly after treatment. While coverage is in force members are entitled to plan benefits, subject to exclusions and limitations. Medicare limiting charges apply. For eligibility and benefits information call the number above. Participating providers are independent contractors and are neither agents nor employees of VNS CHOICE. Plan administered by VNS CHOICE. This card does not guarantee coverage.</p>	<p>Pharmacies: Eligibility and Claims questions, contact CVS/Caremark at 1-888-352-5609 or www.vnschoice.org/pharma Members requiring TTY/TDD assistance for pharmacy questions: 1-800-754-5171 Mental Health and Substance Abuse Benefit – Unless an emergency, services require pre-certification. For coverage, precertification or questions: 1-866-317-7773 In an emergency call the local hotline (e.g. 911) or go to the nearest emergency facility. Notify Member Services promptly after treatment. While coverage is in force members are entitled to plan benefits, subject to exclusions and limitations. Medicare limiting charges apply. For eligibility and benefits information call the number above. Participating providers are independent contractors and are neither agents nor employees of VNS CHOICE. Plan administered by VNS CHOICE. This card does not guarantee coverage.</p>

c. Member Co-Pay

VNS CHOICE Medicare Option 1 and VNS CHOICE Medicare Option 2 are Medicare Advantage products, which **DO NOT** cover the Medicaid co-pays for Covered Services. Providers must bill the New York State Medicaid as appropriate, for Medicaid portion of Covered Services. In order to ensure reimbursement, Providers should always ask Members, at the time of service, about their medical coverage. In the event that the Provider is unable to ascertain benefit or deductible status at the time of service, the Provider may, as appropriate, contact Provider Services for clarification.

VNS CHOICE MLTC Plus is an integrated Medicare Advantage and Medicaid Managed Long Term Care program, which incorporates the Medicaid reimbursement of Covered Services. Providers **MUST NOT** bill New York State Medicaid (except for certain services that are carved out) or the Member for any portion of the Medicaid benefit.

If you have questions about how to bill properly or how to determine the appropriate co-payment, co-insurance or deductible, please contact Provider Services at the contact number listed in the beginning of this section.

5. Administrative Procedures

a. Prior Authorization

For prior authorization review and / or Plan notification:

- 1) Call toll free (866) 783-0222 or
- 2) Fax information to (866) 791-2214
- 3) You can obtain a copy of our Prior Authorization Request Form in Chapter 9 of this manual or on our provider portal at www.vnschoice.org, or
- 4) Mail your request to the address for the Medical Management Department located in the beginning of this Chapter.

Prior Authorization is the process by which VNS CHOICE's Medical Management Department reviews your request for a patient to receive Medically Necessary inpatient or outpatient treatment at a Hospital, ambulatory care facility, Physician's office, or other healthcare setting for a range of procedures determined by VNS CHOICE to require prior authorization. A list of these services is provided in Chapter 9 of this manual or on the provider portal at www.vnschoice.org. Prior Authorization also allows VNS CHOICE to identify Members for pre-service discharge planning and to register them in our specialized programs such as disease management or care management.

Preauthorization requests may be submitted telephonically or by fax submission on the VNS CHOICE Referral Authorization Request Form.

Once the request for Prior Authorization is received in our office, our medical management staff will begin the process to make a Coverage Determination. In order to successfully complete this process, we will require you to provide us with some essential information regarding the clinical condition, requested treatment and history supporting the request for services. There are two components to a Coverage Determination:

- Whether the service is a Covered Service under the VNS CHOICE Medicare Plan.
- Whether the service is Medically Necessary. Coverage Determinations are based on Medicare coverage guidelines, nationally recognized criteria and/or locally developed VNS CHOICE clinical coverage policies.

b. Second Opinion

VNS CHOICE may require that your patient see a Physician, determined by VNS CHOICE, for a second opinion. VNS CHOICE reserves the right to require a second opinion for any surgical procedure or healthcare service. There is no formal list of procedures requiring second opinions. Procedures or services requiring a second opinion will be decided on a case-by-case basis.

Members may request a second opinion related to the need for surgery or for a major non-surgical diagnostic and therapeutic procedure. Members may obtain a second opinion from a Participating Provider within the VNS CHOICE network. In the event that the recommendation of the first and second Physician differs regarding the need for the surgery or other major procedure, a third opinion from a Participating Provider shall also be covered.

c. Coordination of Benefits

Some Members may also have health insurance coverage through another insurance carrier. Coordination of benefits is a great way to maximize health benefit coverage and insure that coverage is provided in a specific sequence when more than one policy covers the claim. To avoid delays in claims processing and payment, please make sure that your Member's primary coverage is through VNS CHOICE before submitting your claim. See Chapter 3 for a more detailed explanation of coordination of benefits.

d. Claims Submission

All claims must be submitted on CMS-1500 or UB-04 claims forms. You may submit claims by mail or electronically. Please note your National Provider Identifier (NPI) and Tax ID on all claims

1) Electronic Claims Submission

VNS CHOICE believes that electronic claims submission offers many benefits including efficiency and improved cash flow. We encourage you to use it. For complete instructions on electronic claims submission, see Chapter 3.

2) Outpatient Claims Submission

PCPs and Specialists must submit a claim form (CMS-1500) as soon as possible, but generally no more than 90 days¹ after each Member visit. Claim forms should be completed in full detail. See Chapter 3 for more information on late claims.

VNS CHOICE pays "clean" claims within 30 days of receipt. If you have not received payment within that timeframe, and you have not received a request for additional information, you may request a status report by contacting Provider Services at the telephone number listed under "claims inquiry" in the beginning of this section. You can also review claims status by visiting our website www.vnschoice.org.

When a claim is paid, you will receive a check and an "Explanation of Payment". This will explain our payment in detail.

3) Inpatient Billing

Hospitals must submit a claim form (UB-04) as soon as possible, but generally no more than 90 days² after each Member discharge. Claim forms should be completed in full detail. See Chapter 3 for more information on late claims.

4) Provider Claims Dispute Resolution

If you are dissatisfied with a claim payment decision, you may request a Claim Dispute Review. Before requesting a formal dispute, you may request, either verbally or in writing, a review of the issue. See Chapter 3 for more information on the Provider Claims Dispute process.

¹ Please refer to your contract for the specific time limit

² Please refer to your contract for the specific time limit

Chapter 2: Physician Services

1. Primary Care Practitioner (PCP) Network Participation Guidelines

- a. Overview:** As a Primary Care Physician (PCP), you are the manager of your patients' total healthcare needs. You provide routine and preventive medical services, and coordinate all care that is given by VNS CHOICE Specialists, VNS CHOICE Participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services).

One of the cornerstones of VNS CHOICE's healthcare philosophy is availability of services. All PCPs must:

- 1) Arrange to have coverage available to provide medical services to their Members, 24 hours a day, seven days a week;
- 2) Treat all patients equally;
- 3) Not discriminate because of race, sex, marital status, sexual orientation, religion, ancestry, national origin, place of residence, disability, source of payment, utilization of medical, mental health services or supplies, health status, or status as a Medicare or Medicaid Recipient, or other unlawful basis; and,
- 4) Agree to observe, protect, and promote the rights of VNS CHOICE Members as patients.

For your reference, we have included a copy of VNS CHOICE's Member Rights and Responsibilities in Chapter 6.

In becoming a VNS CHOICE PCP, you and your staff agree to follow and comply with VNS CHOICE's administrative, medical management, quality assurance, and reimbursement policies and procedures.

b. Responsibility to Your Patients

As a VNS CHOICE PCP, you agree to provide the following, where applicable:

- 1) All the services of a PCP or other health professional typically received in a PCP 's office. These include:
 - (a) Treatment of routine illnesses.
 - (b) Consultations.
 - (c) Injections.

- (d) Periodic physical exams, including any tests and any ancillary services you require to make your appraisal.
 - (e) Pap smears, pelvic exams. Note: While you are required to offer Pap smears and pelvic exams, female Members may also choose an Obstetrician/Gynecologist (OB/GYN) whom they may see without a referral. You may also refer members to a Participating Provider for these services.
- 2) Appropriate coverage for your patients who may be in a Hospital or Skilled Nursing Facility.
 - 3) Educational services including:
 - (a) Information to assist Members in using healthcare services appropriately
 - (b) Information on personal health behavior and lifestyle
 - (c) Information on achieving and maintaining physical and mental health
 - 4) Maintenance of certain standards for your office, service, and medical records. (See Chapter 8 for specific requirements.)
 - 5) Coverage and Availability as follows:
 - (a) Telephone Coverage After Hours:

All Physicians must have either an answering service or a telephone recording that directs a Member to call another telephone number in an urgent or emergent situation. (Please be sure that if the on-call number is a beeper number, Members understand how to punch in their telephone number.)

- (b) Telephone Access During Normal Business Hours:

Physicians are expected to provide an immediate response to all Emergent conditions. Physicians should respond to Urgent conditions within 4 hours and non-urgent / routine calls within 1-2 business days.

- (c) Covering Physicians:

All Primary Care Physicians on extended leave (vacation, illness, etc.) must arrange with another Participating VNS CHOICE Physician, or a non-VNS CHOICE Physician who agrees to accept your negotiated rates, to provide 24-hour coverage for your patients. The covering Physician must also have 24-hour telephone coverage.

(d) Appointments:

Primary Care Physicians must make every effort to see a Member within the following timeframes:

- Emergent – Member should be directed to 911 or the emergency room for treatment.
- Urgent - within 24 hours
- Routine/symptomatic – within 7 days
- Wellness/Non-symptomatic – within 30 days

(e) Office Waiting Time:

Office waiting time for visits should not exceed 30 minutes.

c. Confidentiality and HIPAA

As a VNS CHOICE PCP, you must maintain medical and non-medical records. You and VNS CHOICE agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with VNS CHOICE in the process of claims and medical treatment. You must also make any medical, financial, or administrative records available to VNS CHOICE at no charge, as requested, either for VNS CHOICE administrative purposes, quality assurance purposes, or to comply with state and federal law.

d. Quality Assurance

All VNS CHOICE PCPs must cooperate with and participate in peer review, including utilization review (see Chapter 7), quality assurance, external audits, administrative procedures, and grievance procedures (see Chapter 8).

All services that you provide to Members must be consistent with appropriate medical practice. They must also be in accordance with the AMA's rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.

You must notify VNS CHOICE immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

2. Referring to a Participating VNS CHOICE Specialist

- a. Members may access Participating Specialists without a referral.
- b. Make sure that you are referring Members only to VNS CHOICE Physicians, ancillary facilities, and Providers. If a required specialty is not represented in VNS CHOICE's Directory of Participating Providers or Directory Addenda, call VNS CHOICE's Provider Service Department at telephone number listed in Chapter 1.

3. Physician Specialist Services Network Participation Guidelines

- a. **Overview:** In becoming a VNS CHOICE Specialist, you and your staff agree to follow and comply with VNS CHOICE's administrative, patient referral, utilization review, quality assurance, disease management, and reimbursement policies and procedures. As a Participating Specialist with VNS CHOICE, you must:
 - 1) Treat all your patients equally.
 - 2) Not discriminate because of race, sex, religion, place of residence, health status, or status as a Medicare or Medicaid Member.
 - 3) Observe, protect, and promote the rights of VNS CHOICE Members as patients.

For your reference, a copy of VNS CHOICE's Member Rights and Responsibilities is included in Chapter 6.

b. Responsibility to Your Patients

- 1) Work closely with PCPs to ensure continuity of care for VNS CHOICE Members.
- 2) Advise the PCP, in writing, about ongoing treatment of the PCP's patient.
- 3) Confer with the Member's PCP before referring the Member to another Specialist, except in a serious, life-threatening emergency. Similarly, if a Member under Specialist care must enter the Hospital, the Specialist must get Prior Authorization (except in an emergency), of the admission from VNS CHOICE's Medical Management Department and must notify the Member's PCP of the admission.
- 4) Maintain certain standards for your office, service, and medical records. See Chapter 8 on Quality Management for specific requirements.

5) Coverage and Availability as follows:

(a) Telephone Coverage After Hours:

All Physicians must have either an answering service or a telephone recording that directs a Member to call a special telephone number in an urgent or emergent situation. (Be sure that if the special number is a beeper number, Members understand how to punch in their telephone number.)

(b) Covering Physicians:

All Physicians on extended leave (vacation, illness, etc.) must arrange with a fellow VNS CHOICE Physician, or a non-VNS CHOICE Physician who agrees to accept your negotiated rates, to provide 24-hour coverage for your patients. The covering Physician must also have 24-hour telephone coverage.

(c) Appointments:

Physicians must make every effort to see a Member within the following timeframes:

- Emergent – Member should be directed to 911 or the emergency room for treatment.
- Urgent - within 24 hours
- Routine/symptomatic – within 7 days
- Wellness/Non-symptomatic – within 30 days

(d) Office Waiting Time:

Office waiting time for visits should not exceed 30 minutes.

c. Confidentiality and HIPAA

As a VNS CHOICE Physician, you must maintain medical and non-medical records. You and VNS CHOICE agree to maintain confidentiality in compliance with all state and federal laws and regulations that govern the practice of medicine or operation of a managed care organization. You must also comply with all HIPAA regulations related to medical information and records exchanged with VNS CHOICE in the processing of claims and medical treatment. You must also make any medical, financial, or administrative records available to VNS CHOICE, as requested, either for VNS CHOICE's administrative purposes, quality assurance purposes, or to comply with state and federal law.

d. Quality Assurance

All VNS CHOICE Physician Specialists must cooperate with and participate in peer review, including utilization review (see [Chapter 7](#)), quality assurance programs, external audit programs, administrative procedures, and grievance procedures (see [Chapter 8](#)).

All services that you provide to Members must be consistent with appropriate medical practice. They must also be in accordance with the AMA's rules of ethics and conduct, and in accordance with the rules of any other medical governing or licensing body including HIPAA rules governing privacy of medical records.

You must notify VNS CHOICE immediately if your medical license or board certification or your participation in Medicare or Medicaid is revoked or restricted.

e. Specialist Services Provided by PCPs

Some PCPs are also qualified to perform services ordinarily handled by a Specialist. In this case, the PCP must also be Participating with VNS CHOICE as a Specialist before VNS CHOICE will pay claims submitted for Specialist services. If interested please call VNS CHOICE Provider Services under “Useful Telephone Numbers” listed in Chapter 1 of this provider manual.

Chapter 3: VNS CHOICE Claims Submission and Processing

1. Submitting Claims

When you provide medical services to a Member, submit your claims on the standard CMS-1500 or UB-04 Form. The prompt payment of your claim is contingent on VNS CHOICE's receipt of complete and legible claims information. Please include your National Provider Identifier (NPI) and Tax ID number on the claim.

Claims should be submitted by mail to the VNS CHOICE Claims Department, which is located in Chapter 1 under, "Useful Telephone Numbers and Addresses", or via Electronic Submission.

2. Electronic Claims Submission

VNS CHOICE encourages Providers to submit claims to us electronically. Electronic claims submission can offer you the following benefits:

- a. More efficient claims payment
- b. Improved cash flow
- c. Increased convenience: one universal form to complete for all carriers
- d. Greater reliability than paper systems
- e. Decreased postage and mail time
- f. Reduced paperwork for office staff

Providers may elect to submit claims through electronic data interchange (EDI) to VNS CHOICE through ACS EDI Gateway, Inc. EDI claims are accepted in ANSI X12 837I and 837P 4010 addendum version. If you are a provider currently using a software vendor, clearinghouse or billing agent to submit claims electronically for any other payer, you may do one of the following:

- a. Contact your software vendor, clearinghouse, or billing agent and request that they activate VNS CHOICE (**ACS payer code 77073**) for electronic submission to ACS EDI Gateway, Inc; or
- b. Type this link into your Internet browser:
<https://edirect.acs-inc.com/edirect/info/images/pdfs/1165858999-Provider%20Survey%2020061208.pdf>

Complete and return the Provider Survey to ACS. An ACS representative will contact the software vendor, clearinghouse, or billing agent noted on the survey and will instruct them how to become a Trading Partner for EDI submission on your behalf.

If you are a provider who has the capability to create and submit an X12 837N transaction **directly** to ACS EDI, then you must first enroll as a Trading Partner with ACS EDI.

- c. To become a Trading Partner:
 - 1) Go to <https://edidirect.acs-inc.com>
 - 2) Click the “Claims Payers List” link found at the top of the ACS EDI homepage
 - 3) Click “**VNS CHOICE**” from the list of Payers
 - 4) Click “Enrollment”
 - 5) Click on the “EDI Enrollment Form” and “Trading Partner Agreement” to download and print
 - 6) Complete both forms and submit via fax or mail
 - 7) Upon receipt of your Trading Partner ID, contact an ACS Business Analyst at **800-952-0495**, between 8am – 5pm, EST, to begin the testing process

NOTE: A Companion Guide for Professional and institutional claims with additional information regarding connectivity and submission is also available for download at this website.

3. Timely Filing and Prompt Payment of Claims

- a. Providers are expected to submit claims within the timelines specified in their contract. Claims received after the Timely Filing Limit may be denied.
- b. “Clean Claims”, those completed fully to VNS CHOICE standards, will be paid or denied within 30 calendar days of submission.
- c. Other claims, including those with incomplete information from non-network Providers will be paid or denied within 60 calendar days.
- d. Network Providers will be paid according to the terms of their contract.
- e. Non-network Providers will be paid according to CMS regulations.

4. Payment for Emergent Care, Urgent Care and Out of Area Dialysis

- a. VNS CHOICE will pay for Emergent and Urgently needed services, without prior authorization, until the Member is stabilized.
- b. VNS CHOICE will pay for renal dialysis services while the Member is temporarily out of the area.

5. Payment for Administration Costs of Covered Part D Vaccines

Administration costs for covered Part D vaccines are reimbursed under Medicare Part D. Please submit a CMS 1500 form if you have dispensed a vaccine that is covered under Medicare Part D and/or administered the vaccine in your office. Please refer to the attached sample CMS 1500 claim form attached at the end of this chapter, which demonstrates the required information necessary for processing these claims correctly. It is especially important that you include the drug name and NDC separately for each vaccine administered. The claim must be submitted to CVS/Caremark for reimbursement by submitting the CMS 1500 form to:

**Caremark Medicare Vaccine Processing
PO BOX 52193
Phoenix, AZ 85072-2193**

If you have any questions concerning reimbursement for Part D vaccines, please contact CVS/Caremark at the telephone number listed in Chapter 1 under “Useful Telephone Numbers”.

6. Coordination of Benefits and Balance Billing

If a Member has coverage with another plan that is primary to VNS CHOICE, please submit a claim for payment to the other plan first. The amount payable by VNS CHOICE will be determined by the amount paid by the primary plan and Medicare secondary payer law and policies. Please submit a copy of the primary carrier’s Explanation of Payment with your claim to VNS CHOICE.

- a. You may not bill a Member for a non-covered service unless:
 - 1) You have informed the Member in advance that the service is not a covered service; and
 - 2) The Member has agreed in writing to pay for the non-covered service.

7. Claims Inquiries or Disputes

If you have questions regarding the status of a claim or other inquiries, contact the telephone number indicated in Chapter 1 under “Useful Telephone Numbers” for claim inquiries.

a. Provider Dispute Resolution

It is VNS CHOICE's policy to ensure fair, appropriate resolution and timely handling of Providers' disputes. The Provider dispute resolution process provides a mechanism by which Participating Providers may submit disputes resulting from claim adjustments or denials.

The following are examples of issues that are excluded from the Provider dispute resolution process:

- 1) An Independent Medical Review initiated by or on behalf of a Member through the Member Appeals Process does not qualify for the Provider Dispute Resolution process.
- 2) Denials related to Medical Necessity.

b. Provider Dispute Process

1) Dispute Submission

All disputes must be submitted within 90 days of the date of the Explanation of Benefits (EOB) or according to the timeframes indicated in the contract of the Participating Provider's agreement with VNS CHOICE.

The following procedures are applicable for the Participating Provider who wishes to submit a Provider dispute for evaluation and review by VNS CHOICE:

All Provider disputes must be in writing and must include the following:

- (a) Provider name, National Provider Identifier (NPI) and contact information,
- (b) The VNS CHOICE Member's Identification number,
- (c) The specific item in dispute,
- (d) Clearly stated reason for contesting the determination and the justification as to why the service should be paid or approved, and
- (e) Copies of all relevant information and supporting documentation required for review of the Provider's concerns (e.g.: claims include claim number, medical records, authorizations, etc).

The Provider must either fax his/her dispute to the telephone number indicated in Chapter 1, for Provider Disputes, or mail the dispute to the address designated for Provider Dispute Resolution (see sample Provider Dispute Resolution Request document attached).

2) Dispute Review Process and Timeframes

VNS CHOICE will thoroughly review the Provider's request and all supporting information and documentation.

Written determination of resolution of a dispute will be issued within 30 business days of receipt. If the resolution requires a claim payment, the payment will be issued within 10 business days of the determination.

If additional information is needed, a request will be sent to the Provider within 15 business days. To resolve the dispute, the Provider has 30 business days from the date of requested information to submit additional information or the dispute will be closed.

3) Dispute Resolution

If VNS CHOICE decides in the Provider's favor on a request for payment, VNS CHOICE Select will pay for the service no later than 10 business days from the date of the determination.

If VNS CHOICE Medicare decides against the Provider, VNS CHOICE Medicare will notify the Provider in writing as to the rationale for the decision.

Sample: Completed Claim Form For Covered Part D Vaccine Administration

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID) Q/BOOP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BILLING <input type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (PO)		1a. INSURED'S I.D. NUMBER (For Program in Row 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, One A.		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Patient, One A.	
5. PATIENT'S ADDRESS (No., Street) 1234 N. Q Street		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) 1234 N. Q Street		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Phoenix		CITY Phoenix	
STATE AZ		STATE AZ	
ZIP CODE 85078		ZIP CODE 85078	
TELEPHONE (Include Area Code) (123) 456-7890		TELEPHONE (Include Area Code) (123) 456-7890	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) None		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (PLACE (State)) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER 1221231321321 (various)	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> 1 1 01 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/> 1 1 01 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME Employer Name HERE	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME Insurance Name HERE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) Signature on File SIGNED: _____ DATE: 1/1/2007		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) Signature on File SIGNED: _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Name HERE		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY) 17a. DEA # 17b. NPI: 1234567890	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM (MM DD YY) TO (MM DD YY)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM (MM DD YY) TO (MM DD YY)	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. V05.8		22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From (MM DD YY) To (MM DD YY) B. PLACE OF SERVICE C. ICD-9-CM CODE (EMG) D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual) (CPT/HCPCS) Zostavax E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON LEAF H. UNITS (Qty/Day) I. CL. QUAL. J. RENDERING PROVIDER ID #		25. FEDERAL TAX I.D. NUMBER (SSN EIN) 1234567890 <input type="checkbox"/> <input checked="" type="checkbox"/>	
26. PATIENT'S ACCOUNT NO. 12345678		27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$ 170.04		29. AMOUNT PAID \$	
30. BALANCE DUE \$ 170.04		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Dr. Name HERE DATE	
32. SERVICE FACILITY LOCATION INFORMATION Dispensary: Address City, State, Zip		33. BILLING PROVIDER INFO & PH # Remit to: Address City, State, Zip	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Sample: Completed Claim Form For Vaccine Administration

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> MEDICARE (Member #) <input type="checkbox"/> MEDICAID (Member #) <input type="checkbox"/> THE CARE CHAMPUS (Member #) <input type="checkbox"/> CHAMPVA (Member #) <input type="checkbox"/> GROUP HEALTH PLAN (ID# or ID) <input type="checkbox"/> FECA (SEK/UNG/ISSN) <input checked="" type="checkbox"/> OTHER (ID)		14. INSURED'S I.D. NUMBER (not Project # Item 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, One A.		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 N. Q Street		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Phoenix STATE AZ		7. INSURED'S ADDRESS (No., Street) 1234 N. Q Street	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY Phoenix STATE AZ	
9. EMPLOYER'S NAME OR SCHOOL NAME None		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER 1231231321321 (various)		12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/> 1 1 01	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services classified below) SIGNED Signature on File DATE 1/1/2007		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services classified below) SIGNED Signature on File	
15. DATE OF CURRENT ILLNESS (First symptom OR INJURY (ALLERGY) OR PREGNANCY/IMP) MM DD YY 1 1 07		16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY) FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Name HERE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RECEIVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V05.8		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE (From To) B. ICD-9-CM PROC. CODE C. CPT/HCPCS MODIFIER D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OR UNITS H. UNIT PRICE I. NO. OF UNITS J. PROVIDER ID # 01 01 08 11 90471 Admin Zostavax NDC 0006-4963-41 8 00 1234567890			
25. FEDERAL TAX ID NUMBER (SSN EIN) 1234567890		26. PATIENT'S ACCOUNT NO. 12345678	
27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 170.04	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Dr. Name HERE DATE		30. AMOUNT PAID \$ 170.04	
31. SERVICE FACILITY LOCATION INFORMATION Dispensary: Address City, State, Zip		32. BILLING PROVIDER INFO & PAYEE () Remit to: Address City, State, Zip	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0199 FORM CMS-1500 (08-05)

Sample

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to:

VNS CHOICE
Attn: Provider Dispute Resolution
1250 Broadway, 11th Floor
New York, NY 10001

*Provider Name:	*Provider NPI:
Provider Address	

Provider Type MD Hospital ASC SNF DME/Supplies Rehab
 Ambulance Home Health Other _____
(please specify type of "other")

Claim Information Single Multiple **"LIKE"** Claims (see additional form) *Number of Claims:* ____

*Patient Name		Date of Birth:
*Health Plan ID Number	Patient Account Number	Original Claim Number: <i>(if multiple claims, use attached form)</i>
Service "From/To" Date	Original Claim Amount Billed:	Original Claim Amount Paid:
DISPUTE TYPE		
<input type="checkbox"/> Claim <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Disputing request for overpayment <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Other: _____		
*DESCRIPTION OF DISPUTE		
EXPECTED OUTCOME		

A. Contact Name: _____ Title: _____ Phone: _____

B. Signature: _____ Date: _____ Fax: _____

Chapter 4: Laboratory Services

1. Lab Exams That Can Be Performed in the PCP Office

VNS CHOICE requires that all laboratory testing be conducted by participating laboratories.

VNS CHOICE allows participating physicians to perform laboratory work in their office(s) pursuant to the terms of the Clinical Laboratory Improvement Amendment (CLIA). In order to be reimbursed for laboratory tests provided in the office, the office must have the appropriate CLIA Certificate/ Registration or waiver on file with VNS CHOICE. Reimbursement will be made according to the VNS CHOICE participating physician agreement.

Chapter 5: Long Term Care Facilities

1. Access For VNS CHOICE Staff

The Skilled Nursing Facility (SNF) Provider is expected to provide appropriate access within 14 days of an Enrollee's admission to VNS CHOICE clinical staff, including physicians, nurses, nurse practitioners and care coordinators, in accordance with the Special Needs Program protocols for operation. This may include but not be limited to:

- a. Members, their records, and the SNF Provider's staff.
- b. Information regarding a member's status and overall care management activities, and participation and attendance in care planning conferences and other similar activities.

2. Provision of Services

SNF Provider agrees to provide services to VNS CHOICE Members in accordance with contractual terms. SNF Provider will use the VNS CHOICE clinical and operational protocols, as applicable, when providing services to Members. The protocols (and training materials) will identify the roles and specific services to be rendered by the VNS CHOICE staff and the roles and specific services to be rendered by the SNF Provider's staff. Consistent with the guidelines in the protocols, SNF Provider's staff will provide specific services to Members, facilitate the provision of services by VNS CHOICE staff and Participating Providers, and share information with VNS CHOICE, as appropriate, to assist in the ongoing care management of Members.

3. Training

SNF Provider agrees to accept and participate in VNS CHOICE's staff education and training programs, as appropriate in order to ensure effective coordination of all services. SNF Provider will ensure that all staff providing services to Members will receive training in VNS CHOICE's care management model, clinical and operational protocols, and documentation requirements.

If protocols and/or training materials are modified, VNS CHOICE shall provide updated information to SNF Provider's staff in a timely manner. A copy of the training program and associated training materials will be provided to the SNF Provider in advance of any scheduled training.

4. Procedures for Maintenance of Credentialed Staff

The SNF Provider will comply with procedures that ensure the maintenance of a list of credentialed Participating Providers in accordance with the facilities'

responsibilities under the Medicare Conditions of Participation. VNS CHOICE will provide the SNF Provider with the names and credentials of all professional staff and/or Participating Providers who provide services to the Enrollee.

5. Termination and Transition Plan

The SNF Provider will follow the termination and transition clause that is defined in the contract. If this Agreement is terminated, the SNF Provider will cooperate with VNS CHOICE staff to facilitate the safe transition of any Enrollee receiving long term care services to a Participating Skilled Nursing Facility. Except in cases when the SNF Provider is prohibited by law or regulation from continuing to serve the Enrollee, the SNF Provider agrees to continue to provide care to the Enrollee for an additional period of time as authorized by VNS CHOICE, not to exceed sixty (60) days. In addition, the SNF provider shall provide access to staff in order to assess the Enrollee's needs and shall promptly provide a copy of the Enrollee's medical records to the Participating Skilled Nursing Facility the member is being transferred to.

Chapter 6: Summary of Benefits and Member Rights

1. Summary of Benefits

The following tables were designed to explain the various VNS CHOICE plan benefits. The first Table illustrates a comparison of Original Medicare and benefits of the VNS CHOICE Medicare Option 1 and Option 2 plans. The second Table illustrates a comparison of Original Medicare and the benefits of the VNS CHOICE Managed Long Term Care (MLTC) Plus program.

VNS CHOICE Medicare Summary of Benefits

The following Summary of Benefits applies to members enrolled in the VNS CHOICE Medicare Option 1 and Option 2.

Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1 and Option 2
		<p>Because you are eligible for benefits from Medicaid, the State is required to cover Medicare cost-sharing amounts that you would otherwise be required to pay for VNS CHOICE Medicare Option 1 and Option 2 plans. These amounts may differ based on what kind of Medicaid benefits you have. The cost sharing amounts are listed below. In addition, you will have to pay the co-payment amounts listed below for Part D coverage. Contact VNS CHOICE for additional information.</p>
<p>1. Premium and other important information.</p>	<p>You pay the Medicare Part B premium of \$ 96.40 each month.</p>	<p>There is no monthly premium or yearly deductible for the following Medicare – covered plan services in either Option 1 or Option 2:</p> <ul style="list-style-type: none"> • Doctor Office Visits • Podiatry Services • Outpatient Services/Surgery • Home Health Care • Skilled Nursing Facility Services • Ambulance Services • Emergency Care • Urgently Needed Care • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays, and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Hearing Services • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Cardiac Rehabilitation Services • Renal Dialysis • Blood • Medicare Part B Prescription Drugs

Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
<p>2. Doctor and Hospital Choice</p> <p>(For more information, see Sections #15 Emergency Care and #16 Urgently Needed Care.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You must go to network doctors, specialists, and hospitals, except for emergency and urgent care.</p> <p>You do NOT need a referral to go to network doctors, specialists, and hospitals.</p>	<p>You must go to network doctors, specialists, and hospitals, except for emergency and urgent care.</p> <p>You do NOT need a referral to go to network doctors, specialists, and hospitals.</p>
<p>3. Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay for each benefit period³</p> <p>Day(s) 1-60: An initial deductible of \$1,024</p> <p>Day(s) 61-90: \$256 each day</p> <p>Day(s) 91-150: \$512 each lifetime reserve day¹</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You are covered for 90 days each benefit period.</p> <p>You are covered for 60 lifetime reserve days. There is no co-payment for lifetime reserve days.</p> <p>Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You are covered for 90 days each benefit period.</p> <p>You are covered for 60 lifetime reserve days. There is no co-payment for lifetime reserve days.</p> <p>Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>
<p>4. Inpatient Mental Health</p>	<p>You pay the same deductible and co-payments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You may receive up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You may receive up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>
<p>5. Skilled Nursing Facility (in a Medicare-certified facility)</p>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> – Day(s) 1-20: \$0 for each day – Day(s) 21-100: \$128 for each day <p>There is a limit of 100 days for each benefit period. ³</p>	<p>There is no co-payment for a Medicare-covered stay at a Skilled Nursing Facility. A 3-day prior hospital stay is required.</p> <p>You are covered for a maximum of 100 days each benefit period.</p> <p>Authorization rules apply for services. Contact VNS CHOICE for details.</p>	<p>There is no co-payment for a Medicare-covered stay at a Skilled Nursing Facility. A 3-day prior hospital stay is required.</p> <p>You are covered for a maximum of 100 days each benefit period.</p> <p>Authorization rules apply for services. Contact VNS CHOICE for details.</p>

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no co-payment for all covered home health visits.	There is no co-payment for Medicare-covered home health visits. Authorization rules apply for services. Contact VNS CHOICE for details	There is no co-payment for Medicare-covered home health visits. Authorization rules apply for services. Contact VNS CHOICE for details
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE			
8. Doctor Office Visits	You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for each primary care doctor office visit for Medicare-covered services. There is no co-payment for each specialist visit for Medicare-covered services. Authorization rules apply for certain services. Contact VNS CHOICE for details. See Section 28 – Physical Exams for more information.	There is no co-payment for each primary care doctor office visit for Medicare-covered services. There is no co-payment for each specialist visit for Medicare-covered services. Authorization rules apply for certain services. Contact VNS CHOICE for details. See Section 28 – Physical Exams for more information.
9. Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for Medicare-covered visits (manual manipulation of the spine to correct subluxation). Authorization rules apply for services. Contact VNS CHOICE for details.	There is no co-payment for Medicare-covered visits (manual manipulation of the spine to correct subluxation). Authorization rules apply for services. Contact VNS CHOICE for details.
10. Podiatry Services	You pay 20% of Medicare-approved amounts. ^{1,2} You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	There is no co-payment for each Medicare-covered visit (medically necessary foot care). You are covered for up to 4 routine visits every year. Authorization rules apply for services. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered visit (medically necessary foot care). You are covered for up to 4 routine visits every year. Authorization rules apply for services. Contact VNS CHOICE for details.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
11. Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. ^{1,2}	For Medicare-covered Mental Health services, there is no co-payment for each individual / group therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.	For Medicare-covered Mental Health services, there is no co-payment for each individual / group therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.
12. Outpatient Substance Abuse	You pay 20% of Medicare-approved amounts. ^{1,2}	For Medicare-covered services, there is no co-payment for each individual/group therapy visit. Except in an emergency, your provider must obtain authorization from VNS CHOICE.	For Medicare-covered services, there is no co-payment for each individual/group therapy visit. Except in an emergency, your provider must obtain authorization from VNS CHOICE.
13. Outpatient Services/ Surgery	You pay 20% of Medicare-approved amounts for the doctor. ^{1,2} You pay 20% of outpatient facility charges. ^{1,2}	There is no co-payment for each Medicare-covered visit to an ambulatory surgical center. There is no co-payment for each Medicare-covered visit to an outpatient hospital facility. Except in an emergency, your provider must obtain authorization from VNS CHOICE. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered visit to an ambulatory surgical center. There is no co-payment for each Medicare-covered visit to an outpatient hospital facility. Except in an emergency, your provider must obtain authorization from VNS CHOICE. Contact VNS CHOICE for details.
14. Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. ^{1,2}	There is no co-payment for Medicare-covered ambulance services.	There is no co-payment for Medicare-covered ambulance services.
OUTPATIENT CARE			
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable co-payment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. ^{1,2} You pay 20% of doctor charges. ^{1,2} NOT covered outside of the U.S. except under limited circumstances.	There is no co-payment for each Medicare-covered emergency room visit. Service is available outside of the U.S. (See Section #37 – World Wide Coverage for more details).	There is no co-payment for each Medicare-covered emergency room visit. Service is available outside of the U.S. (See Section #37 – World Wide Coverage for more details).

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Co-payment. ^{1,2} NOT covered outside the U.S. except under limited circumstances.	There is no co-payment for each Medicare-covered urgently needed care visit. Service is available outside of the U.S. (See Section #37 – World Wide Coverage for more details).	There is no co-payment for each Medicare-covered urgently needed care visit. Service is available outside of the U.S. (See Section #37 – World Wide Coverage for more details).
17. Outpatient Rehabilitation services (Occupation Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for each Medicare-covered Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for each Medicare-covered item. Authorization rules apply. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered item. Authorization rules apply. Contact VNS CHOICE for details.
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for each Medicare-covered item. Authorization rules apply for services. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered item. Authorization rules apply for services. Contact VNS CHOICE for details.
20. Diabetes Self-Monitoring Training & Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for Medicare-covered Diabetes self-monitoring training. There is no co-payment for each Diabetes Supply item. Authorization rules apply for services. Contact VNS CHOICE for details.	There is no co-payment for Medicare-covered Diabetes self-monitoring training. There is no co-payment for each Diabetes Supply item. Authorization rules apply for services. Contact VNS CHOICE for details.
21. Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services ^{1,2} . There is no co-payment for Medicare-approved lab services.	There is no co-payment for each Medicare-covered: - Clinical/diagnostic lab service - Radiation therapy service - X-ray visit Authorization rules apply. Contact VNS CHOICE for details.	There is no co-payment for each Medicare-covered: - Clinical/diagnostic lab service - Radiation therapy service - X-ray visit Authorization rules apply. Contact VNS CHOICE for details.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

PREVENTIVE SERVICES			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
22. Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for each Medicare-covered Bone Mass Measurement.	There is no co-payment for each Medicare-covered Bone Mass Measurement.
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for each Medicare-covered Colorectal Screening exam.	There is no co-payment for each Medicare-covered Colorectal Screening exam.
24. Immunizations (Flu vaccine, Hepatitis B vaccine-for people with Medicare who are at risk, Pneumonia vaccine)	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine ^{1,2} . You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no co-payment for the Pneumonia and Flu vaccines. There is no co-payment for the Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no co-payment for the Pneumonia and Flu vaccines. There is no co-payment for the Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.
25. Mammograms (Annual Screening for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts ² No referral necessary for Medicare-covered screenings.	There is no co-payment for each Medicare-covered screening Mammogram. No referral necessary for Medicare-covered screenings.	There is no co-payment for each Medicare-covered screening Mammogram. No referral necessary for Medicare-covered screenings.
26. Pap Smears and Pelvic Exams (for women with Medicare)	There is no co-payment for a Pap Smear once every 2 years, or annually for beneficiaries at high risk ² You pay 20% of Medicare-approved amounts for Pelvic Exams ²	There is no co-payment for each Medicare-covered Pap Smear. There is no co-payment for each Medicare-covered Pelvic Exam.	There is no co-payment for each Medicare-covered Pap Smear. There is no co-payment for each Medicare-covered Pelvic Exam.
27. Prostate Cancer Screening exams (for men with Medicare age 50 and older)	There is no co-payment for approved lab services and a co-payment of 20% of Medicare-approved amounts for other related services ^{1,2} .	There is no co-payment for each Medicare-covered Prostate Cancer Screening Exam.	There is no co-payment for each Medicare-covered Prostate Cancer Screening Exam.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

PREVENTIVE SERVICES (cont'd.)			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
28. Physical Exams	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. You pay 20% of the Medicare-approved amount ^{1,2}.</p>	<p>You are covered for one routine physical per year.</p> <p>There is no co-payment for physical exams.</p>	<p>You are covered for one routine physical per year.</p> <p>There is no co-payment for physical exams.</p>
MEDICARE PRESCRIPTION DRUG COVERAGE			
29. Prescription Drugs Covered Under Part D	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>This plan uses a formulary. A formulary is a list of drugs covered by the plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you and you can see our complete formulary on www.vnschoice.org.</p> <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from VNS CHOICE Medicare for certain drugs.</p> <p>Contact VNS CHOICE Medicare for details.</p>	<p>This plan uses a formulary. A formulary is a list of drugs covered by the plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you and you can see our complete formulary on www.vnschoice.org.</p> <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from VNS CHOICE Medicare for certain drugs.</p> <p>Contact VNS CHOICE Medicare for details.</p>

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

MEDICARE PRESCRIPTION DRUG COVERAGE (cont'd)			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
Deductible	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.	<p>You pay \$0 or \$56 annual deductible. (The amount depends on your income and institutional status.)</p> <p>People who have low incomes, who live in long term care facilities or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs.</p>	<p>You pay \$0 or \$56 annual deductible. (The amount depends on your income and institutional status.)</p> <p>People who have low incomes, who live in long term care facilities or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs.</p>
Initial Coverage In network retail pharmacy		<p>You may receive drugs from an in-network pharmacy for either one-month (30-day) or a three-month (90-day) supply.</p> <p>When you go to an in network pharmacy you will pay:</p> <ul style="list-style-type: none"> - \$ 0 co-payment for generic drugs, including brand drugs treated as generic. <p>When you go to an in network pharmacy, you will pay the following for your drugs depending on your income or institutional status:</p> <ul style="list-style-type: none"> - \$0 to \$5.60 co-payment or 15% co-insurance for brand, preferred and specialty drugs. 	<p>You may receive drugs from an in-network pharmacy for either one-month (30-day) or a three-month (90-day) supply.</p> <p>When you go to an in network pharmacy, you will pay the following for your drugs depending on your income or institutional status:</p> <ul style="list-style-type: none"> - \$0 to \$2.25 co-payment or 15% co-insurance for generic drugs, including brand drugs treated as generic. - \$0 to \$5.60 co-payment or 15% co-insurance for brand, preferred and specialty drugs.
Mail Order		<p>You may receive drugs from a mail-order pharmacy for a three-month (90-day) supply.</p> <p>When you order your drugs through the mail order pharmacy, you will pay:</p> <ul style="list-style-type: none"> - \$0 co-payment for generic drugs, including brand drugs treated as generic. - \$0 to \$5.60 or 15% of the cost for brand, preferred and specialty drugs. 	<p>You may receive drugs from a mail-order pharmacy for a three-month (90-day) supply.</p> <p>When you order your drugs through the mail order pharmacy, you will pay:</p> <ul style="list-style-type: none"> - \$0 to \$2.25 co-payment or 15% co-insurance for generic drugs, including brand drugs treated as generic. - \$0 to \$5.60 or 15% of the cost for brand, preferred and specialty drugs.

MEDICARE PRESCRIPTION DRUG COVERAGE (cont'd)			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
Coverage after you reach your initial coverage limit		<p>When your yearly drug costs reach \$2,510, you will pay:</p> <ul style="list-style-type: none"> - \$ 0 co-payment for generic drugs (including brand drugs treated as generic). <p>Depending on your income or institutional status, you will pay:</p> <ul style="list-style-type: none"> - \$0 to \$5.60 or 15% co-insurance for brand or non-generic drugs. 	<p>When your yearly drug costs reach \$2,510, you will pay the following for your drugs, depending on your income and institutional status:</p> <ul style="list-style-type: none"> - \$0 or \$2.25 co-payment or 15% co-insurance supply generic drugs. - \$0 or \$5.60 co-payment or 15% co-insurance for brand, preferred and specialty drugs.
Catastrophic		<p>When your yearly drug costs reach \$4,050, you will pay:</p> <ul style="list-style-type: none"> - \$ 0 co-payment for generic drugs including brand drugs treated as generic. <p>Depending on your income or institutional status, you pay:</p> <ul style="list-style-type: none"> - \$0 to \$5.60 co-payment for all brand, preferred and specialty drugs. 	<p>When your yearly drug costs reach \$4,050, you will pay the following for your drugs, dependent on your income and institutional status:</p> <ul style="list-style-type: none"> - \$0 - \$2.25 co-payment for generic drugs; or - \$0 to \$5.60 co-payment for brand, preferred and specialty drugs.
Out-of-Network Pharmacies		<p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances, or while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>To learn more about what your costs will be, please contact VNS CHOICE Medicare for more information.</p>	<p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances, or while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>To learn more about what your costs will be, please contact VNS CHOICE for more information.</p>
30. Dental Services	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive and restorative dental services, including periodontic and endodontic services.	<p>You receive preventive and restorative dental services, including periodontic and endodontic services, with no co-payment. Authorization rules apply.</p> <p>Contact VNS CHOICE for more information.</p>

ADDITIONAL SERVICES			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
31. Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams ^{1,2}.</p>	<p>You may receive 1 visit every 3 years for a hearing exam (diagnostic hearing exams) or for an evaluation for a hearing aid.</p> <p>You may receive 1 hearing aid every 3 years for each ear.</p> <p>A maximum of \$1,500 per hearing aid every 3 years applies to this benefit.</p> <p>There is no co-payment.</p> <p>Authorization rules apply. Contact VNS CHOICE for details.</p>	<p>You may receive 1 visit every 3 years for a hearing exam (diagnostic hearing exams) or for an evaluation for a hearing aid.</p> <p>You may receive 1 hearing aid every 3 years for each ear.</p> <p>A maximum of \$1,500 per hearing aid every 3 years applies to this benefit.</p> <p>There is no co-payment.</p> <p>Authorization rules apply. Contact VNS CHOICE for details.</p>
32. Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery ^{1,2}.</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings ^{1,2}.</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye ^{1,2}.</p> <p>You pay 100% for routine eye exams and glasses</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> – Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye) – One routine eye exam visit every year <p>There is no co-payment for the following items:</p> <ul style="list-style-type: none"> – Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) – One pair of glasses every year, or – One pair of contact lenses every year – Lenses – One set of frames every year, up to \$120 for eyewear (frames) every year. – Additional vision benefits are available 	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> – Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye) – One routine eye exam visit every year <p>There is no co-payment for the following items:</p> <ul style="list-style-type: none"> – Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) – One pair of glasses every year, or – One pair of contact lenses every year – Lenses – One set of frames every year, up to \$120 for eyewear (frames) every year. – Additional vision benefits are available

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

ADDITIONAL SERVICES (cont'd.)			
Benefit Category	Original Medicare	VNS CHOICE Medicare Option 1	VNS CHOICE Medicare Option 2
33. Health / Wellness Education	You pay 100%	You are covered for the following: <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline available 24 hours a day, 7 days per week. Assistance in accessing entitlement benefits including Medicaid re-certification, Medicare Savings Program, Low Income Subsidy applications, housing and social programs.	You are covered for the following: <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline available 24 hours a day, 7 days per week. Assistance in accessing entitlement benefits including Medicaid re-certification, Medicare Savings Program, Low Income Subsidy applications, housing and social programs.
34. Health Club Membership	You pay 100%	– Not offered.	You will receive a Health Club membership, including fitness programs and wellness education. In addition, this benefit includes 12 alternative medicine visits per year including massage, personal trainer, chiropractic and acupuncture disciplines. There is no additional cost for this service. Contact VNS CHOICE for details.
35. Transportation (Routine)	You pay 100%	There is no co-payment for up to 4 round trip(s) to a Plan-approved location every three months. Contact VNS CHOICE for details.	There is no co-payment for up to 4 round trip(s) to a Plan-approved location every three months. Contact VNS CHOICE for details.
36. Health Ambassador Program	You pay 100%	The Health Ambassador Program provides one in-home professional visit every 6 months at the member's request and is arranged by the plan. There is no co-payment for each Health Ambassador visit.	The Health Ambassador Program provides one in-home professional visit every 6 months at the member's request and is arranged by the plan. There is no co-payment for each Health Ambassador visit.
37. World Wide Coverage	You pay 100%	You may receive up to \$1,200 every 6 months of medically necessary services when you travel outside the United States. Contact VNS CHOICE for details.	You may receive up to \$1,200 every 6 months of medically necessary services when you travel outside the United States. Contact VNS CHOICE for details.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

VNS CHOICE Managed Long Term Care (MLTC) Plus Summary of Benefits

The following Summary of Benefits applies to members enrolled in the VNS CHOICE Managed Long Term Care (MLTC) Plus program.

Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
		<p>You must be fully eligible for benefits from Medicaid and meet the enrollment eligibility requirements for VNS CHOICE MLTC Plus, to be eligible to enroll. VNS CHOICE covers most of the cost-sharing amounts that you would otherwise have to pay and covers additional services that are covered by Medicaid. The cost-sharing amounts and additional services are listed below. Contact VNS CHOICE for additional information.</p>
<p>1. Premium and other important information.</p>	<p>You pay the Medicare Part B premium of \$96.40 each month.</p>	<p>There is no monthly premium or yearly deductible for the following Medicare – covered plan services:</p> <ul style="list-style-type: none"> • Doctor Office Visits • Podiatry Services • Outpatient Services/Surgery • Home Health Care • Skilled Nursing Facility Services • Ambulance Services • Emergency Care • Urgently Needed Care • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays and Lab Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Hearing Services • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Cardiac Rehabilitation Services • Renal Dialysis • Blood • Medicare Part B Prescription Drugs

Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
<p>2. Doctor and Hospital Choice</p> <p>(For more information, see Sections #15 Emergency Care and #16 Urgently Needed Care.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You must go to network doctors, specialists, and hospitals, except for emergency and urgent care. You do NOT need a referral to go to network doctors, specialists, and hospitals.</p>
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay for each benefit period³</p> <p>Day(s) 1-60: An initial deductible of \$1,024</p> <p>Day(s) 61-90: \$256 each day</p> <p>Day(s) 91-150: \$512 each lifetime reserve day¹</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You are covered up to 365 days per year (366 in a leap year) with no deductible or co-payment. Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>
<p>4. Inpatient Mental Health</p>	<p>You pay the same deductible and co-payments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>	<p>There is no deductible for services received at a network hospital.</p> <p>There is no co-payment for a Medicare-covered stay at a network hospital.</p> <p>You are covered up to 365 days per year (366 in a leap year) with no deductible or co-payment. Except in an emergency, your provider must obtain authorization from VNS CHOICE.</p>
<p>5. Skilled Nursing Facility (in a Medicare-certified facility)</p>	<p>You pay for each benefit period (3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> – Day(s) 1-20: \$0 for each day – Day(s) 21-100: \$128 for each day <p>There is a limit of 100 days for each benefit period. ³</p>	<p>There is no co-payment for a Medicare or Medicaid-covered stay at a Skilled Nursing Facility.</p> <p>There is no prior hospital stay requirement. There are 2 levels of care in a facility for which you are covered:</p> <ul style="list-style-type: none"> - Skilled Nursing and Rehabilitation Services - Long Term Care <p>Authorization rules apply for services. Contact VNS CHOICE for details.</p>
<p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>There is no co-payment for all covered home health visits.</p>	<p>There is no co-payment for Medicare or Medicaid-covered home health visits.</p> <p>Authorization rules apply for services. Contact VNS CHOICE for details.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

OUTPATIENT CARE		
Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
8. Doctor Office Visits	You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for each primary care doctor office visit for covered services. There is no co-payment for each specialist visit for covered services. Authorization rules apply for certain services. Contact VNS CHOICE for details. See Section 28 — Physical Exams for more information.
9. Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for covered visits (manual manipulation of the spine to correct subluxation). Authorization rules apply for services. Contact VNS CHOICE for details.
10. Podiatry Services	You pay 20% of Medicare-approved amounts. ^{1,2} You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	There is no co-payment for each covered visit (medically necessary foot care). You are covered for up to 4 routine visits every year, with no authorization. Authorization rules apply for certain services. Contact VNS CHOICE for details.
11. Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. ^{1,2}	There is no co-payment for each individual/group therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.
12. Outpatient Substance Abuse	You pay 20% of Medicare-approved amounts. ^{1,2}	There is no co-payment for each individual/group therapy visit. Except in an emergency, your provider must obtain authorization from VNS CHOICE.
13. Outpatient Services/ Surgery	You pay 20% of Medicare-approved amounts for the doctor. ^{1,2} You pay 20% of outpatient facility charges. ^{1,2}	There is no co-payment for each covered visit to an ambulatory surgical center. There is no co-payment for each covered visit to an outpatient hospital facility. Except in an emergency, your provider must obtain authorization from VNS CHOICE. Contact VNS CHOICE for details.
14. Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. ^{1,2}	There is no co-payment for ambulance services.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>You pay 20% of the facility charge or applicable co-payment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. ^{1,2}</p> <p>You pay 20% of doctor charges. ^{1,2}</p> <p>NOT covered outside of the U.S. except under limited circumstances.</p>	<p>There is no co-payment for each emergency room visit.</p> <p>NOT covered outside of the U.S. except under limited circumstances.</p>
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	<p>You pay 20% of Medicare-approved amounts or applicable Co-payment. ^{1,2}</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>There is no co-payment for each emergency room visit.</p> <p>NOT covered outside of the U.S. except under limited circumstances.</p>
17. Outpatient Rehabilitation services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	<p>You pay 20% of Medicare-approved amounts. ^{1,2}</p>	<p>There is no co-payment for each Medicare or Medicaid-covered Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit. Authorization rules apply for services. Contact VNS CHOICE for details.</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	<p>You pay 20% of Medicare-approved amounts. ^{1,2}</p>	<p>There is no co-payment for each covered item. Authorization rules apply for services. Contact VNS CHOICE for details.</p>
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	<p>You pay 20% of Medicare-approved amounts ^{1,2}.</p>	<p>There is no co-payment for each covered item. Authorization rules apply for services. Contact VNS CHOICE for details.</p>
20. Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	<p>You pay 20% of Medicare-approved amounts ^{1,2}.</p>	<p>There is no co-payment for Diabetes self-monitoring training.</p> <p>There is no co-payment for each Diabetes Supply item. Authorization rules apply for services. Contact VNS CHOICE for details.</p>
21. Diagnostic Tests, X-Rays, and Lab Services	<p>You pay 20% of Medicare-approved amounts, except for approved lab services ^{1,2}.</p> <p>There is no co-payment for Medicare-approved lab services.</p>	<p>There is no co-payment for:</p> <ul style="list-style-type: none"> - Clinical/diagnostic lab service - Radiation therapy service - X-ray visit <p>Authorization rules apply for services. Contact VNS CHOICE for details.</p>

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

PREVENTIVE SERVICES		
Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
22. Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for Bone Mass Measurement.
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts ^{1,2} .	There is no co-payment for Colorectal Screening exam.
24. Immunizations (Flu vaccine, Hepatitis B vaccine-for people with Medicare who are at risk, Pneumonia vaccine)	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine ^{1,2} . You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no co-payment for the Pneumonia and Flu vaccines. There is no co-payment for the Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.
25. Mammograms (Annual Screening for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts ² . No referral necessary for Medicare-covered screenings.	There is no co-payment for each covered screening Mammogram. No referral is necessary for screenings.
26. Pap Smears and Pelvic Exams (for women with Medicare)	There is no co-payment for a Pap Smear once every 2 years, annually for beneficiaries at high risk ² . You pay 20% of Medicare-approved amounts for Pelvic Exams ² .	There is no co-payment for each covered Pap Smear. There is no co-payment for each covered Pelvic Exam.
27. Prostate Cancer Screening exams (for men with Medicare age 50 and older)	There is no co-payment for approved lab services and a co-payment of 20% of Medicare-approved amounts for other related services ^{1,2} .	There is no co-payment for each covered Prostate Cancer Screening Exam.
28. Physical Exams	If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. You pay 20% of the Medicare-approved amount ^{1,2} .	You are covered for one routine physical per year. There is no co-payment for physical exams.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

MEDICARE PRESCRIPTION DRUG COVERAGE

<p>29. Prescription Drugs Covered Under Part D</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>This plan uses a formulary. A formulary is a list of drugs covered by the plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you and you can see our complete formulary on www.vnschoice.org.</p> <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from VNS CHOICE Medicare for certain drugs.</p> <p>Contact VNS CHOICE Medicare for details.</p>
<p>Deductible</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>You pay \$0 or \$56 annual deductible. (The amount depends on your income and institutional status.)</p> <p>People who have low incomes, who live in long term care facilities or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs.</p>
<p>Initial Coverage</p> <p>In network retail pharmacy</p>		<p>You may receive drugs from an in-network pharmacy for either one-month (30-day) or a three-month (90-day) supply.</p> <p>Depending on your income or institutional status, you pay the following for your drugs when you go to an in network pharmacy:</p> <ul style="list-style-type: none"> – \$0 to \$1.05 co-payment for generic drugs, including brand drugs treated as generic. – \$0 to \$3.10 co-payment for brand, preferred and specialty drugs.
<p>Mail Order</p>		<p>You may receive drugs from a mail-order pharmacy for a three-month (90-day) supply.</p> <ul style="list-style-type: none"> - \$0 to \$1.05 co-payment for generic drugs, including brand drugs treated as generic. - \$0 to \$3.10 co-payment for brand, preferred and specialty drugs.
<p>Coverage after you reach your initial coverage limit</p>		<p>Depending on your income you pay the following for your drugs when you go to an in network pharmacy:</p> <ul style="list-style-type: none"> – \$0 to \$1.05 co-payment for generic drugs, including brand drugs treated as generic. – \$0 to \$3.10 co-payment for brand, preferred and specialty drugs.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
Catastrophic		<p>When your yearly drug costs reach \$4,050, you pay the following (the amount depends on your income and institutional status):</p> <ul style="list-style-type: none"> – \$0 co-payment for any drugs.
Out-of-Network Pharmacies		<p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances, or while traveling outside of the plan’s service area where there is no network pharmacy.</p> <p>To learn more about what your costs will be, please contact VNS CHOICE Medicare for more information.</p>
ADDITIONAL SERVICES		
30.Dental Services	<p>In general, you pay 100% for preventive dental services.</p>	<p>You receive preventive and Medicaid -covered dental services with no co-payment.</p> <p>Except in an emergency, ambulatory or inpatient surgical dental services require prior authorization.</p> <p>Contact VNS CHOICE for more information.</p>
31.Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams ^{1,2}.</p>	<p>You may receive 1 visit every year for a hearing exam (diagnostic hearing exam) or for an evaluation for a hearing aid.</p> <p>You may receive services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing, including hearing aids and hearing aid batteries.</p> <p>A maximum of \$500 limit for each hearing aid applies every year.</p> <p>There is no co-payment.</p> <p>Contact VNS CHOICE for details.</p>
32.Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery ^{1,2}.</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings ^{1,2}.</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye ^{1,2}.</p> <p>You pay 100% for routine eye exams and glasses</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Eye exams (diagnosis and treatment for diseases and conditions of the eye). - One routine eye exam visit every year. <p>There is no co-payment for the following items:</p> <ul style="list-style-type: none"> - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) <ul style="list-style-type: none"> – One pair of glasses every year – Lenses – One set of frames every year, up to \$100 - Contact lenses are only covered when medically necessary. - Additional vision benefits are available.

¹ Each year, you pay a total of one \$135 deductible. ² If a doctor or supplier chooses not to accept assignment, their costs are often higher which means you may pay more. ³A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. ⁴ Lifetime reserve days can only be used once.

Benefit Category	Original Medicare	VNS CHOICE MLTC Plus
33. Health / Wellness Education	You pay 100%	<p>You are covered for the following:</p> <ul style="list-style-type: none"> – Care management and coordination of your medical care and long term care services – Written health education materials, including newsletters – Nursing Hotline available 24 hours a day, 7 days per week.
34. Transportation (Routine)	You pay 100%	<p>You are covered for scheduled transportation that is necessary to get needed medical care and other health related services. Coverage includes: ambulette, car service, and public transportation.</p> <p>Contact VNS CHOICE for details.</p>
LONG TERM CARE SERVICES		
35. Home and Community-Based Long Term Care Services	You pay 100%	<p>You are covered for medically necessary long- term care services provided in your home and/or community-based organizations. These services are based on an individual plan of care developed by your care manager, working with you, your caregivers, and your physician. In addition to the services listed in other sections of this chart, your plan of care may include:</p> <ul style="list-style-type: none"> – Personal care services – Private duty nursing – Nutritional services and nutritional supplements – Medical Social Services – Social and Environment Supports, including home modifications – Home Delivered Meals – Adult Day Health Care – Social Adult Day Services – Personal Emergency Response System (PERS) <p>Authorization rules apply.</p> <p>Contact VNS CHOICE for details.</p>

2. Member's Rights and Responsibilities

a. General Member Rights and Responsibilities

- 1) Timely, Quality Care
 - (a) Choice of a qualified Participating PCP and Participating Hospital,
 - (b) Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage,
 - (c) Timely access to their PCP and referrals and recommendations to Specialists when Medically Necessary,
 - (d) To receive Emergency Services when the Member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists,
 - (e) To actively participate in decisions regarding their health and treatment options,
 - (f) To receive urgently needed services when traveling outside the VNS CHOICE service area or in the VNS CHOICE service area when unusual or extenuating circumstances prevent the Member from obtaining care from a Participating Provider,
 - (g) To request the number of Grievances and Appeals and dispositions in aggregate,
 - (h) To request information regarding Physician compensation, and
 - (i) To request information regarding the financial condition of VNS CHOICE.
- 2) Treatment with Dignity and Respect
 - (a) To be treated with dignity and respect and to have his or her right to privacy recognized,
 - (b) To exercise these rights regardless of the Member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care,
 - (c) To confidential treatment of all communications and records pertaining to the Member's care,
 - (d) To access, copy and/or request amendment to the Member's medical records consistent with the terms of HIPAA,
 - (e) To extend his or her rights to any person who may have legal responsibility to make decisions on the Member's behalf regarding the Member's medical care,

- (f) To refuse treatment or leave a medical facility, even against the advice of Physicians (provided the Member accepts the responsibility and consequences of the decision), and
- (g) To complete an Advance Directive, living will or other directive to the Member's medical Providers.

b. Non-Discrimination

VNS CHOICE and CMS require compliance with the provisions of this paragraph as a condition for participation in Medicare plans:

Participating Provider will comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. Section 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794) and the regulations there under, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Section 1681 et. seq.), the Age Discrimination Act of 1975, as amended (42 U.S.C. Section 6101 et. seq.), Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (42 U.S.C. Section 9849), the Americans With Disabilities Act (P.L. 101-365) and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

Each Participating Provider will provide all Covered Services to Members in the same manner as such services are provided to other patients of Participating Provider, except as required by VNS CHOICE. Participating Provider will not unlawfully discriminate against any Member on the basis of source of payment, medical condition, or in any manner in regards to access to, and the provision of, Covered Services. Participating Provider will not unlawfully discriminate against any Member, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, physical handicap, marital status, age or sex.

c. Patient Self-Determination

VNS CHOICE requires that Participating Providers comply with the requirements of the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990). The Patient Self-Determination Act protects an adult patient's right to participate in health care decisions to the maximum extent of his/her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for health care. All Members must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive. An Advance Directive is a Member's written instructions, recognized under State law, relating to the provision of health care when the Member is not competent to make health care decisions as determined under State law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

Providers must inform a Member of his or her medical condition and all available treatment options, including treatments, which may not be a Covered Service under the Member's VNS CHOICE Evidence of Coverage. In addition, Members must be informed of the risks and benefits of each treatment option. The adult Member's medical record must have documentation indicating whether or not the patient has executed an Advance Directive. The Advance Directive document must be signed by the Member and witnessed. Providers may not

make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

Medicare law gives Members the right to file a complaint with the state survey and certification agency if the Member is dissatisfied with the organization's handling of Advance Directives and/or if a Provider fails to comply with Advance Directive instructions the Member may write the NY State Department of Health.

d. Member Satisfaction

VNS CHOICE periodically surveys Members to measure overall customer satisfaction as well as satisfaction with the care received from Participating Providers. VNS CHOICE reviews survey information and results are shared with Participating Providers.

e. Services Provided in a Culturally Competent Manner

VNS CHOICE is obligated to ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating Providers must cooperate with VNS CHOICE in meeting this obligation.

Chapter 7: Medical Management Program

1. Overview and Program Goals

VNS CHOICE seeks to improve the quality of care provided to its Members. Participating Providers are encouraged to work with VNS CHOICE in its efforts to promote healthy lifestyles through Member education and information sharing. VNS CHOICE will develop its Medical Management standards and policies in consultation with Participating Providers. VNS CHOICE encourages and expects Participating Provider participation in health promotion and disease prevention programs. VNS CHOICE seeks to accomplish the following objectives through its Medical Management Programs:

- a. Identify priority areas for improvement,
- b. Deliver health care in a cost-efficient, effective, and safe manner within the appropriate setting without compromising quality, and
- c. Prevent stress and implement effective management of disease in performance improvement activities including education of the Member.

Participating Providers must comply and cooperate with all VNS CHOICE Medical Management policies, procedures and programs.

2. Prior Authorization

a. Definition

Prior Authorization is the process by which VNS CHOICE's Medical Management Department reviews your request for a patient to receive inpatient or outpatient treatment at a hospital, ambulatory care facility, physician's office, or other healthcare setting for a range of procedures determined by VNS CHOICE to require prior authorization. A list of these services is provided in Chapter 9 of this manual or on the provider portal at www.vnschoice.org. Prior Authorization also allows VNS CHOICE to identify Members for pre-service discharge planning and to register them in our specialized programs such as disease management or care management.

b. Process/Responsibility

- 1) The participating PCP or Specialist who will be providing the service to the Member shall make requests for services requiring Prior Authorization. If the Member is receiving care from a non-participating provider, it will be the responsibility of the Member to obtain the necessary Prior Authorization.

2) Requests can be made by contacting the VNS CHOICE Medical Management Department in the following ways:

(a) Telephone request should be called in to the telephone number for Medical Management located in Chapter 1 under “Useful Telephone Numbers and Addresses”.

(b) Faxed requests should be sent on a completed Prior Authorization Request Form to the toll free fax number for Medical Management located in Chapter 1 under “Useful Telephone Numbers and Addresses”. A copy of this form is provided in Chapter 9 or on our website at www.vnschoice.org, or

(c) By mail to the VNS CHOICE Medical Management Department address located in Chapter 1, under “Useful Addresses”.

3) VNS CHOICE will determine whether:

(a) Patient is an eligible VNS CHOICE Member,

(b) Benefit is a Covered Service available under the Member’s Evidence of Coverage, and

(c) Services are Medically Necessary.

c. Information Required for Prior Authorization:

1) Member Name

2) Member Identification Number

3) Member Date of Birth

4) Diagnosis

5) ICD-9 Diagnosis Code

6) Type of Service

7) Place of Service

8) Dates of Service

9) Procedure, if applicable

10) CPT-4 Procedure Code, if applicable

- 11) Provider Name
- 12) Provider's VNS CHOICE Identification Number
- 13) Assistant or Co Surgeon information, if applicable
- 14) Potential needs upon discharge

c. Coverage Determinations

1) Definition

Coverage Determinations are based on Medicare coverage guidelines, nationally recognized criteria, or locally developed VNS CHOICE clinical coverage policies. A Coverage Determination requires the provision of information to VNS CHOICE regarding the clinical condition and treatment or services proposed for the Member. There are two components to Coverage Determinations:

- (a) Whether the service is a Covered Service under VNS CHOICE, and
- (b) Whether the service is Medically Necessary.

2) Timeframes

(a) Prescription Drug Coverage Determinations

- i. Standard coverage decisions will be rendered within 72 hours of being requested.
- ii. Expedited coverage decisions will be rendered with 24 hours of being requested

(b) Medical Coverage Determinations

- i. Standard decisions will generally be rendered within 14 days of being requested. The plan is allowed a 14-day extension if the time is needed review additional documentation.
- ii. Expedited coverage decisions will be rendered within 72 hours of being requested.

d. Notification Requirements

1) Timeframes for Notification

- (a) You must notify VNS CHOICE's Medical Management Department within the following timeframes:

- i. **Elective Services** - 14 days prior to a scheduled service (both inpatient and outpatient) whenever possible. If notification cannot be made 14 days prior to the service, it should be made as soon as medically possible **prior** to the scheduled service.
- ii. **Urgent Services** - VNS CHOICE should be notified prior to urgent services/admission being rendered, when possible. If circumstances do not allow for notification prior to urgent services being rendered, then notification must occur within one business day.
- iii. **Emergent Services** – Although no authorization is required, VNS CHOICE should be notified within one business day of emergent services/admission.

e. **Approvals**

- 1) VNS CHOICE's licensed professionals will review all requests against approved criteria and make the necessary approvals based upon eligibility and medical necessity.
- 2) Notification will be provided to Provider and/or the Member.

f. **Denials**

- 1) Only VNS CHOICE's Medical Directors can make decisions denying coverage for medical services for reasons of Medical Necessity.
- 2) Denial letters delineate any unmet criteria, standards and guidelines and inform the Provider and Member of the Appeal process.

g. **Criteria**

Our Medical Management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines to guide the Prior Authorization, concurrent review and retrospective review processes. To the extent certain utilization review/care management functions are delegated, such Delegates use criteria that are based on reasonable medical evidence and are consistent with VNS CHOICE's standards and guidelines.

3. Inpatient Hospital Services

a. **Emergent Admissions**

The PCP, Admitting Physician or the Member or Member's designee must notify VNS CHOICE as soon as possible about the emergent hospital admission. Notification requirements apply whether the emergency and treatment occurred

in or out of VNS CHOICE's Service Area. This notification allows VNS CHOICE's Medical Management Department to ascertain whether there are any discharge needs and to begin the discharge planning process. Authorization of post stabilization of services will be required. You must notify us of an Emergent Admission or to request Prior Authorization at the telephone number listed in Chapter 1 under "Useful Telephone Numbers and Addresses", Provider Services.

b. Urgent Hospital Admissions

The PCP, Admitting Physician or the Member or Member's designee should make every attempt to contact VNS CHOICE prior to the Urgent Admission. However, if circumstances are such that Prior Authorization is not feasible, then VNS CHOICE should be notified as soon as the Member is stabilized for Authorization of the hospital admission. Notification requirements apply whether the urgent admission occurred in or out of VNS CHOICE's Service Area. This notification will allow VNS CHOICE's Medical Management Department to identify any discharge needs and to begin the discharge planning process. You must notify us of an Urgent Admission or to request Prior Authorization at the telephone number located in Chapter 1 under, "Useful Telephone Numbers and Addresses", Provider Services.

c. Elective or Non-Urgent Hospital Admissions

All elective and non-urgent Hospital admissions require Prior Authorization. See the Prior Authorization in Chapter 9, for a list of select procedures requiring prior authorization or you can access a current list of services requiring Prior Authorization via the website at www.vnschoice.org. You must notify us of an Elective or Non-urgent Admission or to request Prior Authorization at the telephone number located in Chapter 1 under, "Useful Telephone Numbers and Addresses", Provider Services.

d. Concurrent Review or Extended Length of Stay

You will be given a certified length of stay when you receive admission authorization following your request for Prior Authorization. You must notify us if your patient requires an extended length of stay, additional consultations, or special discharge planning that you did not originally anticipate. You must notify us to update the authorization at the telephone number located in Chapter 1 under, "Useful Telephone Numbers and Addresses", Provider Services.

- 1) Concurrent Review encompasses those aspects of Medical Management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
- 2) Provider requests for a routine extension of an ongoing outpatient course of treatment are handled within the same timeframe as a new preauthorization request.

- 3) Provider requests for extension of coverage for a course of clinically urgent inpatient or outpatient treatment are handled expeditiously as an urgent concurrent review request when a delay in authorizing the extension could result in worsening the medical condition or harm to the Member.
- 4) The Concurrent Review process includes:
 - (a) Obtaining necessary information from Providers and facilities concerning the care provided to the Member,
 - (b) Assessing the Member's clinical condition and ongoing medical services and treatments to determine benefit coverage,
 - (c) Notifying Providers of Coverage Determinations in the appropriate manner and within the appropriate time frame,
 - (d) Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting,
 - (e) Identifying the Member for referral to covered specialty programs, such as Care Management, Behavioral Health and Disease Management.

e. Retrospective Review

Retrospective Review is the process of reviewing coverage requests for medical necessity when the Member is no longer an inpatient and/or after the service has been provided.

Covered Services by a Participating Provider without an authorization, when required, are not eligible for payment by VNS CHOICE, and the Participating Provider may not bill a Member for such services. A Participating Provider may document special circumstances demonstrating that it was not possible for the Participating Provider to obtain an authorization prior to rendering services. After review of such documentation, VNS CHOICE may conduct a retrospective review.

f. Discharge Planning

Discharge Planning is an integral part of concurrent review. Recognizing and planning for discharge needs begins at the time VNS CHOICE is notified that the Member has been admitted to an inpatient facility and continues throughout the Member's stay.

g. Hospital Transfer From Out-of-Network Providers

VNS CHOICE will attempt to coordinate all out-of-network care both locally and out of the Service Area, including informing the network practitioner. Call the Medical Management Department at the telephone number located in Chapter 1

under, “Useful Telephone Numbers and Addresses”, if you become aware of one of your patients receiving out-of-network care. If you are called upon to facilitate transfer to an in-network facility for one of your patients, you must provide the necessary medical guidance for a safe transfer. You must notify us to of an admission to an Out-of-Network hospital or to request our assistance with a transfer into our network at the telephone number located in Chapter 1 under, “Useful Telephone Numbers and Addresses”, Provider Services.

h. Second Opinions

VNS CHOICE may require that your patient see a Physician, determined by VNS CHOICE, for a second opinion. VNS CHOICE reserves the right to require a second opinion for any surgical procedure or healthcare service. There is no formal list of procedures requiring second opinions.

Members may request a second opinion relating to the need for surgery or for a major non-surgical diagnostic and therapeutic procedure. Members may obtain a second opinion from a Participating Provider within the VNS CHOICE network. In the event that the recommendation of the first and second Physician differs regarding the need for the surgery or other major procedure, a third opinion from a Participating Provider shall also be covered.

i. Notification Requirements for Hospitals

Hospitals are required to provide VNS CHOICE with notification of each admission in order to verify eligibility, confirm authorization, including level of care.

For emergency admissions, notification should occur once the Member has been stabilized in the emergency department or, for Members who are not stabilized, within one business day when reasonably feasible based on the Member’s medical condition and information available. Proper notification is required in order to facilitate timely and accurate payment of Hospital claims, prior authorization of post-stabilization services, and to initiate concurrent review and discharge planning, in accordance with the Medical Management Program.

Participating Hospitals are required to notify VNS CHOICE on a daily basis of all Hospital admissions, updates in status, and discharge dates concerning our Members.

The VNS CHOICE Medical Management Department will fax a hospital log to the hospital on a daily basis notifying the hospital of the status of all VNS CHOICE Members.

4. Emergency Room Services

Definition of emergency: An emergency is the sudden or unexpected onset of a condition requiring medical or surgical care, without which a patient

could reasonably be expected to suffer serious physical impairment or death using the prudent layperson standard. In an emergency, a Member should seek care as soon as possible; there is no requirement for the member to obtain an authorization from his/her physician or from VNS CHOICE. VNS CHOICE distinguishes Emergency Services from urgently needed services. See below for a definition of urgently needed services and procedures to follow.

a. When To Use The Emergency Room

It is appropriate for a Member to use a Hospital emergency room when an emergency condition exists, such as:

- Heart attack or severe chest pain, in adults
- Stroke
- Severe shortness of breath or difficulty breathing
- Cyanosis
- Hemorrhaging
- Poisonings
- Major burns
- Spinal injuries
- Shock
- Allergic reaction accompanied by swelling of the face or lips, or wheezing in the chest
- Severe or prolonged bleeding from anywhere on the body
- Loss of consciousness
- Severe or multiple injuries
- Sudden change in mental status
- Convulsive seizures
- Other acute conditions that are determined to be emergencies

b. In-Area Versus Out-Of-Area Emergency Services

- 1) **In-Area:** No authorization is required, however, at the PCP's discretion, you may meet the patient at the Hospital, direct him to the nearest emergency room, or recommend that he see you in your office. In the event the Member cannot notify the PCP before seeking care in the Emergency Room, the Member should call the PCP as soon as possible after the encounter to advise the PCP of the encounter and to facilitate your providing follow up care.

- 2) **Out-of-Area:** Out-of-area coverage is limited to care for accidental injury, unanticipated emergency illness, or other emergency conditions. VNS CHOICE will cover out-of-area emergency room services and urgent care services when they are Medically Necessary, using a prudent layperson standard.

c. Notifying VNS CHOICE

Regardless of whether your patient is in or out of the VNS CHOICE Service Area when the emergency condition begins, the PCP or the Member should contact VNS CHOICE as soon as possible, **but no more than 48 hours after the onset of the emergency** so that we may facilitate any care needed after the emergency room encounter. If the patient is unable to contact us within 48 hours as a result of a medical condition, she/he should do so at the earliest possible time.

d. Coverage

In most cases, Hospital emergency room services are covered by VNS CHOICE without an authorization. Additional care after the doctor says it was not a medical emergency will only be covered at the usual coverage if a plan provider provides the additional care. Follow-up emergency room visits, within VNS CHOICE's Service Area, are not covered. Follow-up Services are covered when they take place in the PCP's office.

5. Urgently Needed Services

Urgently needed care is medical care for a condition that needs immediate attention for an unforeseen illness or injury, and it is not reasonable, given the situation, for the Member to get medical care from their PCP or other plan provider regardless of whether the member is in the VNS CHOICE service area at the time of service. In these cases, the patient's health is not in serious danger or life threatening.

Members should call their PCP if they think they need urgently needed services. If a Member is hospitalized after having received Urgently needed services, the Member (or someone on their behalf) must contact VNS CHOICE within one business day of the Hospital admission.

If a member needs urgent care while outside the Plan's service area, we request that he/she call their PCP first, whenever possible. However, urgently needed services will be covered by the Plan when the member is away. In addition, VNS CHOICE will cover follow-up care that is provided by non-plan providers outside the Plan's service area as long as the care still meets the definition of "urgently needed care".

6. Mental Health/Chemical Dependency

VNS CHOICE has contracts for both in- and outpatient mental health services, and drug and alcohol-related conditions. Please note, these services must be pre-authorized, except in an emergency. If your patient requires these services, you must notify us at the telephone number located in Chapter 1 under, “Useful Telephone Numbers and Addresses”, Provider Services. See Chapter 9 for details on Prior Authorization.

7. Skilled Nursing Facility Services

a. Definition

A skilled nursing facility is an institution that provides skilled nursing or skilled rehabilitation services. It can be a stand alone facility, or part of a hospital or other health care facility. A skilled nursing facility does not include institutions that mainly provide custodial care, such as convalescent nursing homes or rest homes.

Skilled nursing facility care means a level of care ordered by a physician that must be given or supervised by licensed health care professionals.

In the process of working with the healthcare team, particularly the PCP, Hospital discharge planners and/or the VNS CHOICE staff may encourage the appropriate transfer of a Member to a lower level of care at some point in the Member’s Hospitalization. The Medical Management Staff will assist in the placement of Members into skilled nursing facilities based on the Member’s eligibility and approved Medical Management decision-making criteria in the Medical Management Guidelines. Participating skilled nursing facilities, when available and able to provide the required service, are utilized in this process.

b. Requirements:

- 1) The patient must need daily skilled nursing or skilled rehabilitation care, or both.
- 2) Prior Authorization through the VNS CHOICE Medical Management Department is required for all admissions into a Skilled Nursing Facility.

8. Home Health Care

Home health care is skilled nursing care, rehabilitation therapies and certain other health care services that the member gets in the home for the treatment of an illness or injury. If your patient needs home health care services, VNS CHOICE Medical Management staff will arrange these services for your patient, if the requirements are met.

a. Requirements:

- 1) Patient does not need to be homebound.
- 2) The Participating Physician must decide that medical care is needed in the patient's home and must make a plan for that care at home. The Participating Physician's plan of care should describe the services the patient needs, how often the patient needs to get them and what type of health care workers should provide the services.
- 3) The home health agency caring for the patient must be approved by the Medicare program, and must be a VNS CHOICE network provider.
- 4) There must be a need for **at least one** of the following types of skilled care:
 - (a) Skilled nursing care on an "intermittent" basis. Generally this means that the patient must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days.
 - (b) Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of wheel chair or bathtub.
 - (c) Durable medical equipment (DME) & medical supplies and home infusion drugs related to the home health plan of care.
 - (d) Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
 - (e) Continuing occupational therapy, which helps the patient to do usual daily activities on his or her own.
- 5) Home Health Aide

As long as some qualifying skilled services are also included, the home health care the patient may include services from a Home Health Aide.

9. Outpatient Rehabilitative Services

Outpatient Rehabilitative Services help people with physical and developmental problems caused by injury or illness. Rehabilitative Service include:

Physical Therapy: helps to improve movement and function, reduce pain and increase independence. Treatments may include exercise for stretching, strengthening, coordination, balance and ease of movement.

Occupational Therapy: helps people perform their activities of daily living. Treatments may include hand exercises, splinting and making adaptive changes in the home or at work.

Speech Therapy: helps people recover from injuries affecting speech, such as stroke. Treatments include specific exercises and training to improve speaking ability.

a. Pre-Authorization Requirements:

- 1) No authorization is required for the first eight (8) visits.
- 2) All visits beyond eight (8) will require a pre-authorization (refer to Chapter 9).
- 3) All services must be provided by VNS CHOICE network providers.

10. Durable Medical Equipment

The Medical Management staff will assist in the process of evaluating and authorizing the use of durable medical equipment (DME) by Members for the purpose of providing Medically Necessary services. The Medical Management staff will evaluate a Member's illness, injury, degree of disability and medical needs for the proper and timely authorization of DME. The Medical Management staff will authorize and monitor the Medical Necessity and appropriateness of DME and authorize usage by Members according to the Member's eligibility, benefit coverage and the consistent and appropriate application of Medical Management decision-making criteria. Participating Providers will supply the DME to the Members.

Authorizations for selected DME (refer to Chapter 9) are typically made for up to two (2) months at a time. The Medical Management staff conducts monthly assessments of the Member's eligibility and benefits and of the cost of the equipment (to ensure that rental cost does not exceed purchase price).

11. Pharmacy Benefit (Medicare Part D)

VNS CHOICE beneficiaries will obtain all Medicare Part D covered medications using the CVS Caremark Pharmacy Network.

VNS CHOICE offers a very comprehensive 4-tier Formulary that addresses all medically necessary drugs. VNS CHOICE's Formulary can be accessed at www.vnschoice.org.

a. Medications Requiring Prior Authorization

Certain medications require authorization to determine if their use follows acceptable medical practice or if they are being taken for a covered condition,

before they are dispensed to members. In some cases, clinical documentation is necessary to review medication requests. VNS CHOICE reviews all requests promptly and follows Medicare requirements in communicating its decision to the physician or, when applicable, to the member.

For a list of medications requiring prior authorization, please see chapter 9.

To obtain authorization for one of these medications, providers should:

- Call CVS Caremark at the telephone number listed in Chapter 1 under, “Useful Telephone Numbers and Addresses”, and provide the necessary information, or
- Complete the general prior authorization form for the medication and send it to CVS Caremark by fax at fax number listed in Chapter 1 under, “Useful Telephone Numbers and Addresses”.

Providers are encouraged to call for prior authorization to expedite the review process and allow for transition coverage where applicable.

b. Formulary exceptions

In certain cases, a provider may determine that a member requires a non-covered prescription. When this occurs, the provider may request an exception from the formulary by completing an *Exception Request Form* or by calling CVS Caremark. The *Exception Request Form* may be faxed to the fax number listed in Chapter 1 under, “Useful Telephone Numbers and Addresses”. The formulary exception request form is available in Chapter 9 or by visiting our website, www.vnschoice.org.

c. Specialty Pharmacy

VNS CHOICE providers must obtain all Medicare Part B covered medications for VNS CHOICE beneficiaries through the Specialty Pharmacy Division of CVS Caremark, our contracted pharmacy vendor.

Medicare Part B covers a limited set of drugs. Medicare Part B covers injectable and infusible drugs that are not usually self-administered and that are furnished and administered as part of a physician service, either by or under the physician’s direct supervision. If the injection is usually self-administered (e.g., Imitrex) or is not furnished and administered as part of a physician service then the drug may not be covered by Part B. In some instances, these medications may be oral medications (e.g. selected oral chemotherapeutic agents that contain the same ingredient as the injectable or infusible dosage forms that would not be considered as self-administered.) Medicare Part B also covers a limited number of other types of drugs as shown in the attached chart.

VNS CHOICE providers shall prescribe, as usual, a Medicare Part B covered medication, adding a comment, if necessary, to highlight Medicare Part B coverage (e.g. “For treatment of ___- cancer”). The provider will then contact CVS Caremark’s Specialty Pharmacy Division at the telephone number listed in Chapter 1, to request the medication be sent to their office. CVS Caremark will provide the necessary directions as to how to proceed with the request.

Select Part B medications will require prior authorization and will be administered by CVS Caremark using VNS CHOICE criteria.

12. Out-of-Network Services

Out-of-network services are managed by VNS CHOICE’s Medical Management staff in order to assist the Member in obtaining their care from Participating Providers and Participating Facilities.

- a. VNS CHOICE’s Medical Management Staff may initially be notified as a result of out-of-network Emergency Services and/or Urgently Needed Services provided to a Member.
- b. VNS CHOICE will manage and track the Member’s care and arrange for transfer to a Hospital that participates in the VNS CHOICE network.

1) Non-Participating Providers

- (a) All requests for services with a Non-Participating Provider must be submitted to VNS CHOICE’s Medical Management staff for authorization.
- (b) Circumstances under which an authorization will be approved to a non-participating provider include:
 - (i) If it is determined that there is no Participating Provider who can provide the Covered Services required for the Member.
 - (ii) If a currently enrolled member is in active treatment with a provider who terminates his/her participation in the VNS CHOICE network.
 - (iii) If a newly enrolled member joins VNS CHOICE and is under active treatment at the time of enrollment with a provider who does not participate in the VNS CHOICE network.

Item 2) and 3) above will only be covered if the non-participating provider agrees to:

- Accept reimbursement at VNS CHOICE’s fee schedule,
- Adhere to all VNS CHOICE UM and QI requirements; and

- Adhere to all VNS CHOICE policies and procedures.

13. Clinical Trial Coverage

A clinical trial is a way of testing new types of medical care (e.g. how well a new cancer drug works). Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose or treat diseases. Consistent with CMS policy, VNS CHOICE covers the cost of routine Member care in clinical trials qualified under the CMS guidelines to the same extent it reimburses routine care for Members not in clinical trials and in accordance with the limitations outlined below.

- a. Providers will not routinely be required to submit documentation about the trial to VNS CHOICE, but VNS CHOICE can, at any time, request such documentation to confirm that the clinical trial meets current standards for scientific merit and has the relevant institutional review board approval(s),
- b. All applicable VNS CHOICE requirements for authorization and referrals must be met,
- c. All applicable Plan limitations for coverage of out-of-network care will apply to routine Member care costs in clinical trials, and
- d. All Medical Management rules and coverage policies that apply to routine care for Members not in clinical trials will also apply to routine patient care for Members in clinical trials.

VNS CHOICE will **not** cover the following clinical trial costs:

- a. The experimental intervention itself (except Medically Necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials according to VNS CHOICE's terminal illness policy (see benefit plan descriptions for details),
- b. Costs of data collection and record keeping that would not be required but for the clinical trial,
- c. Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., “protocol-induced costs”), and
- d. Items and services provided by the trial sponsor without charge.

14. New Technologies

VNS CHOICE continually reviews and assesses existing and improved technology for health care services benefit applications. This includes medical and behavioral health procedures, pharmaceuticals and devices. VNS CHOICE criteria may change and/or expand because of these revisions and will be reflected in VNS

CHOICE policy and procedure changes. The VNS CHOICE Medical Director is available for discussion of individual cases, which may benefit from improved technological changes.

Additionally, there is a process for Participating Providers to submit new technology for coverage review. Please contact VNS CHOICE for more information.

15. Appeals

VNS CHOICE has a policy and process in place to facilitate the timely, thorough and appropriate resolution of Appeals for Members if a Member is denied coverage through the referral and preauthorization process (see Chapter 8).

16. Interface with Quality Management

The VNS CHOICE Medical Management Director or his or her designee will have substantial involvement in the coordination of the Medical Management staff and programs. Issues, which overlap the quality and utilization areas include, but are not limited to, accessibility of services, appropriateness of care and services, continuity of care, under-utilization and Member compliance and risk minimization. The Medical Management Program will include continuous quality improvement processes, which are coordinated with quality improvement activities as appropriate.

17. Care Management

- a. The purpose of the Care Management Program is to:
 - 1) Increase disease prevention and reduce disease progression,
 - 2) Promote early detection of serious medical problems,
 - 3) Promote Member outreach and education to assist Members in achieving independence through self-care, and
 - 4) Establish a collaborative relationship between VNS CHOICE and the Providers caring for the Member through information sharing.
- b. VNS CHOICE Medical Management staff clinically and administratively identify, coordinate, and evaluate the services delivered to Members with complex, acute and chronic needs on a case-by-case basis. The Care Management program is designed to coordinate the delivery of both short and long-term health services for those Members identified with special needs because of their medical or mental status. The coordination occurs regardless of the care setting, responds to the total health needs of the Member, and attempts to assure the highest quality of care is being delivered to the Member in the most appropriate setting for the Member's medical condition. All Care

Management activity includes collaboration with the PCP and other attending Providers.

c. Identifying Members with Significant Potential for Health Improvement

As part of the Care Management Program, VNS CHOICE conducts a health risk assessment for all members within 90 days of enrollment to initially identify Members with chronic diseases and special health care needs and stratifies them according to severity levels. This includes identifying Members with significant potential for improvement; Members with a catastrophic illness, chronic diseases, traumatic injury, special care needs involving difficult circumstances, or the need for multiple services requiring assistance. This allows our Medical Management staff to tailor education and related assistance including disease management and care management programs, when appropriate, based on the member's specific needs.

A Member may self-refer, or be referred by the Member's family, Provider, or VNS CHOICE staff to any of our Care or Disease Management Programs. In addition, regular analysis of health care, quality and utilization data is performed to identify Members with special medical needs, including:

- 1) Sentinel diagnoses
- 2) Recurrent inpatient episodes of care
- 3) Members with health care costs above a predetermined level
- 4) Pharmacy data analysis
- 5) Medical record and laboratory data analysis identifying members with poorly controlled medical conditions, and
- 6) Medical coordination for those members receiving behavioral health care who are identified as having significant unmet or unstable medical problems.

d. Physician Collaboration

The cornerstone of the VNS CHOICE Care Management program is effective collaboration with Participating Primary Physicians. These collaborative relationships will include:

- 1) Identification of individuals appropriate for disease management, working with Participating Physicians and office staff.
- 2) Development and implementation of Member-specific care plans, using evidence-based treatment regimens that will be coordinated by the Physician and care manager.

- 3) Patient education, focused on supporting self-care management and monitoring.
- 4) Care manager feedback to Physicians regarding patient status and clinical needs

18. Complex Cases Requiring Additional Treatment Planning and Specialty Review

It is the policy of VNS CHOICE that each Member must be provided quality care throughout the period of illness, facilitating movement between the appropriate levels of care as required, within the appropriate time frames, ensuring continuous and appropriate interventions.

Through the Utilization Management process, VNS CHOICE will work with its Participating Providers to identify individuals with complex or serious medical conditions. Once identified, the Medical Management staff will work with the Member's PCP and/or appropriate Participating Specialists to:

- a. Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis, and
- b. Establish and implement a treatment plan that is appropriate to the Member's conditions.

19. Member Confidentiality

VNS CHOICE has processes in place to protect the confidentiality of Member information and records in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). VNS CHOICE has named a Privacy Officer, adopted written policies and procedures regarding Protected Health Information (PHI), and trained staff regarding the implementation of these procedures. These measures are to ensure compliance with HIPAA timeframes and requirements.

The breach of a Member's confidentiality by an employee of VNS CHOICE or a Member of a committee constitutes grounds for disciplinary actions that may include termination.

Chapter 8: Quality Management

1. Overview

a. Quality Improvement Program Mission

VNS CHOICE's Quality Improvement mission is to exceed the expectations of the customer and to continually improve the quality of healthcare for our Members. This is accomplished by providing access to affordable, appropriate and timely health care and services, which is routinely assessed for compliance with established standards. VNS CHOICE will develop its Quality Improvement standards in consultation with Participating Providers. Participating Providers must comply with all VNS CHOICE Quality Management policies, procedures and programs.

b. Program Description

The VNS CHOICE Quality Improvement Program (QIP) provides a framework for the evaluation of the delivery of health care and services provided to Members. This framework is based upon the philosophy of continuous quality improvement and includes:

- 1) Development of quality improvement initiatives,
- 2) Quality measurement and evaluation,
- 3) Corrective action implementation and evaluation,
- 4) Communication with and education of our Members and Providers, and
- 5) Annual evaluation of the program's effectiveness.

c. Purpose

The goal of the QIP is to improve the health outcomes of care to our Membership by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

d. Authority

As the governing body of the Plan, the Board of Directors is accountable for the QIP. The Executive Director is responsible for the implementation of the Quality Assessment & Improvement (QAI) Program. The Plan's Medical Director in conjunction with the Director of Quality, who directly reports to the Executive Director, has overall responsibility for the Plan's clinical strategies and for operationalizing its activities. The Director of Medical Management also plays a key role in quality Improvement activities. The Board of Directors receives written reports on the progress of the QAIP Work Plan from the Plan.

As the governing body of VNS CHOICE, the Board of Directors oversees the QIP. The Executive Director is responsible for the implementation of the QIP. The Plan's Medical Director in conjunction with the Director of Medical Management has overall responsibility for VNS CHOICE's clinical strategies and for operationalizing its Quality Improvement activities. The established Board committee – the Quality Improvement Committee of the Board (QICB), meets at least biannually receiving written reports on the progress of the QIP Work Plan.

e. Program Objectives

- 1) Implement a Quality Improvement structure that will facilitate the identification, development and implementation of improvement activities throughout VNS CHOICE,
- 2) Improve organizational processes to evaluate their ability to support VNS CHOICE's current or new health care products, by identifying, developing and implementing strategies to facilitate improvement,
- 3) Improve organizational communication, by identifying, developing and implementing strategies to facilitate improvement,
- 4) Improve data collection and analysis for the purpose of identifying and developing improvement activities,
- 5) Assessment of the health care delivery system's access and availability of services, and identification, development and implementation of strategies to facilitate improvement,
- 6) Evaluate the QIP's effectiveness by performing an annual evaluation of the activities generated by the program, and
- 7) Develop an annual QIP Work Plan based upon the results obtained from the prior year's evaluative process.

f. Program Scope

The QIP encompasses both clinical care and non-clinical activities, which have either direct or indirect influence on the service Members receive from VNS CHOICE Participating Providers and on the quality of clinical care.

g. Confidentiality

- 1) All Member clinical information is considered confidential information and will be kept confidential by VNS CHOICE staff and committee Members.
- 2) All committee discussions are considered confidential. No clinical information will be sent outside of VNS CHOICE without express consent

of the Member or legal guardian except in accordance with regulatory requirements of the State Department of Health or CMS, or where compelled by court order.

h. QI Work Plan

On an annual basis, the Quality Improvement Committee will develop a QIP Work Plan. The QIP Work Plan outlines the quality improvement monitoring and evaluation activities for the coming year. The QIP Work Plan is a document in progress and activities can be re-evaluated or updated as needed. The QIP Work Plan is presented to the Quality Improvement Committee for recommendations and approval. The QIP Work Plan is then presented to the Board of Directors for final approval.

Each year VNS CHOICE will develop an annual QIP Work Plan that includes specific quality improvement initiatives and measurable objectives for each initiative scheduled. The QIP Work Plan activities are derived from: i) the opportunities for improvement that were identified during the previous year, ii) analysis of data reports, and iii) activities that are required by state, federal and accreditation entities.

i. Conflict of Interest

To ensure that all quality issues are reviewed, without bias, and actions taken are in the best interest of VNS CHOICE Members, VNS CHOICE mandates the following policies:

- 1) All committee Members are required to sign the conflict of interest attestation prior to participation on the committee,
- 2) To avoid actual or perceived conflicts of interest, VNS CHOICE requires all committee Members to provide appropriate disclosure,
- 3) Any committee Member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such Member about the recommendation in question, which might reasonably be construed as adverse to the VNS CHOICE's interests. This includes, but is not limited to, situations in which a committee Member is a competitor of the Provider in question.
- 4) If the committee determines that a conflict of interest exists, it shall require the disclosing Member to excuse him or herself from voting on the issue at hand.

j. Annual Review and Evaluation

The QIP and Work Plan are reviewed on an annual basis for its effectiveness. The results of this evaluation process are contained within a document known as the Quality Improvement Program Evaluation (QIPE). The QIPE is presented to the Quality Improvement Committee for review and to establish the VNS CHOICE's quality improvement activities for the following year. Due to the dynamic process of continuous quality improvement, the need to comply with external accrediting organizations, regulatory requirements and business decisions, the QIP and Work Plan can be subject to change at any time during the year to improve care and service to its Members. This QIP and Work Plan Evaluation will elicit the information necessary to assist in development of the QIP Work Plan for subsequent years.

k. Access and Availability Standards

All Primary Care and Specialist Services provided by Participating Providers are to be provided by duly licensed, certified or otherwise authorized professional personnel in a culturally competent manner and at physical facilities in accordance with i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment; ii) the provisions of VNS CHOICE's QIP and Medical Management Program; iii) the requirements of State and Federal Law; and iv) the standards of accreditation organizations such as NCQA and JCAHO.

Each Participating Provider is required to provide advance written notice to VNS CHOICE in the event of any change in the capacity of the Participating Provider to continue services under the terms of the Participating Provider's agreement with VNS CHOICE.

Participating Providers are solely responsible for the medical care and treatment of Members and will maintain the Physician-patient relationship with each Member. Nothing contained in the Participating Provider's agreement is intended to interfere with such Physician-patient relationship, nor is the Participating Provider agreement intended to discourage or prohibit Participating Providers from discussing treatment options or providing other medical advice or treatment deemed appropriate by Participating Providers.

VNS CHOICE regularly assesses that its panel of Participating Providers can meet the racial, ethnic, cultural, and linguistic needs and preferences of its Members. VNS CHOICE also requires that network Providers assist its Members with limited English speaking proficiency and physical disabilities.

I. Appointment Access

VNS CHOICE has adopted the following standards for appointment access to PCPs and Participating Specialists:

1) Emergency Services - Immediately or Triage to the Emergency Department (911)

PCPs and Participating Specialists are required to have arrangements for coverage 24 hours a day, 7 days a week.

2) Urgent/Non-Emergency Services - Within 24 Hours

Members who call a PCP's or Participating Specialist's office requesting an urgent (non-emergency) appointment are required to be seen within 24 hours of requesting the appointment.

3) Routine/Symptomatic - Within 7 days

Members who call a PCP's or Participating Specialist's office requesting a non-urgent appointment but in need of medical attention are required to be seen within one week of requesting the appointment.

4) Wellness/Non-Symptomatic Care - Within 30 Days

(a) Members who call a PCP's or Participating Specialist's office requesting an appointment for preventive or routine care are required to be seen within 30 days of requesting the appointment.

(b) Routine conditions are usually conditions that are chronic in duration. Preventive health care services are associated with keeping the Member healthy. Preventive health services include, but are not limited to: physicals, mammography, digital rectal exams, and colon screenings.

5) Office Waiting Time - Within 30 Minutes

Office waiting time for appointments should not exceed 30 minutes.

6) Telephone Access Standards

PCPs and Participating Specialists are required to provide 24 hour a day, 7 days a week telephone coverage:

- (a) Emergency conditions must receive immediate response.
- (b) Urgent conditions must be responded to within 4 hours.
- © Non-urgent calls are required to be responded to during the same day the call was received.
- (d) Routine conditions should be responded to within 2 working days.

m. Evaluation Frequencies and Methodology

On at least an annual basis, all PCPs and high volume Participating Specialists will be included in an accessibility audit/review for all categories and appointment types. Member complaints may also trigger an ad hoc measurement of a Provider's accessibility. Data will be analyzed on a system wide and individual Provider level for the development of system wide and/or individual improvement activities.

n. Closing of Provider Panel

When closing a practice to new VNS CHOICE Members, Participating Providers are required to:

- a. Give VNS CHOICE 60 days prior written notice that the practice will be closing to new Members as of a specified date,
- b. Keep the practice open to new VNS CHOICE Members who were patients before the practice closed,
- c. Uniformly close the practice to all new patients, including private payers, commercial or government insurers, and
- d. Give VNS CHOICE prior written notice of the re-opening of the practice, including a specified effective date.

2. Quality Management Subcommittee Structure

The full organizational structure of Committees reporting to the VNS CHOICE Quality Improvement Committee is available by contacting the plan and requesting that information. Below are the committees most important to Providers.

a. Pharmacy and Therapeutics Subcommittee

The Pharmacy & Therapeutic Subcommittee's responsibilities include overall oversight of the delegated relationship with the contracted Pharmacy Benefits Manager (PBM) for the Medicare Part D Plan, the development of the formulary, required reporting for regulatory compliance with the drug plan and monitoring the utilization of Part B drugs. The committee will review new drugs that enter the market to determine if they will be covered. The committee will also track all regulatory changes to Medicare Part D and report regularly to the QM Committee on formulary and regulatory changes as they affect Plan members. This includes recommendations for benefit revisions and development/implementation of utilization management protocols.

b. Peer Review Committee

The responsibilities of the Peer Review Committee are to participate in VNS CHOICE deliberations, reviews, meetings and hearings regarding sanctions or disciplinary actions on Participating Providers and authorized non-contracted Providers. The Medical Director is responsible for the peer review activities performed by the committee structure within VNS CHOICE as well as ad-hoc utilization management peer review activities performed. The Medical Director is the Chairperson of the Peer Review Committee.

c. Utilization Management Subcommittee

The responsibilities of the Utilization Management Subcommittee are to review utilization data including claims, encounters, referrals, hospital and other facility days data. Other information will be reviewed including out-of-plan utilization on a monthly basis to identify possible areas of under/over utilization. This data will be member and population specific categories to identify possible patterns of underutilization, over utilization and/or inappropriate utilization within those categories. Benchmarks and goals for performance are developed for utilization measures and action plans are developed to respond appropriately to under/over utilization and inappropriate medical services. The Director of Medical Management is the Chairperson of the Utilization Management Subcommittee.

d. Credentialing/Re-Credentialing Subcommittee

The responsibilities of the Credentialing/Re-Credentialing Subcommittee are to recommend approval or denial of Providers and facilities for either initial or continued participation in the healthcare delivery system to the Quality Improvement Committee of the Plan. The Director of Network Planning and Provider Relations is the Chairperson of the Credentialing/Re-credentialing Subcommittee.

3. VNS CHOICE Medicare Departments

A full list of VNS CHOICE departments is available on request, below are the departments that Providers will come in contact with most frequently.

a. Medical Management Department

The Medical Management Department is responsible for assuring appropriate utilization of services including the following functions: prospective, concurrent and retrospective clinical reviews and care management of clinical procedures and services, diagnostic testing and interventions/treatments and ongoing care management for complex members.

Specific activities performed include i) assisting Providers in determining and coordinating the most appropriate setting, ii) assisting in providing timely access for the provision of health care services based on Member need, available resources, and community standards of care, iii) assisting in assuring the continuity of patient care that provides early intervention and prompt initiation of discharge planning, iv) assisting in the implementation of related policies and procedures and v) educating Members on prevention and obtaining disease specific interventions.

b. Network Development Department and Provider Relations Department

The Network Development Department and the Provider Relations Department are responsible for managing the Plan's Provider relationships that make up the health care delivery system.

c. Member Services Department

The Member Services Department directs Members' telephone access through the VNS CHOICE call center. The Department's correspondence unit will respond to communications received from Members and Providers.

The Member Services Department obtains feedback from our Members by either inclusion of a member representative on our Quality Assurance Committee or by designating a subcommittee of an advisory body consisting of Member volunteers.

4. HEDIS Reporting

The Healthcare Effectiveness Data and Information Set (formally known as the Health Plan Employer Data Information Set - HEDIS), developed by the National Committee for Quality Assurance (NCQA), is the most widely used set of performance measures in the managed care industry. VNS CHOICE collects and reports HEDIS data on an annual basis for the purpose of tracking and developing performance improvement activities related to care and service. Oversight of HEDIS reporting remains the responsibility of the Quality Improvement Committee. Day to

day operational management and reporting of HEDIS data rests with the Quality Management Department and Data Analysis Unit.

5. Delegation

VNS CHOICE may delegate responsibility to a third party (e.g., independent Provider associations, credentials verification organization), provided that such third party abides by the standards established by the Plan.

Contracted entities may be delegated for one or all of the following functions:

- Credentialing/Re-Credentialing,
- Utilization Management, and
- Claims Processing.

6. Provider Performance Standards and Compliance Obligations

When evaluating the performance of a Participating Provider, VNS CHOICE will review at a minimum the following areas:

- **Quality of Care:** measured by clinical data related to the appropriateness of Members' care and outcomes,
- **Efficiency of Care:** measured by clinical and financial data related to Members' health care costs,
- **Member Satisfaction:** measured by Members' reports and services regarding accessibility, quality of health care, Member-Participating Provider relations, and the comfort of the practice setting,
- **Administrative Requirements:** measured by the Participating Provider's methods and systems for keeping records and transmitting information, and
- **Participation in Clinical Standards:** measured by the Participating Provider's compliance with quality of care standards.

a. Provider Compliance to Standards of Care

VNS CHOICE Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish Covered Services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating Providers must also comply with VNS CHOICE's standards, which include but are not limited to:

- 1) Guidelines established by the Federal Center for Disease Control Prevention (or any successor entity),
- 2) All federal, state, and local laws regarding the conduct of their profession,
- 3) Participation on committees and clinical task forces to improve the quality and cost of care,
- 4) Referral Policies,
- 5) Preauthorization and notification requirements and timeframes,
- 6) Participating Provider credentialing requirements,
- 7) Care Management Program referrals,
- 8) Appropriate release of inpatient and outpatient utilization and outcomes information,
- 9) Accessibility of Member medical record information to fulfill the business and clinical needs of VNS CHOICE,
- 10) Cooperating with efforts to assure appropriate levels of care,
- 11) Maintaining a collegial and professional relationship with VNS CHOICE personnel and fellow Participating Providers, and
- 12) Providing equal access and treatment to all Members.

b. Compliance Process

The following types of non-compliance issues are key areas of concern:

- 1) Inappropriate, out-of-network referrals/utilization,
- 2) Failure to obtain preauthorization from VNS CHOICE for admissions and other services requiring prior authorization,
- 3) Member complaints/Grievances that are determined against the Participating Provider,
- 4) Underutilization, over utilization, or inappropriate referrals,
- 5) Inappropriate billing practices, and
- 6) Non-supportive actions and/or attitude.

Participating Provider noncompliance is tracked on a calendar year basis. Corrective actions may be required, if areas or patterns of noncompliance are found.

Participating Providers acting within the lawful scope of practice are encouraged to advise Members of VNS CHOICE about:

- 3) The Member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered or treatments not covered by VNS CHOICE), including the provision of sufficient information to provide an opportunity for the Member to decide among all relevant treatment options,
- 4) The risks, benefits, and consequences of treatment or non-treatment, and
- 5) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

c. Laws Regarding Federal Funds

Payments that Participating Providers receive for furnishing services to VNS CHOICE Members are, in whole or part, from Federal funds. Therefore, Participating Providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

d. Marketing

Participating Providers may not develop and use any materials that market VNS CHOICE without the prior written approval of VNS CHOICE in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization and its Participating Providers may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

e. Sanctions Under Federal Health Programs and State Law

Participating Providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the Participating Provider.

Participating Providers must disclose to VNS CHOICE whether the Participating Provider or any staff Member or subcontractor has any prior violation, fine,

suspension, or termination, has been disbarred from or had other administrative action taken under Medicare or Medicaid laws, the rules or regulations of New York, the federal government, or any public insurer. Such individuals shall not be allowed to provide services to VNS CHOICE Members.

Participating Providers must notify VNS CHOICE immediately if any such sanction is imposed on Participating Provider, a staff Member or subcontractor.

7. Risk Management Program

The Risk Management Process is concerned with reducing, preventing, and eliminating situations that could lead to member risk and/or financial loss. The Risk Management Program is an ongoing, integral component of the Quality Assessment & Improvement Program. It is designed to identify and resolve potential and/or actual administrative, clinical and service related risk issues of the organization.

Issues that have the potential to cause immediate and/or significant adverse health outcomes(s) may be referred to the Medical Director for review. The Medical Director, using an educational approach, will collaborate with the provider to develop and document a Corrective Action Plan (CAP) addressing the areas of concern for the provider to implement.

Clinical issues that result in individual Provider monitoring will also be considered during re-credentialing. Providers who are noncompliant with required corrective action(s) may be subject to further action(s). A decision to suspend or terminate a VNS Participating Provider is subject to approval by the Quality Improvement Committee of the Plan. If the Provider is suspended or terminated, he or she has the right to appeal the decision. For more information on the appropriate process please refer below to Section 11k.

8. Other Administrative Requirements

VNS CHOICE and Participating Providers are required to adhere to the following regulatory requirements of CMS with respect to Members:

a. Reporting Requirements

Participating Providers must cooperate with VNS CHOICE in meeting its data reporting obligations by providing VNS CHOICE the information required to meet its obligations. For example, CMS regulations require VNS CHOICE to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program and to establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes VNS CHOICE quality and performance indicators such as disenrollment rates for its Members electing to receive benefits through VNS CHOICE for the previous two years, information relating to Member satisfaction and health outcomes data. Additionally, Participating Providers that furnish

diagnostic data (e.g., encounter data) to assist VNS CHOICE in meeting its reporting obligations to CMS must certify (based on best knowledge, information and belief) the accuracy, completeness, and truthfulness of the data.

b. Provider Terminations and Continuity of Care

In the case of any Provider termination, VNS CHOICE will provide for continuity of care for Members.

Termination of hospital contracts will comply with Section 4406-c (5-c) of the NYS Public Health Law, which requires that the contracted hospital and VNS CHOICE, continue to cover all services covered under the contract and abide by the terms of the contract, including reimbursement rates, for a period of two months from the effective date of termination or non-renewal. The exception to this requirement applies when both parties agree to the effective date of the scheduled termination or non-renewal, or when either the contracted hospital or VNS CHOICE, requests a waiver of the “cooling off” period from DOH. The hospital will collaborate with VNS CHOICE, so that an impact/disruption analysis with regard to enrollee access to care is submitted to the NYS Department of Health within the Department’s required timeframes.

9. Medical Records

a. Medical Record Review

A VNS CHOICE representative may visit the Participating Provider’s office or request record be sent to VNS CHOICE offices to review the medical records of VNS CHOICE Members to obtain information regarding Medical Necessity and quality of care. Medical records and clinical documentation will be evaluated based on the Standards for Medical Records listed below. VNS CHOICE will review the medical record audits quarterly. The results will be used in the re-credentialing process. These records will be provided at no charge to VNS CHOICE.

b. Standards for Medical Records

Participating Providers must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in the Members’ medical chart. Each medical record chart must have documented, at a minimum:

- 1) Member name, and identification number,
- 2) Member age, sex, and date of birth,
- 3) Date of service
- 4) Allergies and any adverse reaction

- 5) Chief complaint/purpose of visit
- 6) Subjective findings
- 7) Objective findings, including diagnostic test results
- 8) Diagnosis/assessment/ impression
- 9) Treatment plans, including services, treatments, procedures and/or medications ordered; recommendation and rationale
- 10) Name of Participating Provider including signature and initials
- 11) Instructions to Member
- 12) Evidence of follow-up with indication that test results and/or consultation was reviewed by PCP and abnormal findings discussed with Member/legal guardian
- 13) Health risk assessment and preventative measures

In addition, Participating Providers must document in a prominent part of the Member's current medical record whether or not the Member has executed an Advance Directive.

c. Medical Records Duplication

The Participating Provider is responsible for any costs associated with duplicating and mailing a Member's medical records when referring the Member to a consulting Physician or other Provider where medical records are required. The Participating Provider shall not charge the Member for the cost of copying the medical records that will be used during the Member's course of treatment with a referral Physician.

If a Member is requesting copies of medical records to be sent to another medical professional as a result of the Member's election to transfer to another PCP, the Member may not be charged for copying of the medical record.

When a Member, or the Member's representative, requests copies of medical records for reasons other than those stated above, the Participating Provider may charge a fee for copying the medical record. The Member or Member's representative must provide to the Provider such request for copies of the medical record in writing. In this case the Provider may charge a fee not to exceed seventy-five cents per page.

d. Confidentiality of Member Information

Participating Providers must comply with all state and Federal laws concerning confidentiality of health and other information about Members. Participating Providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

10. Provider Dispute Resolution (See Chapter 3 For Claims Related Disputes)

11. Provider Credentialing

a. Purpose

The Credentialing/Re-credentialing processes are components of the organization's Quality Improvement Program. These processes were designed to protect Members and provide continued assurance that potential and/or current Participating Providers meet the requirements necessary for the provision of quality care and service.

VNS CHOICE may delegate the responsibility of implementing the Credentialing/Re-credentialing to a VNS CHOICE designee.

b. Scope

Credentialing is required for all Physicians who provide services to VNS CHOICE Members and all other health professionals and facilities who are permitted to practice independently under State law and who provide services to VNS CHOICE Members, with the exception of Hospital based health care professionals. VNS CHOICE does not discriminate in terms of participation or reimbursement against any Physician or health care professional that is acting within the scope of his or her license.

Hospitals and other facilities must be licensed by and demonstrate good standing with state and federal regulatory agencies. In addition each facility must be accredited by a recognized and relevant accrediting agency, such as JCAHO, Commission on Accreditation of Rehabilitation Facilities and American Association for Accreditation of Ambulatory Surgery Facilities.

Additional information regarding VNS CHOICE's credentialing policies is available upon request.

c. Initial Credentialing

Procedures for initial credentialing include submission of a written application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare and Medicaid; and site visits as appropriate.

d. Recredentialing

Participating Providers must be recredentialled every 3 years. Procedures for recredentialing include updating information obtained in initial credentialing and consideration of performance indicators.

e. Site Visits

A structured initial site visit review will be conducted for each PCP and obstetrician/gynecologist. The site visit criteria and the review tool will, at minimum, include an assessment of accessibility, adequacy of the examination and waiting rooms, availability of appointments, and adequacy of medical record keeping practices.

f. Confidentiality

At all times, information relating to a Provider obtained in the credentialing/re-credentialing process is considered confidential.

g. Decision

The Credentialing/Re-credentialing Subcommittee will consider all information gathered on the Provider and evaluate it in light of the criteria. For more information on Credentialing Criteria please call Provider Services at the telephone number listed in Chapter 1 under “Useful Telephone Numbers and Addresses”. It will then make a determination to recommend either approval or disapproval of the Provider’s application.

VNS will provide written notice to a Provider whom VNS declines to include in the VNS CHOICE network, setting forth the reason for its decision.

h. Off-Cycle Credentialing

In the event information is obtained by the Plan Credentialing Unit that may indicate a need for further inquiry, the Credentialing/Re-credentialing Subcommittee may decide to conduct an off-cycle review of a Provider’s credentialing status. Information obtained during an off-cycle review includes, but is not limited to, changes in: licensure, DEA certification, malpractice coverage, New York State OPMC actions, and Medicare and Medicaid sanctions.

Notwithstanding the above, Providers who have had their licenses revoked or suspended, or who have been excluded from participation or who have opted out of the Medicare/Medicaid programs will be terminated immediately.

i. Terminations and Appeal Process

The Credentialing/Re-credentialing Subcommittee has responsibility for making recommendations about a Provider’s status to the Quality Improvement

Committee. Such recommendations include suspension and/or termination of a Participating Provider.

j. Formal Disciplinary Action

In the event that the Credentialing/Re-credentialing Subcommittee recommends suspension or termination of a Participating Provider and the Quality Improvement Committee concurs, written notification is sent to the Provider. The Provider may then request a hearing in accordance with applicable law.

k. Appeal of Disciplinary Decisions

The Provider may Appeal any formal disciplinary action. Requests for Appeal must be submitted in writing, and sent by certified mail, return receipt requested, to the Credentialing/Re-credentialing Subcommittee within 30 days after the Subcommittee renders its decision.

Notwithstanding a request for an Appeal, VNS CHOICE may continue the Provider's suspension and/or termination during the pendency of the hearing and/or Appeal, if VNS CHOICE determines that continuation of participation status may create a risk of imminent harm to Members, or negatively impact Member care.

l. Notification of Provider Termination

VNS CHOICE will provide 60 days notice to the Participating Provider when terminating the Participating Provider's agreement without cause.

m. Notification of Members of Provider Termination

VNS CHOICE will make a good faith effort to provide written notice of a termination of a Participating Provider to all Members who are patients seen on a regular basis by that Provider at least 30 calendar days before the termination effective date regardless of the reason for the termination. When a contract termination involves a PCP, VNS CHOICE will notify all Members who are patients of that PCP of the termination.

Members have transitional care rights and may continue to see a terminated provider as outlined below, unless the MD is being sanctioned by Medicare or Medicaid, or if his/her license to practice medicine is revoked or suspended.

12. Transitional Care

Transitional Care is the process used to review and evaluate authorizations to non-participating providers during a transitional period.

Transitional Care will be considered:

- a. When a newly enrolled VNS CHOICE member is under active treatment at the time of enrollment with a provider who does not participate in the VNS CHOICE network.

or

- b. When a current member's healthcare provider has left the VNS CHOICE network (except when the provider was terminated from participation under circumstances involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governing agency that impairs the health care professional's ability to practice).

The out of network provider must agree to accept VNS CHOICE reimbursement as payment in full and agrees to comply with all of VNS CHOICE UM/QI policies and procedures.

A request for continuity of care may be made utilizing our Transitional Care Request Form and must be submitted to our Medical Management Department within 30 days of the member's enrollment date. The form provides detailed instructions on how to submit a request for continuity of care and can be faxed to the Medical Management Department at the fax number indicated in Chapter 1 or by mailing to the address of the Medical Management Department indicated in Chapter 1.

A copy of the Transitional Care Form is located in Chapter 9. Transitional Care requests are reviewed and if the request meets VNS CHOICE's criteria, a provisional approval will be issued with the member being required to transition to a participating provider within 90 days.

VNS CHOICE welcomes new providers to our network. If an out-of-network provider would like information on how to join the plan, we ask that they contact our Provider Services department at the telephone number listed in Chapter 1 under "Useful Telephone Numbers and Addresses".

13. Member Appeals and Grievances

a. Overview and Scope

VNS CHOICE manages reconsiderations and Grievances in accordance with the CMS guidelines and with VNS CHOICE's Appeals and Grievance Policies and Procedures. VNS CHOICE informs each Member of the process and their right to file Grievances and Appeals.

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "Grievances" are the two different types of complaints.

- An “Appeal” is the type of complaint a Member makes when the Member wants VNS CHOICE to reconsider and change an initial decision (by VNS CHOICE or a PCP) about what services are Medically Necessary or are Covered Services.
- A “Grievance” is the type of complaint a Member makes regarding any other type of problem with VNS CHOICE or a Participating Provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the Participating Provider’s facilities are Grievances.
- All Participating Providers must cooperate with VNS CHOICE in the administration of the Medicare Appeals and Grievances Process.

b. Prospective Coverage Decisions

- 1) **Standard Decisions:** VNS CHOICE will make decisions regarding authorization of care that a Member has not yet received within 14 days of a request.
- 2) **Expedited Decisions:** In the event that the standard 14-day time frame would seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, VNS CHOICE will issue an expedited decision within 72 hours of a request for an expedited decision. The Member or a Participating Physician can request an expedited decision if the Member or the Member’s Physician believes that waiting for a standard decision could seriously harm the Member’s health or ability to function.

If a Participating Physician asserts in writing that this standard is met, VNS CHOICE will issue an expedited decision within 72 hours of the request. If the Member makes a request for an expedited decision without the support of his or her treating Physician, VNS CHOICE will, in its sole discretion, determine whether the standard has been met for an expedited decision.

c. Retrospective Coverage Decisions

VNS CHOICE will make decisions regarding payment for care that Members have already received within 30 days.

If VNS CHOICE does not make a decision within the timeframe and does not notify the Member regarding why the timeframe must be extended, the Member can treat the failure to respond as a denial and may Appeal, as set forth below.

d. Participating Provider Obligations

1) Organization Determinations

At each patient encounter with a VNS CHOICE Member, the Participating Provider must notify the Member of his or her right to receive, upon request, a detailed written notice from VNS CHOICE regarding the Member's services. The Participating Provider's notification must provide the Member with the information necessary to contact VNS CHOICE and must comply with any other requirements specified by CMS. If a Member requests VNS CHOICE to provide a detailed notice of a Participating Provider's decision to deny a service in whole or part, VNS CHOICE must give the Member a written notice of the determination.

2) Appeals

Participating Providers must also cooperate with VNS CHOICE and Members in providing necessary information to resolve Appeals within the required time frames. Participating Providers must provide the pertinent medical records and any other relevant information. In some instances, Participating Providers must provide the records and information on an expedited basis (no more than 48 hours, including weekends and holidays) in order to allow VNS CHOICE to make an expedited decision.

Please refer to Chapter 1, "Useful Telephone Numbers", for Appeals and Grievance contact information.

3) Part D Exception Requests

A member may request an exception to a coverage rule regarding prescribed medications not covered in our formulary. A statement by the physician must support the exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request (please see exception request form located in Chapter 9).

e. Appeal Levels

Members have several levels of appeal rights, both internally and externally. Below is a list of the levels of appeal that a Member has a right to:

- 1) Appeal initial decision by VNS CHOICE.
- 2) Review by an Independent Review Organization.
- 3) Review by an Administrative Law Judge. The dollar value of the contested benefit must be consistent with the threshold established by CMS.

- 4) Review by a Medicare Appeals Court.
- 5) Federal Court. The dollar value of the contested benefit must be consistent with the threshold established by CMS.
- 6) A Member may request an expedited review and ask for the Participating Provider's support in requesting an expedited review.

f. Discharge from Facility Based Care

A Member has the right, by law, to ask for a review of a discharge date from the Hospital, SNF, HHA, or CORF. Members must contact the Quality Improvement Organization (QIO) for review. If a Member believes he is being discharged too soon he or she must fill out a **Notice of Medicare Non-Coverage** provided by VNS CHOICE.

If a Member does not ask the QIO for a "fast appeal" by the deadline (no later than **noon** of the day **before** the date the Members' Medicare coverage ends) the Member may VNS CHOICE for a "fast appeal" of their discharge.

g. Additional Information on Appeals and Grievances

For more information on Appeals and Grievance please see our Evidence of Coverage, which is available online at www.vnschoice.org or by contacting the Appeals and Grievances telephone number listed in Chapter 1 under "Useful Telephone Numbers and Addresses".

14. Fraud and Abuse Prevention

Visiting Nurse Service of New York (VNSNY) and VNS CHOICE are committed to preventing and detecting any fraud, waste, or abuse in the organization, related to Federal and State health care programs. To this end, VNSNY maintains a vigorous compliance program and strives to educate our workforce on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments. VNSNY prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. Such a submission is a violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a Federal statute that allows private citizens to help reduce fraud against the United States government. In addition, in New York State the submission of a false claim can result in civil and criminal penalties under portions of the New York Social Services Law and Penal Law.

a. Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA 2005). Some of the savings that the government anticipates from the DRA 2005 will result from changes to federal health care programs, including

changes designed to reduce fraud, waste and abuse. Certain provisions in the DRA 2005 reflect congressional desire to enlist States' and employers' help in combating fraud, waste and abuse in the Medicaid program. The DRA introduced incentives for the States to enact False Claims Act statutes and established compliance program and educational requirements for health care entities that receive \$5 million or more annually in Medicaid reimbursement or payments (including VNS CHOICE). Because compliance with the DRA provisions is a condition of payment, entities that do not update their compliance policies and educational materials risk otherwise qualified reimbursement and potential False Claims Act liability.

Specifically, Section 6032 of DRA 2005 provides that, effective January 1, 2007, any entity that makes or receives at least \$5 million in annual payments under a State Medicaid program must undertake certain measures. These measures include:

- a. Establishing written policies for all of their employees that furnish information on the federal False Claims Act, federal administrative remedies under that act, applicable State false claims acts, and whistleblower protections under these laws;
- b. Including provisions as part of those policies in the entity's policies and procedures for detecting and preventing fraud, abuse, and waste; and
- c. Including in employee handbooks and provider handbooks a specific discussion of these various laws, the rights of employees to be protected as whistleblowers, and the entity's policies for detection and prevention of fraud, abuse, and waste.

b. Federal False Claims Act

The False Claims Act (FCA) permits any person who discovers a fraud on federal government to report it through the law's specialized procedures. If the government collects from the fraudulent contractor, it permits the whistleblower to share in the proceeds. The FCA is the major law utilized to "ferret out fraud against the federal government." It was enacted during the Civil War to "control fraud" in federal contracts" and was subsequently amended in 1986 to encourage whistleblower protection.

The law contains two sections highly relevant to whistleblowers. The first is a *qui tam* provision which permits private citizens and "original sources" (i.e. whistleblowers) to file suit on behalf of the United States to recover damages incurred by the federal government as a result of contractor fraud or other false claims. In return for filing the suit, the whistleblower is entitled to a significant portion of the proceeds, should they prevail. The whistleblower can obtain a large monetary award if he or she follows the "complex" procedures set forth in the FCA when seeking to enforce the anti-fraud law.

The second section contains an anti-retaliation provision that prohibits the discharge or harassment of a whistleblower who makes FCA-protected disclosures or files a *qui tam* suit. The anti-retaliation section permits the whistleblower to file a wrongful discharge suit for double back pay and other damages. The anti-retaliation provision was modeled after other whistleblower laws and operates under the basic principles underlying employment discrimination cases.

Chapter 9: Pre-Authorization Lists and Forms

1. Services Requiring Prior Authorization

a. Inpatient Admissions:

- 1) All hospital admissions, except in an emergency, including:
 - (a) Surgical admissions
 - (b) Medical admissions
- 2) All outpatient surgery, except in an emergency
- 3) All Skilled Nursing Facility (SNF) admissions
- 4) All Rehabilitation facility admissions
- 5) All Sub acute admissions
- 6) All elective mental health and substance abuse admissions

VNS CHOICE requires notification of all emergent admissions. Authorization for post stabilization of services should be obtained within as soon as clinically possible.

Every attempt should be made to notify VNS CHOICE prior to an urgent admission. Should this not be clinically feasible, authorization should be obtained within one business day of admission.

b. Organ Transplants and Transplant Evaluations

c. Dialysis Treatments

d. Reconstructive Procedures that may be Considered Cosmetic:

- 1) Blepharoplasty / canthopexy / canthoplasty
- 2) Septoplasty
- 3) Rhinoplasty
- 4) Excision of excessive skin
- 5) Lipectomy or excess fat removal
- 6) Abdominoplasty/ventral hernia repair
- 7) Breast repair or reconstruction/enlargement/reduction
- 8) Facial reconstruction or repair including:
 - (a) Orthognathic surgery
 - (b) Bone grafts
 - (c) Osteotomies
 - (d) Surgical management of TMJ dysfunction
- 9) Surgical treatment of morbid obesity

- 10) Sclerotherapy or surgery for varicose veins
 - (a) Vision correction surgery that would not be considered cosmetic
 - (b) Any other potentially cosmetic procedure

e. Radiology Services

- 1) CAT scans
- 2) MRI
- 3) MRA
- 4) PET scans
- 5) Nuclear Medicine Studies (including EMG / Nuclear Cardiology)
- 6) Radiation Therapy

f. All Home Health Care Admissions

g. Rehabilitative Therapies (required after the 8th visit)

- 1) Physical Therapy
- 2) Occupational Therapy
- 3) Speech Therapy

h. Pain Management

- 1) Implantation of pumps for pain management
- 2) Spinal cord stimulators

i. Sleep Disorders

- 1) Sleep Studies
- 2) Surgical treatment of sleep disorders

j. Dental Services that are Considered Medical in Nature except in an emergency.

k. Requests for Nonparticipating Physicians and Providers of Non-Emergent Services to be Reimbursed at the In-Network Level of Benefit.

l. Services that may be Considered Investigational or Experimental.

m. Durable Medical Equipment (DME)

- 1) Electric or motorized wheelchairs and scooters
- 2) Electric beds
- 3) Bone stimulators
- 4) Neurostimulators
- 5) Customized braces

6) Prosthetics, Orthotics

p. **Medical Injectables and Select Medicare Part B Drugs:**

- 1) Aranesp
- 2) Azathioprine
- 3) Botox
- 4) Copegus
- 5) Cyclophosphamide
- 6) Cyclosporine
- 7) Daclizumab
- 8) Enbrel
- 9) Epogen
- 10) Genotropin
- 11) Humatrope
- 12) Humira
- 13) Lupron
- 14) Lupron – kit
- 15) Lupron Depot
- 16) Lymphocyte Immune Globulin, Antithymocyte Globulin
- 17) Methotrexate
- 18) Methylprednisolone
- 19) Methylprednisolone Sodium Succinate
- 20) Micophenolate Acid
- 21) Micophenolate Mofetil
- 22) Muromonab- Cd3
- 23) Neulasta
- 24) Neupogen
- 25) Norditropin
- 26) Nutropin
- 27) Nutropin AQ
- 28) Pegasys
- 29) Peg-Intron
- 30) Procrit
- 31) Remicaid
- 32) Ribavirin
- 33) Rocephin
- 34) Saizen
- 35) Serostim
- 36) Synagis
- 37) Tev-tropin
- 38) Zorbive

Medical Coverage Determination Form



An affiliate of
Visiting Nurse Service Of New York*

A Medicare Advantage Plan

FAX AUTHORIZATION REQUEST FORM FOR COVERAGE DETERMINATIONS

Please utilize this form as an alternative to calling in request(s) or services. This form should be faxed to VNS CHOICE Utilization Management Department at 1(866) 791-2214. Should you have any questions please call 1(866) 791-2215. Thank you for your cooperation.

◆ PATIENT & INSURANCE INFORMATION (PLEASE FILL-IN AVAILABLE) ◆		
Patient's Name	Patient Address	
ID #	Date of Birth	
Patient's Home Telephone	Alternate Telephone	
Other insurance	Effective Date	
Is this service related to: <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other		
◆ AUTHORIZATION INFORMATION ◆		
Date of Request	Service Requested	
Date of onset of service/hospital admission	Requested length of stay/service	
Diagnosis	ICD9 Code(s)	
Procedure	CPT Code(s)	
Comments/medical necessity		
In order to expedite your request in a timely manner, please submit copies of all pertinent medical information.		
◆ PHYSICIAN INFORMATION ◆		
Ordering/Attending Physician Name	Tax ID	Provider's area(s) of subspecialty or expertise.
Address	City/State	Zip
Telephone Number	Fax Number	
Facility	Telephone Number	Tax ID Number
Submitted by	Physician Signature	
◆ FOR INTERNAL USE ONLY ◆		
Authorization Status: <input type="checkbox"/> Approved Authorization #: _____		
LOS/# Visits: _____ Dates of Service: _____		
<input type="checkbox"/> Denied <input type="checkbox"/> Pended		
Additional Information _____ Medical Review _____		
<p>CONFIDENTIALITY NOTICE: This fax transmission contains information to the sender, which may include proprietary information of VNS CHOICE. The information is intended only for the use of the individual identified above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this faxed information is strictly prohibited. If you have received this fax in error, please notify us by telephone immediately to arrange for return or destruction of the documents.</p> <p style="text-align: center;">Service request form 8/16/06</p>		

PART-D PRESCRIPTION DRUG COVERAGE DETERMINATION FORM

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee's/Requestor's Information

Enrollee's Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address

City

State

Zip Code

()

Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

Name

Medical Specialty

Address

City

State

Zip Code

()

Work Phone

()

Fax

Office Contact Person

Type of Coverage Determination Request

I need a drug that is not on the plan's list of covered drugs (formulary exception).*

I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

- I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*
- I request prior authorization for the drug my doctor has prescribed.
- I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*
- My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

Additional information we should consider (*attach any supporting documents*):

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requestor's Signature

Date

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Part-D Prescription Drug Coverage Exception Form

Plan Name _____
 Phone # _____
 Fax # _____

Medicare Part D Coverage Exception Request Form

This form cannot be used to request:

- > Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- > Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]

Patient Information				Prescriber Information			
Patient Name:				Prescriber Name:			
Member ID#:				NPI# (if available):			
Address:				Address:			
City:		State:		City:		State:	
Home Phone:		Zip:		Office Phone #:		Office Fax #:	
Sex (circle): M F		DOB:		Contact Person:			
Diagnosis and Medical Information							
Medication:			Strength and Route of Administration:			Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:			Expected Length of Therapy:			Qty:	
Height/Weight:		Drug Allergies:		Diagnosis:			
Prescriber's Signature:						Date:	
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION							
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure) → Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);							
<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change → Specify below: Anticipated significant adverse clinical outcome							
<input type="checkbox"/> Medical need for different dosage form and/or higher dosage → Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason							
<input type="checkbox"/> Request for formulary tier exception → Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome							
<input type="checkbox"/> Other: _____ → Explain below							
REQUIRED EXPLANATION: _____ _____ _____							
Request for Expedited Review							
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] → BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION							

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Transitional Coverage Request Form



Request For Continuity Of Care For Medical Benefits

Subscriber's Name: _____
 ID # _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Daytime Telephone #: (____) _____ Home Telephone #: (____) _____
 Policy Effective Date: _____
 Other insurance? Yes _____ No _____
 If yes, Name of Insurance _____ Effective Date _____

This request applies only to members that are currently in treatment for an unstable, severe or life-threatening condition that requires continuation of care with their current provider or for those who have entered their second trimester of pregnancy on or before their VNS CHOICE effective date. Please have your Provider complete the following:

Form Completed By: _____ Title: _____
 Name of Treating Provider: _____ Hospital Affiliation: _____
 Primary Diagnosis: _____
 Complications: _____
 If pregnant, please give estimated due date: _____
 Date started 2nd trimester _____ Date of Most Recent Visit: _____
 Frequency of Visits: _____
 Date of Most Recent Hospitalization (if applicable) _____ Name of Hospital _____
 For the latest Hospitalization, please provide:
 Primary Diagnosis Copy of discharge summary Copy of operative report Copy of pathology report
 Current Therapy: _____
 Proposed Treatment Plan: _____ Duration Treatment: _____

I agree to accept VNS CHOICE reimbursement as payment in full. I also agree to comply with all of VNS CHOICE UM/QI policies and procedures.

Physician Signature: _____ Date: _____

I understand that requests for continuity of care transition benefits are approved at the sole discretion of VNS CHOICE and the term of any such transition period will terminate when VNS CHOICE determines that care can be safely transferred to a network participating provider. I further understand that once the transition period has expired or my request is denied, the benefit for out-of-network services as stated in my subscriber contract will apply. I understand that any claim by me may be denied and/or coverage cancelled without written notice if I have provided materially false information in my request. My signature below authorizes the provider indicated to release medical records to VNS CHOICE Utilization Management Department in order to review this request. I have reviewed the information supplied on this form and attest to its accuracy to the best of my knowledge.

To expedite this process, please fax form to: 1-866-791-2214
 OR Mail Form to:
 VNS CHOICE
 1250 Broadway
 Attention UM Department
 New York, NY 10001

For Office Use Only Approved <input type="checkbox"/> Denied <input type="checkbox"/>	Date: _____ Signature: _____
--	-------------------------------------

Member's Signature: _____ **Date:** _____

Chapter 10: Glossary of Terms

Advance Directive

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

Appeal

Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a Covered Service.

Basic Benefits

All health care services that are covered under the Medicare Part A and Part B programs except Hospice services and additional benefits. All Members of VNS CHOICE receive all Basic Benefits.

CMS

The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.

Consultation Visit

A type of non-emergency outpatient service provided by a Participating Physician whose advice or opinion regarding the evaluation and/or management of a specific problem is requested by a PCP. Communication in a written report to the PCP is required. Any diagnostic or therapeutic services initiated by the consulting Physician as a result of the consultation would be preauthorized by PCP who made the consultation request, or VNS CHOICE if the visit was Direct Access by the Member. Follow-up visits would be authorized by the PCP and/or VNS CHOICE.

Coverage Determination

A decision by the VNS CHOICE Medical Management Department as to whether a service is payable under the VNS CHOICE Plan. A service will be deemed payable only if the Medical Management Department determines that: i) it is a Covered Service under the VNS CHOICE Plan and ii) the service is Medically Necessary for the Member. The Medical Management Department will base its determination upon the Member's clinical condition, the Medicare coverage guidelines, nationally recognized criteria, and locally developed VNS CHOICE clinical coverage policy.

Covered Services

Medicare Basic and Supplemental benefits, services or supplies, which are:

- Provided or furnished by Participating Providers or authorized by VNS CHOICE.
- Emergency Services and Urgently Needed Services that may be provided by Non-Participating Providers.
- Renal dialysis services provided to a Member who is temporarily outside the Service Area.

Direct Access Specialist Services

Services a Member may access through Participating Specialists without a referral from the Member's PCP or authorization from VNS CHOICE. Such services include: i) Consultation Visits, ii) Evaluation and Management visits, iii) routine and preventive women's health services, iv) influenza and pneumococcal vaccinations, and v) mammography screening. Participating Specialists may not perform or bill for any other services or procedures without a referral by the Member's PCP or an authorization by the VNS CHOICE Medical Management staff.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in i) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; ii) Serious impairment to bodily functions; or iii) Serious dysfunction of any bodily organ or part.

Emergency Services

Covered inpatient or outpatient services that are i) furnished by a Provider qualified to furnish Emergency Services; and ii) needed to evaluate or stabilize an Emergency Medical Condition.

Evaluation and Management Visits

Routine medical office visits on a new or established panel Member whose key components are History, Examination, and Medical Decision Making, and whose contributing components are Counseling, Coordination of Care, Nature of the presenting Problem, and Time. These services are usually provided by PCPs.

Exception Request (Medicare Part D)

A Member may ask VNS CHOICE to cover a non-formulary drug or to reduce cost sharing for a formulary drug. In other words, the Member asks VNS CHOICE to make a

ruling that formulary requirements apply to all plan Members “except for” the requesting Member. An unfavorable exception determination gets a Member into the appeals process. The Providing Physician will play an important role in the exception process, since an exception will only be granted if VNS CHOICE agrees with the doctor certification that no other drug on the formulary would be as effective as the drug in question or formulary drugs would cause adverse consequences to the Member.

Experimental Procedures and Items

Items and procedures determined by VNS CHOICE and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, VNS CHOICE will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Formulary

List of preferred pharmaceutical products to be used by VNS CHOICE’s Network Physicians.

Grievance

Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: waiting times in Physician offices; and rudeness or unresponsiveness of Member Service Staff.

Home Health Agency

A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in a Member’s home when Medically Necessary, when Members are confined to their home and when authorized by their PCP.

Hospice

An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in NY that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Managed Long Term Care (MLTC) Plus

The VNS CHOICE name of New York State's Medicaid Advantage Plus program, which integrates the benefits of a Medicare Advantage plan with the benefits of a Advantage Plus program, so that services are integrated into one benefit plan.

Medically Necessary

Medical Services or Hospital Services that are determined by VNS CHOICE to be:

- Rendered for the diagnosis or treatment of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending Participating Provider, or other Provider of service.

VNS CHOICE will make determinations of Medical Necessity based on peer reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by VNS CHOICE.

Medicare

The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility Care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part B

Part B covers Physician services (in both Hospital and non-Hospital settings) and services furnished by certain non-Physician Providers. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part D

The Medicare Part D program provides beneficiaries with assistance paying for prescription drugs. The drug benefit, added to Medicare by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, began in January 2006. Unlike coverage in Medicare Parts A and B, Part D coverage is not provided within the traditional Medicare program. Instead, beneficiaries must affirmatively enroll in one of many hundreds of Part D plans offered by private companies.

Medicare Advantage (MA) Plan

A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area covered by VNS CHOICE. An MA Organization may offer more than one benefit Plan in the same Service Area. VNS CHOICE is an MA plan.

Member

The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in VNS CHOICE and whose enrollment has been confirmed by CMS.

Non-Participating Provider

Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by New York State or another state to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver Covered Services to VNS CHOICE Members.

Original Medicare (“Fee-for-Service” Medicare)

A payment system used by Medicare by which doctors, Hospitals and other Providers are paid for each service performed (also known as traditional and/or original Medicare.)

Participating Hospital

A Hospital that has a contract to provide services and/or supplies to VNS CHOICE Members.

Participating Physician

A PCP or a Participating Specialist.

Participating Provider

Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by NY State or Medicare to deliver or furnish health

care services. This individual or institution has a written agreement to provide services directly or indirectly to VNS CHOICE Members pursuant to the terms of the Agreement.

Participating Specialist

A Participating Provider who provides specialty medical services to Members pursuant to a written agreement with VNS CHOICE.

Primary Care Physician (PCP)

The Participating Provider who a Member chooses to coordinate their health care. The PCP is responsible for providing Covered Services for VNS CHOICE Members and coordinating referrals to Specialists. PCPs are generally Participating Providers of Internal Medicine, Family Practice or General Practice.

Prior Authorization (Pre-Certification)

A list of services and/or medications VNS CHOICE has identified as requiring approval in advance.

Service Area

A geographic area approved by CMS within which an eligible individual may enroll in VNS CHOICE Plan.

Special Needs Plan

A special type of Medicare Advantage Plan that provides all Medicare Part A and Part B health care and services to people who can benefit the most from things like special care for chronic illnesses, care management of multiple diseases, and focused care management. VNS CHOICE' Medicare Special Needs Plan is focused on members who are eligible for both Medicare and Medicaid.

Urgently Needed Services

Covered Services provided when the Member is temporarily absent from the VNS CHOICE Service Area (or, under unusual and extraordinary circumstances, provided when the Member is in the Service Area but the Member's PCP is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required i) as a result of an unforeseen illness, injury, or condition; and ii) it is not reasonable given the circumstances to obtain the services through the PCP.

* * *

Please contact VNS CHOICE, if you have any questions regarding the definitions listed above or any other information listed in this manual.

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