Provider Manual: Medicaid Managed Care, Child Health Plus, Medicare Advantage and Dual Advantage, Fidelis Care at Home (MLTC), and HealthierLife (HARP)

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Fidelis Care at Home
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HealthierLife – Health and Recovery Plan (HARP)
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INTRODUCTION TO FIDELIS CARE

Fidelis Care was founded in 1993 on the belief that all New Yorkers should have access to affordable, quality health insurance. Today, as part of the Centene family of health plans, Fidelis Care provides coverage for children and adults of all ages and at all stages of life, through the following products: Qualified Health Plans (Metal-Level products), Essential Plans, Medicaid, Child Health Plus, Medicare Advantage, Medicare Dual Advantage, Managed Long Term Care, and Medicaid Advantage Plus.

Quality, affordable coverage from Fidelis Care: NY State of Health, the Official Health Plan Marketplace, is where individuals and families shop for and buy health insurance. Individuals can find the Fidelis Care product in the Marketplace that best meets their or their family’s needs.

- **Child Health Plus** is a New York State-sponsored program for children under the age of 19 and provides free or low-cost comprehensive coverage. Almost every child in New York State is eligible - regardless of family income.
- **Medicaid Managed Care** is a New York State-sponsored program for children and adults who meet income, resource, age, and/or disability requirements.
- **Essential Plan** is a New York State-sponsored program for lower-income people who don’t qualify for Medicaid or Child Health Plus.
- **Qualified Health Plans** are for New York State residents who are not eligible for Child Health Plus, Medicaid, or Essential Plans. Monthly premiums vary based on the selected plan.
- **HealthierLife (HARP)** is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use).
- **Medicare Advantage and Dual Advantage** products through Fidelis Care offer enhanced benefits for those who are eligible for Medicare because of age or disability, or who are eligible for Medicare and Medicaid based on age, disability, and income.
- **Fidelis Care at Home** is a managed long-term care (MLTC) product for people who need long term care services and have or are eligible for New York State Medicaid.

Fidelis Care is operational in all 62 counties of New York State. For a current listing of programs, eligibility guidelines, and counties of operation, please visit our website at fideliscare.org.

With a mission to serve the poor and medically underserved and to ensure that residents have access to quality coverage, care, and service, Fidelis Care is committed to working with providers to achieve our mission.

Fidelis Care is a Prepaid Health Services Plan (PHSP).

**Provider Manual Use and Interpretation**

The Provider Manual is designed to help participating providers and their employees in understanding Fidelis Care policies and procedures, and their role as network providers. Information in this Manual is not intended to alter or modify the benefits to which the member is entitled. If and when operational policies change, the Manual will be updated accordingly. The most current version is the operative version that providers are required to follow, and it is always available on fideliscare.org.
HOW FIDELIS CARE WORKS WITH PROVIDERS AND MEMBERS

Provider Relations Division

The Provider Relations Division is dedicated to fostering strong, long-term partnerships with all contracted providers. This relationship begins with an initial orientation and is followed by continuing education on policies, procedures, and issues that concern healthcare delivery within the guidelines of Fidelis Care.

Quality Health Care Management Division

The Quality Health Care Management Division (QHCM) evaluates the quality and appropriateness of health care services provided to Fidelis Care members. Our Case Managers can assist you with authorizations and care coordination.

Member Services Division

Member Services is available 24 hours a day, 7 days a week, to help members and respond to questions or concerns regarding their health care coverage. This includes information regarding covered benefits, choosing or changing a primary care provider, orienting members to our Plan, and member responsibilities. Member Services also solicits feedback from members as to their satisfaction with services provided by Fidelis Care. It is always our goal to address member concerns or complaints quickly and efficiently.

Claims Division

The Claims Division processes and pays claims for covered services provided in accordance with the provider’s contract and Fidelis Care policies and procedures. Working with QHCM, the Claims Division also collects encounter data for services.

Assessing Provider Satisfaction

On an annual basis, Fidelis Care conducts a Provider Satisfaction survey to assess provider satisfaction with Fidelis Care. The survey includes questions that relate to satisfaction with utilization management/authorization processes, administrative policies, network adequacy, Call Center, and Provider Relations. The survey results are analyzed and reported in various forums and actions are taken to address opportunities. Fidelis Care encourages providers to participate in the Provider Satisfaction Survey.

How to Contact Fidelis Care

The easiest and fastest way to access information regarding membership and eligibility, claims information, and primary care physician assignment, is through Fidelis Care’s Provider Portal. Visit Provider Access Online.

Provider Access Online is easily accessible through the Provider section of the website.

Providers and their staff members can log in using a secure user name and password 24 hours a day, 7 days a week.

For all other information, including contacting your Provider Relations Representative, the Quality Care Incentive (QCI) Program, or authorizations and care coordination, please call: 1-888-FIDELIS (1-888-343-3547).
Regional Offices

As a Statewide health plan, Fidelis Care is committed to maintaining a local, regional presence for members and providers. Regional and satellite office locations are as follows:

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Address</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City Regional Office</td>
<td>95-25 Queens Boulevard Rego Park, New York 11374</td>
<td>(718) 896-1920</td>
</tr>
</tbody>
</table>
| Suffern Satellite Office           | 400 Rella Blvd
                                          Suite 116
                                          Suffern, New York 10901 | (845) 368-0301 |
| Albany Regional Office             | 31 British American Blvd.
                                          Latham, NY 12110 | (518) 427-9584 |
| Mid-Hudson Valley Satellite Office | 25 Market Street
                                          Suite 100
                                          Poughkeepsie, New York 12601 | (845) 483-1296 |
| Buffalo Regional Office            | 480 CrossPoint Parkway
                                          Getzville, New York 14068 | (716) 564-2374 |
| Rochester Regional Office          | 100 WillowBrook Office Park
                                          Fairport, NY | (585) 383-8128 |
| Syracuse Regional Office           | 5010 Campuswood Dr.
                                          East Syracuse, NY 13057 | (315) 448-2236 |

How to Contact Fidelis Care’s Dental, Pharmacy, and Vision Providers

Fidelis Care provides certain benefits through third-party benefits management organizations. Providers should contact the benefits managers below to obtain authorizations and arrange treatment as indicated.
### Section One

**Introduction**

<table>
<thead>
<tr>
<th>Dental (Medicaid* and Child Health Plus)</th>
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<tbody>
<tr>
<td><strong>DentaQuest</strong></td>
</tr>
<tr>
<td>(800) 341-8478</td>
</tr>
<tr>
<td><em>Dental coverage varies by member’s county</em></td>
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<table>
<thead>
<tr>
<th>Pharmacy (Child Health Plus)</th>
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<tbody>
<tr>
<td><strong>Caremark</strong></td>
</tr>
<tr>
<td>(800) 345-5413</td>
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<tr>
<th>Vision</th>
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<tr>
<td><strong>Davis Vision</strong></td>
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<tr>
<td>(800) 773-2847</td>
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### How to Contact eviCore Healthcare

Fidelis Care engaged eviCore healthcare* (eviCore) as a prior authorization program to manage outpatient high-technology Radiology services, non-Obstetrical Ultrasounds, diagnostic Cardiology services, and Radiation Therapy services being rendered on or after October 1, 2017.

<table>
<thead>
<tr>
<th>Authorization Program: Radiology, Cardiology, and Radiation Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>eviCore healthcare</strong></td>
</tr>
<tr>
<td>(866) 706-2108 – phone</td>
</tr>
<tr>
<td>(800)-540-2406 – fax</td>
</tr>
<tr>
<td><a href="https://www.evicore.com/healthplan/fideliscare">https://www.evicore.com/healthplan/fideliscare</a></td>
</tr>
</tbody>
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### How to Contact National Imaging Associates, Inc. (NIA)

Fidelis Care has engaged National Imaging Associates, Inc. (NIA) to provide Utilization Management for outpatient rehabilitative and habilitative physical medicine services (physical therapy (PT), occupational therapy (OT) and speech therapy (ST)), including services rendered in the home, for services being rendered on or after October 1, 2019.

<table>
<thead>
<tr>
<th>Authorization Program: Physical Medicine (PT, OT, ST Therapy)</th>
</tr>
</thead>
</table>
Section One

Introduction

National Imaging Associates, Inc. (NIA)
(800) 424-4952 – phone (Authorization Requests)
(800) 327-0641 – phone (NIA Provider Service Line)
(800) 784-6864 - fax
*https://www1.radmd.com/radmd-home.aspx

Other Useful Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State Child Abuse Reporting Hotline</td>
<td>(800) 342-3720</td>
</tr>
<tr>
<td>Early Intervention Program (EIP)</td>
<td>(518) 473-7016</td>
</tr>
<tr>
<td>Early Childhood Direction Center</td>
<td>(800) 462-7653 (New York State)</td>
</tr>
<tr>
<td>Vaccines for Children (VFC)</td>
<td>(800) 543-7468 or (800) KID-SHOTS</td>
</tr>
<tr>
<td>Women Infants and Children Program (WIC)</td>
<td>(800) 522-5006</td>
</tr>
<tr>
<td>NYS HIV Counseling, Testing and Other Services Hotline</td>
<td>(800) 872-2777</td>
</tr>
<tr>
<td>NYS AIDS Institute</td>
<td>(800) 541-AIDS</td>
</tr>
<tr>
<td>Domestic Violence Hotline</td>
<td>(800) 942-6906 (English)</td>
</tr>
<tr>
<td></td>
<td>(800) 942-6908 (Spanish)</td>
</tr>
</tbody>
</table>
MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Members have rights pursuant to Federal and State law and the applicable program contract. These rights are summarized below. Additionally, member rights and responsibilities are outlined in the Fidelis Care Member Handbook provided to all members upon enrollment.

A Fidelis Care member has the right to:

- Receive information about Fidelis Care, our services, our practitioners and providers, and member rights and responsibilities. For more information, please visit the Fidelis Care website at https://www.fideliscare.org/ or contact Customer Service 24 hours, 7 days a week at 1-888-FIDELIS (1-888-343-3547) TTY: 711.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Have your information remain confidential throughout the Fidelis Care organization. The following are ways Fidelis Care keeps your information confidential:
  - Fidelis Care staff members are prohibited from discussing confidential information in public places, such as elevators or outside of Fidelis Care offices.
  - When discussing your confidential information on the telephone, staff members are required to use appropriate safeguards to confirm they are speaking with someone who has the right to your confidential information.
  - All electronic transmissions contain limited identifiable information and are protected by encryption when sent outside of the organization.
  - Paper documents are stored in secure locked areas and destroyed when no longer needed.
- Participate with practitioners in making decisions about your health care.
- A candid discussion with your practitioners or providers about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- Voice complaints or appeals about Fidelis Care and the care or services we provide. Complaints may be communicated by contacting Customer Service 24 hours, 7 days a week at 1-888-FIDELIS (1-888-343-3547) TTY: 711.
- Make recommendations regarding our Member Rights and Responsibilities Policy.

A Fidelis Care member has the responsibility to:

- Supply information (to the extent possible) that Fidelis Care and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your practitioners.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
THE PROVIDER’S ROLES AND RESPONSIBILITIES

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control.

- Providers shall immediately notify Fidelis Care’s Chief Medical Officer, in writing:
  1. if their ability to practice medicine is restricted or impaired in any way, or
  2. if their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor or is limited in any way, or
  3. if any adverse action is taken, or
  4. an investigation is initiated by any authorized Local, State or Federal agency, or
  5. of any new or pending malpractice actions, or
  6. of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

- Providers shall comply with all Fidelis Care administrative, patient referral, quality assurance, utilization management, and reimbursement procedures.

- Providers shall not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, or source of payment and shall observe, protect, and promote the rights of members as members and any other category protected by law.

- Providers shall cooperate and participate in all Fidelis Care peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by Fidelis Care.

- Providers shall comply with all final determinations rendered by Fidelis Care peer review programs, or external third party reviewers for grievance procedures consistent with the terms and conditions of the provider’s agreement with Fidelis Care and this Provider Manual.

- Providers shall notify Fidelis Care in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) calendar days advance notice is requested.

- Providers shall notify Fidelis Care at least sixty (60) calendar days in advance, in writing, of any decision to terminate their relationship with Fidelis Care or as required by the provider’s agreement with Fidelis Care.

- Providers shall not under any circumstances, including non-payment by or insolvency of Fidelis Care, bill, seek or accept payment from Fidelis Care members for covered services with the exception of any applicable copayments or coinsurance.

- Providers may freely communicate with members about all treatment options, regardless of benefit coverage limitations.

- In the event that an member requires or requests a service that is not covered or authorized by Fidelis Care, and such service is also not covered by the program through which the member is entitled to receive services, the provider is required to:
Section Three

The Provider’s Roles and Responsibilities

1. Inform the member that the member will be responsible for all fees related to the service and the estimated fee for the service;
2. Obtain an executed acknowledgment of financial responsibility from the member prior to the time such services are provided; and
3. Obtain express prior approval from the member and Fidelis Care.

Only if these steps have been taken shall provider be entitled to bill the member and collect for such services.

- At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat Fidelis Care members.
- Providers agree to maintain standards for documentation of medical records and confidentiality for medical records (as per Section 7 of this manual).
- Providers agree to retain medical records for ten (10) years for Medicare recipients and six (6) years) for all other members after the last date of service or, in the case of a minor, for six (6) years after the patient reaches the age of majority, or the length of time required by applicable law.
- Providers will maintain appointment availability in accordance with New York State standards (as defined in Section 4 of this manual)
- Providers will maintain twenty-four (24)-hour access in accordance with New York State standards (as defined in Section 4 of this manual). Providers shall notify Fidelis Care of any extended coverage arrangements for sick leave, vacation, etc.

ADDITIONAL HOSPITAL’S ROLES AND RESPONSIBILITIES

- Provide all contracted services that are within the scope of the facility’s operating certificate
- Discuss discharge planning with Fidelis Care to coordinate the most appropriate care for the member and to ensure services are in place prior to discharge

Restricted Recipient Program

The Restricted Recipient Program is a medical review and administrative mechanism that restricts recipients to one or more health care providers due to a demonstrated pattern of abusing or misusing the Medicaid program. Restricted recipients are Fidelis Care members whose care must be coordinated and authorized through a provider assigned by Fidelis Care. This restriction applies to all non-urgent and non-emergent services. Failure to coordinate care with the member’s Fidelis Care assigned provider may result in a denial of services. Restricted recipients are clearly identified (as an ‘RR’) when checking member eligibility using Provider Access Online.

Cultural Sensitivity

Cultural sensitivity begins with recognition that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another, and they carry over into interactions with health care providers. Cultural sensitivity does not mean, however, that a person need only be aware of the differences to interact effectively with people from other cultures. If health care providers and their patients are to interact effectively, they must move beyond both cultural sensitivity and cultural biases that create barriers. Developing this kind of culturally competent attitude is an ongoing process.

Fidelis Care Provider Manual

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3.2
A culturally competent clinician views all patients as unique individuals and realizes that their experiences, beliefs, values, and language affect their perceptions of clinical service delivery, acceptance of a diagnosis, and compliance.

**The Language Barrier**

Language differences between the clinician and the patient are a further barrier to optimum health care. Where possible, professional translators should be used. It is not always in the client's best interest to have a family member act as an interpreter. The client may feel uncomfortable discussing personal matters in front of a relative. In addition, the interpreter may lack a medical vocabulary, or may reinterpret what the patient says in an effort to "help." Role conflicts may further hinder translation. For example, a child or a person of the opposite sex may be embarrassed by the information or feel it improper to convey the message intended.

When using an interpreter the clinician should:

- Try to find an unrelated interpreter of the same sex as the patient, who is able to translate medical information clearly.

- Schedule more time for the appointment, if possible. Discuss the focus of the session with the interpreter before the patient arrives; be clear about what the interpreter should convey to the patient.

- Have the interpreter meet with the patient before the session to assess his or her educational level. This will determine how complex the discussion can become. If the patient has already met the clinician, the interpreter should be presented as a member of the health care team.

- Speak in short sentences or phrases, to make translating easier for the interpreter. Make sure the patient understands what he or she has been told by asking for him/her to repeat the message in his/her own words.

- Remember who the patient is - keep the focus on the patient, not the interpreter.

- Be sensitive to cultural differences when using nonverbal communication. For example, a touch has many cultural meanings. Clinicians must be aware that personal space has different boundaries in different cultures.

**Communication Access**

Communication is an integral part of providing care to a patient. Communication may become an issue if there are barriers based on physical, social, or language limitations. Fidelis Care providers may bill translator services using Code T1013. If a translator is not available, a language line or TTY line can be accessed by calling the Provider Call Center at 1-888-FIDELIS.

**Physical Access**

An accessible examination room has features that make it possible for patients with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. Detailed diagrams can be found at: [https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm](https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm)
Section Three  The Provider’s Roles and Responsibilities

Informed Consent

The provider will adhere to all Federal and State law requirements for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent.

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to Federal and State laws, rules and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by Federal or State laws, rules, and regulations.

Medical records of recipients enrolled in foster care programs shall be disclosed to local social service officials in accordance with the New York State Social Service Law.

Medical records of all Fidelis Care members shall be confidential and shall only be disclosed to and by the provider’s personnel as necessary to provide medical care and quality, peer, or complaint and appeal review of medical care under the terms of the applicable program contract as required in accordance with applicable laws and regulations.

You Can Help Protect Patient Confidentiality

Protecting your members’ privacy is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following these simple measures:

- Avoid discussing cases within earshot of other patients or visitors.
- If voices can be heard easily through exam room walls, consider adding soundproof panels or piping in soft music.
- Arrange office space to allow privacy for members who are paying bills and making appointments.
- Make sure computer screens that contain patient information are protected from general view.
- Be sure all patient care is provided out of sight from other members (for example; weighing, lab draws).
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.
- Ask your members to sign an Authorization to Release Information prior to releasing medical records to anyone.
- Have a protocol for sending confidential information via fax.

New York State Confidentiality Law and HIV

See Appendix 6 for Confidentiality Law and HIV, and HIV Related Testing.
Section Three  

The Provider’s Roles and Responsibilities

Enrollee Complaints and Grievance Procedures

All Fidelis Care providers must respect Member Rights as outlined in Section 2 of the Provider Manual. In addition, providers should participate in, and are obligated to cooperate with, the resolution of any member complaint or grievance that may arise relating to the services they provided to a Fidelis Care member. Any concerns identified by members with Fidelis Care, a provider, or any of a provider’s personnel with respect to the provision of all services are handled in accordance with Fidelis Care’s compliance and grievance procedures.

Advance Directives

All new Fidelis Care members are told of their right to formulate oral or written advance instructions regarding health care treatment. The PCP is responsible to ask members if they have executed any advance directives. All participating providers are required to comply with all the laws related to advance directives and must provide care and treatment according to the wishes of the member. For additional information go to https://www.health.ny.gov/professionals/patients/patient_rights

Health Care Proxy

A copy of the Health Care Proxy should be kept with the Physician, the Health Care Agent, and the person and any other family member(s) or friend(s) that the person chooses.

Medicare Opt-Out

If you have opted out of Medicare, you are not permitted to submit claims to Fidelis Care for treatment of Medicare Advantage enrollees unless services provided are for emergent or urgent care treatment. If claims submitted are not for emergent or urgent care treatment, the claims will not be paid by Fidelis Care.

Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. The physician or practitioner must initially submit an affidavit to Medicare and to each Medicare contractor with whom the physician or practitioner has an agreement expressing his/her decision to opt-out of the program. For more information on opt-out affidavits, please visit cms.gov and review MLN Matters Number: SE1311. In addition, a private contract must be signed between the physician or practitioner and the beneficiary stating that neither one can receive payment from Medicare for the services that were performed. Once the affidavit has been filed and the contract entered with the beneficiary, neither the physician or practitioner nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician or practitioner out-of-pocket and neither party is reimbursed by Medicare.

By signing a Medicare opt-out Affidavit, physicians and practitioners agree that they will not accept any direct or indirect Medicare payment for Medicare beneficiaries, including payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan. Please refer to cms.gov and review MLN Matters Number: SE1311 for further details.

Moreover, pursuant to Section 15 of the CMS Medicare Benefit Policy Manual:

40.37 - Application to the Medicare Advantage Program
(Rev. 160, Issued: 10-26-12, Effective: 01-28-13, Implementation: 01-28-13)

The Medicare Managed Care Manual contains instructions for Medicare Advantage plans about the impact on managed care.
The manual provides in general that Medicare Advantage plans:

- Must acquire and maintain information from Medicare contractors on physicians and practitioners who have opted out of Medicare.

- Must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted out of Medicare, except for emergency or urgent care services furnished to a beneficiary who has not previously entered into a private contract with the physician or practitioner, in accordance with §40.28.
PRIMARY CARE SERVICES

Responsibilities of the Primary Care Provider

The scope of services expected of a Primary Care Provider (PCP) includes those that are determined by a provider to be necessary and appropriate to promote, preserve, and restore optimal health. Fidelis Care does not require paper referrals, but does require the PCP to coordinate a member's care with other health care providers. The PCP agrees to:

- Coordinate, provide, monitor, and supervise the delivery of all health care services, including inpatient care, for any member assigned to the PCP.

- Provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat conditions not requiring the services of a specialist; arrange inpatient care, consultations with specialists, and laboratory and radiological services when necessary; coordinate findings of consultants and laboratories; and interpret such findings to the patient or the patient's family subject to confidentiality provisions, and maintain a current medical record for the patient.

- For Medicaid members, provide a behavioral health screening by the PCP as appropriate.

- Ensure the availability of provider services to his/her members twenty-four (24) hours per day, seven (7) days per week. See “Appointment Availability and Waiting Time” (4.4)

- Arrange for on-call and after-hours coverage with another PCP who is participating with Fidelis Care.

- Coordinate the medical care of members who have sought medical services at emergency rooms and send to participating specialists, as necessary, following emergency treatment.

- Provide services normally performed in the provider's practice and provide care that conforms to acceptable medical practice standards.

- Contact Fidelis Care members who are new to the practice and perform a comprehensive evaluation within sixty (60) days from the date the member appears on the PCP’s roster.

- Utilize Provider Access Online (PAO) to check member eligibility and to determine if a member is assigned to the PCP or a provider within the PCP’s practice (https://providers.fideliscare.org). A PCP shall only see members that are assigned to their practice.

- Providers will provide periodic assessments and member education, as clinically necessary, including preventive care measures, based upon the "Clinical Guidelines" outlined in Appendix IX.

- Coordinate care for Fidelis Care members who require services outside the scope of the provider's practice to appropriate in-network specialists for consultations and/or medical care. A full list of participating providers can be found on the Fidelis Care website at https://www.fideliscare.org/Find-a-Doctor/#/search. Note: A Fidelis Care PCP who has training in a sub-specialty may be credentialed in that specialty and also participate as a specialist in Fidelis Care’s network. Such providers are called "Dual Providers”.

- Out-of-network referrals require prior authorization. See Section 19 Authorization to Non-Participating Providers for Fidelis Care’s policy on referrals to non-participating providers.
• Provide specific and adequate clinical/diagnostic data with each referral to the specialist.

• Admit and refer members to hospitals that participate in Fidelis Care’s network, except in emergencies or when it is medically unsafe for the member to go to a participating hospital.

• Maintain medical records that meet the medical record standards enumerated in Section 7 of this manual.

• Send copies of member medical records, reports, treatment summaries, and other related documents to Fidelis Care and other participating providers upon request.

• For capitated services, submit encounter reports electronically to Fidelis Care using the CMS 1500 or UB04 format. Encounter reports must be submitted within ninety (90) calendar days of the encounter and should list the appropriate procedure and diagnosis codes.

• Submit claim forms and encounters for non-capitated services electronically within ninety (90) days of the date of service using appropriate procedure and diagnosis codes.

• Seek compensation for provision of covered services to members solely from Fidelis Care except applicable copays and coinsurance. For Dual Advantage Flex Plan members, balances should be submitted to Fee-for-Service Medicaid for reimbursement.

• Maintain professional credentials and liability insurance acceptable to Fidelis Care.

• Comply with all utilization management (UM) protocols as outlined in this Provider Manual. Refer to Appendix I for the Fidelis Care Authorization Grid Detail. For UM procedures, refer to Section 8 Emergency and Inpatient Services, Section 11 Referral and Pre-Authorization, Section 19 Authorizations for Non-Participating Providers and Section 21 Behavioral Health. Contact Fidelis Care’s Quality Healthcare Management (QHCM) Department at 1-888-FIDELIS 1-888-343-3547 for authorization. (Refer to Section 11 and Section 19 of this manual).

• Work closely with Fidelis Care to resolve any problems, complaints, and disputes that may arise between provider, member, and Fidelis Care.

• Treat members with respect and honor the member's right to know and fully understand his or her diagnosis, prognosis and expected outcome of the recommended medical or surgical treatment, and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member’s behalf.

• Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment or any other basis prohibited by applicable federal, state, or local civil rights laws.

• Abide by Fidelis Care policies and procedures relating to member complaints, peer review, quality assurance, and utilization review.

1. **Member Complaints**: Refer to Section 2 Member Rights; Section 14 Member Grievances and Complaints.

2. **Peer Review**: Refer to Section 3 Provider Roles and Responsibilities; Section 9 Provider Credentialing and Termination; Section 10 Health Care Performance Evaluation.
3. **Utilization Review**: Refer to Section 8 Emergency and Inpatient Services; Section 11 Referral and Pre-Authorization; Section 19 Authorizations for Non-Participating Providers; Section 21 Behavioral Health; and, Appendix I Authorization Grid Detail.

- Notify Fidelis Care’s Provider Relations Department of any changes to your practice and/or information included on the Provider Application, e.g., changes in address or office hours, on-call arrangements, provider no longer practicing at office, etc.

- Report and participate in the various State-mandated programs, such as reporting of communicable diseases, participation in immunization registries, lead testing, and reporting consistent with New York State Public Health Law and New York State Regulations.

**Provider Initiated PCP Changes**

In the event that a PCP determines that he/she is unable to provide services to a member, he/she must make a written request to the Fidelis Care Provider Relations Department stating the specific problem. To request the removal of a member from a roster, the PCP must show good cause. Some examples of good cause are:

- Fraudulent acts in obtaining services
- Consistent abuse to the PCP or his/her staff
- Violation of documented office policies and protocols

In no event shall the volume of services requested or utilized by the member be considered a valid reason for transfer of a member.

**Capitation**

The primary care capitation model has been designed to cover most of the services that PCPs are obligated to provide to members who selected or were assigned to them. Examples of primary care services include, but are not limited to:

- Physical examinations and health screenings
- Well Baby/Child Care
- Urgent care visits to the PCP
- Primary care case management services including phone calls, home visits, and care management meetings
- Care provided for acute hospitalization and primary care consultation while the member is receiving inpatient psychiatric, surgical, obstetrical, and other non-primary care services

**“Bill Above” Services**

Fidelis Care recognizes that the PCP may occasionally provide services that are within the scope of the physician’s practice, but are beyond what was envisioned for the primary care capitation arrangement. Specific services (by CPT4 code) have been identified that a PCP may bill Fidelis Care above the capitation rate i.e., "bill above services". See Appendix XV.

If a PCP provides a service that he/she feels is outside the primary care capitation agreement and is not on the list for approved bill above codes listed in Appendix XV, he/she must submit a request for payment, within sixty (60) days of the remittance advice, to Fidelis Care’s Chief Medical Officer if he/she
Section Four  
Primary Care Services

would like to request additional payment. The Chief Medical Officer will review and determine whether the service is included as part of the primary care capitation rate or may be paid above the capitation rate. All decisions regarding payment and any payments made will be consistent with New York State Insurance Law §224-a (i.e., prompt pay law).

Vaccinations:

Fidelis Care Medicaid and Child Health Plus
Fidelis Care requires that vaccines be obtained from New York State's Vaccines for Children immunization program. Providers should call 1-800-KID-SHOTS (1-800-543-7468) for more information.

Fidelis Care will pay providers an administration fee for each covered immunization administered by participating providers.

Behavioral Health and Substance Abuse Screening Tools
Fidelis Care has adopted screening tools and guidelines for the following conditions:

- Identification and Counseling for Smoking Cessation
- Depression
- Anxiety
- Substance Abuse
- Any Nationally accepted Evidence Based Screening Tools

Fidelis Care providers should utilize the following screening tools to aid in the diagnoses of behavioral health and substance abuse issues in the Primary Care and Physical Health settings. Fidelis Care will continue to monitor for additional screening tools that will best assist providers in identifying and treating the member's conditions accurately.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Screening Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>PHQ 2 and 9</td>
</tr>
<tr>
<td>Alcohol</td>
<td>CAGE</td>
</tr>
<tr>
<td>Drugs</td>
<td>DAST</td>
</tr>
<tr>
<td>Substance</td>
<td>SBIRT Model</td>
</tr>
<tr>
<td>Anxiety</td>
<td>GAD-7</td>
</tr>
</tbody>
</table>

Drug & Substance- [https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/additional-screening-resources](https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/additional-screening-resources)

Member Access to Services

Office Hours
Under New York State Department of Health guidelines, Fidelis Care primary care providers must practice at least sixteen (16) hours a week at a primary care site and be available at least four (4) hours on two separate days of the week. If you cannot meet these criteria, please contact your Fidelis Care Provider Relations Specialist.
Appointment Availability, Waiting Time

All Fidelis Care providers must have an appointment system that meets the following standards for appointment availability for primary care services:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediately upon presentation at a service delivery site</td>
</tr>
<tr>
<td>Non-life-threatening emergency mental health or substance abuse visit</td>
<td>Emergency appointment within 6 hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-urgent sick visits</td>
<td>Within 48-72 hours as clinically indicated</td>
</tr>
<tr>
<td>Urgent mental health or substance abuse visit</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Pursuant to emergency hospital discharge or release from incarceration, &amp; Contractor is informed of such release, mental health or Substance Use Disorder follow-up visits with a Participating Provider</td>
<td>Within 5 days or as clinically indicated</td>
</tr>
<tr>
<td>Follow-up visits (pursuant to an emergency or hospital discharge)</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>Non-urgent mental health or Substance Use Disorder visit with Participating Mental Health and/or Substance Use Disorder Out Patient Clinic Provider, including a PROS clinic</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>In-plan mental health or substance abuse, initial routine</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Initial family planning visit</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Initial PCP office visit for newborns</td>
<td>Within 2 weeks of hospital discharge</td>
</tr>
<tr>
<td>Non-urgent mental or substance abuse visit with a PCP</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Behavioral Health Specialist referrals (non-urgent):</td>
<td>Within 2-4 weeks</td>
</tr>
<tr>
<td>A. CDT, IPRT, Rehabilitation for residential SUD</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>B. PROS programs (other than clinic services)</td>
<td></td>
</tr>
<tr>
<td>Initial prenatal visit</td>
<td>Within 3 weeks during 1st trimester, within 2 weeks during 2nd trimester, within 1 week during 3rd trimester</td>
</tr>
<tr>
<td>Routine, non-urgent, or preventive appointments; well child care</td>
<td>Within 4 weeks</td>
</tr>
<tr>
<td>Specialists referrals (non-urgent)</td>
<td>Within 4 weeks</td>
</tr>
</tbody>
</table>
Follow-up visit mental health or substance abuse visit, routine | Within 30 days
---|---
Adult baseline and routine physicals | Within 12 weeks from enrollment (adults > 21 yrs.)

**Note:** CDT = Continuing Day Treatment  
IPRT = Intensive Psychiatric Rehabilitation Treatment  
SUD = Substance User Disorder  
PROS = Personal Recovery Oriented Services

Waiting times within a primary care site should meet the following standards:

- Appointment waiting times should not exceed one (1) hour for scheduled appointments.
- Walk-in members with urgent needs should be seen within one hour.
- Walk-in members with non-urgent needs should be seen within two (2) hours or scheduled for an appointment consistent with the above scheduling guidelines.

**24-Hour Telephone Coverage**

The PCP is responsible for arranging on-call and after-hours coverage to ensure twenty-four (24) hour telephone access to all members.

All Fidelis Care providers are required to maintain twenty-four (24) hours, seven (7)-days-a-week telephone access for their members. The standard for returning a member call is thirty (30) minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider, e.g., a direct beeper connection. The message must direct the member to a live voice.

Fidelis Care is required to conduct twenty-four (24) Hour Access and Appointment Availability studies of our providers annually and submit the results to the New York State Department of Health and each Local Department of Social Services (LDSS). In addition, the New York State Department of Health conducts its own survey.

**Fidelis Care 24-Hour Phone Coverage**

Fidelis Care has implemented an after business hours member information and assistance program. Protocols exist to contact registered nurses and/or medical directors if indicated.

**Required Reporting to Local Department of Health**

PCPs and other providers in the Fidelis Care network are expected to report positive TB test results and active cases of TB to the New York City Department of Health (NYCDOH) or Local County Department of Health (CDOH), as required by State and City Health Codes. In New York City, reports to NYCDOH must include information on HIV+ status, IV drug and other substance abuse, and the status of the case. For additional information go to: https://www1.nyc.gov/site/doh/providers/health-topics/tuberculosis.page

Fidelis Care also expects the PCP and other providers to cooperate with the SDOH or CDOH in identifying case contacts and arranging for or providing services and follow-up care. Fidelis Care encourages all providers to consult with their respective County Health Departments on TB treatment and preventive therapy. Information forms for reporting and consultation in New York City can be obtained by calling the TB Hotline for Physicians at 347-396-7400. For additional information, contact the New York State Department of Health at 518-474-7000. Fidelis Care has a mechanism in place whereby services
needed are coordinated by a Case Manager who will work with all of the members on the Health Care Team servicing the member. Contact the QHCM Department to obtain such services at 1-888-FIDELIS (1-888-343-3547) - authorization prompt. For additional information, go to: https://www1.nyc.gov/site/doh/providers/reporting-and-services/notifiable-diseases-and-conditions-reporting-central.page.

Provider Panel Closing

A provider's panel may be closed upon request or upon reaching the maximum members permitted under New York State standards, based on a forty (40) hour, full-time employment status. Member-to-Provider ratios will be no more than one thousand five hundred (1,500) Medicaid members for each PCP or two thousand four hundred (2,400) for a provider practicing in combination with a Physician Assistant. There may be no more than one thousand (1,000) Medicaid members for each Nurse Practitioner.

PCPs must accept a minimum of four hundred (400) members before closing their panel or as specified in the agreement between the Primary Care Provider and Fidelis Care. If the PCP feels at that time that he/she is unable to provide care for additional members, the provider has the option of closing his/her panel. In that case, the provider should send a letter to the Provider Relations Department and, if approved, the department will close the panel to future members. The Provider Directory will reflect this change by indicating that the provider's panel is only open to current members.

When a single PCP reaches the maximum of one thousand five hundred (1,500) members, he/she will receive notification that his/her panel has been closed by Fidelis Care. Provider Relations will inform the PCP that they can no longer add additional members to their panel. Similarly, panels will be closed for Nurse Practitioners when a maximum of one thousand (1,000) members have been enrolled or a provider practicing with a Physician Assistant when a maximum of two thousand four hundred (2,400) members have been enrolled.

Provider Leaves the Network

If a member's health care provider leaves the Fidelis Care network of providers, or is terminated for reasons other than imminent harm to member care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Fidelis Care shall permit the member to continue an ongoing course of treatment with the member's current health care provider during a transitional period and upon a previously agreed reimbursement rate. The care shall be authorized by Fidelis Care for the transitional period only if the health care provider agrees to accept reimbursement at rates applicable prior to the start of the transitional period, as payment in full, to adhere to quality assurance requirements, to provide medical information related to such care, and to adhere to the organization's policies and procedures.

The transitional period shall continue up to ninety (90) calendar days from the date of notice to the member of the provider's disaffiliation from the network or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery.

Verification of Member Eligibility

Prior to providing services at each visit, the provider's office must verify the member's current eligibility by either using the Integrated Voice Response (IVR) or Provider Access Online. **Failure to verify eligibility at the time of service may result in denial of payment for services rendered.**
To obtain eligibility or status claims, please go to www.fideliscare.org to access Provider Access Online. To verify eligibility, call 1-888-FIDELIS (1-888-343-3547) to access the IVR.

**Services to be Rendered**

Appropriate evaluation and treatment of a member may require a specialist provider to order certain diagnostic tests.

Effective October 1, 2017, Fidelis Care requires providers to obtain prior authorization from eviCore Healthcare for members in all products, except Fidelis Care at Home (FCAH), for outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services. For a full list of the procedure codes that require prior authorization through eviCore Healthcare, visit: https://www.evicore.com/healthplan/fideliscare.

Effective October 1, 2019, Fidelis Care requires providers to obtain prior authorization from National Imaging Associates, Inc. (NIA) for **outpatient rehabilitative and habilitative physical medicine services, including services rendered in the home**, for **physical therapy (PT), occupational therapy (OT), and speech therapy (ST)**. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Qualified Health Plans (Metal-Level products), Fidelis Care at Home (FCAH) (Managed Long Term Care), HealthierLife (HARP), and Essential Plan (EP). Prior authorization is required for all services rendered by a therapy provider after the initial evaluation. Prior authorization is not required for PT, OT, and ST performed in an Inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay. Non-therapy providers (MD, Chiropractors, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care for all Fidelis Care Members. For more information, visit Fidelis Care Physical Medicine Prior Authorization Quick Reference Guide for Providers.

Effective October 1, 2019, Fidelis Care requires providers to obtain prior authorization through Fidelis Care for members undergoing **musculoskeletal surgical procedures**, in both inpatient and outpatient settings. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Medicare Advantage (MA), Dual Advantage (DUAL), HealthierLife (HARP), Qualified Health Plans (Metal-level Products), Essential Plan (EP), and Medicaid Advantage Plus (MAP). Emergency-related procedures do not require authorization. For a list of the procedures requiring prior authorization, visit Musculoskeletal Surgical Procedures.

Before rendering services, providers are required to check the list of services requiring prior authorization from Fidelis Care, which is available at https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids. Fidelis Care reserves the right to deny reimbursement if, in the opinion of the Chief Medical Officer or Medical Director, the test performed is not medically necessary or is not part of a routine exam. Providers are encouraged to call the Fidelis Care QHCM Department at 1-888-FIDELIS (1-888-343-3547) if they have any questions regarding a particular test.

**New Member**

If a new member has a life-threatening or degenerative disease or disabling condition, Fidelis Care shall allow the new member to continue an ongoing course of treatment with the member's current health care provider for a period of up to sixty (60) days effective from the date of enrollment. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery.

The transitional period applies only if the health care provider agrees to accept reimbursement, at rates established by Fidelis Care, as payment in full, to adhere to the organization's quality assurance requirements and to provide medical information related to such care and to adhere to the organization's policies and procedures.
In no event shall this requirement be construed to require Fidelis Care to provide coverage for benefits not otherwise covered as part of the member’s benefit package with Fidelis Care.

Primary Care Provider Selection

In general, Fidelis Care prefers that PCPs practice in the areas listed below. Because managed care programs include members with life threatening or disabling and degenerative medical conditions, specialist and sub-specialist providers may function as PCPs when such an action is considered by Fidelis Care to be medically appropriate. As an alternative, Fidelis Care may restrict its PCP network to primary care specialties only and rely on standing referrals to specialists and sub-specialists for members who require regular visits to such providers.

The types of providers eligible to serve as PCPs are providers who specialize in:

- Family Practice
- General Practice
- General Pediatrics
- General Internal Medicine
- Obstetrics and Gynecology (subject to Plan and State Department of Health qualifications)
- Nurse Practitioners may also function as PCPs, subject to their scope of practice limitations under New York State Law.

Member choosing of a PCP:

- The member has thirty (30) calendar days from the date of enrollment to select a PCP.
- If the member does not select a PCP within thirty (30) calendar days of enrollment, Fidelis Care must assign the member to a PCP and inform the member of the assignment.
- The member can call Member Services if they wish to change the assigned PCP. Please Note: Changes will be made effective the first day of the following month.
- Members can change their assigned PCP by requesting an update via the Member Portal.
- Fidelis Care sends PCPs a monthly eligibility roster of Plan members who have selected them as their PCP.
- When making assignments, Fidelis Care considers:
  1. The member's geographic location
  2. Any special health care needs of the member, if known by Fidelis Care
  3. Any special language needs of the member, if known by Fidelis Care
  4. Quality Performance of the PCP, if applicable
SPECIALTY PROVIDER SERVICES

Participating specialists work in partnership with Primary Care Providers (PCPs) to provide appropriate, quality medical care to Fidelis Care members. PCPs refer members to specialists for specific services based on evaluation, diagnosis, and direction of care. Specialists play a critical role by providing efficient care within their area of expertise and within the scope of the PCP's referral.

Responsibilities of Specialty Care Providers

- Coordinate with the PCP to provide services to Fidelis Care members, except in an emergency.
- Provide services consistent with the provider practice specialty and provide care that conforms to accepted medical and surgical practice standards in the community.
- Report findings and recommendations to the referring PCP by telephone and in writing.
- Admit and refer members to hospitals that participate in Fidelis Care's network, except in emergencies.
- Maintain medical records that meet the medical record standards listed in Sections 3 and 7 of this manual.
- Send copies of member medical records, reports, treatment summaries, and other related documents to Fidelis Care and other participating providers, upon request.
- Submit claim forms for services electronically within ninety (90) calendar days of the date of service.
- For covered services, seek reimbursement only from Fidelis Care. Except for copayments and/or coinsurance, providers may not seek payment from members. The provider may seek compensation for provision of covered services to members solely from Fidelis Care.
- Maintain professional credentials and liability insurance acceptable to Fidelis Care.
- Accept peer review of professional services provided to Fidelis Care members.
- Maintain admitting privileges with at least one hospital that participates in Fidelis Care's network.
- Work closely with Fidelis Care to resolve any problems, complaints, and disputes that may arise between the provider, member, and Fidelis Care.
- Treat members with respect and honor the patient's right to know and fully understand his or her diagnosis, prognosis, and expected outcome of the recommended medical or surgical treatment or medication, and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.
- Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment, or any other basis prohibited by applicable Federal, State, or Local civil rights laws.
- Abide by agreements made with Fidelis Care as a result of member complaints, peer review, quality assurance, and utilization review.

- Immediately notify Fidelis Care's Chief Medical Officer, in writing, if provider's ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital. (See Section 3 of this Provider Manual).

- Immediately notify Fidelis Care's Chief Medical Officer of any adverse actions or sanctions taken by State agencies and any changes in information included on the Provider Application, (e.g., changes in address or office hours, malpractice actions, on-call arrangements).

- At provider sites where participating providers share office space with non-participating providers, only participating providers can treat Fidelis Care members without authorization.

**Appointment System**

Participating specialists shall abide by the applicable appointment availability standards as defined in Section 4 of this Manual.

**Verification of Member Eligibility**

Prior to providing services at each visit, the provider's office must verify the member's current eligibility by either using the Integrated Voice Response (IVR) or Provider Access Online. **Failure to verify eligibility at the time of service may result in denial of payment for services rendered as Fidelis Care does not pay for services rendered to ineligible members.**

To obtain eligibility or status claims, please go to https://providers.fideliscare.org to access Provider Access Online. To verify eligibility, call 1-888-FIDELIS (1-888-343-3547) to access the IVR.

**Services to be Rendered**

Appropriate evaluation and treatment of a member may require a specialist provider to order certain diagnostic tests.

Effective October 1, 2017, Fidelis Care requires providers to obtain prior authorization from [eviCore Healthcare](https://www.evicore.com/healthplan/fideliscare) for members in all products, except Fidelis Care at Home (FCAH), for outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services. For a full list of the procedure codes that require prior authorization through eviCore Healthcare, visit: [https://www.evicore.com/healthplan/fideliscare](https://www.evicore.com/healthplan/fideliscare).

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directly through Fidelis Care for all Fidelis Care Members. For more information, visit Fidelis Care Physical Medicine Prior Authorization Quick Reference Guide for Providers.

Effective October 1, 2019, Fidelis Care requires providers to obtain prior authorization through Fidelis Care for members undergoing musculoskeletal surgical procedures, in both inpatient and outpatient settings. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Medicare Advantage (MA), Dual Advantage (DUAL), HealthierLife (HARP), Qualified Health Plans (Metal-level Products), Essential Plan (EP), and Medicaid Advantage Plus (MAP). Emergency-related procedures do not require authorization. For a list of the procedures requiring prior authorization, visit Musculoskeletal Surgical Procedures Requiring Prior Authorization.

Before rendering services, providers are required to check the list of services requiring prior authorization from Fidelis Care, which is available at https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids.

Fidelis Care reserves the right to deny reimbursement if, in the opinion of the Chief Medical Officer or Medical Director, the test performed is not medically necessary or is not part of a routine exam. Specialists are encouraged to call the Fidelis Care QHCM Department at 1-888-FIDELIS (1-888-343-3547) if they have any questions regarding a particular test.

The specialist is required to provide any relevant documentation with all treatment information to the member’s PCP and referring provider. It is the specialist's responsibility to coordinate all treatment with the member's PCP in order to ensure effective case management. If the specialty referral occurs in a hospital-based specialty clinic, it is the responsibility of the hospital to ensure that consultation reports are forwarded to the PCP in a prompt and efficient manner.
WOMEN’S HEALTH PROVIDER RESPONSIBILITIES

Direct Access to Obstetrics and Gynecological (OB/GYN) Services

As required by New York State law, each female member of Fidelis Care has unrestricted access to at least two annual exams for primary and preventive obstetric and gynecological services from a qualified provider of her choice in the Fidelis Care network. The member also has unlimited access to primary and preventive OB/GYN services required as a result of such an exam, or as the result of an acute GYN condition. In addition, the member has unrestricted access to a qualified provider of OB/GYN services in the Fidelis Care network for any care related to pregnancy. Consequently, a referral from the member’s Primary Care Physician (PCP) is not required for these services. The specialist must, however, discuss the services and treatment plan with the PCP.

Refer to Section 16 for information on the Family Planning Benefit available to members. Members must have access to a live voice after hours for emergency consultation and care.

OB/GYN and Nurse Midwife Provider Responsibilities

Reporting to Fidelis Care’s BabyCare Program

Fidelis Care's BabyCare Program is a single-point, coordinated health program with the Plan’s member and your patient that begins during the prenatal period and continues through the postpartum office visit. The design of the program is both preventive and educational. The goals are to improve birth outcomes and wellness promotion. A BabyCare nurse or associate contacts each pregnant woman and serves as a resource to help her have a healthy baby.

Providers are responsible to notify Fidelis Care of all members receiving prenatal services at your office. Notification may be made to the BabyCare program at 1-800-247-1441. Notification is expected after the member's first visit to the office.

1. The prenatal encounter form must be submitted within thirty (30) calendar days from the member's first visit as a Fidelis Care member.
2. The postpartum encounter form must be submitted within fourteen (14) weeks from delivery date. The postpartum visit should be completed twenty-one (21) to fifty-six (56) days after delivery.

The completed encounter form can be faxed to 1-866-815-7223 or mailed to:

Attention: BabyCare Program
Fidelis Care
480 CrossPoint Parkway
Getzville, New York 14068

Preventive Care

Providers are responsible for delivering preventive gynecological services to female members, including but not limited to, cervical cancer screening, mammography screening services, and annual chlamydia testing for women of child bearing age, and three doses of HPV vaccine between the ages of nine (9) and thirteen (13). Additionally, providers should treat any gynecological-related clinical condition.)
Section Six  Women’s Health Provider Responsibilities

Prenatal Care/Delivery/Postpartum

OB/GYN providers and nurse midwives shall deliver prenatal care to pregnant members according to American College of Obstetricians and Gynecologists (ACOG) standards and New York State's Prenatal Care Standards for Managed Care Plans.

Fidelis Care has adopted New York State's 2009 updated Prenatal Care Standards as set forth in Title 10, Part 85.40 of the New York Code, Rules & Regulations. Please refer to Appendix VIII for a description of the Medicaid Prenatal Standards program for New York State.

OB/GYN providers and nurse midwives shall perform all in-hospital deliveries and provide all subsequent inpatient and outpatient follow-up care.

Providers are responsible for sending records of all treatment and outcomes to the member’s PCP, and for coordinating any follow-up care when necessary.

For billing guidelines for OB Providers, refer to Appendix XIV.

Appointment Systems

Participating OB/GYN and nurse midwives shall schedule appointments with members within three (3) weeks during the first trimester; two (2) weeks during the second trimester; and within one (1) week thereafter, unless the member's condition is urgent, whereby the appointment should be scheduled using appropriate clinical judgment. A postpartum appointment shall be between twenty-one (21) and fifty-six (56) days after delivery.

Maternity Admissions

Pregnancy-related complications admission (Ante-partum admissions)
When a pregnant member presents due to a medical condition, i.e., eclampsia, hyperemesis, etc., and delivery is not imminent, the hospital should call the Fidelis Care QHCM Department for authorization for inpatient admission or other treatment unless the patient presents with an emergent condition. In this instance, the hospital should assess and stabilize the member, and then notify the Fidelis Care QHCM Department.

OB Delivery Information

The hospital must call the QHCM Department within two (2) business days after delivery with the following maternal and newborn admission information for authorization and case management:

• Mother's name
• Mother's Medicaid (CIN) number (if applicable)
• Admission date and time
• Delivery method (normal spontaneous, C-section etc.)
• Newborn information:
  1) Gender
  2) Date of birth
  3) Birth weight
  4) APGAR score
Section Six  Women’s Health Provider Responsibilities

5) Nursery (NICU, newborn etc.) For newborns admitted to the NICU, please provide the working diagnosis, and name and telephone number of the physician of primary responsibility

6) Gestation by week

Infertility Services

Refer to Section 16 – Family Planning and Infertility
STANDARDS FOR MEDICAL RECORD DOCUMENTATION

Medical Records, whether electronic or on paper, communicate the member's past medical treatment, past and current health status, and treatment plans for future health care. Good documentation facilitates communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment.

All Fidelis Care participating providers are required to participate in the Fidelis Care Quality Management and Improvement Program. Providers are obligated by contract to allow inspection of their records, and are expected to meet Federal and State regulatory requirements enabling Fidelis Care to access and review their records.

Fidelis Care’s Medical Record Documentation Standards

A. Fidelis Care requires that providers maintain members’ medical records in a manner that is current, detailed, organized, and legible facilitating effective and confidential member care and quality review. A separate, distinct medical record is required for each member.

B. Fidelis Care requires that providers have an organized medical record keeping system.

1. Adequacy of the Medical Records Filing System
   (includes maintenance of confidentiality, procedures for review of diagnostic test results, etc.).
   i. Storage: medical records are stored in a secure location not accessible to members and unauthorized personnel.
   ii. Patient Identification: there is a unique medical record for each member identified by a medical record identifier (either name or number) on each page.
   iii. Access and Availability: records are organized with a filing system to ensure easy and timely retrievability upon request by legitimate users.

2. Adequacy of Medical Record Keeping
   i. A minimum of two pieces of patient identifying information present on each page of the medical record.
   ii. Biographical data is identified on each intake form (i.e.: DOB, patient address, employer, home/work telephone number, ethnicity).
   iii. The provider is identified on each entry.
   iv. All recorded entries are dated, signed or cosigned.
   v. The record is legible.

C. Content of the Medical Record - Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the PCP, and all diagnostic and therapeutic services for which the member was referred by the PCP (e.g. home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports). Specific content standards are as follows:

   1. Significant illnesses and medical conditions are indicated on the problem list and updated as necessary.
   2. Medication history (past and current) must be reviewed at each visit, documented, and dated. Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record.
3. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (eighteen (18) years and younger), past medical history relates to prenatal care, birth, operation, and childhood illnesses.

4. Health maintenance is noted updated and updated as necessary.

5. BMI, nutrition, exercise, depression assessment, tobacco and alcohol use, substance use, and sexual activity are noted for patients fourteen (14) years and above.

6. Physical exams are performed at least once a year and documented accordingly.

7. Clinical findings and evaluation are documented for each visit.

8. Documentation in the medical record of discussion of advance directive for adult patients who are Medicare Advantage members and documentation on whether or not a patient has executed an advance directive with a copy of such to be in the medical record. Documentation of advance directive discussions and copies of advance directive may be filed for other members.

9. Evidence of review of results of ancillary services, diagnostic tests and studies by the PCP. Labs may be initialed or notation in progress note indicating review of labs.

10. Reviewed consultation reports or documentation of discussions with consulting physicians are to be part of the medical record. Reports may be initialed or notation in progress notes indicating the review must be documented. Documented evidence of instructions/education given to members regarding follow-up visits, treatment, care, medication use and schedules, diagnostic and therapeutic services where members are referred for services.

11. Lead screening per 'New York State requirements and at the physician’s discretion based on community or individual risks.

12. Documentation of childhood, adolescent and adult immunizations per National and New York State Health Department guidelines.

13. Documented age specific preventive screenings according to National and State practice guidelines and requirements.

D. Retention of Medical Records

Medical records must be retained for at least ten (10) years for adults, and six (6) years from the age of majority for children.

E. Confidentiality

1. All offices are required to meet and exceed state and federal confidentiality requirements such as HIPAA and must protect confidential information against unauthorized disclosure. Provider offices are to ensure periodic confidentiality training of staff members.

2. Access to medical records is permitted only to those individuals who are part of the team providing healthcare to the individual. Such information contained in the medical record may be provided to Fidelis Care for purposes directly connected with the performance of Fidelis Care’s obligations.

3. Confidentiality of HIV-Related Information: Providers must develop policies and procedures to assure confidentiality of HIV-related information, as required by Article 27-F of the New York State Public Health Law. These policies must include:

   i. Initial and annual in-service education of the providers’ staff and/or contractors.

   ii. Identification of those staff members allowed access, and the limits of their access to HIV-related information.

   iii. A procedure to limit access to trained staff (including contractors).

   iv. A protocol for secure storage (including electronic storage).
v. Procedures for handling requests for HIV-related information.
vi. Protocols to protect persons with or suspected of having HIV infection from discrimination.

Fidelis Care’s providers are to provide upon request written policies and procedures for patient information release protocols showing compliance with state and federal laws and evidence of periodic confidentiality training of staff members.

Fidelis Care's Process for Medical Record Improvement

Fidelis Care uses medical record review staff to conduct onsite reviews. Providers and their office staffs receive verbal feedback and education, which includes, but is not limited to, Fidelis Care's medical record documentation, New York City and State Department of Health and CMS reporting requirements. Providers receive a written report following the onsite review.

A. Upon review, providers are rated according to the following performance goals:

1. 85%-100% compliance -- compliant with standards
2. Below 85% compliance requires a corrective action plan

B. Any provider below 85% compliance with Medical Records Standards will require corrective action. Within the Corrective Action Plan request, Providers will be asked to:

1. Investigate compliance issues and articulate plans for improvement.
2. Discuss the status of Electronic Medical Record use.
3. If not using a medical record, discuss the use of standardized medical record forms.

Where reasonably possible, Fidelis Care will make best practices known and will provide copies of medical record form templates.

Providers who do not meet expected goals will be referred to the Fidelis Care Credentialing Committee. Committee actions may include counseling actions, focused reviews, suspension and in some cases termination from the Fidelis Care provider network.

C. **Access to Medical Records** Copies of medical records must be made available, without charge, to other participating providers, consultants, or physicians involved with the member's care and treatment. Copies of medical records must be made available to assist in orderly transfer of medical records if member changes their PCP. Copies of medical records must also be made available upon request, and without charge (unless otherwise noted in a Providers contract), to Fidelis Care (e.g., Chief Medical Officer, Quality Health Care Management Staff) for quality assurance and utilization review activities. The handling of medical records must comply with all Federal and State laws and regulations regarding confidentiality of member records.

Copies of medical records must be made accessible to the Local Department of Social Services (LDSS), New York State Department of Health, and/or the Centers for Medicare and Medicaid Services (CMS) upon request.
EMERGENCY SERVICES

Assessment of An Emergency Medical Condition

Authorization is never required prior to providing services for emergency medical conditions.

Consistent with Federal and State law, an **Emergency Medical Condition** is defined by using a Prudent Layperson Standard, which is as follows:

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child, or in the case of a behavioral health condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of the person.

OBSERVATION SERVICES

Medicaid Guidance

- Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge, or transfer cannot be accomplished within eight hours after presenting in the Emergency Department (ED), but can reasonably be expected within 48 hours.
  - In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). This is in addition to any time that the patient spent in the ED prior to receiving observation services.
- Assignment to observation services may be made only through the Emergency Department
- A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is to be admitted, transferred to another hospital or discharged from the facility.

Medicare Guidance

The Centers for Medicare and Medicaid Services (CMS) recognizes observation care as a well-defined set of clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients, or if they are able to be discharged from the hospital. CMS further identifies that observation services are commonly ordered for patients who present to the emergency department, and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Many providers incorrectly assume that when patients stay in the hospital for more than 48 hours, they automatically qualify for inpatient status. However, if the patient does not meet clinical criteria that require inpatient level of care, but could be treated at a lower level of care, this admission may be denied.
INPATIENT SERVICES

Medical and Surgical Emergent/Urgent Admissions

Authorization is required for unscheduled medical and surgical hospital admissions following stabilization of the member. Fidelis Care requires notification of the member’s hospital admission within two business days. This applies to emergency transfers from one acute care hospital to another when the treating hospital cannot provide the needed care and the patient's clinical status makes it unsafe to wait until the next business day to obtain pre-authorization for the transfer from Fidelis Care.

Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547). Follow the voice prompts for “authorizations” to connect to the Authorization Center from 8:30AM-5:00PM Monday through Friday. Notifications can be accepted after hours, holidays, and weekends. Use the standard toll free number and follow the voice prompt as noted above.

Behavioral Health Emergent/Urgent Admissions

Authorization is required for unscheduled behavioral health admissions following stabilization of the member. Fidelis Care requires notification as soon as possible, not to exceed two (2) business days following admission. This applies to emergency transfers from one acute care hospital to another when the treating hospital cannot provide the needed care and the patient's clinical status makes it unsafe to wait until the next business day to obtain pre-authorization for the transfer from Fidelis Care.

Please contact Fidelis Care at 1-888-FIDELIS (1-888-343-3547). Follow the voice prompts for “behavioral health” to connect to the Behavioral Health Authorization Center from 8:30AM-5:00PM Monday through Friday. Notifications can be accepted after hours, holidays, and weekends. Use the standard toll free number and follow the voice prompt as noted above.

Inpatient Emergency Admissions

Fidelis Care follows National Committee for Quality Assurance (NCQA) guidelines for timeliness of Utilization Management (UM) decisions. Emergency inpatient admissions are considered “Urgent Concurrent” requests and must be addressed within 24 hours. In situations where initial Inpatient authorization requests are not accompanied by sufficient clinical documentation, Fidelis Care will contact the facility to request the necessary information. If Fidelis Care is unable to obtain the information within 72 hours (3 calendar days) of receipt of the initial request, the inpatient admission will be subject to denial for lack of sufficient clinical information.

Clinical information for an Inpatient Emergency Admission, should be faxed to Fidelis Care ER eFax at: 347-868-6411.

Transfer of a Fidelis Care Member to Another Hospital

Prior authorization from Fidelis Care is required to transfer a member from one hospital to another. Fidelis Care will not authorize transfers unless:

- The facility that the patient is in cannot provide the care and services the patient's medical condition requires and.
- The member's attending provider has authorized the transfer, and
- A physician at the receiving facility has accepted the patient and the accepting facility has the resources available to care for the member, and
• All statutory and regulatory requirements for the transfer of a member from one institution to another are met.

Fidelis Care's QHCM Department can assist in arranging for pre-authorized transportation for approved transfers if necessary.

Transfer to a non-participating facility requires approval of the Chief Medical Officer or designee and will only be approved if needed care is not available at a participating facility.

The receiving institution is under the same obligation to notify Fidelis Care with clinical information so that concurrent review can take place.

**Concurrent Review**

In order for Fidelis Care to track and monitor the care of our members who have been hospitalized, Fidelis Care conducts concurrent review on selected patient hospitalizations. Fidelis Care will contact the hospital's utilization department to request clinical information in support of the patient's need for continual hospitalization. Failure to submit the requested information may result in an adverse determination.

The purpose of the concurrent review is to:

1. Ensure the level of service provided is consistent with the need for continued hospitalization,
2. Assist in the coordination of services after discharge,
3. Monitor the quality of care provided in the acute care setting as part of the Fidelis Care quality assurance program.

On occasion, a member of the Fidelis Care Case Management staff will need to visit the hospital to review the chart for either quality or utilization purposes.
PROVIDER CREDENTIALING

Subject to limited exceptions, Fidelis Care is required to credential each health care professional, prior to the professional providing services to Fidelis Care members.

Provider Responsibilities

Providers shall immediately notify Fidelis Care’s Chief Medical Officer, in writing, if their ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital.

Provider Rights

Review information submitted to support their credentialing application – This includes information from outside sources. However, Fidelis Care does not need to disclose references, recommendations or peer-review protected information.

Correct erroneous information – In the event that a Fidelis Care Credentialing Specialist discovers inconsistent information in the application/reapplication, the Specialist will reach out to the provider for correct information with a request for a response within 15 business days. In the event that the practitioner discovers incorrect information in the application/reapplication after exercising the above right, the practitioner may then contact the Fidelis Care Credentialing Specialist via letter or email and request that the application/reapplication be updated. Fidelis Care will process and document receipt of the corrected information in the file within 15 business days.

Receive the status of their credentialing or recredentialing application upon request – Fidelis Care will share what documentation is outstanding to complete the application/reapplication and/or will inform the provider when the application/reapplication will be reviewed by the Fidelis Care Credentialing Committee (CR). Fidelis Care will respond to the practitioner’s request by phone or via email.

Credentialing/Re-Credentialing Process

Fidelis Care’s credentialing process uses standards set forth by the New York State Department of Health and National Committee on Quality Assurance (NCQA), including primary verification of training/experience, office site visits, etc. Each provider will be re-credentialed at least every three (3) years. It is the provider’s responsibility to ensure that Fidelis Care has the correct service address(es) to contact when re-credentialing is due. If a provider fails to re-credential, the provider would be terminated and any claims following that date would not be paid without prior authorization. Fidelis Care’s Credentials Committee reviews credentialing information and recommends appointment to the panel.

It is the applicant’s responsibility to supply all requested documentation in a form satisfactory to the Credentials Committee. Fidelis Care’s Provider Application or the CAQH ProView Application Form is required, in addition to applicable credentialing documents/certifications. Applications lacking supporting documentation shall not be considered by the Committee.

Fidelis Care will process the initial application and present for Committee review within sixty (60) calendar days upon receipt of a completed application and contract. The practitioner will be notified in writing of the Credentials Committee’s decision within that time.

During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, Fidelis Care will notify the practitioner of the missing information, and will make every effort to obtain such information as soon as possible.
Practitioners considered to have non-routine or unusual circumstances may require additional time for review.

Fidelis Care will make every effort to make a determination regarding participation status as soon as possible and will notify the practitioner in writing as to whether he/she is credentialed after the Credentials Committee review and decision.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization, or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Credentialing of Ancillary Staff Working in a Participating Provider’s Office

Each provider must require that all ancillary staff be appropriately licensed, registered, or certified in their field, and that such staff practice in accordance with all applicable laws and regulations. Providers must also provide appropriate supervision to ancillary staff and ensure that ancillary staff’s responsibilities do not exceed those responsibilities set forth in applicable New York State laws and regulations for such practices.

Under certain circumstances, ancillary staff working in a participating provider’s office and providing care to Fidelis Care members must also be credentialed by Fidelis Care. It is the responsibility of the participating provider to notify Fidelis Care when any of the following professionals are hired/contracted to provide services:

- Nurse Practitioners
- Physical Therapists/Occupational Therapists/Speech Therapists
- Certified Nurse Midwives
- Physician Assistants

OMH-Licensed/OASAS Certified Behavioral Health Providers and HCBS Providers

Fidelis Care will accept State issued HCBS providers, OMH and OASAS-certified providers with OMH and OASAS license and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. The contract shall collect and will accept program integrity related information as part of the licensing and certification process. Fidelis Care requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

PROVIDER SUSPENSION

Policy Statement

Fidelis Care may elect to suspend providers who have been charged and/or arrested until final resolution of the charges or that are subject to an OPMC or other regulatory agency investigation/action. Providers who are suspended are excluded from participation in all Fidelis Care’s programs.
PROVIDER TERMINATION

Policy Statement

It is the policy of Fidelis Care to provide due process to providers who are terminated by Fidelis Care consistent with Section 4406-d of the New York State Public Health Law. Accordingly, Fidelis Care has a hearing procedure in place allowing providers, in certain circumstances, to appeal a proposed decision terminating their contract with Fidelis Care.

Fidelis Care will immediately remove any provider from the network who is unable to provide healthcare services due to a final disciplinary action by a state licensing board or other governmental agency that impairs the provider’s ability to practice.

Providers who are excluded or terminated by the State Department of Health (SDOH) Medicaid Program will be excluded from participation in Fidelis Care network of providers.

Definitions

Health care Professional – a person licensed, registered, or certified pursuant to Title 8 of New York’s Education Law.

Quality Concerns – concerns regarding the healthcare professional’s competence or professional conduct which adversely affect, or could adversely affect the health or welfare of a Fidelis Care member or any other patient of a healthcare professional.

Clinical Privileges – the ability to furnish medical care to persons enrolled in Fidelis Care, as determined by Fidelis Care.

Members – any subscriber, enrollee, member, patient, designated representative or, where appropriate, prospective enrollee of Fidelis Care.

Applicability

The hearing procedure is available in the following circumstance:

- When Fidelis Care proposes to terminate a participating health care professional’s contract with Fidelis Care prior to the termination date of the contract.

The hearing procedure is not available in any other circumstances, including but not limited to the following:

- An initial denial of a healthcare professional’s application for clinical privileges;
- When Fidelis Care decides not to renew a healthcare professional’s contract.
- When the termination involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice.
Fidelis Care will not terminate or refuse to renew a contract solely because a health care professional has:

- Advocated on behalf of a member.
- Filed a complaint against Fidelis Care.
- Appealed a decision of Fidelis Care.
- Provided information to a member regarding a condition or course of treatment, including the availability of other therapies, consultations, or tests.
- Provided information to a member regarding the provisions, terms, or other requirements of Fidelis Care’s products as they related to the member.
- Made a report to an appropriate governmental body regarding the policies or practices of Fidelis Care that the healthcare professional believes may negatively impact upon the quality of, or access to, patient care.
- Requested a fair hearing or review as provided herein.

Procedure

When Fidelis Care receives information that raises quality concerns regarding a health care professional who has been granted clinical privileges, it will initiate a review and a notation will be placed in the health care professional’s record. Review will also be initiated when Fidelis Care decides to terminate a health care professional, except where the decision to terminate involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.

If the results of the review indicate that action is required which requires a hearing, the health care professional will be notified in writing regarding the proposed action. Such notice shall include the following:

- The proposed action.
- The reasons for the proposed action.
- A statement that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by Fidelis Care;
- The time limit, not less than thirty (30) calendar days, for requesting a hearing.
- A statement that the hearing will be held within thirty (30) calendar days after the date the hearing request is received.
- A summary of the hearing rights.

If the health care professional does not request a hearing within thirty (30) calendar days of the date of the notice, the proposed action will be final, not subject to arbitration or review by a court of law, and the provider will have no additional appeal rights. If a hearing request is received, the health care professional will be apprised, in writing, of the place, time, and date of the hearing and provided a list of the witnesses expected to testify at the hearing on behalf of Fidelis Care. The health care professional will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Hearing dates and times may be granted at the discretion of Fidelis Care, but within thirty (30) days of the health care professional’s request for a hearing.

The hearing panel shall be comprised of at least three (3) persons appointed by Fidelis Care. At least one member of the panel will be a clinical peer in the same discipline and the same or similar specialty as the
health care professional under review. The hearing panel may consist of more than three (3) persons, provided however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel. If the health care professional participates in the Medicare Advantage program, the hearing panel shall be comprised of a majority of individuals who are clinical peers in the same discipline and the same or similar specialty as the healthcare professional under review.

The health care professional shall have the following rights at the hearing:

- The right to call, examine and cross-examine witnesses.
- The right to present evidence that is deemed relevant by the hearing panel. The determination of relevancy shall be determined solely by the panel.
- The right to submit a written statement at the close of the hearing.

After the hearing panel has convened, deliberated, and rendered a decision, it will notify the health care professional, in writing, of the decision not more than fifteen (15) business days after its adjournment. The notification will include a statement of the basis for the decision. Decisions will include one of the following and will be provided in writing to the health care professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. The decision of the hearing panel is final, and it is not subject to arbitration or review by a court of law.

A decision by the hearing panel to terminate a healthcare professional shall be effective not less than thirty (30) calendar days after the receipt by the healthcare professional of the hearing panel’s decision. In no event will the termination be effective earlier than sixty (60) calendar days from the receipt of the initial notice provided to the health care professional. The date of receipt will be presumed to be five (5) calendar days from the date of the initial notice.

Unless the decision to terminate the healthcare professional involves imminent harm to patient care, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice, Fidelis Care would consider allowing a member to continue an ongoing course of treatment with the professional as outlined in section, 4.6, “Provider Leaves the Network” in this Provider Manual.

The health care professional’s record will be noted with the appropriate status determination and all hearing correspondence.

When the decision of the hearing panel will adversely affect the clinical privileges of a health care professional for a period longer than thirty (30) calendar days, Fidelis Care must notify the New York State Board of Medical Examiners within fifteen (15) calendar days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified as required.

Subject to the due process rights described above, Fidelis Care reserves the right to terminate the participation status of any participating provider, without cause, upon ninety (90) calendar days prior written notice delivered to the provider, or as otherwise required under the terms of the provider contract.

In the event that a provider’s license, certification or registration is restricted, revoked, surrendered, or suspended by any State in which they may hold a license, the provider may be terminated without the right to an appeal. In addition, such action may be taken should restrictions, suspension, revocation or termination occur for the provider:

- Malpractice Coverage
- DEA Registration
- Medicaid or Medicare Privileges - Qualified & Approved

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health
care professional's ability to practice is not eligible for a hearing or a review, and such termination shall not be subject to arbitration.

**Fidelis Care’s Duty to Report**

Fidelis Care is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct, or impairment of member safety or welfare.

2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.

3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member’s health.
QUALITY MANAGEMENT AND IMPROVEMENT, INCLUDING PROVIDER AND PRACTITIONER PERFORMANCE EVALUATION

A. QUALITY MANAGEMENT PROGRAM AND PLAN

Fidelis Care is committed to providing members with access to quality care and services. A comprehensive Quality Management Program provides a management structure for continuously monitoring, evaluating, and improving administrative operations, access, and the provision of quality care and services. The Quality Performance Committee (QPC) for the Board of Directors has authority for oversight of the Quality Management Program. Representatives with clinical backgrounds participate in the QPC as well as on the Credentialing/Recredentialing and Pharmacy and Therapeutics Committee. A Clinical Advisory Committee is comprised of network practitioners who give input into provider and member health education materials, clinical and preventive health guidelines, quality improvement initiatives, and policies and procedures that may impact providers.

Annually, a quality improvement plan is approved by the QPC which establishes the content of the Quality Management Program for the year. Each year, the plan encompasses at minimum work in the following areas:

- Member Satisfaction
- Provider Satisfaction
- Member Complaints
- Adherence to Medical Record Documentation Standards
- Compliance with Clinical Treatment, Preventive Health, and Public Health Guidelines
- Clinical Quality Improvement Studies
- SDOH Quality Assurance Reporting Requirements (QARR)
- CMS Reporting Requirements (including HEDIS, HOS, CAHPS)

Our program and plan is evaluated annually, and the output of the evaluation informs the development of the coming year's program and plan. Providers are encouraged to incorporate, Fidelis Care Network Performance Improvement initiatives into their Quality Management Programs and Improvement Plans.

B. Provider Performance Indicators

As part of our efforts to continuously improve quality, we evaluate provider and practitioner performance on key indicators.

Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals serving a comparable patient population. In these circumstances, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population, which may have a bearing on the healthcare professional's profile, and to work cooperatively with Fidelis Care to improve performance.

Fidelis Care is required to provide information used to evaluate the performance of providers and any profiling data. It is important to note that the staff at Fidelis Care is committed to working in partnership with providers in order to assure that quality care is delivered to members. Compliance reports are used as a way to provide feedback, as well as to educate and identify areas for improvement. In addition, Fidelis Care has several programs that focus on preventive health and management of certain chronic conditions.
Fidelis Care encourages providers to refer members to work with the staff of those programs. Currently the programs available are Case Management (medical and behavioral health), BabyCare, Asthma, HIV, and Diabetes Programs.

The care delivered to members by providers is reported on an annual basis to the State Department of Health (SDOH) through the Quality Assurance Reporting Requirements (QARR) and to the National Committee on Quality Assurance (NCQA) through the Healthcare Effectiveness Data and Information Set (HEDIS). Quality is measured using encounter/claim data that may be supplemented by medical record reviews to determine the percentage of members receiving preventive care and care for certain chronic diseases and services. Additional studies and medical record reviews are initiated by the SDOH throughout the year targeting specific areas such as prenatal care.

QARR/HEDIS measures are also used in overall performance evaluation of a practice. Minimum performance standards and requirements of QARR/HEDIS are described in the Quality Care Management Incentive Program (QCMI) brochure.

In addition to QARR and HEDIS based measures, Fidelis Care can gather provider and practitioner specified data on measures from Consumer Satisfaction Surveys, Health Outcome Tools, Access and availability surveys, Member Complaints, and Internal Quality of Care. Fidelis Care also routinely reviews medical records to determine provider and practitioner compliance with medical record documentation, preventive health, clinical condition, and public health guidelines.

Performance measurement results in these areas will also be made available, and where appropriate, will be included in their file for consideration during the recredentialing process.

Where provider or practitioner performance consistently falls below an expected threshold or fails to meet the standard of care, improvement plans will be requested. Plan completion will be monitored. Copies of plan documentation shall be retained in the provider’s or practitioner’s contracting and credentialing folder. Providers and practitioners who fail to complete an action plan and/or fail to improve performance sufficiently will be forward to the Credentialing Committee for further review and action.

C. INCIDENTS AND QUALITY OF CARE REFERRALS AND COMPLAINTS

Member complaints about the quality of care received are forwarded by the Fidelis Care Member Services Department to the Quality Management Department for investigation and resolution. Providers will often be asked to respond to these complaints and to submit the medical record timely. When a complaint is substantiated, a copy of the resolution letter and any requests for provider action plans will be forwarded to the recredentialing file.

Providers are asked to report to Fidelis Care any adverse events or incidents involving our Members. Fidelis Care Clinical Staff can also internally refer for investigation concerns about the quality of care rendered or questions of adverse events or incidents. These can include:

- Unplanned Admission and Readmissions
- Unexpected Medical, Surgical, and Behavioral Health Treatment Complications
- Failure/delay in addressing abnormal results causing adverse outcome or delay in appropriate treatment
- Medication/Pharmacy usage concerns or errors
- Unexpected death or injury
- Questions of abuse or neglect of members
Section Ten  Health Care Performance Evaluation

For Medicaid, this includes Serious Reportable Incidents (SRI) which are defined as any situation in which the participant experiences a perceived or actual threat to his/her health and welfare or to his/her ability to remain in the community. For more information please see: http://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_10/sri.htm

The Office of Mental Health (OMH) has created The New York State Incident Management and Reporting System (NIMRS) which is a secure, web-based, quality management tool used by OMH providers to report incidents in accordance with Part 524 of the NYS Rules and Regulations. NIMRS features a report generator that can be used to examine trends, providing risk management staff the ability to make program changes and better the quality of the lives of the individuals served. This tool can be found at http://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/index.html. For a listing of NIMRS definitions and severity ratings please visit: https://omh.ny.gov/omhweb/dqm/bqi/nimrs/forms/

For Medicare this includes CMS Never Events which are potentially avoidable events.

Providers will often be asked to respond to these complaints and to submit the medical record timely. When a concern, adverse event, or incident is substantiated, a copy of the resolution letter and any requests for provider action plans will be forwarded to the recredentialing file. Where more immediate question of risk to one or more members exist, immediate peer review or administrative intervention may be requested. Where there is a question of significant departure from the standard of care or a serious medical issue or error, the matter will be immediately forward to the Credentialing Committee for consideration of action.

D. QUALITY IMPROVEMENT STUDIES

Fidelis Care is required to conduct quality improvement studies annually for each of its product lines. Study topics can be mandated by SDOH and CMS, or can be selected by the Plan.

Providers and practitioners are required to participate in these studies as requested. Participation often includes time sensitive submission of medical record information on selected members.
REFERRAL PROCESS

Primary Care Provider (PCP) Referrals within Plan Network

Primary Care Physicians may refer members to any Specialty Care Physician (Specialist) or ancillary provider within the Fidelis Care network. Except as noted below, Fidelis Care communicates to members directing them to see their PCP for their health care needs and that the PCP will determine if they need to see a specialist. Fidelis Care does not require that a member return back to his/her PCP for a referral to a different participating specialist if a participating specialist recommends that he/she be treated by another specialist. Fidelis Care does not require PCPs to notify the Plan when a member is referred to a participating specialist. To ensure coordination of care, Fidelis Care does recommend that a specialist notify the member’s PCP when a referral to another specialist is made.

Direct Access

Fidelis Care communicates to members that it isn’t necessary to see their PCP before seeking care for the following services. Members are advised to seek care directly from providers of these services.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Subsance Abuse Services</td>
<td>Members may self-refer one (1) time per year to a participating behavioral health provider, or be referred by a clinical case manager at Fidelis Care. Members are informed of this benefit at the time of enrollment.</td>
</tr>
<tr>
<td></td>
<td>Except in an emergency, all referrals to the following types of service require a Fidelis Care prior authorization: Inpatient, Residential, Partial Hospitalization, Intensive Outpatient, Day Treatment. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than forty-eight (48) hours or the next business day.</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Members may self-refer one (1) time per year to a participating behavioral health provider, or be referred by a clinical case manager at Fidelis Care. Members are informed of this benefit at the time of enrollment.</td>
</tr>
<tr>
<td></td>
<td>Except in an emergency, all other referrals to the following types of service require a Fidelis Care prior authorization: Inpatient, Residential, Partial Hospitalization, Intensive Outpatient, Day Treatment, psychological testing, and neuropsychological testing. Behavioral health providers should contact the Behavioral Health Case Managers to obtain prior authorization. For emergency situations, the provider should treat the patient and notify the Behavioral Health Case Managers as soon as practical, but, no later than 48 hours or the next business day.</td>
</tr>
</tbody>
</table>
| Dental Services                       | Members may self-refer to dental providers within the dental network of Fidelis Care. Please contact Fidelis Care at 1-888-
Eye Care/Vision Services

Members may self-refer to vision providers within the vision network of Fidelis Care. Please contact Fidelis Care at 1-888-343-3547 for more information. Members can also contact Davis Vision directly at 1-800-601-3383. Contact lenses are provided if medically necessary and prior-authorized (A referral is required for specialty consultation or treatment by an Ophthalmologist).

Obstetrics and Gynecology

Members may self-refer to a participating Fidelis Care provider for primary and preventive obstetric and gynecological services and unrestricted services for care related to pregnancy. Refer to section 16 of this manual for information about family planning.

TB Diagnosis and Treatment

Members may self-refer for the diagnosis and treatment of TB by public health agency facilities.

Urgent Care Centers

Members may self-refer to participating (in-network), free-standing urgent care facilities. Services received from a non-participating urgent care facility require authorization. See page 11.5 for more information.

General Information

Please note that in order to determine medical necessity, clinical information is needed. Fidelis Care will make, at minimum, two (2) attempts to obtain necessary clinical information from the facility. Once all of the clinical information needed to determine medical necessity is received, an authorization number will be assigned and the facility will be notified.

Fidelis Care’s QHCM Department is staffed to provide authorization by telephone 8:30 AM to 5:00 PM Monday through Friday except on holidays. For non-urgent services, requests received after business hours (5:00 PM), will be processed the next business day. For urgent situations that cannot wait until the next business day, please call 1-888-FIDELIS (1-888-343-3547) for urgent access.

Services Requiring Prior Authorization

- Fidelis Care requires prior authorization for services listed in Appendix (I)
- Referral Requirements for Behavioral Health Providers - See Section 21 of the Provider Manual
- Effective 10/1/2017, outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services, require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare, visit: https://www.evicore.com/healthplan/fideliscare.
Pharmacy Services Requiring Prior Authorization

Members who have CHP and NY Medicaid Managed Care have prescription drug coverage through Fidelis Care.

- The Fidelis Care Formulary or Preferred Drug List is located on the website at: [https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services](https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services)

  ° Please note: Drugs listed on the formulary with a PA indicator require you to contact Fidelis Care to obtain a prior authorization.

Drugs not covered by the NYS Medicaid Program and administered in the doctor's office will require prior authorization by Fidelis Care.


Fidelis Care does not require prior authorization of drugs that are paid by Medicaid Fee-For-Service.

NYS Medicaid covers some pharmaceuticals and injectables on a fee-for-service basis at the member's local retail pharmacy. The pharmacy will bill Medicaid directly for these drugs. **The NYS Medicaid Program requires prior authorization for certain drugs not on the preferred drug list. Please refer to its website: [https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf) for a list of preferred medications and those requiring prior authorization.**

Medicare Part D Pharmacy Services requiring Prior Authorization


All covered Medicare Part D drugs must be prescribed for medically accepted indications, which are the FDA approved indications or the use of which is supported by one or more Medicare approved compendia. The Medicare approved compendia include: DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service). Additional consideration of anticancer chemotherapeutic regimen can be researched in DRUGDEX (Micromedex), AHFS (American Hospital Formulary Service), Clinical Pharmacology, NCCN (National Comprehensive Cancer Network), PubMed and in the Medicare approved peer-reviewed literature.

**Initiation of a Coverage Determination Request through the following methods:**

- Via fax to fax number 877-882-5892 (dedicated Medicare fax number).
- Oral requests via telephone to Medicare Member Services at 800-247-1447
- Online as an electronic prior authorization request (PA) at via Cover My Meds & Surescript
- By completing an online form available at [https://www.fideliscare.org/Member/Medicare-Information/Request-For-Prescription-Drug-Coverage-Determination](https://www.fideliscare.org/Member/Medicare-Information/Request-For-Prescription-Drug-Coverage-Determination)

**Time Frame for Medicare Part D Coverage Determination Decisions**

All requests for coverage determinations and other prior authorization decisions will be processed and completed in a timely manner, as required by the Medicare Prescription Drug Benefit Manual Chapter 18, as expeditiously as the enrollee’s health condition requires but not to exceed seventy-two (72) hours.
(Medicare Standard Determination) and twenty-four (24) hours (Medicare Expedited Determination). If an enrollee or an enrollee’s prescriber is requesting an exception for a benefit not yet received, Fidelis Care shall not consider the request, until the enrollee’s prescribing physician or other prescriber provides a supporting statement for the exception request. The timeframe for Fidelis Care to respond to the request does not begin until the enrollee’s prescribing physician or other prescriber provides a supporting statement for the exception request.


Referrals to Non-Participating Providers

A Fidelis Care PCP may not refer to non-participating providers. If a PCP believes a patient needs care that is not available from a participating provider, the physician should call the Fidelis Care prior authorization number at 1-888-FIDELIS (1-888-343-3547) to request approval for care. The Chief Medical Officer or designee will review the request.

The PCP as a Specialist

A Fidelis Care PCP who has training in a sub-specialty may be credentialed in that specialty and participate as a specialist in Fidelis Care's network. Such providers are called "Dual Providers."

Dual Providers who wish to provide specialty services (beyond the scope of services included in the primary care capitation or as a "bill above" described earlier in this manual) to their own Fidelis Care patient, must obtain an authorization from Fidelis Care's Quality Health Care Management (QHCM) Department at 1-888-FIDELIS (1-888-343-3547), prior to providing specialty services, unless the provider is credentialed as a Dual Provider with Fidelis Care. The Authorization Number and Taxonomy Code should be included on the bill for specialty services.

A Specialist as the PCP

Should the member present with a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, a specialist with expertise in the condition may be designated by Fidelis Care as the PCP. The decision to designate the specialist as the PCP is made by Fidelis Care's Chief Medical Officer or designee after consultation with the member's PCP and the specialist. Fidelis Care will not permit a member to elect to have a non-participating specialist as a PCP.

Referral to Specialty Care Centers

Should the member present with a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, a referral may be made to an accredited or designated specialty care center with expertise in the condition. The decision to make such referrals is made by Fidelis Care's Chief Medical Officer or designee after consultation with the member's PCP. In no event shall Fidelis Care be required to permit a member to elect to use a non-participating specialty care center, unless Fidelis Care does not have an appropriate specialty care center within the network.

Degenerative and Disabling is defined as any chronic or acute disease entity that, despite appropriate medical intervention, will destroy the body's integrity, leading to patient's dependence on others for activities of daily living (ADL) and eventually to death.
Life threatening is defined as a situation in which the patient's medical condition is such that any delay in treatment would result in the patient's death.

Considerations for Specialty Care Providers

The specialist plays an integral role in the delivery of quality services to our members. As recipients of referrals from the PCP, it is important to keep in mind the following:

- Participating specialty care providers are expected to keep the PCP informed of the member’s clinical condition. If the member requires ongoing treatment, a report should be sent to the PCP at the conclusion of the treatment.
- In the event that the member requires additional treatment (e.g. hospitalization, surgery, etc.), the specialist should keep the PCP apprised.
- Should the member need the services of another participating specialist or ancillary provider, the specialist should contact the PCP as soon as possible informing them of the referral to another specialist.

Urgent Care Centers

An Urgent Care Center (also known as an Urgent Care Facility) is a type of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site. Once the acute illness or trauma has been treated, ongoing care should be provided by the primary care physician or appropriate network specialist provider. Urgent care facilities are not intended for well care, chronic disease management, or services able to be provided timely by the primary care physician. Such facilities are also not intended to be used as emergency rooms and are not subject to the Emergency Medical Treatment and labor Act (EMTALA).

Fidelis Care does not require participating (in-network) Urgent Care Centers to obtain an authorization in order for Fidelis Care to pay for the visit.

Fidelis Care requires out-of-network Urgent Care Centers to obtain an authorization within 24 hours of services being performed in the Urgent Care Center.
- Authorization requests for visits to out-of-network Urgent Care Centers will not be approved unless the member is seeking care outside the Fidelis Care service area (and it was not reasonable given the circumstances to delay receipt of services to obtain the services through one of the contractor’s Participating Providers).

Urgent Care Centers are expected to perform only the services needed to address the urgent medical condition. Since Urgent Care Centers do not perform Emergency Services, all of Fidelis Care’s authorization requirements apply to Urgent Care Centers. Urgent Care Centers are expected to review the authorization grid and obtain authorizations for applicable services, which can be found here: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids

Physicians and other providers who are in Fidelis Care’s network working in an Urgent Care Center will only be reimbursed for Fidelis Care members if the Urgent Care Center is also in Fidelis Care’s network. Physicians (or other practitioners) with an “Emergency Medicine” specialty designation are expected to treat Fidelis Care members in an Emergency Room (which may be in-network or out-of-network), or an in-network Urgent Care Center. Even if the Emergency Medicine physician is in Fidelis Care’s network, a claim for a visit in an out-of-network Urgent Care Facility will not be paid without an authorization.
Authorizations will only be granted for Out-of-Network Urgent Care Center visits when the member is out of the Fidelis Care service area.

Services provided at Urgent Care Centers must be billed using Place of Service 20. Services rendered in a non-Urgent Care Center, billed with place of service 20, are not reimbursable.

PRIOR AUTHORIZATION PROCESS

Purpose for Prior authorization

- Give providers eligibility information based on Fidelis Care's currently available data.
- Confirm that a given service is a covered benefit under Fidelis Care.
- Allow Fidelis Care to evaluate the medical necessity and appropriateness of the proposed treatment.
- Provide Fidelis Care an opportunity to suggest alternative treatments.
- Provide appropriate authorization to allow reimbursement to the provider for treatment.
- Enable the Care Management clinical staff to track the member's care and coordinate services where necessary.

Process to Obtain Prior Authorization

Procedures requiring prior authorization by Fidelis Care are listed on the Authorization Grid, in Appendix I. The prior authorization request must be generated by a Fidelis Care provider and authorized by Fidelis Care's Quality Health Care Management (QHCM) Department. We recommend that a request be sent at least five (5) calendar days before the anticipated date of service.

The following information will be required to process a service for prior authorization:

- Member name/date of birth
- Member’s Fidelis Care ID number
- Ordering provider's name, servicing provider's name and hospital/ambulatory center name if indicated
- Tax Identification Number
- IPA Affiliation, if applicable
- ICD-10 Diagnosis Code
- Current Procedural Terminology (CPT) codes of the procedure, surgery, or service being requested
- Anticipated date and time of procedure
- Necessary clinical information supporting need for procedure, surgery, or service.

The Medical Director may request additional information.

Provider submission of service authorization requests can be accomplished as follows:

- Telephonically: 1-888-FIDELIS (1-888-343-3547)
- Fax: 1-800-860-8720 (Medical)
- Fax 1-718-896-1784 (Behavioral Health)
- Fax: 1-877-533-2405 (Pharmacy)
Section Eleven

Referrals and Prior Authorization

- Fax: 1-347-868-6411 (Inpatient Emergency Admissions)
- On the Fidelis Care Provider Portal (Note- some restrictions apply)

Coverage Determinations for the Part D Pharmacy Drug Benefit

All cases are evaluated for the appropriate level of care and medical necessity based on the clinical findings and plan of care submitted to Fidelis Care. All cases are reviewed using the coverage criteria as indicated on the Fidelis Care website, CMS guidelines as listed in Chapter 6 of the CMS Prescription Drug Benefit Manual, as well as CMS approved compendial references. Chapter 6 of the CMS Prescription Drug Benefit Manual can be obtained at the CMS Website. Medicare Approvals and Denials (including Partial Denials) will be processed in accordance with the guidelines of Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance and can be obtained on the CMS website.


Authorization Processing Timeframes

| MEDICAID |
|-----------------|-----------------|-----------------|-----------------|
| **Type of Review** | **Type of Communication** | **Receiver of Communication** | **Total Process Time** |
| Pre-Service (Prospective) Non-urgent | Telephone and in writing within 3 business days of receipt of information to make decision, not to exceed 14 days from date of request | Member, Designee and Practitioner/Provider | 3 business days not to exceed 14 days |
| Pre-Service (Prospective) Expedited | Telephone and in writing within 72 hours from receipt of request | Member, Designee and Practitioner/Provider | 72 hours |
| Concurrent/ Extension of Care | Telephone and in writing within 1 business day of receipt of request, not more than 14 days after request for information | Member or Designee, which may be satisfied by notice to the Provider | 1 business day not to exceed 14 days |
### Section Eleven  Referrals and Prior Authorization

<table>
<thead>
<tr>
<th>Concurrent/ Extension of Care Expedited (all inpatient)</th>
<th>Telephone within 1 business day but not more than 72 hours from date of request (for Home Health Services following a hospital stay, within 72 hours of receipt of necessary info.)</th>
<th>Practitioner/Provider and/or Member/Designee</th>
<th>1 business day not to exceed 72 hours from date of request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Drug Coverage Determinations</td>
<td>Telephone and in writing within 24 hours of receipt of request</td>
<td>Member, Designee and Practitioner/Provider</td>
<td>24 hours</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Written notice within 30 calendar days of receipt of information to make decision. (No calls required)</td>
<td>Member, Designee and Practitioner/Provider</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>Must occur within 1 business day of receipt of request for prospective, and concurrent determinations</td>
<td>Practitioner/Provider</td>
<td>1 business day</td>
</tr>
</tbody>
</table>

### MEDICARE

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Total Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Request</td>
<td>In writing as expeditiously as members health condition requires &amp; not to exceed 14 calendar days from date of request—may extend for another 14 days</td>
<td>Member, Designee and Practitioner/Provider (for approvals no call to member required)</td>
<td>14 calendar days with option of extension of 14 calendar days for a total of 28 calendar days from date of request.</td>
</tr>
<tr>
<td>Standard Medicare Part-D Pharmacy Coverage Determinations</td>
<td>Fax, online, telephone or in writing are processed as expeditiously as enrollee’s health</td>
<td>Member, Designee and Practitioner/Provider</td>
<td>72 hours</td>
</tr>
</tbody>
</table>
### Section Eleven  Referrals and Prior Authorization

| Expedited Request (including extension of care) | Telephone and in writing within 72 hours from the time of the request | Member, Designee and Practitioner/Provider | 72 hours |
| Expedited Medicare Part D Pharmacy Coverage Determinations | Fax, online, telephone or in writing are processed as expeditiously as enrollee’s health condition requires not to exceed 24 hours | Member, Designee and Practitioner/Provider | 24 hours |

## CHP

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorizations</td>
<td>Telephone and in writing within 3 business days of receipt of necessary information.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>3 business days. Add'l info must be requested within 3 business days. Provider has 45 calendar days to submit info. If info rec'd within 45 days, decision must be made within 3 business days of receipt of this additional information. If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</td>
</tr>
</tbody>
</table>
### Expedited Prior Authorization

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited</td>
<td>Telephone within 72 hours of receipt of request if we have all necessary info. Written notice follows within 1 calendar day of decision.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>Within 72 hours. Add'l info must be requested within 24 hours. Provider has 48 hours to submit the additional information. We must make a decision and provide notice within 48 hours of the earlier of our receipt of the information OR the end of the 48 hour period.</td>
</tr>
</tbody>
</table>

### Home Care Following IP admission

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care</td>
<td>Telephone and in writing within 1 business day of receipt of necessary information. (If the day following the request falls on a w/e or holiday, we will make a determination within 72 hours or receipt of necessary information.)</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>1 business days. Add'l info must be requested within 1 business day. Provider has 45 calendar days to submit info. If info rec'd within 45 days, decision must be made within 1 business day of receipt of this additional information. If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</td>
</tr>
</tbody>
</table>

### Concurrent

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent</td>
<td>Telephone and in writing within 1 Business Day of receipt of all necessary information.</td>
<td>Member or Designee and Practitioner/Provider</td>
<td>1 business days. Add'l info must be requested within 1 business day. Provider has 45 calendar days to submit info. If info rec'd within 45 days, decision must be made within 1 business day of receipt of this additional information. If all necessary information is NOT received, we must make a decision within 15 calendar days of the end of the 45 day period.</td>
</tr>
</tbody>
</table>

### CHP (continued)
Section Eleven  Referrals and Prior Authorization

| Retrospective | In writing within 30 calendar days of receipt of request. | Member or Designee and Practitioner/Provider | Within 30 calendar days of receipt of the request. Additional information must be requested within 30 calendar days. Provider has 45 calendar days to submit info. We will make a decision and provide notice in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45 day period. |
| Reconsideration | In writing and by phone if adverse determination is upheld. | Member or Designee and Practitioner/Provider | Must occur within 1 business day of receipt of request for prior authorization, and concurrent determinations |

An expedited review must be conducted when Fidelis Care or the provider indicates that delay would seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum functions. Members have the right to request an expedited review. If Fidelis Care denies the member's request for an expedited review, Fidelis Care will notify the member that the request will be handled under standard review timeframes.

**Service Authorization Request Determination and Notification**

All cases are evaluated for the appropriate level of care and medical necessity based on the clinical findings and plan of care submitted to Fidelis Care. All cases are reviewed using nationally accepted guidelines (e.g. Milliman Care Guidelines, American Society of Addiction Medicine (ASAM), CMS National and Local Coverage Determinations) or guidelines developed by Fidelis Care. Any case not meeting guidelines will be reviewed by a Chief Medical Officer or designee. For Medicaid, as fast as the member’s condition requires.

All cases are evaluated for the appropriate level of care and medical necessity. “**Medically Necessary**” means health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital, injury or disability.

Fidelis Care will provide the member (or their designee) and provider with verbal (telephonic) and written notification of the determination regarding the requested service, procedure or surgery.

- Approved authorizations: notification will include a description of the service and/or number of visits along with the date(s) of service/approval timeframe.
- Adverse determinations: If the Medical Director concludes, after review of all information submitted, that the service is not medically necessary or the level of care is not appropriate
for the member's condition, a denial notice will be issued in accordance with Article 49 of the NYS Public Health Law and CMS guidelines in Chapter 13, Grievances, Organization Determinations and Appeals. Denials shall be appealed in accordance with Article 49. The appeal process is described in Chapter 13, Grievances, Organization Determinations, and Appeals.

- Denials also are issued when the clinical information submitted is insufficient to make a utilization determination
- Reconsideration of adverse determination: When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.
  - Exception: Retrospective reviews that result in an adverse determination are not eligible for reconsideration.

Fidelis Care must send a notice of determination on the date review timeframes expire. If Fidelis Care fails to make a determination within the time periods prescribed in this section, it shall be deemed to be an adverse determination subject to appeal.

A notice of adverse determination is in writing and includes:

a. The reasons for the determination, including the clinical rationale, if any;
b. Instructions on how to initiate internal appeals (standard and expedited appeals);
c. How to initiate an external appeal; and
d. Notice of the availability, upon request of the member or the member’s designee, of the clinical review criteria relied upon to make the determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by Fidelis Care, in order to render an appeal decision.

e. Description of Action to be taken.
f. Statement that Fidelis Care will not retaliate or take discriminatory action if appeal is filed.
g. Process and timeframe for filing/reviewing appeals, including member's right to request an expedited review.
h. Member's right to contact DOH, with 1-800 number, regarding their concern.
i. Fair Hearing notice including aid to continue rights.
j. Statement that notice is available in other languages and formats for special needs and how to access these formats.
k. For **Medicare Advantage, Dual Advantage, and Medicaid Advantage** the member has a choice of Medicaid or Medicare appeal processes if service is determined by Fidelis Care to be either Medicare or Medicaid. A Medicare appeal must be filed sixty (60) calendar days from denial. Filing a Medicare appeal prohibits the enrollee from filing for a State Fair Hearing. However, a member who files a Medicaid appeal may still file for Medicare appeal, provided that the Medicare appeal is filed within the sixty (60) calendar day period.

**Reversal of Prior-authorized Treatment**

Fidelis Care may reverse a prior-authorized treatment, service, or procedure on retrospective review pursuant to section 4905(5) of PHL when:

(a) relevant medical information presented to Fidelis Care or utilization review agent upon retrospective review is materially different from the information that was presented during the prior-authorization review; and
(b) the information existed at the time of the prior-authorization review but was withheld or not made available; and

(c) Fidelis Care or UR agent was not aware of the existence of the information at the time of the prior-authorization review; and had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Financial Incentives

Fidelis Care is committed to providing members with the best and most appropriate care possible. Utilization management decisions are based only on the appropriateness of care and existence of coverage. At no time does Fidelis Care directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives offered or compensation rewarded to individuals, as UM decision makers, to encourage underutilization of services.

Provider Request for Clinical Criteria

Providers may request a copy of the clinical criteria used to render a utilization management decision, free of charge.

Providers are notified of their right to obtain clinical criteria via:

a. Utilization Management notifications (adverse determinations) include an appeal rights attachment.

b. The provider portal or provider bulletin.

Requests can be submitted by calling 1-888-FIDELIS (1-888-343-3547) and speaking with a Call Center representative.

The applicable clinical criteria will be mailed to the requesting provider within 15 business days.
BILLING AND CLAIMS SUBMISSION GUIDELINES

Instructions for Submitting Claims

The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB-04 claim form.

Timely Filing

All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to Medicaid and Child Health Plus enrollees must be submitted within 90 days. Acceptable reasons for a claim to be submitted late are: litigation, primary insurance processing delays, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Late claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Electronic Claim Submissions (837 – Health Care Claims)

Fidelis Care accepts HIPAA-compliant healthcare claims (x12 5010 837I & 837P) originating from multiple sources. The most efficient and preferred method is through your clearinghouse. Please verify that your clearinghouse will forward your submitted claims to Fidelis Care.

If you have further questions about submitting claims electronically, please contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

Receiver Name: Fidelis Care
Fidelis Care Receiver ID: 113153422
Fidelis Payer ID: 11315

Electronic Remittance Advices (835 – Health Care Claim Payment/Advice)

To receive 835 Electronic Remittance Advices for your Fidelis Care claims, please contact your clearinghouse.

Eligibility Inquiries (270/271 – Eligibility, Coverage or Benefit Inquiry/Information)

Fidelis Care offers secure responses to eligibility inquiries.

Eligibility benefit inquiries/responses provides information on covered individual eligibility, coverage verification, and patient liability (deductible, copayment, and coinsurance). You may receive these either through your claims clearinghouse or directly from Fidelis Care.

For clearinghouse delivery, please contact your clearinghouse for availability. If you wish to inquire as to submitting eligibility requests directly to Fidelis Care, please contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

Response Reports

- **277 Report** - is the electronic claim acknowledgement in X12 format.
- **999 Report** - acknowledges the receipt of claims and whether the transaction is in compliance with HIPAA requirements.
Section Twelve – Part 1

Claims Submission

- **RPT Report** - is used by Fidelis Care to give further information, in a non X12 format, on the status of submitted claims (837 transactions).

Fidelis Care Claims Editing Software

Fidelis Care uses Change Healthcare Claims Editing Software to automatically review and edit healthcare claims submitted by physicians and facilities.

Mailing Addresses for Paper Claims Submission

<table>
<thead>
<tr>
<th>Fidelis Care Line of Business</th>
<th>Claim Type</th>
<th>Claims PO Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid, CHP, and Essential Plan</td>
<td>UB-04</td>
<td>Fidelis Care PO Box 806 Amherst NY 14226-0806</td>
</tr>
<tr>
<td>Medicaid, CHP, and Essential Plan</td>
<td>CMS-1500</td>
<td>Fidelis Care PO Box 898 Amherst NY 14226-0898</td>
</tr>
<tr>
<td>Medicare</td>
<td>CMS-1500 UB-04</td>
<td>Fidelis Care Dual Advantage and Fidelis Care Medicare Advantage PO Box 170 Amherst NY 14226-0170</td>
</tr>
<tr>
<td>Fidelis Care at Home (FCAH)</td>
<td>CMS-1500 UB-04</td>
<td>Fidelis Care at Home PO Box 1707 Amherst NY 14226-1707</td>
</tr>
<tr>
<td>Fidelis Care FIDA</td>
<td>CMS-1500 UB-04</td>
<td>Fidelis Care FIDA Plan PO Box 1206 Amherst NY 14226-1206</td>
</tr>
<tr>
<td>HealthierLife (HARP)</td>
<td>UB-04</td>
<td>Fidelis Care HealthierLife PO Box 1205 Amherst NY 14226-1205</td>
</tr>
<tr>
<td>COB - All Lines of Business</td>
<td>COB: CMS-1500 UB-04</td>
<td>COB Fidelis Care PO Box 905 Amherst NY 14226-0905</td>
</tr>
</tbody>
</table>

Claim Forms

Physician Services

Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims and encounter information for services within ninety (90) calendar days of the date of service using the CMS-1500 claim.

Fidelis Care accepts claim submissions on the CMS-1500 claim form, version 02/12. Fidelis Care is no longer accepting claim submissions on the CMS-1500 claim form version 08/05. A copy of the 02/12 claim form can be viewed by visiting https://www.fideliscare.org/Portals/0/Providers/FormsApplications/2018-Fidelis-Care-Insurance-Claim-Form-CMS1500.pdf?ver=2018-08-02-141549-260

Fidisi Care Provider Manual Return to Top V19.0-10/30/19 12.1.2
Hospital Providers

Claims can be submitted electronically, refer to section 12.1. Claims for hospital services must be submitted on a UB-04 claim form within ninety (90) calendar days of the date of service or the date of discharge.

Ancillary Providers

Claims can be submitted electronically; refer to section 12.1. Providers must submit claims for home healthcare services, durable medical equipment (DME), respiratory care, physical, occupational and speech therapies on a CMS-1500 or UB-04 claim form within ninety (90) calendar days of the date of service.

Coordination of Benefits (COB)

Fidelis Care will coordinate the benefits with the other carrier(s) when other coverage exists to ensure that Fidelis Care's liability does not exceed more than 100% of Fidelis Care's allowable expenses. This effort involves coordinating coverage and benefits, where appropriate, for illnesses, injuries, and accidents covered by:

- Personal Automobile coverage
- Workers’ Compensation
- Veteran's Administration
- No-Fault
- Other Health Insurance Plans

Payments Involving COB

In the event a claim is initially filed with Fidelis Care for which another carrier is determined to be the primary payer, the provider will be notified on a remittance advice to file with the primary insurer.

All participating providers agree to provide Fidelis Care with the necessary information for the collection and coordination of benefits when a member has other coverage. The provider will be required to do the following:

- Determine if there is duplicate coverage for the service provided;
- Recover the value of services rendered to the extent such services are provided by any other payer; and,
- File the claim with Fidelis Care along with the primary carrier's Explanation of Benefits (EOB) attached for reconsideration within ninety (90) calendar days of receiving the primary carrier's explanation of benefits.

Fidelis Care will coordinate benefits up to Fidelis Care's allowable as secondary payer. Fidelis Care is not responsible for payment of benefits determined to be the responsibility of another primary insurer.

Mailing Address for all Claims Related to Coordination of Benefits (COB) Submission:

<table>
<thead>
<tr>
<th>UB-04 or CMS-1500</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB</td>
</tr>
<tr>
<td>Fidelis Care</td>
</tr>
<tr>
<td>PO Box 905</td>
</tr>
<tr>
<td>Amherst NY 14226-0905</td>
</tr>
</tbody>
</table>
Payments and Reimbursements

Fidelis Care reimburses providers for services that are billed correctly to Fidelis Care on a weekly basis. Clean claims are paid within the guidelines stipulated by Section §3224-a of the New York State Insurance Law. A “Clean Claim” is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 Form. Refer to Section 12 – Part 2 for detail on the data elements required for clean claims.

Payments to Primary Care Providers

Each PCP or group with a Capitation Agreement will receive capitation payments for enrolled members. Capitation payments are made at the beginning of each month in accordance with a schedule which is published and distributed to providers on an annual basis. All encounter data must be submitted to Fidelis Care and adhere to all industry standard coding guidelines.

Payments to Specialty Providers

Each specialist provider will receive a check reflecting payment for covered services provided to eligible members and correctly billed to Fidelis Care. The check may be made payable to the individual provider or to a designated medical or professional group.

- Nutritional Counseling
  - Appendix K of the Model Contract (Medicaid Managed Care) indicates nutritional counseling is covered under the Preventive Health Services section. It further advises targeted outreach to diabetics and pregnant mothers.
  - Nutritional counseling is not reimbursable as a stand-alone service. Medicaid does not enroll nor reimburse nutritionists or dieticians unless they are certified in diabetes management. Nutritional counseling should be provided as part of a comprehensive medical encounter when the patient is seen by a recognized practitioner (physician, physician assistant, nurse practitioner, licensed midwife).

Multiple Specialty Providers

It is important for providers with multiple specialties to submit the appropriate taxonomy code when submitting claim forms. This will ensure accurate payment and the appropriate application of cost-sharing when applicable.

NOTE:
Any changes in a provider's status, address, corporate name, or other changes should be reported to Fidelis Care immediately to ensure prompt and accurate reimbursement.

Remittance Advice

Remittance Advice is available via Fidelis Care’s Provider Access Online (provider portal). A Remittance Advice should be obtained by logging onto Provider Access Online - https://providers.fideliscare.org. For providers who need assistance obtaining their ID/password, please contact your local provider relations representative for assistance.
Section Twelve – Part 1
Claims Submission

The Remittance Advice identifies which members and services are covered by a particular check. Claims are listed in alphabetical order according to the member’s last name. Each item in the listing includes the following:

- Fidelis Care claim number as assigned by Fidelis Care
- Member's name
- Member’s Fidelis Care ID number
- Provider's name
- Date of service
- Procedure code
- Patient account number
- Denied amount
- Allowed amount

The Remittance Advice should be examined to reconcile payments from Fidelis Care with accounts receivable records.

Electronic Fund Transfer (EFT)

Providers can request to receive payments electronically if they’ve met the following criteria:

- Participating provider
- Submitting claims electronically for at least two months
- Receiving remittances and/or rosters electronically
- Agrees to receive all payments in an EFT format; claims, capitation and QCMI (if applicable)
- Agrees to receive other communication electronically

Fidelis Care Claim Inquiry

To check the status of claims submitted over thirty-five (35) days, please go to [https://providers.fideliscare.org](https://providers.fideliscare.org) to access Provider Access Online. You can also contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547) Monday through Friday, 8:30 AM to 5:00 PM.

Stop payment and reissue of checks

To request a stop payment and reissue of a check, the request must be sent in writing to the following address:

Attn: Finance Department  
Fidelis Care  
95-25 Queens Blvd  
Rego Park, NY 11374

The written request must have the following information:

- A completed and notarized affidavit (affidavit form, refer to Section 12A of this manual )
- The contact person and phone number
- Verification of the correct remittance address for the check
- Who the check was made payable to, if known

Please note that if the check has been cashed, an additional Affidavit form will need to be obtained, signed, and notarized.
Corrected Claim

If a provider disagrees with the payment determination, a corrected claim must be submitted within sixty (60) days of the remittance advice for that claim. If Fidelis Care does not receive a request for a corrected claim within sixty (60) days of the remittance advice for that claim, the provider shall be deemed to have waived all rights to assert that the claim is incorrect.

A Corrected Claim is a claim that has any changes made to an original claim previously submitted that includes, but not limited to a change of the following:

- Date of Service
- Place of Service
- Procedure Codes - including adding or removing modifiers
- Diagnosis Billed
- Units per service
- Dollar amounts
- Provider status changed
- Provider specialty change
- Provider tax id# change

Paper Corrected Claims – The following claim and field billing guidelines below must be followed, or the corrected claim will not be accepted and will be returned:

- **UB-04 Corrected Claims:**
  - FL 04: Type of Bill field must be billed with a code ending in a “7”, and
  - FL 64: Document Control Number field must be billed with the Fidelis Care original claim number.

- **CMS-1500 Corrected Claims:**
  - FL 22: Resubmission Code field must be billed with a “7” and the Original Reference Number field must be billed with the Fidelis Care original claim number.

Corrected Claims Address
Fidelis Care
Attn: Corrected Claims
480 CrossPoint Parkway
Getzville, New York 14068

Claim Denials for Invoice

In some cases Fidelis Care may need to deny a claim because a copy of the manufacturer's invoice* is required for claims processing. Providers may send a copy of the unaltered invoice via fax or mail to the contact information below. Please be sure to include the member’s name and member ID, as well as the claim number associated with the invoice request:

By Mail - Fidelis Care
Attn: Claims Reconsideration
480 CrossPoint Pkwy
Getzville, NY 14068

By Fax - 1-877- 247- 9187 | Attn: Claims Reconsideration (this fax is for invoice purposes only)

*Claims Requiring Manufacturer's Invoice

Claims that require a manufacturer's invoice for payment consideration (e.g. “By Report” (BR) procedure) must be submitted with all of the following required information in order to be validated as an acceptable invoice:

- Manufacturer's Name
- Provider Name
- Item with Description
- Acquisition Cost on the invoice
- Invoice Date

Some examples of unacceptable invoices are: altered manufacturer's invoice, purchase orders, sales orders, order confirmations packing slips and delivery receipts.

Note, any claim received by Fidelis Care that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice, will be denied.

Electronic Submission of Corrected Claims

When submitting a Corrected Claim electronically, the original claim number must be submitted and the claim frequency type code must be a 7 (replacement of prior claim). Please go to Fidelis Care’s website for additional information. Please note that corrected claims must be submitted within sixty (60) days of receiving the remittance advice.

Quick Guide to Claims Processing

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do I direct billing questions?</td>
<td>1-888-FIDELIS (1-888-343-3547) and follow the prompts for the Provider Services Department</td>
</tr>
<tr>
<td>Where do I submit claims?</td>
<td>Refer to the Fidelis Care website at fideliscare.org for information about submitting claims electronically</td>
</tr>
</tbody>
</table>
| Which forms may be used for billing?                                    | Professional - CMS-1500
Facility - UB-04                                                         |
| Which patient identifier(s) should be used?                             | Fidelis Care Identification Number or Medicaid Number (CIN)             |
| What is the time frame for submitting the claim?                        | Ninety (90) Days                                                        |
| What is the time frame for payment of a completed and clean claim?      | Thirty (30) days after receipt of a clean claim submitted electronically |
## Section Twelve – Part 1  
### Claims Submission

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forty-Five (45) days after receipt of a clean claim submitted via paper</td>
<td>(In accordance with NYS Insurance Law Section 3224-a)</td>
</tr>
<tr>
<td>How do I check on the status of a claim?</td>
<td>To check claim status please visit <a href="https://portal.fideliscare.org/provider/">https://portal.fideliscare.org/provider/</a> to access our secure Provider Portal.</td>
</tr>
<tr>
<td>To whom do I direct a claims inquiry?</td>
<td>1-888-FIDELIS (1-888-343-3547) and follow the prompts for the Provider Call Center.</td>
</tr>
<tr>
<td>What is the process if you believe a claim has been underpaid or wish to appeal a denied claim?</td>
<td>Submit Form 13A with supporting documentation within sixty (60) days of the remittance advice for the claim at issue.</td>
</tr>
</tbody>
</table>
BILLING AND GUIDELINES

The billing guidelines contained within this section adhere to industry standards as defined by Center for Medicare and Medicaid Services (CMS); National Correct Coding Initiative (NCCI); National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); the American Medical Association’s (AMA) Current Procedural Terminology Manual (CPT-4); Healthcare Common Procedure Coding System (HCPCS); and International Classification of Diseases 10th Revision (ICD10).

General Claims and Billing Guidelines

Claims are processed Mondays through Fridays and clean claims are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A “Clean Claim” is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 Form. The following data elements are required for a claim to be considered a clean claim:

<table>
<thead>
<tr>
<th>CMS-1500 and UB-04 Data Elements</th>
<th>CMS-1500</th>
<th>UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Member Name/Address</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fidelis Care Member ID Number</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)/other insured’s information</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Date(s) of Service</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ICD- Diagnosis Code(s), valid and coded to the appropriate digit</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ICD – Procedure Code (s) (if applicable)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>CPT-4 Procedure Code(s)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HCPCS Code(s)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service Code Modifier (if applicable)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Place of Service</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Service Units</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Charges per Service and Total Charges</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provider Name</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provider Address/Phone Number</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tax ID Number</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fidelis Care Provider Number – For Paper Claims Only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fidelis Care Provider Number 11315 – For EDI Claims Only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital/Facility Name and Address</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Type of Bill</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admission Date and Type</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Patient Discharge Status Code</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Condition Code(s)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Occurrence Codes and Dates</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Value Code(s)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Revenue Code(s) and corresponding CPT/HCPCS Codes (outpatient)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Suggestions to Expedite Claims

Please follow the guidelines below in completing and submitting claim forms to expedite your reimbursement for services rendered. Claims that do not contain all required data elements may be returned or denied:

- Have correct and complete information on the claim form.
- Verify member eligibility.
- Do not submit duplicate claims. Initiate an inquiry if payment is not received within forty-five (45) days after billing date.
- Provide Coordination of Benefits (COB) information before claim is filed.
- Include your NPI and TIN on all claims submitted.
- Electronic submission is the best way to expedite claims (refer to section 12.1 in this manual). Validate that this is the correct section 12.1 still. However, if you must submit paper claims, please mail claims routinely. By mailing claims routinely throughout the month, you will assure faster turnaround and avoid an end of the month backlog.
- For the submission of paper claims, please use the appropriate PO Box. Please see Section 12.2 of this manual for a listing of PO boxes.
- Complete a single claim form for each patient encounter.
- Submit a separate claim form for each Provider and for each site where services were rendered.
- For services that require authorization, you must ensure you have obtained an authorization.

Please note the following applicable place of service codes:

1 Pharmacy 21 Inpatient Hospital
21 Outpatient Hospital (Effective 1/1/2016: Defined as On Campus – Outpatient Hospital)
3 School Based 22 Emergency Room - Hospital
3 School Based 22 Outpatient Hospital (Effective 1/1/2016: Defined as On Campus – Outpatient Hospital)
5 Indian Health Service Free-standing Facility
5 Tribal 638 Free-standing Facility
6 Indian Health Service Provider-based Facility
6 Tribal 638 Provider-based Facility
7 Indian Health Service Free-standing Facility
7 Tribal 638 Free-standing Facility
8 Indian Health Service Provider-based Facility
8 Tribal 638 Provider-based Facility
10 Office 32 Nursing Facility
11 Office 32 Nursing Facility
12 Patient's Home 33 Custodial Care Facility
13 Assisted Living Facility 34 Hospice
### Supplemental Claim Documentation

- For the following services, please attach the appropriate documentation to the claims:
  - Any services defined as “By Report” must be submitted with an invoice to assist with adjudication and payment.
  - Supplies, drugs, and DME – Claims must include an unaltered manufacturer's invoice for HCPC codes that require a report.
  - **Claims Requiring Manufacturer's Invoice**
    - Claims that require a manufacturer’s invoice for payment consideration (e.g. “By Report” (BR) procedure) must be submitted with the following required information in order to be validated as an acceptable invoice:
      - Manufacturer’s Name, and
      - Provider Name, and
      - Item with Description, and
      - Acquisition Cost on the invoice, and
      - Invoice Date

  Some examples of unacceptable invoices are: purchase orders, sales orders, order confirmations, packing slips and delivery receipts.

Note, any claim received by Fidelis Care that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice, will be denied.

### BILLING OF MEMBERS

**NOTE:**

Participating providers may not under any circumstances bill a Fidelis Care member (except for copayments or coinsurance for applicable lines of business for any services rendered under an agreement with Fidelis Care) unless the provider has advised the member, prior to initiating service, that the service is not covered by Fidelis Care for that specific member's product line of business, and has obtained the member's written consent agreeing to personally pay for the service.

Copayments may be collected at the time of service. However, providers should not bill members for any cost-sharing amounts until after the Remittance Advice (RA) is received.
CODING AND BILLING REQUIREMENTS

Billing with the appropriate procedure and diagnosis codes expedites processing and speeds payment for services. It is important that providers code to the highest level of specificity based on the diagnoses of their patients.

CMS-1500

When completing field 21 of the CMS-1500 claim form, if more than one diagnosis is appropriate, list all the diagnoses that affect the treatment received, including any disease being managed by the provider.

UB-04

To group diagnoses into the proper DRG, CMS needs to capture a Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional.

Payments to Specialty Providers

Each specialist provider will receive a check reflecting payment for covered services provided to eligible members and correctly billed to Fidelis Care. The check may be made payable to the individual provider or to a designated medical or professional group.

Multiple Specialty Providers

It is important for providers with multiple specialties to submit the appropriate taxonomy code when submitting claim forms. This will ensure accurate payment and the appropriate application of cost-sharing when applicable.

National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Service (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate claim payment. These policies are based on coding conventions defined in the American Medical Association's (AMA) CPT Manual, National and Local Coverage Determinations (NCD and LCD), coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. These standards set the coding requirements that all plans and providers must follow in order to secure reimbursement for all lines of business. Claims that are found to be noncompliant with these guidelines may be returned and/or denied.

Please visit the sites below for additional information:

AMA - http://www.ama-assn.org/ama
Evaluation and Management (E&M) Codes

According to the CPT Manual and CMS guidelines for Evaluation and Management (E&M) codes, the level of service for E&M codes is based primarily on the extent of history obtained, the extent of examination performed, and the complexity of medical-decision making. Additional reporting issues include counseling and/or coordination of care, the nature of presenting problems(s), and the duration of face-to-face time spent with the patient and/or family. It is imperative that providers bill the appropriate level of E&M to avoid unnecessary claim edits.

Coding Requirements for HCPCS Modifier -59

Effective January 1st, 2015 CMS has established new coding requirements related to HCPCS modifier -59 which is used to define a “Distinct Procedural Service.” CMS guidelines will require billers use the following newly established HCPCS modifiers to define a specific subset of the -59 modifier:

- XE Separate Encounter - A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure - A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner - A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service - The Use of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. For additional information please visit -

Anesthesia Modifiers

In accordance with the Centers for Medicare & Medicaid Services (CMS) coding guidelines, Anesthesiology claims for patients must include the appropriate modifier(s), in the correct positions, in order to qualify for payment by Fidelis Care.

For Medicaid claims, when a CRNA is employed by an anesthesiologist, modifier QK should not be used. The anesthesia CPT code should be billed without a modifier under the NPI of the anesthesiologist or anesthesia group.

For Medicare claims, please visit the following links for a summary of anesthesia coding guidelines,
please visit:
https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html

Billing Requirements for Assistant Surgeon & Surgical Assist Claims

Participating surgeons may utilize the services of an assistant surgeon when the complexity of the surgical procedure deems it appropriate. Assistant surgeon is only permitted when the service is recognized as allowing an assist. When multiple complex surgeries are being performed, the surgeon can be the primary surgeon on some of the surgeries and the assist on others. These services can be billed on the same claim.
Section Twelve – Part 2  Billing and Guidelines

- A surgeon may not assist on his/her own surgery.

  **Assistant Surgeon performed by a physician:**
  - Modifier 80, 81 or 82 should be used.
  - The assistant surgeon should be billed on a separate CMS-1500 claim form.
  - When multiple complex surgeries are being performed, the assistant surgeon can be the assistant surgeon on some of the surgeries and the primary surgeon on others. These services can be billed on the same claim (they will be identified as different CPT codes).
  - These modifiers must be billed by a physician. They cannot be billed by physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist.

  **Surgical assist performed by a PA, NP or other qualified health professionals:**
  - Must be billed by the physician. Claims submitted by the PA, NP, or clinical nurse specialist will be denied.
  - Modifier AS should be used.
  - Only one (1) claim line should be billed with the surgical CPT code and AS modifier.
  - **Medicare Only** – The AS modifier should be billed by PA, NP or other Qualified Health professionals for Medicare Claims using their own NPI.

**Well Care and Sick Visit Billing**

- To receive the Well Care Evaluation (WCE) incentive, the provider must bill a preventive medicine code (99381-99397).
- In the event that two separately identifiable services are provided on the same day, a sick visit and a well care visit, and both services are documented in the medical record, providers should bill for both using modifier 25.
- Visits billed in this manner that meet all of the other WCE requirements, will qualify for a WCE incentive.

**Obstetric Delivery Billing Requirements**

All obstetric deliveries will require the use of a modifier or condition code to identify the gestational age of the fetus as of the date of the delivery. Failure to provide a modifier/condition code with the obstetric delivery procedure codes listed below will result in the claim being denied.

**Practitioner Claims**

Medicaid claims submitted by practitioners for obstetric delivery procedure codes 59400, 59409, 59410, 59415, 59416, 59610, 59612, 59614, 59618, 59620, or 59622 will require a modifier. All obstetrical deliveries, whether prior to, at, or after 39 weeks gestation, require the use of a modifier (U7, U8, or U9). Practitioner claims for obstetric deliveries that fail to include a U7, U8, or U9 modifier, as appropriate, on a claim will result in denial of the claim.

- **U7** – Delivery less than 39 weeks for medical necessity
- **U8** - Delivery less than 39 weeks electively
- **U9** - Delivery 39 weeks or greater
Consistent with Medicaid policy, a payment reduction will be applied on elective deliveries less than 39 weeks without medical indication.

Modifiers 52, 53, 73, 74 and Reimbursement Rate

Claims received by Fidelis Care in 2018 and forward, billed with modifier 52, 53, 73 or 74, containing a date of service in 2017 and forward, will have the following reimbursement reduction applied to the claim:

Reimbursement:

**Modifier 52 – Reduced Services:** 50% of base rate
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual CPT code and the addition of modifier 52.

**Modifier 53 – Discontinued Procedure:** 50% of base rate
Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to the extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance is reported by adding modifier 53 to the CPT code reported for the discontinued procedure.

**Modifier 73 – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia:** 50% of base rate
Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation, but prior to the administration of anesthesia. The intended procedure that is prepared for but cancelled can be reported by the usual procedure code with the addition of modifier 73.

**Modifier 74 – Discontinued Out-Patient Hospital/Ambulatory surgery Center (ASC) Procedure After Administration of Anesthesia:** 50% of base rate
Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate the surgical or diagnostic procedure after the administration of anesthesia. Under these circumstances, the procedure started but terminated can be reported with its usual procedure code and the addition of modifier 74.

**Hospital Claims**

Medicaid fee-for-service claims submitted by hospitals for obstetric deliveries; ICD 10 procedure codes 73.01, 73.1, 73.4, 74.0, 74.1, 74.2, 74.4, and 74.99 OR ICD 10 procedure codes 10900ZC, 10903ZC, 10904ZC, 10907ZC, 10908ZC, 0U7C7ZZ, 3E0P7GC, 10D00Z0, 10D00Z1 and 10D00Z2, will require a condition code. Hospital claims for obstetric deliveries must include one of the following Conditioning codes. Failure to include one of the two modifiers below on a claim will result in denial of the claim.

- 81 – C-sections or inductions performed at less than 39 weeks gestation for medical necessity. If reported with an acceptable diagnosis, the claim will be paid in full. For this condition code, diagnosis code 650 or O80 (normal delivery) will be considered an acceptable diagnosis code, when reported as the primary diagnosis code and the claim will be paid in full.

- 82 – C-sections or inductions performed at less than thirty-nine 39 weeks gestation electively. If reported without an acceptable primary diagnosis code, the claim payment will be reduced.

- 83 – C-sections or inductions performed at 39 weeks gestation or greater. If reported, this claim will be paid in full.
Immunization Administration Processing Guidelines

VFC (Vaccine for Children) Program:
- Applicable for Medicaid Line of Business
- Applicable for Child Health Plus Line of Business
- Immunizations that are covered by the VFC will not have a reimbursement rate
  https://www.fideliscare.org/Portals/0/Providers/ProviderManuals/Appendices/2019-FidelisCare-ProviderManual-Appendix3-Vaccines-English.pdf

Vaccine Administration Codes/Fees:
Fidelis Care will reimburse the administrative fee for an immunization separately from the immunization code per Medicaid Billing Guidelines. Fidelis Care will pay one (1) administration fee per immunization.

Drug Code Billing Requirements

In order to comply with Section 6002 of the 2005 Federal Deficit Reduction Act (DRA), providers submitting drug codes administered in an office based or ambulatory setting must include the 11-digit National Drug Code (NDC) number, the NDC dispensing quantity and the NDC unit of measure. NDC information can be obtained from the drug invoice and/or package information. Claims that are missing this required information will be rejected.

Coverage of Medical Language Interpreter Services

Medicaid fee-for-service will reimburse Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with Limited English Proficiency (LEP) and communication services for people who are deaf and hard of hearing.

The medical language interpreter services will also be reimbursed by Medicaid Managed Care in accordance with rates established in provider agreements or, for out-of-network providers, at negotiated rates.

Patients with limited English proficiency shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff.

The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI).

Reimbursement of medical language interpreter services is payable with HCPCS procedure code

<table>
<thead>
<tr>
<th>HCPCS Procedure Code</th>
<th>Units</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1013</td>
<td>1</td>
<td>Includes a minimum of eight and up to 22 minutes of medical language interpreter services</td>
</tr>
<tr>
<td>T1013</td>
<td>2</td>
<td>Includes 23 or more minutes of medical language interpreter services</td>
</tr>
</tbody>
</table>

Locum Tenens
If a locum tenens physician is needed for the traditional “holding one's place” type of scenario (i.e. coverage for vacations, illness/medical leave, continuing education, etc.), providers may bill for locum tenens professional fees using the absent physician’s billing information as long as the following conditions are met:

- The regular physician is unavailable to provide the visit services
- The patient has arranged or seeks to receive services from the regular physician
- The locum tenens provider is paid for services on a per diem or similar fee-for-time basis
- The substitute physician does not provide services to members for a continuous period of 60 days or more.

If these conditions are met, providers may bill for Locum Tenens professional services using the absent provider’s NPI number in box 24 of the CMS-1500. Providers must also use modifier –Q6 (Services furnished by a Locum Tenens physician) in box 24d for each line item on the claim provided by a Locum Tenens.

Billing for Gastroenterology Procedures – Effective March 1, 2016

In order to obtain reimbursement for gastroenterology procedure, hospital providers must acquire prior authorization when an office-based or ambulatory surgery center is available to provide the services listed below. No prior authorization will be required if the procedures are performed at an ambulatory surgery center or an office-based surgery center. These requirements are applicable to all products offered by Fidelis Care.

List of Prior Authorization Procedure Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>Upper GI endoscopy biopsy</td>
</tr>
<tr>
<td>45380</td>
<td>Colonoscopy and biopsy</td>
</tr>
<tr>
<td>45378</td>
<td>Diagnostic colonoscopy</td>
</tr>
<tr>
<td>45385</td>
<td>Lesion removal colonoscopy</td>
</tr>
<tr>
<td>45384</td>
<td>Lesion removal colonoscopy</td>
</tr>
</tbody>
</table>

Beginning June 1, 2018, in addition to the codes listed above, Fidelis Care will additionally require prior authorization for the gastroenterology procedures listed below:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235</td>
<td>Upper GI endoscopy diagnosis</td>
</tr>
<tr>
<td>46260</td>
<td>Remove in/ex hem groups 2+</td>
</tr>
<tr>
<td>43248</td>
<td>Upper GI endoscopy/guide wire</td>
</tr>
<tr>
<td>46270</td>
<td>Remove anal fistula subq</td>
</tr>
<tr>
<td>46255</td>
<td>Remove int/ext hem 1 group</td>
</tr>
</tbody>
</table>
AFFIDAVIT OF LOST / STOLEN / DESTROYED CHECK

________________________________ deposes and says:

(Name of Payee’s Representative)

1. That the payee, _____________________, has not received Check No. __________, in the amount of $___________, and that the check has been lost/destroyed/stolen on or about ___ / ___ / ___.

2. That the payee requests that Fidelis Care notify the bank to place a stop payment on Check No. __________, and that Fidelis Care issue a duplicate check in lieu of such stopped check.

3. That neither the payee nor any person acting under orders, authority, or control of the payee has attempted or will attempt to negotiate Check No. _________________.

4. That if Check No. __________ is negotiated, the payee hereby agrees to complete and sign an affidavit of forgery for such check.

Signed by _________________________, as ____________________________, of the payee.

(name)                 (title)

Payee Signature

The foregoing affidavit was acknowledged before me, the undersigned Notary Public, by

____________________ this _________ day of __________________, 20__.

(name of payee)

Notary Public

Send this ‘Affidavit of Lost/Stolen/Destroyed Check’ to:

Attn: Provider Reimbursement
Fidelis Care
95-25 Queens Blvd
Rego Park, NY 11374
PROVIDER APPEALS

This section deals with appeals from two kinds of denials: (i) denials for lack of medical necessity, discussed in Part I, and (ii) administrative denials discussed in Part II. If providers disagree with a denial made by Fidelis Care due to lack of medical necessity or an administrative denial, providers shall follow the process set forth in this Section 13.

Part I. Denial of Services For Lack of Medical Necessity

Fidelis Care will not reimburse treatment that is not medically necessary. Decisions denying claims for medical necessity, i.e. clinical denials, are made only by Fidelis Care’s Chief Medical Officer or a Medical Director. Providers, members, or the member’s designee shall appeal Fidelis Care’s decisions regarding the medical necessity of treatment as described below if they disagree with a denial based on lack of medical necessity.

Appealing a Determination Based on Medical Necessity

Standard Appeals

If Fidelis Care denies a request for services based on lack of medical necessity, the provider, member, or member’s designee shall appeal the denial if they disagree with the denial.

The appeal shall be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the provider and member, and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if they disagree with the denial.

An appeal is initiated by contacting Fidelis Care’s Chief Medical Officer or designee either in writing or by telephone. Verbal appeals shall be followed up by written appeal. Fidelis Care strongly urges that all appeals be made in writing and include the following documentation: the member's medical records for the treatment at issue, an appeal or a summary of that treatment prepared by the provider's utilization management department, and a copy of the original denial letter from Fidelis Care. All appeals for medical necessity shall be sent to:

Fidelis Care Appeals Department
490 CrossPoint Parkway
Getzville, NY 14068
Phone: 718-896-6500 ext. 13159
Fax: 718-393-6779

If the original denial letter is not available, the appeal should indicate the dates of service at issue, the member’s name, and Fidelis Care member ID number. Although this documentation may be forwarded following the filing of the appeal, Fidelis Care may deny the appeal if such written documentation is not provided and Fidelis Care, in its own discretion, is unable to assess the basis for the appeal.

Fidelis Care will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal and will respond to the appeal.

Fidelis Care must make a standard appeal determination within:

a. Thirty (30) calendar days after receipt of the appeal.
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b. For Medicaid, as fast as the member’s condition requires, and no later than thirty (30) calendar days from receipt of the appeal. This time may be extended for up to fourteen (14) calendar days upon member or provider request, or if Fidelis Care concludes that more information is needed and an extension of time is in the best interest of the member and notifies the member accordingly.

Members or a designee may view their case file. The member may also present evidence to support their appeal in person or in writing.

If Fidelis Care requires additional information to conduct a standard internal appeal, then Fidelis Care shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.

Fidelis Care’s written determination regarding the appeal will be mailed to the member, the member’s designee, and the provider within two (2) business days of the determination of the appeal. Fidelis Care will indicate the reasons for its decision and, if the appeal is denied, the clinical rationale for upholding the clinical denial. The written notice of determination includes a notice of the member’s right to an external appeal and a description of the external appeal process, if applicable (see section below on External Appeals), as well as the member’s right to request a fair hearing, if applicable.

Each notice of the final adverse determination will be in writing, dated and will include:

- The basis and clinical rationale for the determination.
- The words “final adverse determination”
- Fidelis Care contact person and phone number
- Member coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/provider and developer/manufacturer of service as available.
- Statement that enrollee may be eligible for external appeal and timeframes for appeal. If health plan offers two levels of appeal, the member cannot be required to exhaust both levels.
- Clear statement in bold that member has 4 months from the final adverse determination to request an external appeal and that choosing 2nd level of internal appeal may cause time to file external appeal to expire. Providers acting on their own behalf have sixty (60) calendar days to request an external appeal.
- Standard description of external appeals process attached

For Medicaid, the notice will also include:

- Summary of appeal and date filed
- Date appeal process was completed
- Description of member’s fair hearing rights if not included with initial denial
- Right of enrollee to complain to the Department of Health at any time via 1-800 number
- Statement that notice is available in other languages and formats for special needs, as well as an explanation regarding how to access these formats.

Expedited and standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

The physician reviewing the appeal will be different from the physician or Medical Director who first reviewed and determined that the treatment was not medically necessary. If the appeal determination is adverse (denial upheld) it is considered a final adverse determination (FAD).
If Fidelis Care fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

Fidelis Care and the member may jointly agree to waive the internal appeal process. If this occurs, Fidelis Care will provide a written letter to the member within twenty-four (24) hours of the waiver agreement, setting forth the information necessary for the member to file an external appeal.

If Fidelis Care and the member agree to waive the internal appeal process, no additional internal appeals are available. However, providers may seek to file an external appeal pursuant to the process described below.

**Expedited Appeals**

A provider, member, or member’s designee may seek an expedited appeal in the event of the following:

- If Fidelis Care determines that continued or extended health care services, procedures or treatments, or additional services for a member undergoing a continued course of treatment prescribed by a health care provider are not medically necessary.
- If the provider believes an immediate appeal is necessary, provided that the initial determination regarding a lack of medical necessity was not retrospective (for example, appeals of elective admissions or surgeries).
- For **Medicaid** provided i) Fidelis Care honors the member's request for an expedited review; or ii) if Fidelis Care denies the member's request for an expedited review, Fidelis Care must provide the member with notice by phone immediately, followed by written notice within two (2) calendar days of denying the request.
- Fidelis Care will render a decision for **Medicaid** as fast as the member's condition requires and within two (2) business days of receipt of necessary information, but no more than three (3) business days of receipt of the member's appeal. This time may be extended for up to fourteen (14) calendar days either i) upon the member's or provider's request; or ii) if Fidelis Care demonstrates more information is needed, an extension of time is in the best interest of the member, and notifies the member accordingly. If the provider is not satisfied with Fidelis Care's response to the expedited appeal, the provider or member may further appeal the decision through the standard appeal process described above or the external appeal process as described below.

If Fidelis Care requires information necessary to conduct an expedited appeal, Fidelis Care shall immediately notify the member and provider by telephone or facsimile to identify and request the necessary information, followed by written notification.

Written notice of Fidelis Care's final adverse determination concerning an expedited UR appeal shall be transmitted to the enrollee within twenty-four (24) hours of Fidelis Care rendering the determination. For **Medicaid**, Fidelis Care will make reasonable efforts to provide verbal notice to the member and provider at the time the determination is made.

**Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.**

In connection with an expedited appeal, Fidelis Care will make a clinical peer reviewer available within one (1) business day.

In addition, Fidelis Care will render a decision within two (2) business days of receiving all information necessary to process the expedited appeal. If the provider is not satisfied with Fidelis Care's response to
the expedited appeal, the provider may further appeal the decision through the standard appeal process described above.

Written notice of Fidelis Care’s final adverse determination concerning an expedited appeal shall be transmitted to the member within twenty-four (24) hours of rendering the determination. The notice will include the description of the member’s right to further appeal through the standard appeal process. Reasonable efforts will be made to provide verbal notice to the member and the provider at the time the determination is made.

External Appeals

Pursuant to Article 49 of the New York State Public Health Law, an external appeal process is available through the State Department of Financial Services. The time period to file an external appeal is within four (4) months from the receipt of the Final Adverse Determination (FAD) of the first level appeal. Providers acting on their own behalf shall file external appeals within sixty (60) calendar days. The external appeal decision will be rendered in thirty (30) calendar days and within seventy-two (72) hours for an expedited external appeal. External appeal decisions are final, and shall not be subject to arbitration or further review by a court of law. The application to request an external appeal will accompany the FAD.

In order to qualify for an external appeal, the following circumstances must be met:

- The service or treatment was denied as medically unnecessary, experimental/ investigational; or out-of-network service or referral;
- The appeal is for a service or procedure that was otherwise covered under the member’s contract with Fidelis Care;
- The member has exhausted the internal utilization review process, unless a waiver is signed by the member;
- The appeal must be requested by the member or the member's designee within four (4) months of receiving the final determination of the first level internal appeal or within sixty (60) calendar days if a provider is acting on his / her own behalf.
- To appeal an experimental/investigational, clinical trial, or out-of-network service or out-of-network referral denial, the physician must be a licensed, board-certified or board-eligible physician i) qualified to practice in the area of practice appropriate to treat the patient; and ii) who recommended the patient's treatment. For an appeal involving a rare disease, a physician must meet the above requirements, but need not be the patient's treating physician.
- To appeal to an experimental/investigational denial, the member’s attending physician must attest that (i) standard health services or procedures have been ineffective or would be medically inappropriate; or (ii) there does not exist a more beneficial standard health service or procedure covered by the health care plan and the member's physician must have recommended either a health service or procedure (including a pharmaceutical product within the meaning of PHL Section 4900(5)(b)(B)), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure.
- To appeal a clinical trial denial for which the member is eligible, the member's physician must attest that i) there exists a clinical trial that is open; ii) the patient is eligible to participate; and iii) the patient has or will likely be accepted. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board; and (2) approved by i) one of the National Institutes of Health (NIH), or an NIH cooperative group or center; or ii) the Food and Drug Administration in the form of an investigational new drug exemption; or iii) the federal Department of Veteran Affairs; or iv) a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support.
Grants; or v) an institutional review board of a facility which has multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

- To appeal an out-of-network referral denial, the physician must attest that i) the out-of-network health service is materially different from the alternate in-network service recommended by the health plan; and ii) based on two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health services and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health services. The out-of-network provider’s name, address and training and experience must be included.

- To appeal an out-of-network denial to a Non-Participating provider, the physician must certify that the Participating Provider recommended by Fidelis Care does not have the appropriate training and experience to meet the member’s health care needs, and recommend a Non-Participating Provider with the appropriate training and experience to meet the member’s particular health care needs who is able to provide the requested health care service.

- To appeal a rare disease treatment denial, a physician other than the member’s treating physician must attest that i) the patient has a rare disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service; and ii) the requested service is likely to benefit the patient in the treatment of the patient’s rare disease, and such benefit outweighs the risk of service. The physician must also attest he / she does not have a material financial or professional relationship with the provider of the service AND (a) the patient’s rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network OR (b) the patient’s rare disease affects fewer than 200,000 U.S. residents per year. If the provision of the service requires approval of an Institutional Review Board, include or attach the approval.

A member may request an External Appeal in the following ways:

1. Calling the Department of Financial Services at 1-800-400-8882
3. Contacting Fidelis Care at 1-888-FIDELIS. Member Services will mail or fax the application to the member.

For helpful hints for completing the External Appeal Application:

- Go to the Department of Financial Services’ website at [https://www.dfs.ny.gov](https://www.dfs.ny.gov) and download External Appeals: [Helpful Hints for Completing the External Appeal Application](https://www.dfs.ny.gov/search/site?search=external+appeal+application+)

Medical Necessity Denials from subcontracted Utilization Review (UR) agents (any agent conducting UR services on behalf of Fidelis Care members) are subject to the same appeal rights described above.

**Provider External Appeal Rights**

A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Fidelis Care.

Fidelis Care is responsible for the full cost of an appeal for a concurrent adverse determination that is overturned.
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Provider Appeals

Fidelis Care and the provider must evenly divide the cost of a concurrent adverse determination that is overturned in-part.

The fee requirements do not apply to providers who are acting as the member's designee. In such a case, the cost of the external appeal is the responsibility of Fidelis Care. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member, the external appeal application and the designation shall be completed.

External appeal decisions are final, and shall not be subject to arbitration or review by a court of law.

Alternative Dispute Resolution

A facility licensed under Article 28 of the Public Health Law and Fidelis Care may agree to Alternative Dispute Resolution (ADR) in lieu of an external appeal under PHL Section 4906(2) after the internal utilization review process has been exhausted. Any such agreement to ADR in lieu of an external appeal shall be memorialized in a fully executed written agreement between the provider and Fidelis Care. Providers who have contracted to ADR in lieu of an external appeal must request review by ADR within sixty (60) calendar of receiving the final determination of the first level internal appeal. This provision does not impact a member's external appeal rights or right of the member to appoint the provider as their designee. The cost of the ADR in lieu of an external appeal is a matter between Fidelis Care and the provider.

If the member files an external appeal, the external appeal determination takes precedence over the ADR.

Fair Hearings

In some cases, certain members may ask for a Fair Hearing from New York State. A member with Fair Hearing rights may request a Fair Hearing with regard to: i) enrollment/disenrollment decisions made by the Local Department of Social Services; or ii) the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member with Fair Hearing rights may also request a Fair Hearing if he/she believes that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the Fair Hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the Fair Hearing officer and/or Administrative Law Judge will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

A provider does not have standing to request a Fair Hearing on his/her own behalf. Providers may, however, assist members in asking for a Fair Hearing from New York State.
For additional information on appeals for the Medicare Part D benefit refer to Section 22A of this manual.

Part II. Administrative Denials

An administrative denial is defined as a denied request for authorization of services that is not based on medical necessity, as well as a claim payment denial. Examples include denials based on a lack of member coverage, timely submission of a claim, member eligibility, or the absence of a required authorization.

This section describes how a provider and/or member shall appeal an administrative denial.

Authorization Appeals

If Fidelis Care denies a request for authorization of services and the basis for the denial is not lack of medical necessity, the provider, member, or member’s designee shall appeal the denial if they disagree with the denial. Examples include a non-covered benefit, a benefit that has been exhausted, and an eligibility issue.

The appeal must be made within sixty (60) business days of the provider receiving the denial. The denial letters are sent to the provider and member, and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if he/she disagrees with the denial.

An appeal is initiated by contacting Fidelis Care’s Appeal Department either in writing or by telephone. Verbal appeals shall be followed up by a written appeal. Written appeals shall be mailed to the address below and shall include the justification for the appeal and a copy of the original denial letter from Fidelis Care. If the original denial letter is not available, the appeal should indicate the dates of service(s), the member’s name, and Fidelis Care member ID number. Although this documentation may be forwarded following filing of the appeal, Fidelis Care may deny the appeal if such written documentation is not provided and Fidelis Care, in its own discretion, is unable to assess the basis for the appeal.

Fidelis Care Appeals Department
490 CrossPoint Parkway
Getzville, NY 14068
Phone: 718-896-6500 ext. 13159
Fax: 718-393-6779

Fidelis Care will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal.

Fidelis Care must make a standard appeal determination within:

a. Thirty (30) calendar days after receipt of the appeal.

b. For Medicaid, as fast as the member’s condition requires, and no later than thirty (30) calendar days from receipt of the appeal. This time may be extended for up to fourteen (14) calendar days i) upon the member’s or provider’s request; or ii) if Fidelis Care demonstrates more information is needed and the extension of time is in the best interest of the member and Fidelis Care notifies the member accordingly.

If Fidelis Care requires additional information to conduct a standard internal appeal, then Fidelis Care shall notify the provider, in writing, within five (5) business days of receipt of the appeal, requesting the additional information needed.
Fidelis Care’s written determination regarding the appeal will be mailed to the member, the member’s
designee and the provider within two (2) business days of the determination of the appeal. Fidelis Care
will indicate the reasons for its decision and, if the appeal is denied, the rationale for upholding the denial.
The written notice of determination includes notice of the member’s right to request a Fair Hearing, if applicable.

Each notice of the appeal determination will be in writing, dated and include:

a. The rationale for the determination.
b. Fidelis Care contact person and phone number
c. Member coverage type
d. Name and address of UR agent, contact person and phone number
e. Health service that was denied, including facility/provider and developer/manufacturer of service
   as available

   For Medicaid, notice will also include:

f. Summary of appeal and date filed
g. Date appeal process was completed
h. Description of member’s fair hearing rights if not included with initial denial
i. Right of enrollee to complain to the State Department of Health at any time with 1-800 number
j. Statement that notice available in other languages and formats for special needs and how to
   access these formats

If Fidelis Care fails to make a determination within the applicable time periods, it shall be deemed to be a
reversal of the original adverse determination.

There is only one level of standard appeals on any internal decision.

Following Fidelis Care’s notice of appeal determination, members or a designee may view their case file.
The member may also present evidence to support their appeal in person or in writing

Expedited Appeals

A provider, member, or member’s designee may seek an expedited appeal in the event of the following:

- If the provider believes an immediate appeal is necessary
- For Medicaid, i) when Fidelis Care honors the member’s request for an expedited review; or ii) if
  Fidelis Care denies the member’s request for an expedited review, Fidelis Care must provide the
  member with notice by phone immediately, followed by written notice two (2) calendar days
  thereafter.
- Fidelis Care will render a decision for Medicaid as fast as the member’s condition requires and
  within two (2) business days of receipt of necessary information, but no more than three (3)
  business days of receipt of the member’s appeal. Fidelis Care may extend this time for up to
  fourteen (14) calendar days i) upon the member’s or provider’s request; or ii) if Fidelis Care
  demonstrates that more information is needed and an extension of time is in the best interest of
  the member and notices the member accordingly. If the provider is not satisfied with Fidelis
  Care’s response to the expedited appeal, the provider or member may further appeal the decision
  through the standard appeal process.
Fidelis Care’s written notice of the appeal determination concerning an expedited appeal shall be transmitted to the enrollee within twenty-four (24) hours of rendering the determination. For Medicaid, Fidelis Care will make a reasonable effort to provide verbal notice to the member and provider at the time the determination is made.

Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process.

Fidelis Care will render a decision within two (2) business days of receiving all information necessary to process the appeal. If the provider is not satisfied with Fidelis Care’s response to the expedited appeal, the provider may further appeal the decision through the standard appeal process described above.

Fidelis Care’s written notice of the appeal determination concerning an expedited appeal shall be transmitted to the member within twenty-four (24) hours of rendering the determination. The notice will include the description of the right to further appeal through the standard appeal process. Reasonable efforts will be made to provide verbal notice to the member and the provider at the time Fidelis Care’s determination is made.

A provider, member, or member’s designee may seek an External Appeal in the event an out-of-network denial. Please see section 13.4 for the External Appeal process.

Claim Appeals

Denial of payment

If a provider disagrees with a claim denial, the provider must attach documentation supporting payment along with a Claim Appeal Form (Section 13A) within sixty (60) days of the remittance advice for the claim. If a provider does not submit a Claims Appeal Form within sixty (60) days of the remittance advice, Fidelis Care’s claim determination is final, and shall not be subject to arbitration or review by a court of law.

Underpayments

If a provider disagrees with the claim payment amount, the provider shall attach documentation supporting additional payment along with a Claims Appeal Form (Section 13A) and submit the request to Fidelis Care within sixty (60) days of the remittance advice for the claim. If a provider does not submit a Claims Appeal Form within sixty (60) days of the remittance advice, Fidelis Care’s claim determination and payment amount is final, and shall not be subject to arbitration or review by a court of law.

Overpayments

If a claim is overpaid, providers shall request an adjustment by submitting to Fidelis Care a Claims Appeal Form (Section 13A) and a copy of the remittance advice that indicates the overpayment. If Fidelis Care agrees with the request for adjustment due to an overpayment, the overpayment will be withdrawn from a future payment. The provider should not return the check containing the overpayment.

If Fidelis Care identifies that an overpayment has been made to a provider, prior to engaging in overpayment recovery efforts Fidelis Care shall furnish the provider with thirty (30) calendar days advance written notice when required by New York State Insurance Law Section 3224-B. Such notice will state the member name, service date, payment amount, proposed adjustment, and a reasonable explanation supporting the proposed adjustment.

Please send claims appeals to:
Fidelis Care
Attn: Claims Reconsideration
480 CrossPoint Pkwy
Getzville, NY 14068

Claim Denials for Invoice

In some cases Fidelis Care may need to deny a claim because a copy of the manufacturer’s invoice is required for claims processing. Providers may send a copy of the invoice via fax or mail to the contact information below. Please be sure to include the member’s name and member ID, as well as the claim number associated with the invoice request:

By Mail - Fidelis Care  
Attn: Claims Reconsideration  
480 CrossPoint Parkway  
Getzville, NY 14068

By Fax - 1-877-247-9187 | Attn: Claims Reconsideration (this fax is for invoice purposes only)

For Corrected Claims, please see Section 12 Part 1.

Where Fidelis Care does not receive a request for reconsideration within sixty (60) calendar days of the date the claim was paid or denied, the claim determination shall be deemed final and without further recourse, and shall not be subject to arbitration or review by a court of law.
Section Thirteen A  Provider Reconsideration / Appeal Form

Use this form as part of the Fidelis Care Reconsideration/Appeal process to address a previous claims adjudication decision. NOTE: All claim requests for reconsideration, corrected claims or claims disputes must be received within 60 calendar days, or your contract terms, from the date of the remittance. This form should be utilized if a claim has been processed and a remittance advice has been issued from Fidelis Care. Do not use for first time claims. All fields below are required information. Failure to complete this form in its entirety may result in a delay or denial of your reconsideration/appeal request.

MEMBER NAME: ____________________  MEMBER ID: ____________________
CLAIM NUMBER: ____________________  DOS: ____________________
PROVIDER NAME: ____________________
NATIONAL PROVIDER IDENTIFIER or TAX IDENTIFICATION NUMBER: ____________________
NAME OF REQUESTOR: ____________________  DATE OF REQUEST: ____________________

Please check the appropriate box to indicate if your request is a Reconsideration or an Appeal:

☐ RECONSIDERATION: The action you take if the claim(s) was/were originally submitted with incorrect/insufficient information.

A Reconsideration is a request for Fidelis Care to review a claim with additional information submitted by the provider that was not previously submitted. If you are submitting a corrected claim, please do not use this form. Please follow the “Corrected Claim” process in the provider manual. Supporting documentation for review includes, but is not limited to:

- Copy of invoice for pricing review
- Additional documentation which would clarify services
- Primary Explanation of Benefits (EOB) from another payer

REQUIRED: Brief description of your reason for the Reconsideration Request:
_________________________________________________________________________________________________
_________________________________________________________________________________________________

☐ APPEAL: The action you take if you disagree with the coverage and/or payment decision made.

An appeal is a formal written request to Fidelis Care for reconsideration of a medical, payment, or contractual adverse decision. Types of claim denials that would be an appeal include but are not limited to:

- Services/Precertification
- Experimental/Investigational
- Not Medically Necessary

REQUIRED: Brief description of your reason for the Appeal Request:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Please include relevant information and any supporting medical or clinical documentation with this form and mail to:

<table>
<thead>
<tr>
<th>Product</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Managed Care</td>
<td>Fidelis Medicaid</td>
</tr>
<tr>
<td>Child Health Plus</td>
<td>P.O. Box 10500</td>
</tr>
<tr>
<td>Fidelis Care at Home (MLTC)</td>
<td>Farmington, MO 63640-5001</td>
</tr>
<tr>
<td>HealthierLife (HARP)</td>
<td></td>
</tr>
<tr>
<td>Qualified Health Plans</td>
<td>Fidelis MarketPlace</td>
</tr>
<tr>
<td>Essential Plan</td>
<td>P.O. Box 10600</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>Farmington, MO 63640-5002</td>
</tr>
<tr>
<td>Dual Advantage</td>
<td></td>
</tr>
<tr>
<td>Medicaid Advantage Plus</td>
<td>Fidelis Medicaid</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 10700</td>
</tr>
<tr>
<td>Fidelis Care</td>
<td>Farmington, MO 63640-5003</td>
</tr>
</tbody>
</table>

Fidelis Care will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (you will be notified by a letter) or overturn our original decision and any additional payment due will appear on your remittance advice.
Request for Claim Reconsideration of Claim Denial for Invoice

Fax Number 1-877-247-9187

Member Name: __________________________ Member ID: ____________________
Provider Name: ________________________________________________________
National Provider Identifier or Tax Identification Number: ______________________
Name of Requestor: ______________________ Date of Request: __________________

Please limit each form to 1 member with same provider and 3 claims per form.

Claim# ____________________________ Date of Service ______________
Claim# ____________________________ Date of Service ______________
Claim# ____________________________ Date of Service ______________

Comments:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Note: Requests for claim reconsiderations must be submitted within 60 days of the date of the remittance advice (RA) for the claim at issue. For all requests, attach a copy of the original claim and remittance advice. Failure to provide sufficient documentation may result in denial of your request. Requests for claims reconsiderations not submitted within 60 days of Fidelis Care’s adjudication will not be reconsidered and the decision shall be final, unable to be appealed, and not subject to arbitration or review by a court of law.

Please make copies as necessary and submit your fax request for a claim reconsideration of the manufacturer’s invoice(s) to Fidelis Care at the following fax number:

1-877-247-9187
MEMBER GRIEVANCES AND COMPLAINTS

All Fidelis Care members have a right to file a complaint at any time if they are dissatisfied with Fidelis Care, a Fidelis Care provider, or with the care or services they have received. If a complaint involves a physician or provider, a Provider Relations Representative will contact the provider to discuss the complaint. The findings will be reported back to the Appeals and Grievances Team for consideration as to action or disposition.

Members are advised to call Member Services to file a complaint. Fidelis Care will attempt to resolve complaints immediately by taking prompt corrective action and educating members regarding Fidelis Care policies and procedures. The substance of the complaint and the agreed upon disposition will be documented.

Complaints are submitted in writing or recorded by Fidelis Care staff on behalf of members. All complaints are logged and acknowledged by Fidelis Care in writing. Complaints relative to the delivery of health care services will be referred to Fidelis Care's QHCM Department for investigation.

A member or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written Complaint Appeal. Complaint Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination - at least one of whom must be a clinical peer reviewer.

Upon the member’s request, Fidelis Care will expedite the complaint process if a delay would risk the member’s health.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file and in the provider's Total Quality Profile on an annual basis.

NOTE: Members may always file a complaint with the State Department of Health and/or the City or respective County.

COMPLAINTS

If a member has a problem or dispute with care or services, the member may file a complaint with Fidelis Care. Any concerns that require a thorough review from the Plan or that are received in writing, will be responded to in the applicable timeframe based on the type of plan the member is enrolled in. Fidelis Care is always available to assist a member in filing a complaint, complaint appeal, or action appeal. A Member Services Associate can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, Fidelis Care can help with this.

A Medicaid member also has the right to contact the New York State about their complaint at 1-800-206-8125 or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237.

A Managed Long Term Care member also has the right to contact New York State about their complaint at 1-866-712-7197 or write to New York New York State Department of Health, Bureau of Managed Long Term Care, One Commerce Plaza, 16th Floor, Albany, NY 12210.
The member may also contact their local Department of Social Services with a complaint at any time. A member may call the New York State Department of Financial Services at (1-800-342-3736) if their complaint involves a billing problem.

**Filing a Complaint with the Plan:**

To file by phone, the member should call Member Services at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30AM to 6:00 PM. If the member contacts Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, the member will be notified. The member can write Fidelis Care with his or her complaint or call the Member Services number and request a complaint form. It should be mailed to Attn: Member Services Department, Fidelis Care95-25 Queens Boulevard, Rego Park, NY 11374.

If Fidelis Care does not solve the problem right away over the phone or if Fidelis Care receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Fidelis Care will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint, but the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Fidelis Care will send the member a letter with the reasons for the decision. When a delay would risk a member’s health, Fidelis Care will make a decision within forty-eight (48) hours of when Fidelis Care has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Fidelis Care will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Fidelis Care is unable to make a decision about a complaint because we don’t have enough information, a letter will be sent to the member.

**A Same Day Grievance** means a grievance that is resolved by Fidelis to the satisfaction of Enrollee the same day the grievance is lodged. A Same Day Grievance does not require written acknowledgement from Fidelis, however the information about the Same Day Grievance will be documented in Fidelis’ records. If the grievance cannot be decided immediately (same day), Fidelis will decide if grievance is expedited or standard.

**Complaint Appeals:**

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Fidelis Care. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member will sign and return the form to Fidelis Care. The member may make any needed changes before sending the form back to us.

Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about the complaint.

If Fidelis Care has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member's health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the
member or their designee can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

**FAIR HEARINGS AND ACTION APPEALS**

In some cases, a member may ask for a Fair Hearing from New York State. A member may request a Fair Hearing with regard to: enrollment/disenrollment decisions made by the Local Department of Social Services; the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member may also request a Fair Hearing if they believe that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

**A member may request a Fair Hearing in the following ways:**

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the Fair Hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the Fair Hearing officer will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

A provider does not have standing to request a Fair Hearing on their own behalf. Providers may, however, assist members in asking for a fair hearing from New York State.

For additional information on appeals for the Medicare Part D benefit refer to Section 22A of this manual.

**ACTION APPEALS**

If a member disagrees with Fidelis Care's decision with a Service Authorization Request, a payment denial, or timeliness of an action taken by Fidelis Care, the member or their designee can file an action appeal. The member has sixty (60) business days after hearing from Fidelis Care to file an appeal. The action appeal must be in writing. If the appeal is by telephone, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member must sign and return the form to Fidelis Care. The member may make any changes to the form before sending it back to us. After receipt of the action appeal, an acknowledgement letter will be sent within fifteen (15) calendar days.

If Fidelis Care has all the information needed, the member will know our decision within thirty (30) calendar days. If a delay would significantly increase the risk to the member's health, the member or their designee can request an expedited review of the action appeal, which will be decided within two (2) business days. The timeframe for deciding an action appeal can be extended for up to fourteen (14) calendar days if the member or his/her designee requests one or if Fidelis Care determines that the extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.

The member will be given the reasons for Fidelis Care's decision and clinical rationale. Fidelis Care will attempt to reach the member with the action appeal decision by phone. If the member is still not satisfied
with Fidelis Care's decision, the member or someone on his or her behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125. Filing an action appeal is the member’s right, and the Fidelis Care will not retaliate or take any discriminatory action against the member because they filed an action appeal.

An action appeal should be made in writing within sixty (60) business days of receipt of the letter to:

Attn: Quality Health Care Management
Fidelis Care
95-25 Queens Boulevard
Rego Park, N.Y. 11374
Phone#: 1-888-FIDELIS – (1-888-343-3547)
Fax#: 1-800-374-9808

EXTERNAL APPEALS

1. Refer to Section 13 for information on External Appeals.
FAMILY PLANNING and INFERTILITY SERVICES

Fidelis Care covers family planning services and certain other reproductive health care services. Starting January 1, 2019, Fidelis Care members will obtain family planning and reproductive health benefits directly from Fidelis Care. Members do not need a referral from their PCP and should present their Fidelis Care Member ID card. Previously, these services were provided to members by Medicaid Fee for Service or other third party vendors. There are no changes to our members’ covered family planning and reproductive health benefits. However, the changes in how member obtain these benefits from Fidelis Care are listed below by product.

<table>
<thead>
<tr>
<th>Product</th>
<th>Entity providing coverage through 12/31/2018:</th>
<th>Entity providing coverage as of 1/1/2019:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Managed Care (including HealthierLife - Health and Recovery Program)</td>
<td>NYS Medicaid FFS</td>
<td>Fidelis Care</td>
</tr>
<tr>
<td>Child Health Plus</td>
<td>Affinity, GHI/Emblem Healthfirst</td>
<td>Fidelis Care</td>
</tr>
</tbody>
</table>

Members can obtain the following family planning services through Fidelis Care: birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. Members can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to their test results. Screenings for cancer and other related conditions are also included in family planning visits.

Fidelis Care has notified its primary care providers, obstetricians, and gynecologists, and certain other specialties, that Fidelis Care covers reproductive and family planning services as a standard benefit. **Providers should begin billing Fidelis Care directly for any such services provided on or after January 1, 2019.** Members who choose to see a provider who is not in the Fidelis Care network may still be able to get these services from a provider that accepts Medicaid. If a member does not use one of our network providers for these services, they should use their New York State Medicaid card. As a reference, members can call the New York State Growing Up Healthy Hotline at (1-800-522-5006).

Ovulation Induction and Infertility

Infertility is defined as a condition characterized by the inability to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse for individuals 21-34 years of age, or after six months for individuals 35-44 years of age.

**Effective October 1, 2019,** ovulation enhancing drugs and related medical services are covered when billed with the appropriate infertility diagnosis codes: E22.1, E28 through E28.x, E23.0, L68.0, N97.0 or Z31.41 and when performed solely for the intent to establish pregnancy. Related lab services are covered. Related ultrasound codes 76856, 76857, and 76830 are covered and require prior authorization through eviCore Healthcare. 76856, 76857, and 76830 have a combined lifetime limit of 10. 74740 and 76831 (billed with 58340) are covered and could be rendered separately. 74740 and 76831 have a combined lifetime limit of 1. 76831 requires prior authorization through eviCore Healthcare.
The following services are considered medically necessary when performed solely for the treatment of infertility, with the intent to establish pregnancy, in an individual in who fertility would naturally be expected when meeting clinical criteria.

**Females:**
1. FDA approved medications: clomiphene, bromocriptine, letrozole and tamoxifen covered as a group and not individually for a benefit limit of 3 cycles of treatment per lifetime.
2. Office visits
3. Hysterosalpingograms
   - to monitor the ovulation induction
   - to diagnose Polycystic ovary syndrome
5. Blood testing
   - to diagnose the cause of anovulation
   - to monitor the ovulation induction.
ENROLLMENT AND ELIGIBILITY

ALERT:
Verification of membership is not to be construed as authorization for services.

Enrollment of Recipients
Fidelis Care functions related to enrollment focus on:

- New member orientation
- Initial selection of primary care physician (PCP)
- PCP changes
- Member identification
- Enrollment of newborns
- Identification and documentation of third party insurance

When Fidelis Care is notified of an enrollment, or an enrollment is verified by New York State, Fidelis Care will send the new member a Member Handbook, and identification card. Additionally, a Health Risk Assessment (HRA) form is included, and the member is asked to complete the HRA and return it to Fidelis Care in the return addressed envelope provided.

The HRA form given to new members is a standardized tool. The Member Services Department receives the HRA and forwards each case to a Special Triage Nurse for review. When appropriate, a member is referred for Case Management or Health and Disease State management. Each HRA is entered into a database and a report is sent directly to the member's PCP.

Verification of Member Eligibility

Fidelis Care Medicaid and Fidelis Care Child Health Plus

All providers must verify a member's eligibility at each visit. This can be accomplished in several ways:

- The provider can verify the member's current eligibility by either using the Fidelis Care Provider Access Online by going to https://portal.fideliscare.org/provider/ or using the Integrated Voice Response (IVR), by calling 1-888-FIDELIS (1-888-343-3547).
- Providers who have eMedNY access can verify eligibility on ePACES for Medicaid members.
- PCPs can consult their current roster to see if the member appears on their list. If the member is on the roster, then the patient is a member of Fidelis Care. For providers who have a user ID/password on Provider Access Online, a roster should be obtained by going to fideliscare.org. Click on the Quick Navigation Link and search for Provider Access Online or go to the site's Provider section and locate the link for Provider Access Online. Providers may also connect directly to https://providers.fideliscare.org/Login. For providers who have not established a user id/password, please contact your local provider relations representative for assistance.

Fidelis Care will reimburse providers only for services rendered to members eligible on the date of service. It is the responsibility of the provider to verify eligibility prior to providing services. The hospital, physician, or office must verify eligibility/current enrollment each time a member presents or is referred for service. Possession of a Fidelis Care member Identification (ID) Card is not sufficient to verify current eligibility or identity. For a sample Member ID Card, see appendix XIII.
ALERT
Medicaid eligibility continually changes. Fidelis Care recommends providers verify current enrollment information by accessing the Fidelis Care portal, IVR or the SDOH ePACES. Please remember that since Fidelis Care cannot retrieve ID cards from members who disenroll, a Fidelis Care membership card alone DOES NOT guarantee eligibility.

Misuse of ID Card
If you suspect that an individual is misusing a Fidelis Care ID Card, by using a card that has been lost or stolen or by borrowing another person's card, please report the incident to Fidelis Care's Special Investigation Unit (SIU) Fraud Hotline at 1-800-455-4420.
PRODUCT INFORMATION

Fidelis Care Medicaid Managed Care

Medicaid recipients are required to join a Medicaid Managed Care Plan. Individuals covered under a Medicaid Managed Care plan retain certain benefits via fee-for-service Medicaid. Based on the member's county, some benefits are carved out of the Medicaid Managed Care Plan and are only covered by fee-for-service Medicaid. There are pre-existing condition requirements or deductibles in Medicaid Managed Care.

### Product Overview

<table>
<thead>
<tr>
<th><strong>Product Type</strong></th>
<th>Fidelis Care Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Panel</strong></td>
<td>Fidelis Care Medicaid Managed Care Network</td>
</tr>
<tr>
<td><strong>Primary Care Physician (PCP) Required</strong></td>
<td>Members joining Fidelis Care Medicaid are required to choose a PCP from the Fidelis Care Medicaid Managed Care Network.</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health, nursing, radiological and rehabilitative services. Services are provided under the direction of a physician, certified nurse practitioner, or dentist.</td>
</tr>
<tr>
<td><strong>Alternate Level of Medical Care</strong></td>
<td>Continued Care in a hospital pending placement in an alternate lower level of care.</td>
</tr>
<tr>
<td><strong>Ambulatory Services</strong></td>
<td>Outpatient hospital services are provided through ambulatory care facilities including hospital outpatient departments (OPDs), and treatment centers (D&amp;Ts or free-standing clinics), and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health, Child/Teen Health Plan (C/THP) services, and ambulatory care facilities.</td>
</tr>
</tbody>
</table>
| **Preventive Health Services** | There are three levels of preventive care:  
• Primary, such as immunizations, aimed at preventing disease;  
• Secondary, such as disease screening programs aimed at early detection;  
• Tertiary, such as physical therapy, aimed at restoring function. |
| **Health Care Services Covered through Fidelis Care** |  
• Physician Service  
• Nurse Practitioner Services  
• Midwifery Services |
Health Care Services Covered through Fidelis Care (con’t)

- Preventive Health Services
- Second Medical Surgical Opinion
- Laboratory Services Radiology Services
- Smoking Cessation Products
- Rehabilitation Services
- EPSDT/(Child Teen Health Program)
- Home Health Services
- Private duty nursing
- Hospice
- Emergency services
- Foot Care Services
- Eye Care and Low Vision Services
- Durable Medical Equipment
- Audiology, hearing aid services and products when medically necessary
- Emergency transportation depending on county of residence)** See below for the process
- Non-Emergency transportation depending on county of residence)** See below for process
- Dental Services
- Prosthetics, Orthotics
- Mental Health and Substance Abuse Services for members 21 years of age and older including:
  - Mental Health and Substance Use Disorder Outpatient Clinic Treatment
  - Methadone Maintenance Treatment Program (MMTP)
  - Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs
  - Medically Supervised Chemical Dependence Outpatient Rehabilitation Program
  - Intensive Psychiatric Rehabilitation Treatment (IPRT) Programs
  - Personalized Recovery Oriented Services (PROS) programs
  - Continuing Day Treatment (CDT)
  - Partial Hospitalization Program (PHP)
  - Short-term Residential Health Care Facility Services
  - Renal dialysis
  - Personal Care Agency Services as of 8/1/11, see Section 18A of this manual for additional information
  - Personal Emergency Response System
  - Directly Observed Tb Therapy
  - Adult Day Health Care
  - AIDS Adult Day Health Care
  - Prescription and Non-Prescription Drugs, Supplies and Enteral Formulas
  - Case Management
  - Family Planning
  - Effective 10/1/2019, Ovulation enhancing drugs and related medical services, females ages 21 to 44, refer to Section 16.
Transportation

Members will get transportation through Fidelis Care if they live in a county where transportation is provided. Call Member Services at 1-888-FIDELIS (1-888-343-3547) for more information. Transportation must be scheduled in advance by 4:00 PM the business day before the member’s appointment. Members that reside in counties other than Rockland, Nassau, and Suffolk can contact MAS to arrange transportation. Members who reside in Nassau or Suffolk counties should contact Logistacare at 1-844-678-1103 to arrange transportation. Claims for livery/ambulette for Rockland do not get processed through Fidelis, only ambulance service.

Health Care Services covered by Fee-for-Service Medicaid include but are not limited to

- Family Planning (if you want to go to a doctor/clinic outside our plan)
- Permanent residence in a Residential Health Care Facility
- Substance Use Disorder Services for members 20 years old and younger, including:
  - Methadone Maintenance Treatment Program (MMTP)
  - Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs
  - Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs
  - Outpatient Chemical Dependence for Youth Programs
  - Mental Health Services for members 20 years old and younger:
    1. Intensive Psychiatric Rehabilitation Treatment Programs
    2. Day Treatment
    3. Home & Community Based Services Waiver for SED Children
    4. Case Management
    5. Partial Hospitalization
    6. See your Representative for further information
- Early Intervention Program
- Preschool Supportive Health Services
- School Supportive Health Services
- Comprehensive Medicaid Case Management
- School-Based Health Centers
- Mental Retardation and Developmental Disability Services

Non-covered Services

- Cosmetic surgery, unless medically indicated
- Personal and comfort items
- Routine hygienic foot care in the absence of a pathological condition
- Fertility/Infertility Treatment, except: Effective 10/1/2019, Ovulation enhancing drugs and related medical services, females ages 21 to 44, refer to Section 16.

Referrals/Authorizations

Members can self-refer to participating providers for the following benefits/services:
<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• OB/GYN Care</td>
</tr>
<tr>
<td>• HIV Counseling and Testing</td>
</tr>
<tr>
<td>• Mental Health and Substance Abuse Outpatient Clinic</td>
</tr>
<tr>
<td>Services</td>
</tr>
<tr>
<td>• Eye Care</td>
</tr>
<tr>
<td>• Dental Care</td>
</tr>
</tbody>
</table>

For a listing of services requiring a prior authorization, please see Appendix I.

Effective 10/1/2017, outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services, require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare, visit: https://www.evicore.com/healthplan/fideliscare.

Effective 10/1/2019, Fidelis Care requires providers to obtain prior authorization from National Imaging Associates, Inc. (NIA) for outpatient rehabilitative and habilitative physical medicine services, including services rendered in the home, for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Qualified Health Plans (Metal-Level products), Fidelis Care at Home (FCAH) (Managed Long Term Care), HealthierLife (HARP), and Essential Plan (EP). Prior authorization is required for all services rendered by a therapy provider after the initial evaluation. Prior authorization is not required for PT, OT, and ST performed in an Inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay. Non-therapy providers (MD, Chiropractors, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care for all Fidelis Care Members. For more information, visit Fidelis Care Physical Medicine Prior Authorization Quick Reference Guide for Providers.

Effective 10/1/2019, Fidelis Care requires providers to obtain prior authorization through Fidelis Care for members undergoing musculoskeletal surgical procedures, in both inpatient and outpatient settings. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Medicare Advantage (MA), Dual Advantage (DUAL), HealthierLife (HARP), Qualified Health Plans (Metal-level Products), Essential Plan (EP), and Medicaid Advantage Plus (MAP). Emergency-related procedures do not require authorization. For a list of the procedures requiring prior authorization, visit Musculoskeletal Surgical Procedure CPT Code List.

For all other services members should be encouraged to speak with their PCP.
Fidelis Care Medicaid provides members with the following enhanced services:

- BabyCare Program
- High Risk Maternity
- Diabetic Management
- Depression Management
- Women’s Health Program
- Smoking Cessation
- Stress Management
- Case Management
- Chronic Condition Management

Fidelis Care Child Health Plus (CHP)

The New York State health insurance plan for kids is called Child Health Plus. Depending on a family's income, a child may be eligible to join either Medicaid or Child Health Plus. Both Children's Medicaid and Child Health Plus are available through Fidelis Care. Based on the family size and income, Child Health Plus is free or low cost. There are no copayments, pre-existing condition requirements, or deductibles.

To be eligible for either Medicaid or Child Health Plus, children must be under the age of nineteen (19) and be residents of New York State. Whether a child qualifies for Medicaid or Child Health Plus depends on gross family income. Children who are not eligible for Medicaid can enroll in Child Health Plus if they don't already have health insurance and are not eligible for coverage under the public employees' state health benefits plan. Some children who were covered by employer-based health insurance within the past six months may be subject to a waiting period before they can be enrolled in Child Health Plus.

### Product Overview

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Fidelis Care Child Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Panel</td>
<td>Fidelis Care Child Health Plus Network</td>
</tr>
<tr>
<td>Primary Care Physician Required</td>
<td>Members joining Fidelis Care Child Health Plus are required to choose a PCP from the Fidelis Care Child Health Plus network.</td>
</tr>
</tbody>
</table>

### Benefit Package

- Health Promotion Visits
- Inpatient Hospital or Medical or Surgical Care
- Inpatient Mental Health & Alcohol & Substance Abuse Services
- Inpatient Rehabilitation
- Professional Services for Diagnosis & Treatment of Illness & Injury
- Hospice Services & Expenses
- Outpatient Surgery
- Diagnostic & Laboratory Tests
- Durable Medical Equipment
- Prosthetic Appliances & Orthotic Devices
## Therapeutic Services
- Speech & Hearing Services including hearing aids
- Pre-Surgical Testing
- Second Surgical & Medical Opinion
- Outpatient Mental Health visits for Diagnosis & Treatment of Alcoholism & Substance Abuse
- Home Health Care
- Prescription & Non-prescription drugs
- Emergency Medical Services
- Ambulance Services
- Maternity Care
- Diabetic Supplies & Equipment, Education & Home visits
- Emergency, Preventive & Routine Vision Care
- Autism Spectrum Disorder Services
- Family Planning

## Non-Covered Services
These benefits are not covered by Fidelis Care Child Health Plus and are defined as non-covered services by the Child Health Plus contract:
- Experimental medical or surgical procedures
- Administration or injection of any drugs
- Replacement of lost or stolen prescriptions
- Experimental drugs
- Nutritional supplements taken electively
- Non-FDA approved drugs except that Fidelis Care will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type of which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer by one of these publications
  1. AMA Drug Evaluations
  2. American Hospital Formulary Service
  3. U.S. Pharmacopoeia Drug Information
- Drugs which can be bought without a prescription, except as defined
- Prescription drugs used for purposes of erectile dysfunction
- Prescription drugs & biologicals and the administration of these drugs & biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person
- Private duty nursing
- Home health care, except as defined
- Chiropractic Care
- Services in a skilled nursing facility or rehabilitation facility
| Non-Covered Services | • Cosmetic, plastic, or reconstructive surgery except as defined  
|                      | • In vitro fertilization, artificial insemination or other means of conception and infertility services  
|                      | • Services covered by another payment source  
|                      | • Transportation except as defined  
|                      | • Personal or comfort items  
|                      | • Residential Psychiatric Treatment  
|                      | • Orthodontia Services  
|                      | • Services which are not medically necessary  
| Referral/Authorizations | Members can self-refer to participating providers for the following benefits/services:  
|                      | • OB/GYN Care  
|                      | • Mental Health and Substance Abuse Assessments - 1st assessment in a calendar year.  
|                      | • Eye Care  
|                      | • Dental Care  
|                      | The following benefits/services require PCP involvement or prior authorization:  
|                      | • Specialist  
|                      | • Special services such as x-rays, laboratory services, Durable Medical Equipment, and hospital inpatient and outpatient services.  
|                      | • Effective 10/1/2017, outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, and outpatient radiation therapy services, for all products except Fidelis Care at Home (FCAH) and Fully Integrated Duals Advantage (FIDA), require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare, visit: https://www.evicore.com/healthplan/fideliscare.  
|                      | • Effective 10/1/2019, Fidelis Care requires providers to obtain prior authorization from National Imaging Associates, Inc. (NIA) for outpatient rehabilitative and habilitative physical medicine services, including services rendered in the home, for physical therapy (PT), occupational therapy (OC), and speech therapy (ST). This prior authorization program applies to members in the following products: Medicaid Managed |
Referral/Authorizations (con't)

Care (NYM), Child Health Plus (CHP), Qualified Health Plans (Metal-Level products), Fidelis Care at Home (FCAH) (Managed Long Term Care), HealthierLife (HARP), and Essential Plan (EP). Prior authorization is required for all services rendered by a therapy provider after the initial evaluation. Prior authorization is not required for PT, OT, and ST performed in an inpatient setting, Emergency Room, Skilled Nursing Facility, or during an Observation stay. Non-therapy providers (MD, Chiropractors, etc.) should request prior authorization for all services after the initial evaluation directly through Fidelis Care for all Fidelis Care Members. For more information, visit Fidelis Care Physical Medicine Prior Authorization Quick Reference Guide for Providers.

- Effective 10/1/2019, Fidelis Care requires providers to obtain prior authorization through Fidelis Care for members undergoing musculoskeletal surgical procedures, in both inpatient and outpatient settings. This prior authorization program applies to members in the following products: Medicaid Managed Care (NYM), Child Health Plus (CHP), Medicare Advantage (MA), Dual Advantage (DUAL), HealthierLife (HARP), Qualified Health Plans (Metal-level Products), Essential Plan (EP), and Medicaid Advantage Plus (MAP). Emergency-related procedures do not require authorization. For a list of the procedures requiring prior authorization, visit Musculoskeletal Surgical Procedure CPT Code List.

- Members may self-refer to a participating behavioral health provider, be referred by a participating PCP or specialist physician, or be referred by a clinical case manager at Fidelis Care's Behavioral Health Unit. Members are informed of this benefit at the time of enrollment.

- Except in an emergency, all referrals require a Fidelis Care prior authorization. Behavioral health providers should contact the Behavioral Health Unit to register the patient's care and obtain a prior authorization in all but emergency cases. For emergency situations, the provider should treat the patient and notify the Unit as soon as practical but not later than 48 hours or the next business day after stabilization.

- For a complete list of services that require prior authorization from Fidelis Care, visit: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids
Enhanced Fidelis Care Services

Fidelis Care Child Health Plus provides members with the following enhanced services:
- BabyCare Program
- Case Management
- Diabetic Management
- Depression Management
- Chronic Condition Management
FIDELIS CARE MEDICAID PERSONAL CARE SERVICES (PCS)

Means some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the member’s health and safety in his or her own home, as determined by Fidelis Care in accordance with the regulations of the Department of Health. Services are ordered by the attending physician, based on an assessment of the member's needs and of the appropriateness and cost-effectiveness of services, provided by a qualified person in accordance with a plan of care, and supervised by a registered professional nurse.

Some or total assistance shall be defined as follows:

- **Some assistance** shall mean that a specific function or task is performed and completed by the member with help from another individual.
- **Total assistance** shall mean that a specific function or task is performed and completed for the member.
- **Continuous 24-hour personal care services** shall mean the provision of uninterrupted care, by more than one person, for a member who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.

Fidelis Care Medicaid Consumer Directed Personal Assistance Services (CDPAS)

Means some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, as well as health related and nursing tasks. Such services must be essential to the maintenance of the consumer’s health and safety in his or her own home, as determined by Fidelis Care in accordance with the regulations of the State Department of Health.

Consumer Directed Personal Care Services include tasks that may be performed by a personal care aide, home health aide, or a nurse. The consumer assumes full responsibility for hiring, training, supervising, and, if necessary, terminating the employment of persons providing the services.

Fidelis Care Personal Emergency Response System (PERS)

Means telephonic communication to emergency responders when signaled by member’s device in the case of an emergency. This is covered when medically necessary and is authorized in conjunction with authorized PCS services.

Prior Authorizations

Fidelis Care is responsible for coordinating, arranging, and authorizing payment to providers for the member’s medically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Fidelis Care’s Provider Directory.

Initial Authorization for Personal Care Services must be based on the following:

A physician’s order that meets the requirements of the DOH guidelines:

- Downstate (NYC) DOH M11Q
- Upstate DOH 4359

Go to [fideliscare.org](https://fideliscare.org) in the Provider section under Provider Resources to obtain copies of the physician's order forms.
Providers need to fax the completed order form to Fidelis Care at 1-877-882-5875 before an in-home assessment can be scheduled. The order needs to include the date the member was last seen by the physician, which must be within the last thirty (30) days. Once a request is made – a home visit assessment will be done to determine the level of care appropriate for the member’s need. Once services are approved, ongoing authorizations will require an updated physician’s order every twelve (12) months. Members will continue to require a physician visit within thirty (30) days of the order.

A nursing and social assessment that meets the requirements of DOH guidelines:

- UAS Assessment
- Time Task Tool

The assessing agency will upload the completed nursing and social assessment to the UAS system and fax Fidelis Care the time task tool to 1-877-433-7085 for determination.

Purpose of the assessment:

- Assess functionality in activities of daily living
- Work from primary diagnosis
- Does member need Level one (1) or Level two (2) PCS?
- A standardized tool will be used

Process:

- This assessment will be done by a registered nurse employed by Fidelis or from an agency contracted by Fidelis Care to do the assessment
- Fidelis Care will put up an authorization for this agency to do the assessment after the request is received. This is in addition to the authorization which may (or may not) be put up for the actual PCS services
- If the services are approved – an authorization will be created for the appropriate level and quantity of services. The member and provider will be notified by mail
- PCS authorizations are effective for up to six (6) months
- If denied, the member will receive a denial notice
- Determinations are based on medical necessity

Standard of Care:

Personal Care Services shall include the following two levels of care, and be provided in accordance with the following standards:

<table>
<thead>
<tr>
<th>Level I</th>
<th>Level II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shall be limited to the performance of nutritional and environmental support functions. Nutritional and environmental support functions shall include some or total assistance with the following:</td>
<td>shall include the performance of nutritional and environmental support functions and personal care functions. Personal care functions shall include some or total assistance with the following:</td>
</tr>
<tr>
<td>Making and changing beds</td>
<td>Bathing of the member</td>
</tr>
<tr>
<td>Dusting and vacuuming the rooms</td>
<td>Dressing</td>
</tr>
<tr>
<td>Light cleaning of the kitchen, bedroom and bathroom</td>
<td>Grooming</td>
</tr>
<tr>
<td>Dishwashing</td>
<td>Toileting</td>
</tr>
<tr>
<td>Listing needed supplies</td>
<td>Walking</td>
</tr>
<tr>
<td></td>
<td>Transferring from bed to chair or</td>
</tr>
</tbody>
</table>
• Shopping for the member if no other arrangements are possible
• Member's laundering, including necessary ironing and mending
• Payment of bills and other essential errands
• Preparing meals, including simple modified diets

wheelchair
• Preparing of meals in accordance with modified diets
• Feeding
• Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication and administration, disposing of used supplies and materials and storing the medication properly
• Providing routine skin care
• Using medical supplies and equipment such as walkers and wheelchairs
• Changing of simple dressings

Services include the following:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Codes and Rates Effective up to 03/31/2018</th>
<th>Codes and Rates Effective 04/01/2018 forward</th>
<th>Contract Note Regarding Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Assistance (PCA)</td>
<td>Previous HCPCS Code</td>
<td>Previous Service Billing Units</td>
<td>New HCPCS Code</td>
</tr>
<tr>
<td>Level I (housekeeping)</td>
<td>T1019</td>
<td>Per 15 mins</td>
<td>S5130U1</td>
</tr>
<tr>
<td>Level II</td>
<td>T1019TG</td>
<td>Per 15 mins</td>
<td>T1019U1</td>
</tr>
<tr>
<td>Level II Mutual Case (multiple)</td>
<td>T1020</td>
<td>Hourly Code</td>
<td>T1019U1</td>
</tr>
<tr>
<td>Level II Shared Aide (up to two)</td>
<td>T1020TF</td>
<td>Hourly Code</td>
<td>T1019U2</td>
</tr>
<tr>
<td>Level II-Hard to Serve</td>
<td>T1020TG</td>
<td>Hourly Code</td>
<td>T1019U4</td>
</tr>
<tr>
<td>Live In Level II</td>
<td>T1022</td>
<td>Per Diem*</td>
<td>T1020</td>
</tr>
<tr>
<td>Live In Level II Mutual Case (multiple)</td>
<td>T1022TT</td>
<td>Per Diem*</td>
<td>T1020U2</td>
</tr>
<tr>
<td>Live In Level II -</td>
<td>T1022TG</td>
<td>Per Diem</td>
<td>T1020U5</td>
</tr>
<tr>
<td>Service Description</td>
<td>Code 1</td>
<td>Rate 1</td>
<td>Code 2</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Two Client Hard to Serve</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Home Health Aid (HHA)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Aid Services</td>
<td>S9122</td>
<td>Hourly</td>
<td>S9122</td>
</tr>
<tr>
<td><strong>Consumer Directed Personal Aid Services (CDPAS)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Direct 1 Client</td>
<td>T1019U1</td>
<td>Per 15 mins</td>
<td>T1019U6</td>
</tr>
<tr>
<td>Consumer Direct 2 Client</td>
<td>T1019U2</td>
<td>Per 15 mins</td>
<td>T1019U7</td>
</tr>
<tr>
<td>Consumer Direct 1 Client Enhanced</td>
<td>T1019U3</td>
<td>Per 15 mins</td>
<td>T1019U8</td>
</tr>
<tr>
<td>Consumer Direct 2 Client Enhanced</td>
<td>T1019U4</td>
<td>Per 15 mins</td>
<td>T1019U9</td>
</tr>
<tr>
<td>Consumer Direct Live In 1 Client</td>
<td>T1020U1</td>
<td>Per Diem*</td>
<td>T1020U6</td>
</tr>
<tr>
<td>Consumer Direct Live In 2 Client</td>
<td>T1020U2</td>
<td>Per Diem*</td>
<td>T1020U7</td>
</tr>
<tr>
<td><strong>Nursing Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Assessment including PRI &amp; Intense cases</td>
<td>T1001</td>
<td>Per Visit</td>
<td>T1001</td>
</tr>
<tr>
<td>UAS Assessment</td>
<td>T1001TG</td>
<td>Per Diem*</td>
<td>T2024</td>
</tr>
<tr>
<td>UAS Reassessment</td>
<td>T1001TF</td>
<td>Per Diem*</td>
<td>T2024</td>
</tr>
<tr>
<td>Private Duty (LPN)- 15 Min</td>
<td>T1000</td>
<td>Per 15 mins</td>
<td>T1003</td>
</tr>
<tr>
<td>Nursing Care in Home (LPN)</td>
<td>T1031</td>
<td>Per Diem</td>
<td>T1031</td>
</tr>
<tr>
<td>LPN- Hourly</td>
<td>S9124</td>
<td>Hourly Code</td>
<td>S9124</td>
</tr>
<tr>
<td>Private Duty Nursing (RN)- 15 Min</td>
<td>T1000TG</td>
<td>Per 15 mins</td>
<td>T1002</td>
</tr>
<tr>
<td>Nursing Care by RN in Home (including Med Prepour)</td>
<td>T1030</td>
<td>Per Diem*</td>
<td>T1030</td>
</tr>
<tr>
<td>Nursing Care by RN (including Med Prepour)- Hourly</td>
<td>S9123</td>
<td>Hourly Code</td>
<td>S9123</td>
</tr>
</tbody>
</table>
Billing/Claims

- Claims Remittances are available through Fidelis Care’s Provider Access Online. If you do not have a logon and password to access this resource, please contact your Provider Relations Representative. Remittances are also available through a HIPAA-mandated 835 Electronic Remittance Advice.
- All claims must be submitted electronically within ninety (90) days from the date of service.
- The unique payer ID for Fidelis Care – ID 11315 – is needed for all submissions. For a complete list of vendors please visit Fidelis Care’s Web site at fideliscare.org.
- Obtain the status of a claim through Provider Access Online by clicking on https://providers.fideliscare.org

Please refer to section 12 of this manual for additional information.

Appeals and Grievance Reconsideration Process

Please refer to section 13 of this manual for additional information.

Quality Assurance

Please refer to section 10 of this manual for additional information.

Provider Credentialing and Termination

Please refer to section 9 of this manual for additional information.

Retention of Medical Records

For additional information, please refer to section 7 of this manual.

Confidentiality

For information, please refer to section 3 of this manual

Fidelis Care at Home MLTC

For information, please refer to section 22B
AUTHORIZATIONS FOR NON-PARTICIPATING (NON-PAR) PROVIDERS

It is the policy of Fidelis Care to direct the care of members to participating providers. The primary care physician (PCP), specialists or facility, and Quality Health Care Management (QHCM) staff have responsibilities to make every effort to minimize the use of non-participating providers.

I. Non-Emergent Services by non-participating providers, including services provided in a non-participating Urgent Care Centers*, are considered out-of-network (OON) referrals and must meet all of the following:

1) The services to be provided are Covered Benefits.
2) Fidelis Care does not have a participating provider within an appropriate geographic area, or with the appropriate training and experience, to meet the particular health care needs of the member.
3) An authorization request is submitted to Fidelis Care prior to the start of the service, and the service is authorized by Fidelis Care.

*An Urgent Care Center (also known as an Urgent Care Facility) is a type of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centers are distinguished from similar ambulatory healthcare centers such as emergency departments and convenient care clinics by their scope of conditions treated and available facilities on-site. Such facilities are also not intended to be used as emergency rooms and are not subject to the Emergency Medical Treatment and labor Act (EMTALA).

Fidelis Care requires non-participating Urgent Care Centers to obtain an authorization within 24 hours of services being performed in the Urgent Care Center. Authorization requests for visits to out-of-network Urgent Care Centers will not be approved unless the member is seeking care outside the Fidelis Care service area (and it was not reasonable given the circumstances to delay receipt of services to obtain the services through one of the contractor’s Participating Providers).

Urgent Care Centers are expected to perform only the services needed to address the urgent medical condition. Since Urgent Care Centers do not perform Emergency Services, all of Fidelis Care’s authorization requirements apply to Urgent Care Centers. Urgent Care Centers are expected to review the authorization grid and obtain authorizations for applicable services, which can be found here: https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids

Physicians and other providers who are in Fidelis Care’s network working in an Urgent Care Center will only be reimbursed for Fidelis Care members if the Urgent Care Center is also in Fidelis Care’s network. Physicians (or other practitioners) with an “Emergency Medicine” specialty designation are expected to treat Fidelis Care members in an Emergency Room (which may be in-network or out-of-network), or an in-network Urgent Care Center. Even if the Emergency Medicine physician is in Fidelis Care’s network, a claim for a visit in an out-of-network Urgent Care Facility will not be paid without an authorization. Authorizations will only be granted for Out-of-Network Urgent Care Center visits when the member is out of the Fidelis Care service area.

Services provided at Urgent Care Centers must be billed using Place of Service 20. Services rendered in a non-Urgent Care Center, billed with place of service 20, are not reimbursable.

If a new member has an existing relationship with a health care provider who is not a member of the Fidelis Care provider network, Fidelis Care shall permit the new member to continue an ongoing course of treatment by the non-participating provider during a transitional period of up to sixty (60) days from the
effective date of enrollment, if the conditions outlined in parts I(1), I(3), II and III of this Section 19 of the Provider Manual are met.

If the new member is within her second or third trimester of pregnancy on the date her enrollment is effective, the transitional period shall include the provision of prenatal care until delivery and the provision of postpartum care directly related to the delivery up until sixty (60) days postpartum. If the new member elects to continue to receive care from such non-participating provider, such care shall be authorized by Fidelis Care for the transitional period only if the conditions outlined in sections I(1), I(3), II and III of this document are met.

All out-of-network (OON) referrals are subject to prior authorization review in accordance with the procedures outlined in Section 8 Emergency and Inpatient Services, and Section 11 Referral and Pre-Authorization.

II. Responsibilities of the Primary Care Physician (PCP):

- The PCP has authority to make referrals to participating providers for medically necessary services. PCPs will consult the Fidelis Care Provider Directory and use participating specialists and facilities. Authorization is only required for those services listed on Fidelis Care's Authorization Grid Detail. See Appendix I.
- If the PCP believes the member should receive care from a non-participating specialist or facility, the PCP must request prior authorization from QHCM’s Utilization Management Department by calling 1-888-FIDELIS (1-888-343-3547) and provide supporting clinical information.

III. Responsibilities of Specialist:

- The Specialist has authority to make referrals for medically necessary services. The Specialist will consult the Fidelis Care Provider Directory and use participating specialists and facilities whenever possible. When the Specialist elects to refer the member to a participating specialist or facility, authorization is only required for those services listed on Fidelis Care’s Authorization Grid Detail. See Appendix I.
- If the Specialist believes the member should receive care from a non-participating specialist or facility, the Specialist must request prior authorization from QHCM’s Utilization Management Department by calling 1-888-FIDELIS (1-888-343-3547) and provide supporting clinical information.

IV. Responsibilities of Quality Health Care Management (QHCM):

When QHCM receives a request for out-of-network provider:

- QHCM advises of any participating providers who can meet the member’s needs.
- If QHCM receives a request for a non-participating provider to be used, the request is referred to the Medical Director for review.
- Fidelis Care’s Medical Director will review the request for medical necessity and will discuss care with the member's PCP/referring provider as indicated.
- If Fidelis Care denies the request for an out-of-network provider, QHCM will notify the member that services are available within the Fidelis Care network. QHCM will provide the member with the names of at least three (3) participating providers who can provide the requested services along with their office locations and contact information, provided that three (3) participating providers are available. If three (3) participating providers are not available, QHCM will provide
the names, office location, and contact information of the available provider(s). If indicated, Fidelis Care will ensure that the member receives assistance in making an appointment.

- QHCM will contact the PCP and/or referring provider with the decision to either approve or deny the request for an out-of-network provider. See Section 8 Emergency and Inpatient Services or Section 11 Referral and Pre-Authorization of this manual for additional information.
BEHAVIORAL HEALTH

INTRODUCTION

This section of the Fidelis Care Provider Manual (hereafter called the Manual) was created to assist participating Behavioral Health providers and their office staff in understanding Fidelis Care's policies and procedures regarding behavioral health. It applies only:

- to those providers that are directly contracted with Fidelis Care to provide behavioral health services to Fidelis Care members; and
- for services rendered on or after October 1, 2015.

Nothing stated in this section of the manual is intended to alter or modify the benefits the member is entitled to or the executed agreement between the provider and Fidelis Care. In the event of a dispute or conflict between the manual and an executed contract, the terms of the provider agreement and the regulations of the Medicaid Managed Care Program govern.

FIDELIS CARE’S BEHAVIORAL HEALTH DEPARTMENT

The Behavioral Health Department is part of the Quality Health Care Management Department and is staffed by licensed and/or certified clinical staff as well as paraprofessional associates.

A provider or member may contact the department through the toll free number 1-888-FIDELIS (1-888-343-3547) by following the voice prompts to connect directly to Behavioral Health. The Department operates each weekday from 8:30 AM to 5:00 PM. Telephonic emergency services are available after hours, holidays, and weekends by dialing the same toll free number and following the voice prompts to reach the after-hours services.

All adverse determinations are reviewed and made by the Behavioral Health Department's Medical Director, a psychiatrist, or other clinical peer reviewer in consultation with the provider and the clinical case manager. All inpatient level of care psychiatric treatment denials will be made by a board certified psychiatrist. All inpatient level of care denials for substance abuse treatment will be made by a physician certified in addiction treatment.

Fidelis Care will not deny coverage of an ongoing course of care unless an appropriate provider of an alternate level of care is approved for such care.

COVERED SERVICES

- Medically supervised outpatient withdrawal services
- Outpatient clinic and opioid treatment program
- Outpatient clinic services
- Comprehensive psychiatric emergency program (CPEP)
- Continuing day treatment program (CDTP)
- Partial hospitalization program (PHP)
- Personalized recovery oriented services (PROS)
- Assertive Community Treatment (ACT)
- Health Home Care Coordination and Management
- Inpatient hospital detoxification service
- Inpatient medically supervised inpatient detoxification
- Inpatient treatment services (OASAS)
- Inpatient rehabilitation services
- Rehabilitation services for residential SUD treatment supports (OASAS)
I. BEHAVIORAL HEALTH REFERRALS

A. Who may refer?

1. **Member Self-Referral (Medicaid only):**
   a. Medicaid members may self-refer to a participating Fidelis Care Behavioral Health (BH) provider without limitation for mental health and substance abuse assessments (except for ACT, inpatient psychiatric hospitalization, partial hospitalization, and Home and Community Based services). At enrollment, all Medicaid members are informed of their self-referral benefit and provided with information about participating BH providers.
   b. Providers should note that except in the case of an emergency or a valid self-referral by a Medicaid member, all inpatient and most non-routine outpatient services require prior authorization by the Behavioral Health Department. Routine outpatient services do not require prior authorization.

2. **Provider or Member Calls/Referrals to the Behavioral Health Department:**
   (Applies to Medicaid and Child Health Plus)
   a. Members may call Fidelis Care directly to receive a referral(s) from staff in the Behavioral Health Department.
   b. Behavioral Health providers should contact the BH department to register, and obtain authorization for elective (or non-emergent) member care for those services as described below under 1B.
   c. Emergency services DO NOT require prior authorization. This includes emergency admissions, emergency room visits, and CPEP For emergency situations, the provider should treat the member and notify the BH Department as soon as is practical, but no later than forty-eight (48) hours, or the next business day, after evaluation/treatment of the member and stabilization of acute symptoms.
   d. Behavioral Health crisis calls:
      During business hours:
      An employee who is not on the line with the caller will contact the Behavioral Health Call Center. The Behavioral Health Associate will immediately notify the designated BH
clinician (on a rotating schedule) who will immediately connect directly with the caller without transfer or hold being required.

The clinician has the discretion to triage the call and redirect the intervention as needed. The clinician will follow up to assure that an appropriate immediate disposition has been achieved, and will notify their supervisor so that any further clinical follow up necessary can be assigned and completed.

In any situations in which a clinician was not readily available to assist with the call, after the immediate crisis has been handled, the department that received the crisis call will notify a clinical supervisor so that appropriate clinical follow up can be assigned and completed.

After Business Hours:
Fidelis Care’s contracted after-hours member line vendor will immediately respond to after-hours crisis calls, assuring warm transfer access to a clinician for triage and appropriate immediate disposition. Emergency services will be engaged whenever necessary.

Fidelis Care’s clinical staff will review calls received by the after-hours vendor as a first priority on the next business day. A clinician will, as a first priority that day, follow up on all crisis calls received to determine member’s status and assure ongoing required services are in place.

Fidelis Care collaborates with the Health Homes and network PCPs to establish consistent BH screening for all members with particular focus on those with high-risk medical conditions including, but not limited to tobacco use disorder, stroke, myocardial infarction, cancer, HIV, and chronic pain. Fidelis Care screening activities will especially screen for depression, anxiety, and substance use disorders.

Health Homes and PCPs will screen all individuals including those with the above high-risk medical conditions using screening tools such as the PHQ-9 for depression, CAGE and SBIRT model for substance use, the GAD 7 for anxiety and the Life Event Checklist for trauma or similar state approved instruments. Adoption and deployment of these screening tools will be done in collaboration with the Health Homes in support of their efforts toward integration of behavioral health and primary care.

B. Services That Require Prior Authorization:

ALL COVERED NON-EMERGENT INPATIENT, RESIDENTIAL, AND MOST NON-ROUTINE AMBULATORY SERVICES (EXCEPT THE MEMBER SELF-REFERRAL AS OUTLINED ABOVE) REQUIRE AUTHORIZATION BEFORE SERVICES OCCUR INCLUDING:

1. Initial evaluation and treatment;
2. Medically necessary continued treatment;
3. Services or visits beyond those already authorized;
4. Any change in level of care;
5. Referral for psychological or neuropsychological testing;
6. Referral for Electro-convulsive therapy (ECT).
7. Referral for partial hospitalization
8. Referral for mental health continuing day treatment (CDT)
9. PROS admission and active rehabilitation
10. Assertive Community Treatment (ACT)
11. Intensive psychiatric rehabilitation treatment (IPRT)
12. Rehabilitation services for residential SUD treatment supports (OASAS)*
13. Intensive case management / supportive case management
14. Health home care coordination and management

* Effective 01/01/2017, Fidelis Care will not conduct prior authorization review for the initial 14 days of OASAS licensed Inpatient Detoxification, Inpatient Rehabilitation or Inpatient Residential treatment services. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or LOCADTR@fideliscare.org

Providers must preauthorize the above non-routine or urgent services with the Fidelis Care Behavioral Health Department prior to the delivery of care. Failure to authorize services may result in coverage denial and non-payment for services.

The following non-routine or urgent services DO NOT require prior authorization: Crisis intervention, mental health and substance use disorder intensive outpatient treatment, opioid treatment program services, outpatient substance use disorder rehabilitation services, mobile crisis Intervention, and PROS pre-admission.

See VII. Prior Authorization and Concurrent Review Guidelines Summary for further guidance on prior authorization and concurrent review requirements by service.

C. Appointment Availability Standards

1. Non-urgent (Routine) Services:

   Definition: The member is not in imminent danger and further deterioration resulting in crisis is not likely to occur before he/she is seen.

   Procedure: The provider must call to request a prior authorization for a new member prior to rendering those services that require prior authorization (see 1B above, “Services that require prior authorization”). For routine ambulatory services that do not require prior authorization, the provider should proceed directly to scheduling an Initial evaluation appointment.

   Standard: For the following services, the member must be seen within 1 week of the request: Non-urgent mental health or Substance Use Disorder visits with a Participating Provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS with clinical treatment

   For the following services, the member must be seen within 2 weeks of the request: PROS programs other than clinic services.

   For the following services, the member must be seen within 2-4 weeks of the request:
CDT, IPRT, and Rehabilitation services for residential Substance Use Disorder treatment services.
The provider must schedule an initial evaluation appointment so that the member will be seen within two weeks of the initial member contact.

2. **Urgent Services:**

   **Definition:** Significant deterioration and/or stressors exist contributing to the member’s diminished capacity to cope with the ordinary demands of life. Unless some support or intervention is provided within a few days, further deterioration or crisis is likely to occur. Urgently needed services include Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs

   **Procedure:** The provider must call to request a prior authorization to a participating provider for a new member before rendering any urgently needed service as defined above.

   **Standard:** Provider must provide face-to-face intervention within twenty-four (24) hours of the member’s request for care.

3. **Emergent Services:**

   **Definition:** Acute danger exists for the member, another person, or the environment if immediate intervention does not occur.

   **Procedure:**
   - No authorization or referral is required for emergent care. Provider must call within forty-eight (48) hours of the initial service to initiate the review process for authorization.
   - Emergency pharmacy services:
     - Except where otherwise prohibited by law, Fidelis allows immediate access without prior authorization to a seventy-two (72) hour emergency supply of the prescribed drug or medication for an individual with a behavioral condition who is experiencing an emergency condition
     - Fidelis will immediately authorize a seven day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

   **Standard:** Provider must provide face-to-face intervention within ninety (90) minutes of the initial member contact. For CPEP, inpatient mental health, inpatient detox, and crisis intervention services, member must be seen immediately upon presentation at service delivery site. In rural areas this may not be feasible. In the event of imminent danger, local police, sheriff, crisis services or ambulance may need to be used so that the member can be safely transported to a clinician for evaluation within a time frame reasonable for the circumstances.

   **Follow up:** Members must be seen within 5 days of request, or as soon as clinically indicated, following discharge from the hospital, an emergency, or release from incarceration (if known).

D. Behavioral Health Authorization Procedures

1. **Procedures for Referral to a Behavioral Health Provider:**
a. Routine outpatient mental health referrals are made by either a case assistant or BH clinician. The initial screen, if initially processed by a case assistant, will be referred to clinical case manager under any of the following circumstances:
   - there is evidence of potential danger to self or others
   - Assistance is needed to help link members with specialized resources. For example, follow up assistance may be needed to help connect members and/or their families/significant others with appropriate resources in cases of suspected child abuse or neglect (such as child advocacy centers, child clinics, or domestic violence shelters). However, all health professionals who learn of suspected abuse are mandated by law to report it directly.
   - There is a potential need for complex care coordination (e.g., a need for treatment of co-morbid physical and behavioral health conditions)

The clinical case manager receiving the request will perform an initial assessment to determine the most appropriate, course of action, or referral for the provision of necessary care.

b. Psychological and/or neuropsychological testing requires the submission of a prior authorization request specifically for testing and a clinical review by a BH clinician.

c. To obtain additional visits, the provider contacts the BH call center for clinical review prior to the expiration of the visits and/or time frame that was initially authorized.

d. Clinical case managers will review the clinical information supplied by the provider and will determine continued authorization of care based on:
   - Medical necessity;
   - Treatment progress; and/or
   - Change in the treatment plan due to lack of progress.

e. The member and provider will be notified telephonically and by mail of the authorization decision. In the event that there is some concern regarding the treatment plan, the provider will receive a phone call from the case manager to discuss the case and resolve the issue of concern. In the event an agreement is not reached between the case manager and the provider, the case manager will refer the case to the Fidelis Care physician advisor for review.

f. Providers shall have policies and procedures addressing enrollees who present for unscheduled non-urgent care with aim of promoting enrollee access to appropriate care in the most appropriate setting in order to meet the recovery needs of the person seeking care.

2. **Information Necessary for All Behavioral Authorizations:**

   The following information is essential for the Behavioral Health Department to initiate an appropriate referral and authorization:

   a. Member name and Fidelis Care ID number;

   b. Current address and phone number of the member. If the member is a child, the parent or guardian's name(s) and phone number(s);

   c. Initial date of service (and time of admission as indicated);

   d. Requested length of stay/treatment;
e. Requested frequency of treatment (as applicable);

f. Place of service and phone number;

g. Admitting/attending and treating providers (as applicable);

h. Current (DSM/ICD) diagnosis;

i. Requested treatment/procedures;

j. History (medical, psychiatric, substance abuse, developmental, social and occupational, as applicable);

k. Functional assessment;

l. Mental status exam and risk assessment; and

m. Indications for the requested level of care.

3. **Alcohol and Substance Abuse Outpatient and Intensive Outpatient Care Authorization Procedures:**

   a. Routine outpatient treatment will not require prior authorization or concurrent review. Appropriate utilization will be monitored using claims data through clinical triggers and analysis of provider, member, and other trends.

   b. All intensive outpatient chemical dependence treatment is considered urgent.

   c. Intensive outpatient treatment will not require prior authorization. Providers will notify Fidelis through a completed LOCADTR (http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm) report within 10 visits of starting treatment. Subsequent visits will require concurrent review. LOCADTR (OASAS) criteria will be used to determine the appropriate level of intervention and the medical necessity for services. The checklist below covers the clinical data required to determine medical necessity for this type of care and to monitor progress in the care (see section D5 below "Chemical Dependency Clinical Guidelines for Initial and Concurrent Reviews").

4. **Screening Brief Intervention and Referral to Treatment (SBIRT) (applies to only Managed Medicaid))**

   a. Qualified primary care providers and other qualified staff can identify individuals at risk for substance abuse (screenings) and can perform brief counseling to motivate change and prevent substance abuse (interventions).

   b. Individuals requiring more intensive substance use services should be referred to formal OASAS treatment programs.

   c. SBIRT services can be provided to individuals ten (10) years of age or older.

   d. Members are entitled to two (2) screening services per calendar year without prior authorization and six (6) intervention services per calendar year without authorization.
f. Authorization is required for services beyond two (2) screenings and six (6) interventions per calendar year.

g. Members must receive an intervention service in the same visit as a positive screening.

h. Claims for SBIRT services should be submitted as follows:

- Screening services must be submitted with HCPCS code H0049 and diagnosis V82.9
- Brief intervention services must be submitted with HCPCS code H0050 and diagnosis V65.42

NYSDOH has stipulated that SBIRT services can only be provided by certified providers using screening tools advocated or approved by OASAS. In addition, the provider must have a current referral agreement with an accessible OASAS-certified treatment provider. Claims may be submitted by a certified Fidelis Care provider or a certified staff member submitted under the name of the Fidelis Care contracted provider. This service is included in the capitation rate for capitated providers. Fidelis Care will randomly audit the certification status of providers who render SBIRT-related services and the quality of the screenings and interventions provided.

5. Chemical Dependency Clinical Guidelines for Initial and Concurrent Reviews:

Effective 01/01/2017, Fidelis Care will not conduct prior authorization review for the initial 14 days of OASAS licensed Inpatient Detoxification, Inpatient Rehabilitation or Inpatient Residential treatment services. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or LOCADTR@fideliscare.org

The following information is essential for the Behavioral Health Department to conduct an initial or concurrent review for chemical dependency (CD):

- DSM IV: Axis 1-5;
- Reason for seeking treatment at this time: job jeopardy, legal problems, marital ultimatum, specific physical consequences, etc.;
- Substance of choice, amounts, frequency, age at onset, route, last use, consequences of use/dependence;
- Prior treatment history: CD inpatient and outpatient history (where treated, how long, longest period sober/clean after treatment, etc.) and mental health treatment history;
- Current medications: type, dosage, term of use;
- Current medical problems or history: history of seizures, DTs, or complications from CD;
- Legal issues: Was probation involved? Was treatment mandated? Did the provider receive permission from the member to collaborate with probation and/or court officials? If not, how will this be addressed in the care?;
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Behavioral Health

h. Recent employment issues related to CD: Is job jeopardy an issue? Is a third party involved in monitoring the care? Has permission to collaborate with these systems been gained by the provider? If not, how will this be addressed in the care plan?

i. Family and social supports: Does the member live with other users? Are there sober supports for the member? Are there family issues that can explain CD?

j. Self Help involvement: Attendance, sponsor, home group, appropriate service, current and in the past;

k. Treatment plan: modality, frequency, self-help attendance, urine screening, and third party/family involvement, medication monitoring when appropriate; and

l. Participate in care coordination and discharge planning with Fidelis Staff at least weekly, if not more, depending on member need for the purposes of supporting care transitions.

E. Guidelines for Other Levels of Care

1. Inpatient/Partial Hospitalization Discharge Procedures:

a. An aftercare plan should begin when a member is admitted to an acute care hospital, residential facility or partial hospitalization program. The admitting provider should relay information regarding expected length of stay and disposition to facility staff at the time of admission. A Fidelis Care BH Case Manager will assist in coordination of aftercare plans.

b. First Episode Psychosis (FEP): The provider, in collaboration with Fidelis and the Health Home (when involved), will utilize available data to identify members with FEP. Appropriate resources, such as those available through OnTrack NY (through the Center for Practice Innovations) will be engaged to assure comprehensive and integrated aftercare planning designed to facilitate prompt, extended follow up of these members to identify and address barriers to successful community tenure and avoidance of readmission.

c. Once the member is ready for transition to the next level of care, the attending physician (and/or a designated professional member of the treatment team) will:
   1. Provide a written aftercare plan with a copy for the member;
   2. Inform the member of any post-discharge aftercare appointments;
   3. Collaborate with the aftercare treatment providers as indicated;
   4. Forward a copy of the discharge summary to the post-discharge provider; and
   5. Give the member specific information for appropriate self-help groups such as AA/NA/CA (e.g. meeting times, locations, contact, if possible).

2. Post-Inpatient/Partial Hospitalization/Emergency Psychiatric/Post-incarceration Discharge Standards:
In accordance with regulations put forth by the New York State Office of Mental Health, Fidelis Care Behavioral Health Department requires that the discharged member be given a follow-up appointment within five (5) days post-discharge from the inpatient treatment setting. This is a "quality indicator of care" measure that will be monitored by Fidelis Care for purposes of reporting to the New York State Department of Health. As part of the oversight procedure, BH case managers or case assistants will be making aftercare calls to the appropriate provider to determine if the member has actually attended their post-discharge appointments.

a. For those members who do not keep their aftercare appointments, the BH aftercare case manager will intervene and attempt to shore up the discharge plan, offering support and encouragement to the member to follow up with the necessary aftercare to prevent regression and relapse.

**II. CASE MANAGEMENT AND COORDINATION ACTIVITIES**

**A. Confidentiality**

1. For guidelines, refer to the section on Member/Provider Confidentiality in Section 2 of this manual.

2. Collaboration of care with the PCP or other specialist can occur only with the member's expressed permission, except in clinical situations that threaten the life of the member or someone else. When this degree of danger exists, providers can contact the PCP directly without member authorization. It is recommended in all other circumstances that the provider have on-file a signed release of information to the PCP or other specialist.

**B. Collaboration/Coordination of Care**

1. Effective working relationships between providers and other treatment partners and service sites is an evidence-based practice, and thus will result in improved member health outcomes, improved continuity and coordination of care, increased quality, efficiency and effectiveness of services, and increased member satisfaction. All collaboration efforts should be documented in the medical record.

2. **Why Collaboration with Primary Care Physicians (PCPs) is Necessary:**

   Persons with mental illness die on average 25 years sooner than the average population. Members may remain untreated or under-treated if PCPs do not recognize members at risk for or with active mental or addictive disorders. Physical symptoms or general medical co-morbidity complicates most behavioral conditions. Psychotropic medications may interact adversely with other medications or cause physical side effects. Medical laboratory or physical examinations may be necessary for members on psychotropic medications. The PCP may prescribe psychotropic medications themselves.

3. In addition to mitigating the physical health risks associated with mental illness, promoting healthy behaviors also requires close collaboration and coordination with PCPs and other health professionals for member safety and optimal quality of care.

4. Behavioral healthcare providers should communicate with the member's PCP:

   a. For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment;
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b. When the PCP's support for a treatment plan would enhance member satisfaction and/or compliance;

c. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and

d. When PCP has requested immediate feedback.

5. Fidelis Care has a specialized pharmacy management program to promote coordination/collaboration with BH providers, primary care providers, and other specialty provider types.

   a. Areas of focus include, but not limited to, polypharmacy and metabolic and cardiovascular side effects of psychotropic medications.
   
   b. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost.

6. If the member is using behavioral health services in a clinic that also provides primary care services, enrollee may select lead behavioral health provider to function as their PCP.

7. Fidelis Care staff conducts annual site visits to selected providers' offices to provide education and performs a chart review to verify that collaboration of care is occurring and clinical documentation is meeting industry standards.

C. High Risk Case Management Overview

1. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and tailors services to meet an individual member's needs. When there is a high potential for recurrence or exacerbation of the member's symptoms, and/or the high potential for rapid re-hospitalization, such high-risk members may benefit from more intensive case management activities.

2. Providers can assist Behavioral Health Services in identifying members who may benefit from high-risk case management using the following screening criteria:

   a. All members who have been hospitalized three or more times for inpatient BH psychiatric treatment within the last 12 months;

   b. Anyone who has received chemical dependency treatment who has a serious psychiatric condition and/or history of a serious medical condition; and

   c. Anyone presenting in an emergency room with behavioral health symptoms but not admitted three or more times within the last 12 months.

3. Members who meet above high risk criteria will be reviewed for referral to a Health Home, if not already assigned. The Fidelis Case Manager will coordinate closely with the Health Home Care Manager and involved providers in assuring the member's needs are comprehensively assessed, and that the resulting individualized care plan includes the full range of required behavioral, medical, pharmacy, and other home and community services.

4. If a member is identified as high risk, the member has the right to agree or not agree to participate in the case management process. If the member agrees to participate, the Behavioral Health Case Manager (in consultation with the provider) will conduct a member assessment and
work with the member and provider to develop a care plan that will include, but not be limited to, mutually agreed upon goals, measurable objectives, and action steps toward goal achievement.

5. For members who have received inpatient care in the recent past, the plan for high risk follow-up should optimally be presented to the member during the current hospital admission process and again prior to the member’s discharge from the inpatient facility. The goal of the inpatient treatment team should be to gain the member's understanding and engagement in working with the team to not only prevent further hospitalizations, but also to design and coordinate aftercare services and supports that supports the Member’s recovery goals.

6. Care plan implementation includes referring the member to appropriate providers or facilities, monitoring the services to ensure that those being provided are addressing the member's specific behavioral health care needs, and ensuring adherence to with the treatment plan by measuring progress against defined short-term and long-term goals. This may include follow-up with the member and providers by calling and/or visiting, monitoring claims activity, coordinating with the Health Home care manager and/or downstream providers, documenting progress in the treatment plan, and re-evaluating and revising the treatment plan as necessary.

7. The Behavioral Health Case Manager will work with the provider to provide the member and family information to make empowered decisions regarding:
   a. The disease process;
   b. Available benefits; and
   c. Available community resources.

III. ADMINISTRATIVE POLICIES/PROCEDURES

A. Coverage by another Provider

1. **Independent Providers:**
   a. Services are only to be rendered by the provider named in the authorization process. Only participating Fidelis Care providers will be approved by the Fidelis Care Behavioral Health Department to render routine or urgent services.

   b. Providers should not schedule routine services to be rendered by another provider (e.g., vacation, time off) unless approved in advance by the Fidelis Care Behavioral Health Department. In the event a member requires treatment and the approved provider is not available, the Fidelis Care Behavioral Health Department must be contacted to arrange for covering treatment by another participating provider.

   c. *If a covering provider submits a claim for routine or urgent services without authorization, the claim will be denied.* Authorization expectations should be clearly explained to the covering provider and arrangements made for reimbursement directly between the provider of record and the covering provider in the event an authorization is not obtained.

2. **Agency Providers:**
   If a behavioral health agency is under contract with Fidelis Care and has met all credentialing standards, authorized services may be provided by any of the agency's participating facilities or staff providers. *Prior notification to Fidelis Care is not required as long as the facility or staff provider serving the Fidelis Care member has met all professional credentialing standards.*
Credentialing criteria for OMH-licensed and OASAS certified behavioral health providers
When credentialing OMH-licensed, OMH-operated and OASAS-certified providers, plans will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. The Contract shall collect and will accept program integrity related information as part of the licensing and certification process.

Credentialing criteria for designated HCBS providers (subject to final HCBS credentialing issues)
- Fidelis Care will accept State-issued HCBS designation in place of plan credentialing process for HCBS providers and any individual employees, subcontractors or agents.
- Fidelis Care will collect and accept program integrity related information as part of the licensing and certification process.

Fidelis Care requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

B. Member/Provider Confidentiality:

Release of Information to Other Health Care Providers
Based on State and Federal mandates, confidentiality of members must be protected by providers. Providers are encouraged to have members sign a release of information form for all parties involved in collaboration efforts including but not limited to: Primary Care Physicians, other medical providers, and other behavioral health providers. A sample release of information form can be found in the Fidelis Care Provider Manual.

Each healthcare provider shall develop policies and procedures to assure confidentiality of Mental Health/Substance Use related information. These policies and procedures must include:

(a) initial and annual in-service education of staff, contractors
(b) identification of staff allowed access and limits of access
(c) procedure to limit access to trained staff (including contractors)
(d) protocol for secure storage (including electronic storage)
(e) procedures for handling requests for Mental Health/Substance Use information and protocols to protect persons with behavioral health and/or substance use disorder from discrimination

C. Provider training including cultural competency. Fidelis Care will make available to all providers training on the levels of care available to its members to make effective and efficient use of these non-traditional models of care. Training will also be made available on Person Centered Care, Trauma Informed Care and Cultural Competency at least annually.

IV. BEHAVIORAL HEALTH CLINICAL POLICIES AND PROCEDURES

A. Fidelis Care Medical /Clinical Necessity Review Criteria

The Fidelis Care Quality Management and Peer Review Committee reviews all protocols, criteria, guidelines, and procedures utilized in the Medical Management Program at a minimum of once yearly. These pre-established criteria are used for decision-making related to the clinical or medical appropriateness of care, least restrictive yet acceptable safety level of care, appropriate setting of care, and appropriate provider of care.
Updated criteria are obtained from the following sources as they become available and incorporated into Fidelis Care's Policies and Procedures Manual and the Medical Management Program Description. Criteria as described in the clinical section of this manual include:

Fidelis Care uses the most current version of OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) to determine medical necessity for all levels of substance abuse rehabilitation and other outpatient levels of chemical dependency treatment. Fidelis Care utilizes the most current version of the MCG Behavioral Health Care Guidelines (Milliman criteria) to determine medical necessity for all required mental health services for which guidelines have been developed. These services include:

- Inpatient psychiatric services
- Comprehensive psychiatric emergency room
- Partial hospitalization

Outpatient clinic (OMH services): Routine outpatient mental health clinic services do not require authorization. For those more intensive services that do require authorization, such as intensive outpatient treatment, Milliman Care Guidelines will be used for all services covered by the guidelines. Fidelis Care will utilize its own criteria, developed based on review of best practices and available evidence, for those services requiring authorization when no Milliman Care Guidelines exist, such as psychological criteria developed by Fidelis Care based on review of best practices, guidelines made available in the public domain by other MCOs, BHOs, and government agencies, and other available evidence will be utilized for those required services for which no established national criteria sets or State required criteria are found to exist. These services include:

- Continuing day treatment
- PROS
- ACT
- Rehab services for residents of community residences

1. **Determination of Level of Care/Mental Health:**

   All members referred for evaluation and/or treatment of mental health must have an evaluation to determine the appropriate level of care. Mental health evaluators and therapists must have experience in the evaluation and treatment of the identified disorder and meet the following standard:

   Initial mental health evaluators and therapists providing the ongoing mental health care must be licensed mental health professionals with a minimum of a Master’s Degree in a mental health discipline, or if not licensed, they must be supervised by a licensed mental health professional.

   a. **Psychiatric Visits:**

   The Behavioral Health Department of Fidelis Care will evaluate the need and arrange for an evaluation by a psychiatrist or consultation with a psychiatrist if the member manifests one of the following symptoms:

   1. Active suicidal ideation with plan and/or intent;
   2. Psychotic symptoms;
   3. Symptoms of depression marked by disturbances in appetite, concentration and/or sleep;
   4. Severe impairment causing inability to care for self;
5. Confusion or disorientation of a significant duration and intensity; or

6. Sudden change in behavior or mental status.

b. **Outpatient Mental Health Psychotherapy Guidelines:**

   1. Documentation must indicate a member/family assessment at the start of the treatment that includes a risk factor assessment. Ongoing notes must reflect any movement toward stated behavioral, observable goals within a stated time frame. Changes in diagnosis or treatment plan must be documented.

   2. A plan for termination and discharge plan must be made during the assessment period. The only exception to this will be therapeutic stabilization and medication management for chronic conditions.

   3. Referral for medication assessment must be made in a *timely* manner for diagnoses such as panic disorder and depression. There must be collaboration between the medicating physician and the psychotherapist.

   4. Standard of care for individual sessions is at least thirty (30) minutes. Medication management sessions can be of shorter duration. The standard of care for group sessions is sixty (60) to ninety (90) minutes.

   5. Only one provider will be authorized to provide individual psychotherapy to the member.

   6. Psychotherapy should not occur within twenty-four (24) hours following an ECT treatment or while the member is significantly cognitively impaired.

   7. Psychodynamic Psychotherapy is not indicated for a member who is actively using drugs or alcohol and cannot reliably contract for abstinence while attending the treatment. Focus of intervention with the member should be assessing for the Member’s current readiness for change, and transitioning the member into substance abuse treatment within a defined number of sessions accordingly.

2. **Determination of Level of Care/Chemical Dependency**

   All members referred for evaluation and/or treatment of chemical dependency must have an evaluation completed to determine the appropriate level of care. Authorization of services is not required for routine outpatient services, but is required for more intensive services (as described above) that are covered by the plan according to the benefit package.

   **Levels of Care for Chemical Dependency:**

   a. **Outpatient Services:**

      1. Treatment provided by professional staff;

      2. Supplemented by self-help groups;

      3. One (1) to three (3) hours/day for up to three (3) days/week;
4. Uses a multidisciplinary team to provide individualized physical, psychiatric and addiction treatment (It is preferable that all services are provided in the context of a chemical dependency environment.); and

5. Primary treatment modality is group. (Family and individual counseling sessions should be based on an individualized treatment plan. Individual counseling should be available for members with co-occurring conditions and other members based on their clinical needs.)

b. **Intensive Outpatient/Partial Hospitalization Services:**
   1. Used as an alternative to inpatient treatment;
   2. Treatment provided by professionals with daily physician availability, if needed;
   3. Intensive outpatient is more than three (3) hours per day, three (3) to five (5) days per week; and
   4. Partial hospital service is four (4) or more hours per day, five (5) days per week, and requires medical supervision.

c. **Residential/Inpatient Services:**
   1. Medically supervised by multidisciplinary staff;
   2. Conjunctive treatment available for members with co-occurring diagnoses;
   3. Length of stay determined by criteria for admission and discharge;
   4. May be used as an adjunct to inpatient detoxification to prepare for step-down to a lower level of care; and
   5. Providers must utilize the LOCADTR tool for the utilization review process to determine the next level of care.

d. **Intensive Inpatient Services:**
   1. Usually a general acute care medical facility; and
   2. Used when a medical condition is the predominant concern, such as a medically complex detoxification due to co-morbid medical conditions.

3. **Managing the Member with Co-occurring Diagnoses (MH & SUD):**

   Most benefit plans differentiate coverage/benefits for mental health and chemical dependency treatment. The benefit that will be applied will be determined based on the primary diagnosis using current version of DSM- criteria and level of care guidelines.

   a. Regardless of the point of entry for services (e.g., inpatient mental health unit, inpatient detox or rehab unit) providers are expected to comprehensively assess members for co-occurring disorders and treatment needs. Inpatient units admitting members with co-occurring conditions are expected to have the expertise and resources available to assess the full range of such conditions and make adequate provisions for treatment...
required on the basis of such assessment. If the provider is unable to do so, they are required to work with Fidelis Care BH staff to arrange appropriate transfer or referral.

b. Integrated treatment is required, with the sequencing and emphasis of treating the co-occurring disorders (e.g., stabilizing psychiatric symptoms, initiating detox, and initiating substance abuse rehab services) determined by the nature, acuity and intensity of the member’s symptoms. c. Aftercare plans must include appropriate coordinated follow up treatment for all co-occurring disorders. When feasible, referral to outpatient programs that can provide integrated services for both mental health and substance use disorders should be considered. When separate outpatient providers are used to treat mental health and substance use disorders, coordination of services and collaboration among providers is expected.

4. Guidelines for Other Disorders:

   a. Attention Deficit Disorders (ADD/ADHD):
      A PCP evaluation is recommended and efforts should be made to obtain copies of any PCP and/or specialist evaluation results prior to psychiatric evaluation or treatment.

   b. Eating Disorders:

      1. Inpatient Services for eating disorders are clinically indicated when the member exhibits one or more of the following conditions:
         - The member’s life is in danger due to physical impairment from an eating disorder;
         - Requires twenty-four (24) hour nursing care and close supervision;
         - Has a suicidal intent and/or plan;
         - Has another primary psychiatric diagnosis and is in need of acute care and/or;
         - Fails to respond to intensive outpatient treatment
         - Severity of malnutrition (e.g. BMI below 15)

      2. Eating Disorder Intensive Outpatient Programs requirements include:
         - Evaluation by a registered dietitian;
         - Individual or group nutritional education;
         - Weekly progress notes by psychiatrist;
         - Supervision during any meal or medication time;
         - Weighing member at least 2x/week; and
         - Family therapy, unless contra-indicated.

V. CLINICAL CRITERIA FOR BEHAVIORAL HEALTH

A. Determining Medical Necessity

Clinical criteria, the markers used to determine medical necessity decisions, are based on national standards for mental health and chemical dependence practice.

Medically necessary treatments are defined as services that are:

1. Provided for the diagnosis or care and treatment of a disease or condition defined by the standard diagnostic classification system of the current DSM version.
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2. Essential for the care and treatment of the behavioral health condition, indicating treatment is essential since no less restrictive level of care can provide the clinical intervention required to ensure the safety and effective treatment of the member;

3. Adequate for the care and treatment of the behavioral health condition indicating treatment is considered adequate if the assessment and treatment plan are clinically appropriate, comprehensive, and active, with timely monitoring and revision;

4. Considered generally acceptable medical practice based on national standards of clinical practice and current clinical research; and

5. Have a reasonable expectation of being successful in alleviating symptoms and/or improving member functioning.

B. General Criteria for Behavioral Health Clinical Review

Inpatient Care

The following conditions substantiate the necessity of inpatient admission for clinical care of a behavioral health condition:

1. Serious psychiatric symptoms indicating the inability of the member to care for him/herself or that are potentially life threatening if not treated at this level of care;

2. Actual or high probability of being a danger to self, others or property, with serious current display of these symptoms and behaviors;

3. Identified psychosocial stressors occurring immediately prior to admission that may be precipitants of the escalation of severe symptoms and may have significant impact on the safety of the member and diminish the capacity of the member to comply with lesser level of care treatment; and

4. An inability of the member to engage in management at a lesser level of care due to acute symptoms that result in one or more of the following:
   a. not keeping outpatient appointments;
   b. high risk or runaway behavior;
   c. profound decrease in social and/or occupational functioning from baseline;
   d. not taking medications as prescribed; or
   e. worsening of significant symptoms despite stepped up outpatient treatment as member's symptoms increased.

The following are required to support medical necessity and the adequacy of the inpatient treatment plan:

1. A comprehensive assessment of previous behavioral health treatment plans;

2. Evaluation of the outcome of the prior treatments;
3. Documentation that the proposed treatment plan for the current level of care addresses the specific clinical presentation of the member and is not a repetition of a previously unsuccessful plan of treatment (unless the circumstances and/or member’s condition has changed such that specific indications are now evident to suggest the member would benefit from the same treatment plan to a greater extent than previously); and

4. Clear identification of the target symptoms, goals, and objectives of treatment include objective measures that can be assessed within a specified time frame.

The following should be present to validate the medical necessity for continued inpatient care:

1. Progress in diminishing the target symptoms is evident and measurable;

2. Treatment is active and realistic in its goals and flexibly revised if the member's condition does not improve within an expected time frame;

3. Family and social supports have been assessed in a substantive manner with the member and family participating in the treatment program to the extent that they are capable and to the extent that the Member consents; and

4. Discharge planning is initiated during the assessment phase of treatment.

The following should be present to validate the readiness of the member for discharge to a lower level of care:

1. The member's level of functioning has improved to the extent that clinical stability can be maintained in a less restrictive treatment setting and the member does not require twenty-four (24) hour supervision; and

2. Improvement in the following areas:
   a. Increased self-control over the expression of thoughts and feelings and demonstrated appropriate behavior and increased self-management;
   b. Identification, if not implementation, of appropriate coping strategies to deal with stressors;
   c. Member has verbalized and/or demonstrated a commitment to the aftercare planning process;
   d. Re-established relationships with significant others and activities that are necessary in order to maintain adequate social and/or occupational functioning;
   e. Understanding of and informed consent to the prescribed medication regime. Member is willing and able to collaborate with their community provider, independently or with the help of a significant other, to address any issues regarding their medication;
   f. The member has made a commitment to the aftercare plan for continued treatment at a lesser level of care.

C. Acute Care Inpatient Clinical Criteria for Behavioral Health

C.1: Adult Admission Criteria:
For all levels of care, there are two major dimensions: "Seriousness of the Illness" and the "Intensity of the Treatment".

1. For admission to an acute care facility, the case must meet at least one of the "seriousness of the illness" criteria and at least one of the "intensity of treatment" criteria.
   a. Seriousness of the Illness Criteria:
      1. A continued dangerousness to self or others is demonstrated by a suicidal and/or homicidal specific attempt or plan with means to accomplish.
      2. Acute psychotic thoughts that likely constitute a danger to self or others if the member acts on them (e.g. not eating secondary to paranoia)
      3. Intensification of psychiatric symptoms despite intensive outpatient treatment as a treatment response to the member's deteriorating condition.
      4. Presence of life-threatening behaviors that cannot be safely treated on an outpatient or partial hospital basis.
      5. A loss of impulse control which is life threatening.
   b. Intensity of Treatment Criteria:
      1. Detoxification program where mediation and skilled nursing are required to control withdrawal symptoms that are life-threatening.
      2. ECT, initial and subsequent, when outpatient ECT cannot be safely administered.
      3. Administration of IM/IV medications daily.
      4. Twenty-four (24) hour medication supervision for pharmacotherapy and/or concomitant medical conditions where severe side effects are possible.
      5. Suicide and homicide precautions or close observation and step-down precautions are required for the safety of the member.

2. In addition to meeting the above criteria, the admission must not meet any of the following conditions.
   a. The admission is for "custodial care" to treat a chronic condition without any evidence of an acute exacerbation of symptoms.
   b. The admission is "voluntary" and being considered solely to avoid incarceration or other legal consequences, in the absence of clinical indications for admission.
   c. The member's condition could be adequately managed at a less restrictive level of care.
   d. Admission is solely for the need of an alternative living environment.

C.2: Adult Continued Stay Inpatient Criteria
1. For continued stay at an acute care facility, at least one of the following "seriousness of the illness" criteria and at least one of the "intensity of treatment" criteria must apply.

   a. **Seriousness of the Illness Criteria:**


      2. Persistence of acute specific threat to self or others defined by a suicidal or homicidal attempt or a plan with means and intent.

      3. Despite aggressive treatment interventions, continued evidence of severe symptoms or impairments such as:
         a. acute psychosis;
         b. acute disorientation;
         c. severe dysfunctional behavior such as psychomotor retardation or agitation; or
         d. catatonia, or
         e. inability to perform basic self-care and activities of daily living.

   b. **Intensity of Treatment Criteria:**

      1. Inpatient detoxification protocol continues to be required to control life-threatening withdrawal symptoms.

      2. Monitoring or changing of drug regime with possible serious side effects.

      3. Inpatient course of ECT is continuing where outpatient ECT is not clinically indicated.

      4. Continuing daily administration of IM/IV medications.

      5. Continuing close medical supervision for psycho-pharmacotherapy and/or concomitant medical conditions where severe side effects are possible.

      6. Continuing need for the use of suicide and homicide precautions or close observation and step-down precautions are required for the safety of the member.

2. In addition to meeting the above criteria, the continued stay must not meet any of the following conditions:

   a. Member is non-responsive to the acute care treatment with no change in clinical status (or has exhibited additional serious symptoms) and there is no change in the treatment plan that indicates a clinical explanation for such stasis.

   b. Continued stay solely because there is no alternative placement or disposition available, unless member meets criteria and has been formally placed on alternate level of care.
status by the provider, with an adequate discharge & placement plan and active, frequent placement efforts demonstrated on a continued basis.

c. Treatment and the length of stay are dictated solely by a research protocol or program design, not the needs of the member.

d. Refusal of active treatment intervention by the member or family when treatment is medically advised.

e. Therapeutic passes greater in length than twelve (12) hours when member shows the ability to function in a less structured environment.

C.3 Child/Adolescent Admission and Continued Stay Inpatient Criteria

1. For admission and continued stay at an acute care facility, at least one of the following “seriousness of the illness” and one of the “intensity of treatment” criteria must apply:

   a. Seriousness of the Illness Criteria:

   1. Current and persistent life-threatening danger to self or others is demonstrated by a specific suicidal and/or homicidal attempt or plan with means to accomplish this plan.

   2. Current dangerous behavior such as self-mutilation and significant risk-taking where lesser levels of care will not adequately contain the adolescent or child.

   3. Acute psychotic thoughts that likely constitute a danger to self or others if the member acts on these thoughts.

   4. Intensification of serious psychiatric symptoms that impede normal development, despite intensive outpatient treatment as a treatment response to the member’s deteriorating condition.

   5. Presence of life-threatening behaviors that are not safely treated on an outpatient or partial hospital basis.

   6. Presence of other behaviors or symptoms to such a degree that non-acute residential services or partial hospitalization would be insufficient due to:

      a. Repeated running away from home (other than to an acquaintance or structured shelter or runaway program) that poses a clear risk to physical safety;

      b. Ritualistic/obsessive compulsive behavior;

      c. Verbal aggression coupled with a history of violence and severe aggression; or

      d. Explosive behavior without provocation, or serious loss of impulse control.

   b. Intensity of Treatment Criteria:
1. Detoxification program where medication and skilled nursing are required to control withdrawal symptoms which are life-threatening.

2. Administration of IM/IV medications daily.

3. 24 hour medication supervision for pharmacotherapy and/or concomitant medical conditions where severe side effects are possible.

4. Suicide and homicide precautions or close observation and step-down precautions are required for the safety of the child/adolescent.

5. Rapid in-depth, assessment, and treatment of family dysfunction that has failed to improve with intensive outpatient attempts at remediation.

2. In addition to meeting the above criteria, the admission must not meet any of the following conditions:

   a. The admission is for "custodial care" to treat a chronic condition without any evidence of an acute exacerbation of symptoms.

   b. The member’s condition could be adequately managed at a less restrictive level of care.

   c. The admission is "voluntary" and being considered solely to avoid incarceration or other legal consequences, in the absence of clinical indications for admission.

   d. Inability to function in a regular school environment is the sole reason for admission, with the goal being to attain a special school placement.

   e. Admission is solely for the need of an alternative living environment.

3. Fidelis supports the following national standards for timely adolescent/child evaluation when admitted to an acute psychiatric care setting:

   a. Within twenty-four (24) hours of admission:

      1. Contact with family to determine, at a minimum, the history of the presenting problem and what measures have been taken to address the problem.

      2. History of the present illness and previous recent treatment, including a substance abuse history.

   b. For continuing care (Within three (3) days after admission):

      1. Assessment of the following: substance abuse, eating disorders, physical/sexual abuse, school functioning.

      2. Face to face family meeting. (The standard of care for family involvement in treatment is twice weekly family sessions.)

      3. Assessment of developmental strengths and limitations of the child/adolescent.

      4. Coordinate current care with any community provider who had been treating the child or adolescent prior to admission.
5. Initiate formal discharge plan.

4. **Adolescent and child inpatient treatments offer specific challenges to providers and practitioners.** The following is a list of common problem areas in the care of children and adolescents that are flags for review of medical necessity and appropriateness of care:

   a. Treatment of a child or adolescent without assessment of the family.
   
   b. Treatment of a child or adolescent far from home, making family involvement in the treatment very difficult.
   
   c. Use of hospitalization of a child or adolescent when the major issue is a disposition problem rather than an illness so severe as to meet medical necessity criteria for inpatient acute care.
   
   d. Acute treatment beyond a brief evaluation of conduct disorder and oppositional defiance disorder.
   
   e. Failure to assess chemical dependence in the child or adolescent.
   
   f. Failure to involve the family in active and timely treatment.
   
   g. Lack of intervention when sexual abuse, substance abuse, neglect or violence in the family endangers the health or safety of the child or adolescent.
   
   h. Failure of the provider to appropriately contact and do follow-up with protective services when reporting of child or adult abuse is indicated.
   
   i. Continued inpatient treatment of a child or adolescent when the family refuses to comply with an essential aspect of the treatment plan as ordered by the physician.
   
   j. Lack of active and dynamic discharge planning during the initial phase of admission and throughout the hospital course, particularly concerning whether the child or adolescent can return home when ready for discharge.

D. Partial Hospital Care-Clinical Criteria for Behavioral Health

1. **Adult/Child/Adolescent Admission and Continued Stay Partial Hospital Criteria:**

   The purposes of utilizing a Partial Hospitalization program include the following:

   a. Provide stabilization of acute severe mental illness
   
   b. Provide therapeutic diversion from inpatient care; or
   
   c. Minimize and/or stabilize the acute exacerbation of symptoms in a chronic illness.
   
   d. Provide supportive transitional services to members who have stepped down from acute care, require minimal supervision to avoid risk, and need transition services to restore family, school, or employment functioning;
   
   e. Provide stabilization of medication regime, monitoring for possible toxicity, or medication compliance problems; and
f. The purpose of partial hospitalization does NOT include continuing care day treatment to provide long term custodial social rehabilitation for chronic behavioral health problems.

2. For admission to, and continued stay at, a partial hospital program, at least one of the following "seriousness of the illness" and at least one of the following "intensity of treatment" criteria must apply:

a. **Seriousness of the Illness Criteria:**

1. Treatment for the disorder requires a structured psychiatric setting that can also treat a concomitant substance abuse disorder if indicated.

2. Suicidal ideation may be present but is without intent and the member can contract for safety within the partial program.

3. There is a recent history of self-mutilating, risk taking, or other self-destructive behaviors but no current imminent risk.

4. Although there may be a history of assaultive behavior and threats to others, the member shows the ability to reliably attend the program and continue on medication; therefore risk to self and others is reduced and the member does not require twenty-four (24) hour supervision for containment and safety.

5. Daily psychiatric structure and supervision is required for a significant portion of the day due to:
   - Disordered or bizarre behavior;
   - Disorder of mood, or thought; or
   - Psychomotor agitation or retardation, in order to monitor and effect improvements in the member's activity of daily living functions.

b. **Intensity of Treatment Criteria:**

1. Routine daily medical observation and supervision are needed to effect regulation of psychotropic and other medication;

2. To manage serious side effects of medication;

3. To coordinate management of the coexisting medical condition with the psychiatric medication regime;

4. Nursing observation and behavioral intervention are needed to increase present functioning and to continue to decrease the risk to self, others, and property; or

5. Step-down from inpatient care where a comprehensive multi-modal treatment plan requiring medical supervision and coordination was begun and the member can now function without continuous twenty-four (24) -hour observation, but is not stable enough for outpatient care.

E. Behavioral "Home Care" Clinical Criteria and authorization requirements

1. \textit{Psychiatric home care fills an important gap in the mental health continuum of care.} It can:
• provide members with an alternative level of care that complements partial hospitalization, outpatient psychotherapy, or medication management with a psychiatrist; and

• be used as a diversion from inpatient admission

• assist members in their aftercare transition from inpatient to community based care

2. The first three mental health aftercare home visits by a participating provider do not require authorization when provided by a licensed mental health practitioner on referral from Fidelis Care BH staff for the specific purpose of assisting the member with aftercare transition from inpatient to community based care, AND when rendered in accordance with the provider’s contract. All other behavioral health home care services require prior authorization.

Behavioral health home care visits require, the following "seriousness of the illness" criteria and "intensity of treatment" criteria to be met.

a) **Seriousness of Illness Criteria:**

1. The service is provided, on referral from Fidelis Care BH staff, to assist the member in transitioning from inpatient to community based care following discharge; or,

2. Professional psychiatric home care services are an essential part of active treatment and there is an expectation that the member’s condition will improve as a consequence of the monitoring; or,

3. This service is required to prevent deterioration of the member who would otherwise likely need to be hospitalized, or to prevent a re-

b) **Intensity of Treatment Criteria:**

1. The service is provided by an RN who has psychiatric training and/or experience beyond the standard nursing curriculum in behavioral health (for example, a Masters in Psychiatric nursing or significant nursing experience in a mental health setting), a licensed psychiatric social worker, or other licensed behavioral health professional; and

2. The service is initiated on a timely basis (e.g., within seven (7) days of discharge if used to support aftercare transition); and

3. The service has a defined short-term focus, with careful monitoring to determine if the member needs to be stepped-up or down for continued care, or if the member needs further assistance to engage in aftercare follow up outpatient treatment.

F. Outpatient Mental Health Clinical Criteria

1. **Outpatient services require the following criteria to be met.**

   a. **Level of Functioning Criteria (All Must Apply):**
1. Member has a behavioral health diagnosis based on the most current version of DSM being utilized. There is reasonable expectation that the member is capable of making changes as a result of the proposed treatment plan.

2. Functional Deficits. At least one of the following applies:

   a. Evidence of symptoms that clearly affect functioning such as:
      - Impaired performance on job or at school,
      - Impairments in marital or parenting functioning,
      - Impairments in social and interpersonal relationships, or
      - Impairments in caring for self;

   b. Potential for more serious illness in the absence of the current proposed treatment plan;

   c. Clear potential for de-compensation or life-threatening behaviors in the absence of the current proposed treatment plan; or

   d. Clear potential for loss of impulse control in the absence of the current proposed treatment plan.

b. Additional Criteria:

   1. All information—including mental status exam, current and prior mental health and chemical abuse history, and psychological and lab test results, if applicable—must fit the documented diagnosis;

   2. Impairment in functioning must correlate with the diagnosis;

   3. Co-occurring substance use disorders must be identified, assessed, and provisions made for adequate treatment by qualified providers. Any treatment for substance use disorders must be appropriately coordinated with the mental health treatment. The member must have been evaluated for medication, or this option must be discussed with the member, if the disorder has a biological component responsive to medication;

   4. If the member is a child or adolescent, there must be evidence of parental involvement in the treatment plan to the extent that it is appropriate, given age, developmental level, clinical status, and dynamic issues of the member, and the functional capacity of the family to participate; and

   5. Evidence that members receiving psychotropic medications are re-evaluated periodically for continued maintenance and monitored for side effects.

2. In addition to meeting the above criteria, the treatment proposed must not include:

   a. More than one session per day with any one therapist (see exceptions below);

   b. More than one session per day per outpatient treatment modality (see exceptions below); or

   c. More than one therapist concurrently providing the same modality of treatment.
3. Exceptions to above rule: If the request for treatment is for a frequency of more than once a week, the proposed treatment must be a clinically appropriate response for the purpose of:
   a. Stabilizing a member in acute crisis;
   b. Crisis intervention;
   c. Preventing an inpatient admission; or
   d. Stepping-down the treatment modality from inpatient care to outpatient.

G. Community Mental Health Clinical Continuing Care or Concurrent Review Criteria

1. Level of Functioning Criteria (All must apply):
   a. Member has a DSM Axis one (1) or Axis two (2) behavioral health diagnosis; and
   b. There is reasonable expectation that the person is capable of making changes as a result of the proposed treatment plan.

2. Functional Deficits (At least one of the following must apply):
   a. Continued evidence of symptoms that clearly affect functioning, such as:
      1. Impaired performance on the job or at school;
      2. Impairments in marital or parenting functioning;
      3. Impairments in social and interpersonal relationships; or
      4. Impairments in caring for self;
   b. Potential for more serious illness in the absence of the current proposed treatment plan;
   c. Clear potential for decompensation or life-threatening behaviors in the absence of the current proposed treatment plan; or
   d. Clear potential for loss of impulse control in the absence of the current proposed treatment plan.

3. In addition to the above criteria, all of the following conditions must be met:
   a. There is an adequate explanation of the lack of achievement of the psychotherapeutic and/or medication objectives. If there is not a change in the treatment plan, there must be a cogent, clinically driven explanation why a change in is not indicated;
   b. Updated clinical information, including current mental status exam, additional mental health and chemical abuse history, and psychological and lab test results, if applicable, must fit the documented diagnosis;
   c. Information regarding impairment in functioning must correlate with the diagnosis;
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d. Any treatment for co-occurring substance use disorders must be appropriately coordinated with the mental health treatment. If the member is a child or adolescent, there must be ongoing evidence of the parental involvement in the treatment plan, to the extent that it is appropriate given the age, developmental level, clinical status, and dynamic issues of the member; and

e. Evidence that member receiving pharmacotherapy has been re-evaluated periodically for continued maintenance and evidence of side effects.

4. In addition to meeting the above criteria, the treatment proposed must not include:

   a. More than one (1) session per day with any one therapist (see exceptions below);
   b. More than one (1) session per day per outpatient treatment modality (see exceptions below); or
   c. More than one (1) therapist concurrently providing the same modality of treatment.

5. Exceptions to the above rule: If the request for treatment is for a frequency of more than once a week, the proposed treatment must be a clinically appropriate response for the purpose of:

   a. Stabilizing a member in acute crisis;
   b. Crisis intervention;
   c. Preventing an inpatient admission; or
   d. Stepping-down the treatment modality from inpatient care to outpatient.

Assertive Community Treatment (ACT)

Admission Criteria: In the State of New York, ACT serves persons who have a severe and persistent mental illness listed in the diagnostic nomenclature (current diagnosis per DSM IV) that seriously impairs their functioning in the community. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizo-affective disorder), bipolar disorder and/or major or chronic depression, because these illnesses more often cause long-term psychiatric disability. Priority is also given to individuals with continuous high service needs that are not being met in more traditional service settings. Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT.

1. Recipients with serious functional impairments demonstrate at least one of the following conditions:

   a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
   b. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
   c. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

2. Recipients with continuous high service needs demonstrate one or more of the following conditions:

   a. Inability to participate or succeed in traditional, office-based services or case management.
   b. High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
c. High use of psychiatric emergency or crisis services.
d. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
e. Co-existing substance abuse disorder (duration greater than 6 months).
f. Current high risk or recent history of criminal justice involvement.
g. Court ordered pursuant to MHL §9.60 to participate in Assisted Outpatient Treatment.
h. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
i. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.

Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.

**Concurrent Criteria:** Continues to meet admission criteria; in collaboration with the ACT treatment team it is determined that progress is evident in acquiring functional skills, avoiding crises, and managing symptoms but remains unable to engage in traditional mental health services; Does not require a more intensive level of care, and no less intensive level of care would be adequate to meet member's needs.

**Transition Criteria:** No longer meets admission criteria and/or is able to engage effectively in traditional mental health services and other necessary services independently or with the assistance of natural supports; or, requires a more intensive level of services

**Continuing Day Treatment**

**Admission Criteria:** Diagnosis of serious and persistent psychiatric disorder with symptoms that significantly impair functioning and cannot be adequately managed at a less intensive level of care; Can be reasonably expected to benefit from an organized program of multiple services within a structured treatment environment; does not require 24 hour supervision and management such as an inpatient or residential treatment program; has capability to improve home and community functioning through development of more complex personal and social skills; Voluntary consent to admission & treatment

**Concurrent Criteria:** Continues to meet admission criteria; Actively engaging in an individualized treatment plan with specific, realistic, measurable goals & objectives at a level consistent with member's condition; Progress is clearly evident but member has not yet achieved treatment goals; more intensive care continues not to be required, and no less intensive level of care would be adequate to meet member's needs; Treatment includes family and / or other support systems available; Documented evidence of active discharge planning throughout the course of treatment.

**Transition Criteria:** No longer meets admission criteria and/or demonstrates sufficient progress such that member can be safely and adequately managed at a less intensive level of service; or, requires a more intensive level of service; or, member is not progressing toward treatment goals and there is no reasonable expectation of progress despite sustained efforts to modify the treatment plan; or, withdraws consent to treatment

**Health Home Care Coordination & Management**

**Admission Criteria:** In accordance with the criteria set forth by the State of New York, at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, and substance abuse
disorder; one chronic condition and at risk for another; or one serious and persistent mental health condition.

**Concurrent Criteria:** Continues to meet admission criteria; Services are based on an integrated care plan that: Derives from a comprehensive assessment of medical, behavioral, social, legal, housing, educational, employment, and financial history and status; includes coordination and management by an interdisciplinary team; includes person centered interventions developed with involvement of the member and family/caregiver(s); identifies all necessary referrals; identifies and addresses barriers to accessing and following through with care; includes crisis intervention services and addresses relapse prevention; Implementation of the care plan is monitored on a continued basis, including: Execution and follow up of all referrals; service gaps identified and how they are addressed; case management contact frequency and interventions; coordination among service providers; care transitions and how they are managed; There is evidence of progress toward care plan goals, or the care plan is adjusted accordingly.

**Transition Criteria:** Withdraws consent to participate; No longer responds to assertive and sustained outreach efforts; Consistently declines services despite sustained and clinically appropriate efforts to modify the care plan and honor member's preferences; Opt for an alternative, person centered service plan capable of meeting member's needs; Relocates out of geographic area and is referred for appropriate services in their new location; No longer requires health home level of care coordination and management due to substantial and lasting improvements in: Symptom control, community tenure, self-sufficiency, ability to function across multiple life domains, quality of life, and involvement in needed services, and has a continued service plan in place capable of providing the necessary level of ongoing support.

**Partial Hospitalization (PHP)**

Admission/Concurrent/Discharge Criteria: MCG 18th Edition BH Care Guidelines

**Comprehensive Psych Emergency Room (CPEP)**

Admission/Concurrent/Discharge Criteria: MCG 18th Edition BH Care Guidelines

**Personalized Recovery Oriented Services (PROS)**

**Admission Criteria:** Adult with diagnosis of severe and persistent psychiatric disorder, a functional disability due to severity and duration of mental illness in one or more of the following areas: self-care; activities of daily living; interpersonal relations including family and social support networks; or adaptation to change or task performance in work or work-like settings; recommended for admission by licensed practitioner of the healing arts

**Concurrent Criteria:** Continues to meet admission criteria; Services are based on an individualized recovery plan that includes: Person centered goals, objectives, and services that reflect the member's circumstances and preferences; a summary of all assessments; a relapse prevention plan; measureable, achievable objectives with target dates related to goals; identified services directly related to barriers; evidence of active member participation and approval (signature); All program components are identified and include the specific services to be provided, as well as the associated needs, goals, expected duration, and anticipated outcome for each service.

**Transition Criteria:** No longer meets admission criteria and/or demonstrates sufficient progress such that member can be safely and adequately managed at a less intensive level of service; or, requires a more intensive level of service; or, no longer benefits from the program despite sustained efforts to modify the individualized recovery plan and array of program services to meet the member's needs
Rehabilitation services for residents of community residences

Admission Criteria: Diagnosis of severe and persistent psychiatric disorder; Requires an array of rehabilitative therapies and activities in order to reduce functional and adaptive behavior deficits so as to achieve greater stability and/or greater independence in housing arrangements and community functioning, including but not limited to: Daily living skills training, assertiveness / self-advocacy training, socialization, family support training, medication management, symptom management, rehabilitation counseling, and substance abuse services; Written authorization by a physician following a face to face visit

Concurrent Criteria: Continues to meet admission criteria; Services are based on an individual service plan developed with the member's involvement that includes specific goals, objectives, services needed, and staff responsible; Progress is clearly evident but has not yet achieved service plan goals or service plan has been modified to address lack of progress; Does not require a more intensive level of care; Services continue to be authorized by a physician

Transition Criteria: No longer meets admission criteria and/or has demonstrated sufficient improvement in adaptive skills and functioning so as to be able to maintain a stable housing arrangement with natural supports and traditional services; or, withdraws consent or declines to participate in rehabilitative services; or, is unable to benefit from service plan despite sustained efforts to modify plan to better meet individual needs and preferences; or, requires a more intensive level of service

Mobile Crisis Intervention

Admissions/Eligibility Criteria: All adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis receiving this service are experiencing or at imminent risk of experiencing a psychiatric crisis.

Limitations/Exclusions: No Limits

VI. Behavioral Health Benefits under Medicaid and Child Health Plus

Please note: There are no Co-payments or Deductibles Allowed for either the Medicaid or Child Health Plus Programs

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicaid</th>
<th>Child Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community (Outpatient) Mental Health</td>
<td>Unlimited benefit that is based on medical necessity. Routine visits do not require prior authorization. In addition, members are allowed one self-referred visit to an in-network Fidelis Care provider within a twelve (12) month period.</td>
<td>As of November 1, 2009, Child Health Plus members have an unlimited benefit based on medical necessity. Routine visits do not require prior authorization</td>
</tr>
</tbody>
</table>
## Community (Outpatient) Substance Abuse
Unlimited benefit that is based on medical necessity. Routine visits do not require prior authorization. In addition, members are allowed one self-referred visit to an in-network Fidelis Care provider within a twelve (12) month period. Ambulatory detoxification is covered by the plan based on medical necessity.

As of November 1, 2009, Child Health Plus members have an unlimited benefit based on medical necessity. Routine visits do not require prior authorization.

## Inpatient Mental Health and Chemical Dependence (Substance Abuse) Combined
All medically necessary inpatient days are covered.

## Inpatient Detoxification
Covered for unlimited days in a general acute care hospital setting.

## Inpatient Chemical Dependency Rehabilitation
Covered, based on medical necessity.

## Transportation
See provider transportation manual

### Mental Health Service Prior Auth Concurrence Review Medical/Clinical Necessity Criteria Additional Guidance

<table>
<thead>
<tr>
<th>Mental Health Service</th>
<th>Prior Auth</th>
<th>Concurrence Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic services (OMH services)</td>
<td>No</td>
<td>No</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>Internal report of Outpatient visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or changes in services.</td>
</tr>
<tr>
<td>Intensive Outpatient (OMH)</td>
<td>No</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>7 service days, then concurrent</td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
<td>Yes</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td></td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission</td>
<td>No</td>
<td>No</td>
<td>NYS guidelines</td>
<td>Begins with initial visit and ends when Initial Service Recommendation</td>
</tr>
<tr>
<td>Service Description</td>
<td>Approved</td>
<td>Denied</td>
<td>Notes</td>
<td></td>
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<td>-----------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Admissions: Individualized Recovery Planning</td>
<td>Yes</td>
<td>No</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: Clinical Treatment; Intensive Rehabilitation (IR); or Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.</td>
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</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Active Rehabilitation</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services.</td>
<td></td>
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</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness consistent with ACT guidance.</td>
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<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Prior Auth</td>
<td>Concurrent Review</td>
<td>Medical/Clinical Necessity Criteria</td>
<td>Additional Guidance</td>
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<tr>
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</tr>
<tr>
<td>Comprehensive Psych Emergency Room (CPEP)</td>
<td>No</td>
<td>No</td>
<td></td>
<td>Milliman Care Guidelines, most recent edition</td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Internal report of crisis visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or the need for changes in services.</td>
</tr>
<tr>
<td>Mobile Crisis Intervention</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Rehabilitation services for residents of community residences</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>NYS guidelines</td>
</tr>
<tr>
<td>SUD Outpatient Clinic Services (non-intensive)</td>
<td></td>
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<tr>
<td>OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
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<tr>
<td>Substance Use Disorder Intensive Outpatient</td>
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<tr>
<td>OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
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<tr>
<td>Medically Supervised Outpatient Withdrawal</td>
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<tr>
<td>Opioid Treatment Program Services</td>
<td></td>
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<tr>
<td>OASAS Part 822 Outpatient Opioid Treatment Program (OTP) Services</td>
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<tr>
<td>Outpatient Substance Use Disorder Rehabilitation Services</td>
<td></td>
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<tr>
<td>OASAS Part 822 Outpatient Rehabilitation</td>
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<td></td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification (OASAS service)</td>
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<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Required</td>
<td>Authorized</td>
<td>LOCADTR Code</td>
<td>Details</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>Inpatient Medically Supervised Inpatient Detoxification (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Inpatient Treatment (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Rehabilitation Services for Residential SUD Treatment Supports (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Services</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
</tbody>
</table>
### HOME & COMMUNITY BASED SERVICE

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Auth</th>
<th>Concurrent Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Habilitation/Residential Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Family Support and Training</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Short Term Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td>3 service days, then concurrent. No HCBS Assessment Required</td>
</tr>
<tr>
<td>Intensive Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td>3 service days, then concurrent. No HCBS Assessment Required</td>
</tr>
<tr>
<td>Education Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Empowerment Services-Peer Supports</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Prevocational Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Transitional Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Intensive Supported Employment (ISE)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Ongoing Supported Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
<tr>
<td>Supportive Living Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines</td>
<td></td>
</tr>
</tbody>
</table>
MEDICARE ADVANTAGE and DUAL ADVANTAGE

This section of the Fidelis Care Provider Manual provides information for providers serving Fidelis Medicare Advantage/Dual Advantage members. Fidelis Care offers the following Medicare Advantage and Dual Advantage products:

<table>
<thead>
<tr>
<th>Fidelis Medicare Advantage Products</th>
<th>Fidelis Dual Advantage Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelis Medicare Advantage Flex</td>
<td>Fidelis Dual Advantage Flex</td>
</tr>
<tr>
<td>Fidelis Medicare Advantage Without Rx</td>
<td>Fidelis Dual Advantage</td>
</tr>
<tr>
<td>Fidelis Medicare Advantage $0 Premium</td>
<td>Fidelis Medicaid Advantage Plus</td>
</tr>
</tbody>
</table>

"Fidelis Medicare Advantage without Rx and Fidelis Medicare Advantage Flex, are HMO Point of Service products. This permits members to have treatment rendered by non-network providers, generally at a higher out-of-pocket cost. Fidelis Dual Advantage, Fidelis Dual Advantage Flex, Fidelis Medicare $0 Premium and Fidelis Medicaid Advantage Plus are HMO products, which require members to obtain all of their care in-network except for emergent or urgent care."

SPECIAL NEEDS PLANS (SNP) MODEL OF CARE

CMS requires that all SNP have a model of care (MOC), namely, a structure and process by which they deliver healthcare services and benefits to the special needs individuals they elect to target, especially those with chronic illnesses. CMS emphasizes that as Medicare Advantage Plans, all SNPs offer coordinated care delivered by a network of providers who have the clinical expertise to meet the target population's specialized needs, and who do not discriminate against its most vulnerable beneficiaries.

Please see Appendix XVII for Fidelis Care's SNP Model of Care Annual Provider Training

Medical Records

Medical Records, whether electronic or on paper, communicate the member's past medical treatment, past and current health status, and treatment plans for future healthcare. Good documentation facilitates communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment.

When reviewing medical records it is important to note that the following elements are present:

- The record is legible
- All pages contain member identification numbers
- The member's biographical/personal data is present
- The author is identified on each entry
- All entries are dated
- A completed problem list is present
- All allergies and adverse reactions to medications are displayed prominently
- There is an appropriate past medical history in the record
- There is documentation of smoking habits and history of alcohol use or substance abuse
- There is a record of pertinent history and physical examinations
- Lab and other studies have been ordered as appropriate
- Working diagnoses are consistent with findings
• Plans of action/treatment are consistent with diagnoses
• A date for a return visit or a follow-up plan for each encounter is present
• Problems from previous visits been addressed
• Evidence of appropriate uses of consults
• Evidence of continuity and coordination of care between primary and specialty physicians
• Consult summaries, labs, and imaging studies reflect primary care physician’s review
• The care appears to be medically appropriate
• Preventive services are appropriately used
• Documentation of prescriptions given, including drug name, dosages, and dates of initial and refill prescriptions
• Documentation about Advance Directives (includes Health Care Proxy, Living Wills, DNR)

Medical records must be retained for at least ten (10) years.

For additional information regarding Fidelis Care’s standards for medical record documentation, please see section 7 of this manual.

**Dual Eligible Beneficiaries and Financial Protection**

Persons in both Medicare and Medicaid plans are referred to as Qualified Medicare Beneficiary Program (QMB). Through QMB, Medicaid pays Medicare premiums and cost-sharing (subject to State limits).

• Federal law prohibits Medicare providers from charging QMBs for Medicare cost-sharing (“balance billing”) Social Security Act Sections 1902 (n)(3)(C) 1905 (p)(3); 1866(a)(1)(A); 1848 (g)(3)(A).

• Billing protections may apply to other dual eligible if the State holds them harmless for dual eligible cost-sharing 42 CRF § 422.504 (g)(1)(iii).

• Medicare Advantage providers cannot refuse to serve enrollees based on QMB status (Managed Care Manual, Ch. 4, Section 10.5.2).

• Although Medicaid covers QMB cost-sharing, the Balanced Budget Act of 1997 allows States to limit their payment of Medicare deductibles, coinsurance and copays.

• States can limit QMB payments by adopting “lesser-of” policies:
  o Apply the Medicare or Medicaid payment rate, whichever is less.
  o Usually eliminates or reduces the Medicare cost-sharing payment.
  As of 1/2015, NYS and most states apply “lesser of” policies to physician services.

• Refer to CMS Evaluation of QMB beneficiary perspectives, 2015 report at:
  [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf)

• 1-800-MEDICARE – Provided by CMS as a resource and support for QMBs to help resolve billing issues

**Revised Instructions for Providers**

• Revised Medicare Learning Network (MLN) article regarding QMB balance billing

• Revised MLN fact sheet regarding dual eligible:
  • Visit [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf)
Other Resources

- MMCO Q&A regarding balance billing [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareMedicaidGeneralInformation.html](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareMedicaidGeneralInformation.html)

Delivery of Services to Medicare Advantage / Dual Advantage Members

- Each Fidelis Care Medicare Advantage/Dual Advantage member has a member identification card on which is the name and telephone number of the member’s Primary Care Physician (PCP), as well as co-payment requirements. Members shall not use their red, white and blue Medicare Card when accessing care.

- To verify eligibility, call 1-888-FIDELIS (1-888-343-3547) to obtain eligibility or status of claims please go to [fideliscare.org](http://fideliscare.org) to access our secure Provider Portal.

- Primary Care Physicians and Specialist physicians collect the appropriate co-payment from the member at the time of the office visit. Fidelis Care will be billed for the balance of the contracted amount for the visit.

- Fidelis Care is responsible for administering all Medicare and Medicaid approved benefits for members enrolled in our Dual Advantage and Medicaid Advantage Plus plans.

- **Fidelis Care’s Medicare Dual Advantage Flex Program:**
  Fidelis Care’s Medicare Dual Advantage Flex is a program where Fidelis Care is responsible to manage the Medicare benefit only, and Medicaid Fee-for-Service (FFS) manages the Medicaid benefit. The provider initially bills Fidelis Care for the Medicare reimbursement and then bills Medicaid FFS for the remaining cost share. Member co-pays/coinsurance amounts and Medicaid only benefits must be submitted to the New York State Department of Health (NYSDOH) for reimbursement. Providers who are NOT participating with Fee-for-Service (FFS) Medicaid cannot bill Medicaid for applicable services and cannot bill the member for the unpaid portion of the bill.

- In rendering care to Dual Advantage members, you shall monitor health status, manage chronic diseases, avoid inappropriate hospitalizations, and help beneficiaries move from high risk to lower risk on the care continuum. Please refer to the Summary of Benefits at [fideliscare.org](http://fideliscare.org) for co-pays and coinsurances associated with each service listed below, as well as for a list of Medicaid only benefits that must be submitted to the NYSDOH for reimbursement:

Please refer to the Evidence of Coverage or the Summary of Benefits at [fideliscare.org](http://fideliscare.org) for co-pays and coinsurances associated with each service listed below:
• Women may self-refer once each year for a well-woman exam to any Fidelis Medicare Advantage provider contracted for these purposes.

• Members may self-refer for Influenza or Pneumococcal vaccine shots to any Fidelis Medicare Advantage provider.

• Outpatient diagnostic and therapeutic services and supplies are covered benefits.

• Emergency care is covered anywhere worldwide, with the exception of Dual plans. Emergency care for Dual members is covered within the United States only. The definitions and rules for determining coverage are the same as for Medicare.

• “Urgently needed services” are defined as being immediately needed services as a result of an unforeseen illness, injury, or condition when it is not reasonable, given the circumstances, to obtain the services through the member’s PCP or other plan providers. Ordinarily, these services are provided when the member is out of the service area. In extraordinary cases, these services are provided within the service area. In all urgent situations, the member is advised to call his/her PCP.

• Inpatient Skilled Nursing Facility care is covered up to one hundred (100) days, with the exception of Dual plans which are unlimited. The definition of “inpatient Skilled Nursing Facility” care is the same as that used by Medicare. Three criteria must be met: a qualifying skilled service (skilled nursing, physical therapy, speech therapy or occupational therapy); the need to receive the service on a daily basis; and the skilled nursing facility is the only practical way to receive the service.

• Custodial care is not covered. “Custodial Care” is for personal needs rather than medically necessary needs. These services could be provided by people who do not have professional skills or training.

• Members are informed about and encouraged to complete advance directives. It is important that these be retained in a prominent place in member’s medical records.

• Providers serving Medicare beneficiaries must be informed about and responsive to the cultural needs of the beneficiaries.

• Through welcome letters and phone calls, new Fidelis Medicare Advantage/Dual Advantage members are encouraged to make an appointment with their selected PCP as soon as possible. New members are also sent a Health Risk Assessment Form for the member to complete and return to Fidelis Care in a return-addressed envelope. PCPs are notified of high risk and complex cases as soon as possible. PCPs are requested to notify Fidelis Care Case Management about any high-risk or complex cases they identify.

• All Medicare billing guidelines must be followed when submitting your Claims to Fidelis Medicare Advantage/Dual Advantage. Physicians must include the National Provider Identifier and Tax Identification Number on all claims.

• Fidelis Care receives electronic claims submission, for a complete list of vendors, visit the Fidelis Care Web site at fideliscare.org. The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

Mailing Address for Direct Claims Submission
Fidelis Medicare Advantage
PO Box 170
Hierarchical Condition Categories (HCC’s)

HCC Risk Adjustment is the mechanism that CMS uses to adjust the premium payments made to Medicare Advantage plans based on the actual health status of the plan’s beneficiary population. Risk adjustment classifies patient health using Hierarchical Condition Categories (HCC’s), which are groups of related diagnosis codes. When providers submit these codes, additional funds are allocated to cover the projected costs associated with treating their members with these conditions. In order for Fidelis Care to maintain the current benefit levels needed for providing quality patient care, it is critical that providers code to the highest level of specificity based on the diagnoses of their patients.

For additional information regarding the HCC Risk Adjustment Model, you can also visit the CMS website at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Pharmacy

Fidelis Medicare Advantage without Rx does not offer an outpatient prescription drug benefit. However, there are certain drugs and supplies for which Fidelis Medicare Advantage members are eligible. Please visit fideliscare.org for a comprehensive list of covered drugs and supplies listed on our formulary. Fidelis Care has contracted Caremark Advance PCS (a pharmacy benefit management company) to provide these covered drugs and supplies. Please consult the Fidelis Medicare Advantage Provider Directory for a list of participating Caremark Advance PCS pharmacies. Caremark Advance PCS can be reached at 1-800-235-5660.

Member Grievance Resolution Procedure

Members have the right to have their grievances heard and resolved in accordance with the guidelines that are prescribed in law.

A member may ask someone they trust (such as a legal representative, a family member, friend or provider) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, the Plan can help with this.

Definition of Grievances

A grievance is any complaint or dispute, other than a claims issue, where a member is dissatisfied about the way Fidelis Care or a provider handled a situation. Grievances include complaints about quality of care, marketing, member sales materials, office wait time, rudeness, etc. A member may make the complaint either orally or in writing, to Fidelis Care, a provider, or facility. An expedited grievance may also include a complaint that Fidelis Care refused to expedite (known as an organizational determination or reconsideration), or invoked a time extension to create a response to an issue.

Other examples of grievances include complaints about:

- Quality of service
- Office waiting times, physician behavior, adequacy of facilities
- Involuntary disenrollment situations
- Disagreement with plan decision to process member’s request for service or to continue a service under the standard fourteen (14)-calendar day time frame rather than the expedited seventy-two (72) hour time frame.
Time Frames for Processing and Resolving Grievances

<table>
<thead>
<tr>
<th>TYPE OF GRIEVANCE</th>
<th>REASON</th>
<th>WRITTEN ACKNOWLEDGEMENT</th>
<th>RESOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Grievance</td>
<td>Delay may affect Enrollee’s Health</td>
<td>Yes</td>
<td>Resolution within seventy-two (72) hours of receipt of necessary information. Notice by phone. Written response within three (3) calendar days.</td>
</tr>
<tr>
<td>Standard Grievance</td>
<td>A type of complaint an enrollee makes about Fidelis or one of our plan providers, including a complaint concerning the quality of care.</td>
<td>Yes</td>
<td>Resolution within thirty (30) days after receipt of necessary information.</td>
</tr>
<tr>
<td>Grievance Extension</td>
<td>We can take up to fourteen (14) additional days if the enrollee requests the additional time or if we need more time to gather information that might benefit the enrollee.</td>
<td>Yes</td>
<td>Resolution within forty-four (44) days after receipt of necessary information.</td>
</tr>
</tbody>
</table>

Grievances Misclassified as Appeals

Should Fidelis Care misclassify a grievance as an appeal and issue a denial notice, and if the independent review entity determines that the complaint was misclassified as an appeal, then the independent review entity must dismiss the appeal and return the complaint to Fidelis Care for proper processing. Fidelis Care will notify the member in writing that the complaint was misclassified and will be handled through Fidelis Care’s grievance process. Fidelis Care will conduct monthly internal audits of their appeals and grievance system for the presence of errors, and institute appropriate quality improvement projects as needed.

Filing a Complaint with the Plan

To file by phone, members shall contact Member Services at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30am to 6:00pm. If they contact Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, Fidelis Care will notify the member. The member shall write Fidelis Care with their complaint or call the Member Services number and request a complaint form. It should be mailed to Attn: Member Services Department, Fidelis Care, 95-25 Queens Boulevard, Rego Park, NY 11374.

Time Frames for Processing and Resolving Appeals

<table>
<thead>
<tr>
<th>TYPE OF APPEALS</th>
<th>REASON</th>
<th>WRITTEN ACKNOWLEDGEMENT</th>
<th>RESOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Appeal</td>
<td>Delay may affect Enrollee’s</td>
<td>Yes</td>
<td>Resolution within seventy-two (72) hours of receipt of necessary information. Notice by phone. Written response within three</td>
</tr>
</tbody>
</table>
A. **Organizational Determinations:**

The required time frames for making an organizational determination are:

<table>
<thead>
<tr>
<th>Standard Appeal</th>
<th>Health Related to Service</th>
<th>Yes</th>
<th>Resolution within thirty (30) days after receipt of necessary information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Appeal</td>
<td>Health Related to Payment</td>
<td>Yes</td>
<td>Resolution within sixty (60) days after receipt of necessary information.</td>
</tr>
</tbody>
</table>

**Expedited Determinations**

Fidelis Care is required to make an expedited organizational determination as quickly as the member's health requires, but not later than seventy-two (72) hours after receiving the request. The member, the member's authorized representative, or any physician shall request an expedited determination. The member and providers involved in treating the member are notified directly by telephone and within three (3) calendar days by letter. An extension of up to an additional fourteen (14) calendar days is permitted, if the member requests the extension or if Fidelis Care can justify the need for additional information and the extension of time benefits the member. If the extension is taken, the member is notified by letter.

If the request is not approved, the member is informed by telephone and within three (3) calendar days by letter, of the right to appeal and how to enter an appeal.

**Standard Determination for Service**

Fidelis Care is required to make a standard organization determination to provide, authorize, deny, or discontinue a service as expeditiously as the member’s health condition requires, but no later than fourteen (14) calendar days after the request is received.

Extension of up to an additional fourteen (14) calendar days is permitted, if the member requests the extension or if Fidelis Care can justify the need for additional information and the extension of time benefits the member. If the extension is taken, the member is notified by letter.

The member is notified of the decision by letter, sent within three (3) calendar days of the date on which the decision was made. If the request is denied, the member is informed of the right to appeal and how to enter an appeal.

**Standard Determination for Payment**

Fidelis Care is required to make a standard organization determination to pay or deny payment for service within thirty (30) calendar days after receipt of the request. If more information is needed, Fidelis Care can take up to thirty (30) additional calendar days to make a determination. (For non-contracted providers, within thirty (30) calendar days for “clean” claims and within sixty (60) calendar days for all other claims.)

The member is notified of the decision on their monthly EOB, as well as on the weekly Integrated Denial Notice if they have claims that apply.

In addition to the seriousness of matters involved in making organization determinations and reconsideration determinations, failure to meet the required time frames for the determinations and related notifications are themselves appealable events.
B. Appeals of Adverse Administrative Organization Decisions

The member must submit a “written” request for reconsideration within sixty (60) calendar days of notice of the organization’s initial decision.

Expedited Appeals

Expedited Appeals come in through the Member Services Department by telephone and are forwarded directly to the Appeals and Grievance department. The member will be notified by telephone whether the request will be processed through the expedited seventy-two (72) hour process or the standard review process. Written confirmation of this will be sent within three (3) calendar days.

If expedited, the request must be processed as expeditiously as the member’s health requires but not later than seventy-two (72) hours from receipt of the appeal.

Standard Appeals

Appeals related to service
The member will be notified of the reconsideration determination as expeditiously as the member’s health requires, but no later than thirty (30) calendar days after the appeal is received. This may be extended up to fourteen (14) calendar days if the member requests the extension or if Fidelis Care justifies the need for additional information and how the extension benefits the member. Fidelis Dual Advantage members shall follow Medicaid appeal guidelines for Medicaid covered services.

Appeals related to payment
All appeals for payment are standard appeals. There are no expedited payment appeals. Written confirmation of receipt of the appeal is sent to the member within eight (8) business days.

The member will be notified of the reconsideration decision no later than sixty (60) calendar days after receipt of the appeal.

If the decision is fully in favor of the member, Fidelis Care will make the requested payment within sixty (60) calendar days of the date on which the appeal was received.

If an appeal is partially or fully denied, it will qualify as an adverse reconsideration. For non-par providers, an adverse reconsiderations forwarded to the IRE/Maximus, the CMS contracted reviewer.

Appeals IRE/Maximus

The first appeal automatically goes to IRE/Maximus. IRE/Maximus has sixty (60) calendar days to make a decision about payment matters; thirty (30) calendar days to make a decision about standard appeals for medical care (plus fourteen (14) more calendar days if it is to the member’s benefit); seventy-two (72) hours if it is an expedited appeal (plus fourteen (14) calendar days if it is to the member’s benefit).

If IRE/Maximus upholds the appeal:
  • If the matter was about payment, Fidelis Care will pay within sixty (60) calendar days.
  • If it was a standard appeal about medical care, Fidelis Care will authorize the care within seventy-two (72) hours and supply the care within fourteen (14) calendar days.
  • If it was an expedited appeal about medical care, Fidelis Care will authorize or provide the care within seventy-two (72) hours.

If IRE/Maximus denies the appeal, in whole or in part, the member can appeal to an Administrative Law Judge if the matter concerns $150 or more. IRE/Maximus notifies the member of the right to appeal and
how to go about it. The member must appeal within sixty (60) days of the IRE/Maximus notice. (The member can also appeal to the Social Security Administration and Railroad Retirement Board).

**Appeal Administrative Law Judge**

If the Administrative Law Judge upholds the appeal:
- Fidelis Care will pay for, authorize or provide the payment or service sought within sixty (60) calendar days.

If the Administrative Law Judge decides not to review the case, or reviews the case and denies the appeal, the member shall appeal to the Medicare Appeals Council if the member continues to want to challenge Fidelis’ decision.

**Medicare Appeals Council**

The Medicare Appeals Council reviews the case as soon as possible.

If the Medicare Appeals Council upholds the appeal:
- Fidelis Care will pay for, authorize or provide the payment or service sought within sixty (60) calendar days.
- If the Medicare Appeals Council decides not to review the case, or reviews the case and denies the appeal, the member can appeal to a Federal Court Judge if the matter concerns $1460 or more.

**Appeal Federal Court Judge**

Fidelis Care will abide by the findings of the Federal Court Judge.

**Notice of Discharge and Medicare Appeals Rights (NODMAR)**

When Fidelis Care has authorized coverage of an member’s inpatient hospital admission, either directly or by delegation (or the admission constitutes emergency or urgently needed care), Fidelis Care will issue the member a written notice of non-coverage to inform the Medicare enrollee their covered hospital care is ending. Consistent with the regulation (42 CFR 422.620), Fidelis Care (and hospitals that have been delegated responsibility by Fidelis Care to make the discharge/non-coverage decision) will distribute the NODMAR (by 12:00 pm the day preceding discharge) only when:

1. The member expresses dissatisfaction with his or her impending discharge; or
2. Fidelis Care (or the hospital that has been delegated the responsibility) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay.

**Fast Track Appeals Process**

Fidelis Care Medicare Advantage members will receive a notice at least two days before any planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Members then shall request an independent review of Fidelis Care’s decision to end such coverage. In the event of a timely appeal request, Fidelis Care will issue a second request that explains the reasons why their Medicare coverage will end.

Fidelis Care will use the standardized CMS forms to notify members. The initial notice the enrollee will receive will be the “Notice of Medicare Non-Coverage” (NOMNC). The follow-up notice that will be used if
the member disputes their coverage termination decision will be the “Detailed Explanation of Non-Coverage” (DENC).

Notice Requirements for Non-Contracted Providers

If Fidelis Care denies a request for payment from a non-contracted provider, Fidelis Care will notify the non-contracted provider of the specific reason for the denial and provide a description of the appeals process. If the non-contracted provider wishes to appeal, he/she can only appeal after they sign the Waiver of Liability (WOL). By signing this form the non-contracted provider waives his rights to balance bill the member. The provider has sixty (60) from the date of the notice to return this form. Failure to do so will result in the dismissal of the appeal.

Complaints That Apply to Both Appeals and Grievances

Complaints may include both grievances and appeals. Complaints can be processed under the appeal procedures, under the grievance procedure, or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations. One complaint letter could contain a grievance issue and an appeal issue. If a member addresses two or more issues in one complaint, each issue will be processed separately and simultaneously (to the extent possible) under the proper procedure by Fidelis Care.

Good Cause Extensions

If a party shows good cause, Fidelis Care may extend the timeframes for filing a request for reconsideration. Fidelis Care will consider the circumstances that kept the member from making the request on time and whether any organizational actions might have misled the member.

The party requesting the good-cause extension shall file the request with Fidelis Care, the Social Security Office, or the Railroad Retirement Board office in writing, including the reason why the request was not filed timely. If Fidelis Care denies a member’s request for a good cause extension, the member shall file a grievance with Fidelis Care.

Withdrawal of Request for Reconsideration

The party that files a request for reconsideration from Fidelis Care may withdraw the request for reconsideration at any time before a decision is made by writing to Fidelis Care, the Social Security Office, or the Railroad Retirement Board office.

Compliance with Centers for Medicare and Medicaid Services (CMS) Requirements:
Fidelis Medicare Advantage is in full compliance with all CMS (formerly called HCFA) requirements including: Quality Assurance, Health Services Delivery, Contracting, Marketing, Enrollment and Disenrollment, Grievances and Appeals, Claims, Monitoring, Reporting and Financial Accountability.

Reopening and Revising Determinations and Decisions

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. That action may be taken by:

• A Medicare health plan to revise the organization determination or reconsideration;
• An IRE to revise the reconsidered determination;
• An ALJ to revise the hearing decision; or
• The MAC to revise the hearing or review decision.
A Medicare health plan must process clerical errors (which include minor errors and omissions) as reopenings, instead of reconsiderations. If the organization receives a request for reopening and disagrees that the issue is a clerical error, the organization must dismiss the reopening request and advise the party of any appeal rights, provided the time frame to request an appeal on the original denial has not expired. For purposes of this section, clerical error includes human and mechanical errors on the part of the party or the Medicare health plan, such as:

- Mathematical or computational mistakes;
- Inaccurate data entry; or
- Denials of claims as duplicates.

When a party has filed a valid request for an appeal of an organization determination, reconsideration, ALJ hearing, or MAC review, no adjudicator has jurisdiction to reopen an issue that is under appeal until all appeal rights at the particular appeal level are exhausted (except for clerical errors, as described above). Once the appeal rights have been exhausted, the Medicare health plan, IRE, ALJ, or MAC may reopen as set forth in this section. A party cannot have an appeal and a reopening occurring simultaneously with respect to the same coverage determination.

The Medicare health plan’s, IRE’s, ALJ’s, or MAC’s decision on whether to reopen is final and not subject to appeal. Also, the filing of a request for a reopening with the IRE, ALJ, or MAC, does not relieve the Medicare health plan of its obligation to make payment for, authorize, or provide services as specified in this chapter.

**Guidelines for a Reopening**

The following are guidelines for a reopening request:

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and
- The request should be made within the time frames permitted for reopening (as set forth in section 130.2).

**Time Frames and Requirements for Reopening**

Reopenings of organization determinations and reconsiderations initiated by a Medicare health plan:

- Within 1 year from the date of the organization determination or reconsideration for any reason;
- Within 4 years from the date of the organization determination or reconsideration for good cause as defined in §130.3;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;
- At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

Reopening of organization determinations and reconsiderations requested by a party:

- A party may request that a Medicare health plan reopen its organization determination or reconsideration within 1 year from the date of the organization determination or reconsideration for any reason;
• A party may request that a Medicare health plan reopen its organization determination or reconsideration within 4 years from the date of the organization determination or reconsideration for good cause in accordance with section 130.3; or
• A party may request that a Medicare health plan reopen its organization determination at any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Reopening reconsiderations, hearing decisions and reviews initiated by an IRE, ALJ, or the MAC:
• An IRE may reopen its reconsideration on its own motion within 180 days from the date of the reconsideration for good cause in accordance with §130.3. If the IRE's reconsideration was procured by fraud or similar fault, then the IRE may reopen at any time;
• An ALJ may reopen his or her hearing decision on his or her own motion within 180 days from the date of the decision for good cause in accordance with §130.3. If the ALJ's decision was procured by fraud or similar fault, then the ALJ may reopen at any time; or
• The MAC may reopen its review decision on its own motion within 180 days from the date of the review decision for good cause in accordance with §130.3. If the MAC's decision was procured by fraud or similar fault, then the MAC may reopen at any time.

Reopening IRE reconsiderations, hearing decisions, and reviews requested by a party:
• A party to a reconsideration may request that an IRE reopen its reconsideration;
• Within 180 days from the date of the reconsideration for good cause in accordance with §130.3; and
• A party to a hearing may request that an ALJ reopen his or her decision within 180 days from the date of the hearing decision for good cause in accordance with §130.3; or
• A party to a review may request that the MAC reopen its decision within 180 days from the date of the review decision for good cause in accordance with §130.3.

Good Cause for Reopening
Good cause may be established when:
• There is new and material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or
• The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude organizations from conducting reopenings to effectuate coverage (NCD) decisions.

Notice of a Revised Determination or Decision
Reopenings Initiated by the Medicare Health Plan, IRE, ALJ, or the MAC
When any determination or decision is reopened and revised as provided in §130, the Medicare health plan, IRE, ALJ, or the MAC must mail its revised determination or decision to the parties to that determination or decision at their last known address. An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal and must also be provided to the enrollee at his/her last known address.
Reopenings Initiated at the Request of a Party

The Medicare health plan, IRE, ALJ, or the MAC must mail its revised determination or decision to the parties to that determination or decision at their last known address. An adverse revised determination or decision must state the rationale and basis for the reopening and revision and any right to appeal.

If the enrollee is the party which initiated the reopening, the adverse revised determination or decision must also be provided at his/her last known address.

Definition of Terms in the Reopening Process

Meaning of New and Material Evidence

The submittal of any additional evidence is not a basis for reopening in and of itself. “New and material evidence” is evidence that had not been considered when making the original decision. This evidence must show facts not previously available, which could possibly result in a different decision. New information also includes an interpretation of existing information that the adjudicator deems to be credible (e.g., a different interpretation of a benefit).

Meaning of Clerical Error

A clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, and computer errors.

Meaning of Error on the Face of the Evidence

An error on the face of the evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file. For example, a piece of evidence could have been contained in the file, but misinterpreted or overlooked by the person making the determination.
FIDELIS CARE AT HOME

This section of the Fidelis Care Provider Manual provides information for providers serving Fidelis Care at Home (FCAH) members.

Member Eligibility

Fidelis Care at Home provides managed long-term care services to members who have Medicaid, are at least eighteen (18) years of age, and reside in an approved service area. Each member must be assessed by a Fidelis Care Assessment Nurse, to be capable, as of the time of enrollment, of remaining in their home and community without jeopardizing their health or safety, or that of others. Members can continue to use their Medicare and/or Medicaid cards for non-covered services while in FCAH and can continue to use or select their own primary care physician.

Delivery of Services to Fidelis Care at Home Members:

- Each FCAH member has a member identification card, which shows the plan name, member's name, member identification number, member effective date and important telephone numbers. There are no copays or deductibles for FCAH members.

- The provider can also verify the member's current eligibility by either accessing Fidelis Care’s Provider Access Online at fideliscare.org or by using the Integrated Voice Response (IVR) by calling 1-888-FIDELIS (1-888-343-3547).

- Members are informed about, and encouraged to complete advance directives. It is important that these be retained in a prominent place in the member's medical records.

- Providers serving FCAH members must be informed and responsive to the cultural needs of the beneficiaries.

Fidelis Care is responsible for coordinating, arranging, and authorizing FCAH payment to providers for the member's medically necessary covered services. Covered services are provided through a network of Fidelis Care participating healthcare providers as listed in our Provider Directory.

Member Benefits

Below is the list of covered services under the FCAH program.
### Services covered by FCAH include

- Care Management
- Home health care
- Nursing
- Home health aide
- Outpatient Physical therapy (certain limitations apply)
- Outpatient Occupational therapy
- Outpatient Speech pathology
- Medical social services
- Adult day health care
- Personal care aides
- Consumer Directed Personal Assistance Services
- Durable medical equipment and oxygen
- Medical and surgical supplies (certain limitations apply)
- Prosthetics and orthotics (certain limitations apply)
- Personal emergency response system
- Non-emergency transportation
- Podiatry
- Dentistry
- Optometry/eyeglasses
- Audiology/hearing aids and hearing aid batteries
- Home delivered or congregate meals
- Social day care
- Respiratory therapy
- Nutritionist
- Social and environmental supports
- In-home Physical therapy, occupational therapy, and speech pathology.
- Nursing Home care (Please note that if you have Medicaid but are not eligible for 'Institutional Medicaid' you will be disenrolled from FCAH if you require such care).

### Services covered by Fee for Service Medicaid and/or Medicare

FCAH may assist in obtaining these services and in making appointments and arranging non-emergency transportation and follow-up care if needed.

- Inpatient hospital services
- Outpatient hospital services
- Physician services including services provided in an office setting, a clinic, a facility, or in the home (includes nurse practitioners and physicians' assistants acting as "physician extenders")
- Laboratory services
- Radiology and radioisotope services
- Emergency transportation
- Rural health clinic services
### Care Management

A Nurse Care Manager will be assigned to each member. She/he will assist members in living at home for as long as possible and will help them access services available in the community. Providers are required to contact the Nurse Care Manager to request authorization for all non-emergency services; please call FCAH at 1-888-FIDELIS (1-888-343-3547).

- Fidelis Care will call members monthly to ensure that members are satisfied with the services offered.

Members may leave the service area temporarily. Fidelis Care will continue to provide non-emergency covered services to the extent they can be arranged with area providers. Members should notify their Nurse Care Manager as early as possible so that appropriate services can be arranged.

- Fidelis Care will discuss Advance Directives with all applicants.

- Fidelis Care will collaborate with the member, family, significant other and the member’s primary care physician to evaluate the member’s medical history and care needs and, with the member’s cooperation, will formulate a member service plan of care outlining the services a member will be receiving. (i.e.: daycare, personal care, home delivered meals, personal emergency response system, durable medical equipment etc).

### Authorizations

Fidelis Care will coordinate and manage the covered services.

To obtain an updated provider listing, please contact the Fidelis Care Call Center at 1-888-FIDELIS (1-888-343-3547).

- Fidelis Care may also assist members in obtaining non-covered services or those covered by Medicaid or Medicare.

- Fidelis Care will also arrange transportation for the members if needed for medical appointments.

- If services are approved, Fidelis Care will issue an authorization for each service.

- Providers should notify Fidelis Care if a member requires any additional services.

- Fidelis Care will be on call after regular business hours, from 5:00 PM to 8:30 AM and on weekends and holidays, in order to assist you with urgent care or other issues twenty-four (24) hours a day. Please call FCAH at 1-888-FIDELIS (1-888-343-3547).
Emergency Services

Authorization is never required prior to providing services for emergency medical conditions.

Consistent with Federal and State law, an Emergency Medical Condition is defined by using a Prudent Layperson Standard, which is as follows:

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child, or in the case of a behavioral health condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of the person.

Billing/Claims

Providers

Claims must be submitted electronically; providers must submit claims for home healthcare services, durable medical equipment (DME), respiratory care, physical, occupational and speech therapies on a CMS-1500 or UB04 claim form within ninety (90) calendar days of the date of service.

Mailing Address For Direct Claims Submission:

Fidelis Care at Home
Corporate Claims Department
P.O. Box 1707
Amherst, New York 14226-1707

Please refer to section 12 of this manual for additional information.

Clinical Appeals Process

Providers shall appeal Fidelis Care's clinical decision, within sixty (60) days of the adverse determination by calling or sending clinical and/or other pertinent information to:

Attn: Member Services
Fidelis Care
95-25 Queens Blvd.
7th Floor
Rego Park, NY 11374

Please refer to section 13 of this manual for additional information.

Quality Assurance

For information please refer to Section 10 of this manual.
Provider Credentialing and Termination

Please refer to Section 9 of this manual for additional information.

Retention of Medical Records

- Medical records must be retained for at least ten (10) years.

For additional information please refer to section 7 of this manual.

Confidentiality

For information please refer to section 3 of this manual.
MEDICAID ADVANTAGE PLUS

Fidelis Medicaid Advantage Plus (MAP) is for individuals who have Medicare and Medicaid coverage and who have a chronic illness or disability.

Member Eligibility

Fidelis Medicaid Advantage Plus provides managed long-term care services to members who: have Medicaid and Medicare, are at least eighteen (18) years of age, and reside in Fidelis Care's service area. The information presented here in no way supersedes any part of the Provider Service Agreement. With the exception of those items mentioned below, the Provider Manual remains in full effect with regard to the Fidelis Medicaid Advantage Plus program.

Each potential member must be assessed by a Fidelis Care Assessment Nurse to determine whether they are capable, as of the time of enrollment, of remaining in their home and community without jeopardy to health or safety, or to that of others. Members can continue to use their Medicare and/or Medicaid cards for non-covered services while in Fidelis Care.

Delivery of Services to Fidelis Medicaid Advantage Plus Members

- Each MAP member has a member identification card that shows the Plan Name, member’s name, member identification number, member effective date and important telephone numbers.

- Members can continue to use their Medicare and/or Medicaid cards for services which are not covered by Fidelis Care but may be covered by Medicare and/or Medicaid directly.

- Members need to use providers in Fidelis’ provider network, including your Primary Care Provider (PCP). Members can select their own PCP. There are no co-payments or deductibles for MAP members.

- The provider can verify the member's current eligibility by calling 1-888-FIDELIS (1-888-343-3547) or using the Web portal by going to https://providers.fideliscare.org

- Members are informed about and encouraged to complete advance directives. It is important that these be retained in a prominent place in the member’s medical records.

- Providers serving MAP beneficiaries must be informed and responsive to the cultural needs of the beneficiaries.

Member Benefits

Below is the list of covered services under the MAP program. The care must be “medically necessary” as determined by the member’s physician. This means that the services provided are needed to prevent, diagnose, correct, or cure any conditions that the member might have that may cause acute suffering, endanger life, result in illness or infirmity, interfere with the member’s capacity for normal activity, or threaten some significant disability.
<table>
<thead>
<tr>
<th>MAP Services</th>
<th>How to Obtain Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Day Health Care</strong></td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance.</strong></td>
</tr>
<tr>
<td>• medical</td>
<td></td>
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<tr>
<td>• nursing</td>
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<td>• food and nutrition</td>
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<tr>
<td>• social services</td>
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<tr>
<td>• rehabilitation therapy</td>
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<td>• leisure activities</td>
<td></td>
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<tr>
<td>• pharmaceutical</td>
<td></td>
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<tr>
<td>• other ancillary services.</td>
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<tr>
<td><strong>Dental Care -Medicaid covered dental services including</strong></td>
<td><strong>See participating provider listing or contact Member Services at 1-888 FIDELIS 1-888-343-3547 for assistance.</strong></td>
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<tr>
<td>• necessary preventative</td>
<td></td>
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<tr>
<td>• prophylactic</td>
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<tr>
<td>• other routine dental care services</td>
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<tr>
<td>• supplies and dental prosthetics to alleviate a serious health condition.</td>
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<tr>
<td>• ambulatory or inpatient surgical (when not covered by Medicare) dental services.</td>
<td></td>
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<tr>
<td>• the replacement of lost or damaged dentures will be considered based on individual circumstances. <strong>Dental implants are excluded from coverage.</strong></td>
<td></td>
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<tr>
<td><strong>• home Delivered Meals</strong></td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance.</strong></td>
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<tr>
<td>• meals in a group setting such as a day care</td>
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<tr>
<td><strong>Home Health Care Services Not Covered by Medicare</strong></td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</strong></td>
</tr>
<tr>
<td>• nursing</td>
<td></td>
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<tr>
<td>• home health aide</td>
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<tr>
<td>• occupational</td>
<td></td>
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<tr>
<td>• physical and speech therapies</td>
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<tr>
<td>• inpatient mental health care (over the 190 day lifetime Medicare limit)</td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</strong></td>
</tr>
<tr>
<td>• medical social services - assessment, arranging, providing aid for social problems related to maintaining and individual at home.</td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</strong></td>
</tr>
<tr>
<td>• medical/surgical supplies</td>
<td><strong>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</strong></td>
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<tr>
<td>• enteral/parenteral formula</td>
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<tr>
<td>• supplements</td>
<td></td>
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<td>• hearing Aid Batteries</td>
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<tr>
<td><strong>Non-Emergency Transportation</strong></td>
<td><strong>Contact the Transportation Department at 1-888-444-3144 for assistance</strong></td>
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<tr>
<td>• ambulette</td>
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<td>• invalid coach</td>
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<tr>
<td>• taxicab</td>
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<td>• livery</td>
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<tr>
<td>• public transportation</td>
<td></td>
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<tr>
<td>• other means</td>
<td></td>
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<tr>
<td>Service Description</td>
<td>Contact Information</td>
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<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
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<tr>
<td>Appropriate to the member's medical condition and a transportation attendant to accompany the member, if necessary.</td>
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<tr>
<td><strong>Transportation requests</strong> must be made twenty-four (24) to forty-eight (48) hours before scheduled appointments. Same day requests must be confirmed as urgently needed medical follow-up.</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Care - not covered by Medicare (provided the member is eligible for institutional Medicaid).</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Members can self-refer to participating providers in a twelve (12) month for the following benefits/services</td>
<td>Contact Member Services at 1-888 FIDELIS 1-888-343-3547 for assistance.</td>
</tr>
<tr>
<td>• outpatient Mental Health assessment</td>
<td></td>
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<tr>
<td>• outpatient Substance Abuse assessment</td>
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<tr>
<td>Outpatient Rehabilitation</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
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<tr>
<td>• OT</td>
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<td>• PT</td>
<td></td>
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<tr>
<td>• Speech</td>
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<tr>
<td>Personal Care (assistance with bathing, eating, dressing toileting and walking)</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Consumer Directed Personal Assistance (CDPAS)</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Personal Emergency Response System / Lifeline Unit</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance in arranging Lifeline services.</td>
</tr>
<tr>
<td>Podiatry - Medically necessary foot care, including care for medical conditions affecting lower limbs. (Visits for routine foot care are limited to four (4) visits per year)</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Private Duty Nursing Services</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Social Adult Day Care</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Social/Environmental Supports (chore, services, home modifications, respite services)</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>Contact the Nurse Care Manager at 1-800-688-7422 for assistance</td>
</tr>
</tbody>
</table>
Fidelis Care Guidelines

All services must be coordinated by Fidelis Care's Nurse Care Manager. If a member requires services in your office or agency other than those that have been pre-authorized by Fidelis Care, you must call Fidelis Care so that we can monitor and determine whether to authorize benefits being recommended. The provider must inform the Care Manager of any identified barriers to maintaining the member’s health. A corrective plan of action will be implemented to address any issue or concern identified. Supportive documentation will be maintained in the patient’s file and at the subcontracting provider. Subcontracted providers, as listed in the service benefits package, shall refer members to other participating network providers, unless there is no provider in Fidelis Care’s network.

The members must use providers that are participating in the program; out-of-network care must be pre-authorized and arranged by Fidelis Care.

Service Authorizations and Actions

When Fidelis Care determines that services are covered solely by Medicaid, we will make decisions about care following these rules:

Prior Authorization

Some covered services require prior authorization (approval in advance) from Fidelis Care before the member receives them or in order to be able to continue receiving them.

Please contact Fidelis Care’s Nurse Managers regarding all prior authorization requests. Fidelis Care’s Nurse Care Managers coordinate and manage each member’s overall care, including care by PCP, specialty, ancillary, tertiary, and out-of-network providers, to the extent possible.

- Primary care physicians and other providers shall call or fax a treatment request that Fidelis Care will consider as a basis for authorizing services.
- When referring for services covered in the service benefits package, ensure that the provider is contracted and participating in the network. If you have any questions, please contact Fidelis Care. To obtain an updated provider listing, please call 1 (877) 533-2404.
- Members can choose any participating hospital or specialist they wish; however, please contact the member’s Nurse Care Manager. This will aid the Nurse Care Manager in properly coordinating services. Nurse Care Managers may also assist members in obtaining non-covered services or those covered by Medicaid fee for service or traditional Medicare, and will arrange transportation for the members.
- Once a request has been approved by Fidelis Care, authorizations will be issued for each service.
- Please be sure to notify the Nurse Care Manager if a patient requires Dental, Podiatry, Nutritional, Optometry, or Audiology services that are subject to Utilization Review.
- A Nurse Care Manager will be on call after regular business hours, from 5pm to 8:30am and on weekends and holidays, in order to arrange care and coverage twenty-four (24) hours a day. Please call 1-800-688-7422.

Fidelis Care is responsible for coordinating, arranging, and authorizing payment to providers for the member’s medically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Fidelis Care’s Provider Directory.
Referral Process

Primary Care Provider (PCP) Referrals within Plan Network, please refer to Section 11 of this manual for additional information.

Case Management

A Nurse Care Manager will be assigned to each member. She/he will assist members in living at home for as long as possible and will help them access services available in the community. Providers are required to contact the Nurse Care Manager to request authorization for all non-emergency services, please call 1-800-688-7422.

- The Nurse Care Manager will call members on a regular basis to ensure that members are satisfied with the services offered.
- Members may leave the service area temporarily. The Nurse Care Manager will make any necessary arrangements for the member to receive non-emergent services outside Fidelis Care’s service area.
- The Nurse Care Manager will discuss Advance Directives with all applicants.
- The Nurse Care Manager will work with the member’s primary care physician to evaluate the member’s medical and treatment histories and care needs and, with the member’s cooperation, will formulate a written Member Service Plan of Care.

Services that will not be covered by the Fidelis Care MAP program

Below is a list of the services that the Fidelis Care MAP program does not cover, but which the member can still receive. Medicare and/or Medicaid may cover these or any other non-MAP service that the member needs, on a fee-for-service basis from a provider who accepts Medicare and/or Medicaid. Although the member can obtain these services his/herself without Fidelis Care’s authorization, Fidelis Care may assist in obtaining these services and in making appointments and arranging non-emergency transportation and follow-up care if needed.

DESCRIPTION OF NON-COVERED SERVICES

The following services are excluded from the Fidelis Care’s Medicare and Medicaid Benefit Packages, and are covered, in most instances, by traditional Medicare or Medicaid fee-for-service:

1. Hospice Services Provided to Medicare Advantage Members

If a member in Fidelis Care becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access Fidelis Care’s Benefit Package while Hospice costs are paid for by traditional Medicare.

2. Pharmacy Benefits as Permitted by State Law

NYS Medicaid continues to provide coverage for certain drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, and some prescription vitamins, and some non-prescription drugs.

3. Family Planning Services

Please refer to Section 16 of this manual for additional information.

4. Methadone Maintenance Treatment Program (MMTP)
5. Certain Mental Health Services

Fidelis Care is not responsible for the provision and payment of the following services which are reimbursed through Medicaid fee-for-service.

   a. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)
   b. Day Treatment
   c. Continuing Day Treatment
   d. Case Management for Seriously and Persistently Mentally ill Sponsored by State or Local Mental Health Units
   e. Partial Hospitalization Not Covered by Medicare
   f. Assertive Community Treatment (ACT)
   g. Personalized Recovery Oriented Services (PROS)

6. Rehabilitation Services Provided to Residents of Office Mental Health (OMH) Licensed Community Residences (CRs) and Family Based Treatment Programs, as follows:

   a. OMH Licensed CRs*
   b. Family-Based Treatment

7. Office of Mental Retardation and Developmental Disabilities (OMRDD) Services

   a. Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities
   b. Day Treatment
   c. Medicaid Service Coordination (MSC)

8. Directly Observed Therapy for Tuberculosis Disease

Fidelis Care remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT Provider.

9. AIDS Adult Day Health Care

10. HIV COBRA (Community Follow-up /Case Management Program)

BILLING/CLAIMS

Mailing address for direct claims submission

    Fidelis Medicaid Advantage Plus
    P.O. Box 1707
    Amherst, New York 14226-0825

Please refer to Section 12 of this manual for additional information.

Appeals and Grievance Reconsideration Process

Appeals Process
Providers shall appeal a Fidelis Care's clinical decision, within forty-five (45) days of the adverse determination by calling or sending clinical and/or other pertinent information to:

    Attn: Member Services
Fidelis Care
95-25 Queens Blvd.
7th Floor
Rego Park, NY 11374

Please refer to Section 10 of this manual for additional information.

Provider Credentialing and Termination
Please refer to Section 9 of this manual for additional information.

Retention of Medical Records
Medical records must be retained for at least ten (10) years.
For additional information, please refer to Section 7 of this manual.

Confidentiality
For information, please refer to Section 3 of this manual.
Effective December 31, 2017, Fidelis withdrew from and is not participating in the Fully Integrated Duals Advantage line of business; FIDA has terminated. The following Billing and Claims information is provided as a reference for claims and billing activity prior to January 1, 2018.

BILLING AND CLAIMS

Timely Filing

All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to FIDA enrollees must be submitted within ninety (90) days. Acceptable reasons for a claim to be submitted late are: litigation, retroactive eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Instructions for Submitting Claims

The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB04 claim form.

Electronic Claims Submission

Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org.

The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

All Medicare and Medicaid billing guidelines must be followed when submitting your Claims to Fidelis. Physicians must include the National Provider Identifier and Tax Identification Number on all claims.

Fidelis Care receives electronic claims submissions. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org.

Mailing Address For Direct Claims Submission:

Fidelis Care FIDA
P.O. Box 1206
Amherst NY 14226-1206

Balance Billing

<table>
<thead>
<tr>
<th>BALANCE BILLING NOTE:</th>
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<tbody>
<tr>
<td>Participating providers may not under any circumstances bill a Fidelis Care member.</td>
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</tbody>
</table>

For additional Billing and Claim information, please refer to Section 12 of the Fidelis Care Provider Manual.
HEALTHIERLIFE – HEALTH and RECOVERY PLAN (HARP)

This section of the Fidelis Care Provider Manual provides information for providers serving Fidelis HealthierLife Health and Recovery Plan (HARP) members. HealthierLife is presently available in the following counties: Bronx, Kings, New York, Queens, and Richmond.

This manual is reviewed and updated periodically. The manual version and date of review or revision is included in the footer of this document.

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HEALTHIERLIFE MODEL OF CARE

Consistent with the vision put forth by the State of New York, Fidelis Care seeks to create an environment where managed care plans, service providers, peers, families, and government agencies partner to help members prevent chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on the following values:

1. **Person-Centered Care**: Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma.

2. **Recovery-Oriented**: The system should include a broad range of services that support recovery from mental illness and/or substance use disorders.

3. **Integrated**: Service providers should attend to both physical and behavioral health needs of members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met.

4. **Data-Driven**: Providers and plans should use data to define outcomes, monitor performance, and promote health and wellbeing.

5. **Evidence-Based**: The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices.

DELIVERY OF SERVICE TO MEMBERS

- Each Fidelis HealthierLife Member has a member identification card on which is the name and telephone number of the member’s Primary Care Physician (PCP).

- To verify eligibility, call 1-888-FIDELIS (1-888-343-3547). To obtain eligibility or status of claims please go to https://providers.fideliscare.org to access our secure Provider Portal.

- Fidelis Care is responsible for administering Medicaid approved benefits for members enrolled in our HealthierLife plan. In rendering care to HealthierLife members, you are asked to provide integrated treatment that helps move a person toward his or her individual recovery goals, monitor health status, manage co-occurring chronic diseases, avoid inappropriate hospitalizations, and help beneficiaries move from high risk to lower risk on the care continuum.

MEMBER ELIGIBILITY

Eligible Populations

The HealthierLife will be available to individuals who meet all of the following criteria:

1. Adult Medicaid beneficiaries 21 and over¹ who are eligible for mainstream MCOs are eligible for enrollment in the HealthierLife if they meet either:

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¹ One exception: individuals in nursing homes for long term care will not be eligible for enrollment in HARPS.
2. Target criteria and risk factors as defined below (Individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or NY State); or
3. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
   a. A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
   b. Completion of HealthierLife eligibility screen.

HealthierLife Target Criteria: The State of New York has chosen to define HealthierLife targeting criteria as:
1. Medicaid enrolled individuals 21 and over;
2. SMI/SUD diagnoses;
3. Eligible to be enrolled in Mainstream MCOs;
4. Not Medicaid/Medicare enrolled ("duals");
5. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

HealthierLife Risk Factors: For individuals meeting the targeting criteria, the HealthierLife Risk Factor criteria include any of the following:
   i. Supplemental Security Income (SSI) individuals who received an "organized"² MH service in the year prior to enrollment.
   ii. Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
   iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
   iv. SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
   v. SSI and non-SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
   vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
   vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
   viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
   ix. Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
   x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
   xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.
   xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
   xiii. Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

² An “organized” MH service is one which is licensed by the NYS Office of Mental Health.
SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Services Covered in HealthierLife</th>
<th>Medically supervised outpatient withdrawal services</th>
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<tbody>
<tr>
<td></td>
<td>Outpatient clinic and opioid treatment program</td>
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<td>Outpatient clinic services</td>
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<td></td>
<td>Comprehensive psychiatric emergency program (CPEP)</td>
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<td>Continuing day treatment program (CDTP)</td>
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<td>Partial hospitalization program (PHP)</td>
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<td>Personalized recovery oriented services (PROS)</td>
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<td></td>
<td>Assertive Community Treatment (ACT)</td>
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<td></td>
<td>Intensive Case Management/Supportive Case Management</td>
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<td></td>
<td>Health Home Care Coordination and Management</td>
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<td></td>
<td>Inpatient hospital detoxification service</td>
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<tr>
<td></td>
<td>Inpatient medically supervised inpatient detoxification</td>
</tr>
<tr>
<td></td>
<td>Inpatient treatment services (OASAS)</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services for residential SUD treatment supports (OASAS)</td>
</tr>
<tr>
<td></td>
<td>Inpatient psychiatric services (OMH)</td>
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<tr>
<td></td>
<td>Rehabilitation services for residents of community residences</td>
</tr>
<tr>
<td></td>
<td>Mobile Crisis Intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home and Community Based Services (HCBS) Covered in the HealthierLife Enhanced Benefit Package</th>
<th>Psychosocial Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Psychiatric Support and Treatment (CPST)</td>
</tr>
<tr>
<td></td>
<td>Habilitation/Residential Support Services</td>
</tr>
<tr>
<td></td>
<td>Family Support and Training</td>
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<tr>
<td></td>
<td>Education Support Services</td>
</tr>
<tr>
<td></td>
<td>Empowerment Services – Peer Supports</td>
</tr>
<tr>
<td></td>
<td>Non-Medical Transportation</td>
</tr>
<tr>
<td></td>
<td>Pre-vocational Services</td>
</tr>
<tr>
<td></td>
<td>Transitional Employment</td>
</tr>
<tr>
<td></td>
<td>Intensive Supported Employment</td>
</tr>
<tr>
<td></td>
<td>Ongoing Supported Employment</td>
</tr>
</tbody>
</table>

Please see the HCBS Manual for service definitions.

ACCESS AND AVAILABILITY STANDARDS

Physical health and behavioral health services:

The following minimum appointment availability standards apply to physical health and behavioral health services:

- For emergency care: **immediately** upon presentation at a service delivery site.
- For urgent care: within **twenty-four (24) hours** of request.
- Non-urgent “sick” visit: within **forty-eight (48) to seventy-two (72) hours** of request, as clinically indicated.
- Routine non-urgent, preventive appointments: within **four (4) weeks** of request.
- Specialist referrals (not urgent): within **two (2) to four (4) weeks** of request.
- Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a provider (as included in the Benefit Package): within **five (5) days** of discharge.
- Non-urgent mental health or substance abuse visits with a provider
included in the Benefit Package): within **two (2) weeks** of request.

- Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work within **ten (10) Business days** of request.
- Mental Health Clinics must provide a clinical assessment within **five (5) days** for individuals in the following designated groups:
  - Individuals in receipt of services from a mobile crisis team not currently receiving treatment
  - Individuals in domestic violence shelter programs not currently receiving treatment
  - Homeless individuals and those present at homeless shelters who are not currently receiving treatment
  - Individuals aging out of foster care who are not currently receiving treatment
  - Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment
  - Individuals referred by rape crisis centers
  - Individuals referred by the court system.

**After Hours:**

PCP, Behavioral Health Service, and specialty Participating Provider contracts shall provide on-call coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.
### Table 4. Appointment Availability Standard by BH Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent MH/SUD</th>
<th>BH Specialist</th>
<th>Follow-up to emergency/hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic/PROS Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>ACT</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>PROS</td>
<td>Within 24 hrs of request</td>
<td>Within 2 wks</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>IPRT</td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPEP</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Upon presentation</td>
<td>Within 24 hours for short term respite</td>
<td></td>
<td></td>
<td></td>
<td>Immediate</td>
</tr>
<tr>
<td>Community Mental Health Services (These are 599 clinic services offered in the community)</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>OASAS Outpatient Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk of request</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Rehab</td>
<td>Upon presentation</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>Within 24 hrs of request</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
</tr>
</tbody>
</table>

### Table 5. Follow-up to Emergency/Hospital Discharge

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent MH/SUD</th>
<th>BH Specialist</th>
<th>Follow-up to emergency/hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Addiction Services</td>
<td>Within 24 hrs of request</td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
</tr>
</tbody>
</table>

#### Behavioral Health Home and Community Based Services

- Psychosocial Rehabilitation, CPST/Habilitation, and Family Support and Training: n/a, n/a, Within 2 weeks of request, Within 5 days
- Short Term and Intensive Crisis Respite: Immediately, Within 24 hours, n/a, Immediate
- Educational and Employment Support Services: n/a, n/a, Within 2 weeks of request, n/a
- Peer Supports: n/a, Within 24 hours for symptom management, Within 1 week of request, Within 5 days
PROVIDER TRAINING

The Fidelis Care HARP/HealthierLife Provider Training Program is a comprehensive provider training and support program designed for network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. The development and coordination of the annual training will be done with the Regional Planning Consortium (RPCs) and will include input from members and their families. Fidelis Care will work with these individuals to the extent possible to incorporate their insights and provide support in delivering the trainings themselves.

This training will be made available at a variety of times and modalities to ensure all providers have an opportunity to participate. Materials and training schedule will be made available on the website and will be updated as needed (and at least annually).

- Technical assistance on billing, coding, data interface, documentation requirements, UM requirements, (re)credentialing
- Training on person-centered planning
- Use of evidence-based practices and specific levels of quality outcomes
- Linguistically- and culturally-competent services
- Clinical training as appropriate by specialty and provider type

Consistent with the guiding principles of the Health and Recovery Program (HARP), Fidelis Care is dedicated to insuring that the provider network adheres to recovery-oriented principles, including provision of person-centered services. Training opportunities will be coordinated with Health Homes and other resources such as the Regional Planning Partnerships to ensure that person-centered, recovery-oriented services are delivered in a culturally competent fashion.

LANGUAGE LINES

The Fidelis Care HealthierLife Plan makes resources available (such as language lines) to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Members that require culturally, linguistically, or disability-competent care.

Providers may provide and be reimbursed for translator services using Code T1013 and other standard claim fields relevant for the provider’s billing methodology (such as APG). Behavioral health home and community-based providers can submit claims on a UB-04 form with procedure code T1013 and leave the rate code field blank. If a translator is not available, a language line or TTY line can be accessed by calling the Fidelis Care Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

INTERDISCIPLINARY CARE TEAM

A HealthierLife Care Manager will be assigned to each HealthierLife member to assist with care coordination. In coordination with the assigned Health Home, the Care Manager will develop an initial person centered service plan (PCSP), ensure that requested services are appropriate and authorized, and will ensure that acceptable, appropriate and accessible alternative services are coordinated and authorized when the requested services are not congruent with the Member’s individual recovery goals.

HealthierLife is a recovery-oriented, person-centered model of care. The member is at the center of the inter-disciplinary team and all activities of the team are focused on identifying needs and providing for the whole health and well-being of the member. In the HealthierLife model, the team is comprised of individuals who will provide person-centered care coordination and care management to members. In HealthierLife, each member will be eligible for Health Home services, and the Health Home care manager will be the lead in coordinating both physical and behavioral healthcare needs, as well as assessing the
need for and coordinating the member's HCBS services. The Fidelis Care Manager will support this effort, identify any gaps, and ensure that any gaps have been adequately addressed. The collective activities are done in collaboration to promote the Member's physical and behavioral health and wellness, improve social and occupational functioning, sustain community tenure, and maximize self-determination.

The interdisciplinary team facilitates timely and thorough coordination between the HealthierLife Plan, the Health Home, the behavioral and physical health providers, HCBS other providers, and the member’s natural supports. The PCSP will be based on the assessed needs and articulated preferences of the member, and delineate coverage determinations consistent with this Plan. The finalized PCSP will articulate service authorizations, and are appealable by the member, their providers, and their representatives.

PCSPs shall include Home and Community Based Services (HCBS) eligibility assessment process including use of HCBS Brief Eligibility assessment tool, guidance on care planning process, guidance on care management, care coordination, and working with health homes. Assessments must be conducted by a health home or state designated entity in compliance with conflict free case management requirements and members must be re-assessed annually.

Health Home participation is not mandatory and individuals who do not want to participate can “opt-out” of the program. The Health Home Opt-out Form (DOH 5059) should be filled out and signed.

- The Opt-out Form can be filled out in person or over the telephone and signed by either the Health Home eligible Medicaid client or the care manager.
- The form includes a place where the reason for opting out can be listed.
- If a Health Home member who has already consented decides at any time to discontinue receiving Health home services, the person or their legal representative must sign the Health Home Patient Information sharing Withdrawal Consent Form (DOH-5058).
- All health information is protected even when the individual decides to discontinue participation in the Health Home program.

**Collaboration/Coordination of Care**

Effective working relationships between providers and other treatment partners and service sites is an evidence-based practice, and thus will result in improved member health outcomes, improved continuity and coordination of care, increased quality, efficiency and effectiveness of services, and increased member satisfaction. All collaboration efforts should be documented in the medical record.

**Why Collaboration with Primary Care Physicians (PCPs) is Necessary:**
Persons with mental illness die on average 25 years sooner than the average population. Members may remain untreated or under-treated if PCPs do not recognize members at risk for or with active mental or addictive disorders. Physical symptoms or general medical co-morbidity complicates most behavioral conditions. Psychotropic medications may interact adversely with other medications or cause physical side effects. Medical laboratory or physical examinations may be necessary for members on psychotropic medications. The PCP may prescribe psychotropic medications themselves.

In addition to mitigating the physical health risks associated with mental illness, promoting healthy behaviors also requires close collaboration and coordination with PCPs and other health professionals for member safety and optimal quality of care.

Behavioral health care providers should communicate with the member's PCP:

1. For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment;
2. When the PCP's support for a treatment plan would enhance member satisfaction and/or compliance;

3. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and

4. When PCP has requested immediate feedback.

If the member is using behavioral health services in a clinic that also provides primary care services, enrollee may select lead behavioral health provider to function as their PCP.

**First Episode Psychosis (FEP)**

The provider, in collaboration with Fidelis Care and the Health Home (when involved), will utilize available data to identify members with FEP. Appropriate resources, such as those available through OnTrackNY* (through the Center for Practice Innovations) will be engaged to assure comprehensive and integrated aftercare planning designed to facilitate prompt, extended follow up of these members to identify and address barriers to successful community tenure and avoidance of readmission.

*OnTrackNY is a treatment program for adolescents and young adults who have had a FEP. This program helps people achieve their goals for school, work and relationships. Programs are located throughout New York State. To make a referral to OnTrackNY, contact your nearest OnTrackNY program site listed here: [OnTrackNY Program Locations](#).

Fidelis Care staff conducts annual site visits to selected providers' offices to provide education and performs a chart review to verify that collaboration of care is occurring and clinical documentation is meeting industry standards.

Fidelis Care has a specialized pharmacy management program to promote coordination/collaboration with BH providers, primary care providers, and other specialty types.

a. Areas of focus include, but not limited to, polypharmacy and metabolic and cardiovascular side effects of psychotropic medications.

b. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost stratified by age group.

**PRIOR AUTHORIZATION**

Expedited and standard requests for prior authorization of services not already authorized as part of the HealthierLife member’s PCSP may be submitted through the traditional prior authorization process. Primary care physicians and other providers can call or fax a treatment request that Fidelis Care may use as a basis for authorizing services.

When referring for services covered in the service benefits package, ensure that the provider is contracted and participating in the network. If you have any questions, please contact Fidelis Care.

Members can choose any participating hospital or specialist they wish; however, please contact the member’s HealthierLife Care Manager. This will aid the Care Manager in properly coordinating services.

Once a request has been approved by Fidelis Care, authorizations will be issued for each service.
A licensed Behavioral Health Case Manager will be available after regular business hours, from 5:00pm to 8:30am and on weekends and holidays, in order to arrange care and coverage 24 hours a day for physical health and behavioral health care, respectively. Please call 1-877-533-2404.

Providers shall have policies and procedures addressing enrollees who present for unscheduled non-urgent care with aim of promoting enrollee access to appropriate care in the most appropriate setting in order to meet the recovery needs of the person seeking care.

Fidelis Care is responsible for coordinating, arranging, and authorizing payment to providers for the member's medically and clinically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Fidelis Care's Provider Directory.

<table>
<thead>
<tr>
<th>MENTAL HEALTH SERVICE</th>
<th>PRIOR AUTH</th>
<th>CONCURRENT REVIEW</th>
<th>MEDICAL/CLINICAL NECESSITY CRITERIA</th>
<th>ADDITIONAL GUIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic services (OMH services)</td>
<td>No</td>
<td>No</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>Internal report of Outpatient visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or changes in services. This review criteria will be consistent with the OMH Clinic Standards of Care, and can be found here: <a href="https://www.omh.ny.gov/omhweb/clinic_restructuring/default.html">https://www.omh.ny.gov/omhweb/clinic_restructuring/default.html</a></td>
</tr>
<tr>
<td>Intensive Outpatient (OMH)</td>
<td>No</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>7 service days, then concurrent</td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
<td>Yes</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td></td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission</td>
<td>No</td>
<td>No</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
<td>Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.</td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services</td>
<td>Yes</td>
<td>No</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
<td>Admission begins when ISR is approved by Plan. Initial</td>
</tr>
</tbody>
</table>
(PROS) Admission:
Individualized Recovery Planning

| (PROS) | Health | Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for:
|        |        | • Clinical Treatment;
|        |        | • Intensive Rehabilitation (IR); or
|        |        | • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.

### Personalized Recovery Oriented Services (PROS)

<table>
<thead>
<tr>
<th>PROS</th>
<th>Health</th>
<th>NYS guidelines – See Section 21 Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services.</td>
</tr>
</tbody>
</table>

### Assertive Community Treatment (ACT)

<table>
<thead>
<tr>
<th>ACT</th>
<th>Health</th>
<th>NYS guidelines – See Section 21 Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness consistent with ACT guidance</td>
</tr>
</tbody>
</table>

### Intensive Psychiatric Rehabilitation Treatment (IPRT)

<table>
<thead>
<tr>
<th>IPRT</th>
<th>Health</th>
<th>NYS guidelines – See Section 21 Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Comprehensive Psych Emergency Room (CPEP)

<table>
<thead>
<tr>
<th>CPEP</th>
<th>Health</th>
<th>Milliman Care Guidelines, most recent edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

### Inpatient Psychiatric Services

<table>
<thead>
<tr>
<th>Inpatient Psychiatric Services</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Mobile Crisis Intervention

<table>
<thead>
<tr>
<th>Mobile Crisis Intervention</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Rehabilitation services for residents of community residences | Yes | Yes | NYS guidelines – See Section 21 Behavioral Health | recovery services, quality issues, and/or the need for changes in services.

<table>
<thead>
<tr>
<th>Substance Use Service</th>
<th>Prior Auth</th>
<th>Concurrent Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Outpatient Clinic Services (non-intensive) OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td>Internal report of Outpatient visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or the need for changes in services. This review will be consistent with the OASAS Clinical Guidance that can be found here: <a href="https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm">https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm</a></td>
</tr>
<tr>
<td>Substance Use Disorder Intensive Outpatient OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td>7 service days, then concurrent</td>
</tr>
<tr>
<td>Medically Supervised Outpatient Withdrawal</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program Services OASAS Part 822 Outpatient Opioid Treatment Program (OTP) Services</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td>30 service days, then concurrent</td>
</tr>
<tr>
<td>Outpatient Substance Use Disorder Rehabilitation Services OASAS Part 822 Outpatient Rehabilitation</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td>14 service days, then concurrent</td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form</td>
</tr>
<tr>
<td>Service Description</td>
<td>Approval Required</td>
<td>Prior Authorization Required</td>
<td>Effective Date</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Inpatient Medically Supervised Inpatient Detoxification (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Inpatient Treatment (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Rehabilitation Services for Residential SUD Treatment Supports (OASAS service)</td>
<td>No</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Services</td>
<td>No</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Effective 01/01/2017, Inpatient OASAS licensed providers are not subject to prior authorization for the initial 14 days of treatment. Providers are required to notify Fidelis Care of each admission within 48 hours by faxing or emailing the OASAS Appendix A Form and LOCADTR tool to <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a> or faxing to 646-829-1421.</td>
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<tr>
<td>Home &amp; Community Based Service</td>
<td>Prior Auth</td>
<td>Concurrent Review</td>
<td>Medical/Clinical Necessity Criteria</td>
<td>Additional Guidance</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
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<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
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<tr>
<td>Habilitation/Residential Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Family Support and Training</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Short Term Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Intensive Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
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<td>Education Support Services</td>
<td>Yes</td>
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<td>NYS guidelines – see below</td>
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<td>Empowerment Services-Peer Supports</td>
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<td>NYS guidelines – see below</td>
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<td>Non-Medical Transportation</td>
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<td>Prevocational Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
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<td>Transitional Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
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<td>Intensive Supported Employment (ISE)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
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<tr>
<td>Ongoing Supported Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
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<tr>
<td>Community Residential Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
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</tr>
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<td>Supportive Living Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
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</table>

**Home and Community Based Services – Review Guidelines and Criteria**

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HealthierLife) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service
Section Twenty-Four  
HealthierLife – Health and Recovery Plan (HARP)

providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders. These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is a collaboration between all pertinent participants including but not limited to the Health Home Care Manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member’s chosen goals. These conversations will focus on the member’s needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual’s needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HCBS eligibility will be guidelines using a standard needs assessment tool, typically administered by the individual’s Health Home (HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery. MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: http://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/). This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals and preferences, and also ensures member choice of service options and providers.

The figure on the following page outlines the process for authorizing specific HCBS.

For members receiving Home and Community Based Services, Fidelis Care will work closely with the Health Home Care Manager and the BH HBCS provider through our care management process and will report clinically relevant utilization data to evaluate the member’s level of care. Fidelis care regularly monitors the HCBS utilization for each enrollee to ensure compliance with regulatory requirements and coordinates with providers as needed.

The following is a description of the various HCBS services.

1) Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are designated as a cluster.

a. Psychosocial Rehabilitation (PSR):

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s Recovery Plan. The intent of PSR is to restore the individual’s functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

b. Community Psychiatric Support and Treatment (CPST):

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual’s Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing,
education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

2) **Vocational Services**

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

a. **Pre-vocational Services:**

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as guidelines by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual’s person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

b. **Transitional Employment (TE)**

This service is designed to strengthen the participant’s work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

c. **Intensive Supported Employment (ISE)**

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs,
require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

d. Ongoing Supported Employment
This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

3) Short-Term Crisis Respite Services

a. Short-term Crisis Respite
Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person’s home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person’s symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

b. Intensive Crisis Respite
Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring
diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service.

4) Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

5) Empowerment Services - Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

6) Habilitation / Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with
landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

7) Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team. For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant.
## HCBS Criteria:

All provider agreements will have procedures for monitoring Home and Community Based Services utilization for each enrollee.

### Admission Criteria:

All of the following criteria must be met:

1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.
2. Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual.
3. A Plan of Care has been developed, informed and signed by the member, Health Home care manager, and others responsible for implementation. The POC has been approved by the Plan.
4. The HCBS provider develops an Individual Care Plan (ICP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation.
5. The ISP and subsequent service request supports the member’s efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.
6. The member must be willing to receive home and community based services as part of their ISP.
7. There is no alternative level of care or co-occurring service that would better address the member’s clinical needs as shown in POC and ISP.

### Continued Stay Criteria:

All of the following criteria must be met:

1. Member continues to meet admission criteria and an alternative service would not better serve the member.
2. Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider.
3. Member is making measureable progress towards a set of clearly defined goals;  
   Or
   There is evidence that the service plan is modified to address the barriers in treatment progression  
   Or
   Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration.
4. There is care coordination with physical and behavioral health providers, State, and other community agencies.
5. Family/guardian/caregiver is participating in treatment where appropriate.

### Discharge Criteria:

Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6 is recommended, but optional:

1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive.
2. Member or parent/guardian withdraws consent for treatment.
3. Member does not appear to be participating in the ISP.
4. Member’s needs have changed and current services are not meeting these needs. Member’s self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member’s Health Home and HCBS provider and MCO.
5. Member’s ISP goals have been met.
6. Member’s support system is in agreement with the aftercare service plan.
Home and Community Based Services – Allowable billing combinations: State and federal regulations limit members’ access to certain HCBS when the member is receiving certain state plan behavioral health services as noted in the table below:

<table>
<thead>
<tr>
<th>HCBS/State Plan Services</th>
<th>OMH Clinic/OLP</th>
<th>OASAS Clinic</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS</th>
<th>OMH IPRT/CDT</th>
<th>OMH Partial Hospital</th>
<th>OASAS Outpatient Rehab</th>
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<tbody>
<tr>
<td>PSR</td>
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<td>Yes</td>
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<td>Yes</td>
<td></td>
<td></td>
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<td>Yes</td>
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</table>

Detailed lists of services requiring authorization can be found on the Fidelis Care Provider website at [https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids](https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids)

**QUALITY PROGRAMS**

Fidelis Care has identified the following goals for our HealthierLife Members.
- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Decreasing utilization of inpatient and emergency services through provision of comprehensive, person centered, and integrated community based services
- Improving coordination of care through an identified point of contact
• Improving access to preventive health services
• Assuring appropriate utilization of services

In addition, Fidelis Care has a robust quality program that supports providers in achieving HEDIS/QARR measures. Detailed information on this program can be found on Provider Access Online, as well as the Fidelis Care Website in the Quality Management section.

The Fidelis Behavioral Health Quality Management Committee will meet monthly to review quality of care measures, accessibility to care and other issues of concern. Membership and attendance will be documented and include, at a minimum, the HARP Behavioral Health Medical Director and Clinical Director, Director of Quality Improvement and peer, provider, family or member representation. Fidelis will submit to OMH and OASAS a quarterly report of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers. Fidelis Care will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

**HealthierLife Stakeholder Regional Advisory Sub-Committees**

HealthierLife Stakeholder Regional Advisory Sub-Committees are composed of HealthierLife Members, Peers, Family Members, Advocates, Providers, Local and State Agency Representatives, Community Group Representatives, and other Key Stakeholders, such as Regional Consortium Planning representatives. One sub-committee will be convened for each NYSDOH region as enrollment goes live in that area. The purpose of this committee is for Fidelis to ensure a 360 degree perspective on HealthierLife quality, and to obtain consensus with key stakeholders on next steps in advancing all aspects of quality for HealthierLife. This committee performs the following functions:

- Provide the guidance on crisis intervention, recovery and rehabilitation services in that region, including HCBS and Health Home services.
- Assists in the development of level of care specific performance standards, measures and measurement methodologies, root-cause analyses, QI intervention, and implementation plan development
- Provides input on policies, procedures, protocols and guidelines
- Informs about access and availability of regionally based services, including wait times and capacity
- Assists with identifying and devising plans to remove any barriers to care for HealthierLife and Mainstream Medicaid enrollees
- Reviews and assists with monitoring performance measures for access, service quality, quality of care, utilization, customer service and health plan operations
- Advises on quality improvement initiatives including initiatives aimed at improving the integration of physical and behavioral health care
- Ensures an emphasis is maintained on the clinical outcomes of care
- Identifies regionally-specific challenges and opportunities for performance improvement

All parties in attendance are expected to bring to this committee information, data and their specific perception on all matters presented on the agenda related to Fidelis’ HealthierLife. These Committees will report to the HealthierLife Quality Management Committee, meet at minimum quarterly.

**BILLING AND CLAIMS**

**Timely Filing**

All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider.
contract. Claims for services provided to HealthierLife enrollees must be submitted within 90 days. Acceptable reasons for a claim to be submitted late are: litigation, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Instructions for Submitting Claims

The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB04 claim form.

Electronic Claims Submission

Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org.

The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

All Medicaid billing guidelines must be followed when submitting your Claims to Fidelis. Physicians must include the National Provider Identifier and Tax Identification Number on all claims.

Fidelis Care receives electronic claims submission, for a complete list of vendors; visit the Fidelis Care website at fideliscare.org

Mailing Address For Direct Claims Submission:

Fidelis Care HealthierLife
Corporate Claims Department
P.O. Box 1205
Amherst NY 14226

Balance Billing

<table>
<thead>
<tr>
<th>BALANCE BILLING NOTE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating providers may not under any circumstances bill a Fidelis Care member.</td>
</tr>
</tbody>
</table>

For additional Billing and Claim information, please refer to Section 12 of the Fidelis Care Provider Manual. An additional tip sheet for BH HCBS billing and claiming is also available on fideliscare.org.

INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH

People with mental illness die younger than the general population, and have more co-occurring conditions such as hypertension, diabetes, heart disease, obesity, tobacco use and asthma. One in five adults with mental illness also have a co-occurring substance use disorder (SUD). Only 20 percent of adults with mental health disorders are seen by mental health specialists and many prefer to receive treatment in primary care settings. The evidence clearly shows that improving health, improving the patient experience, and driving down costs is no longer possible without attending to both physical and behavioral health.
Section Twenty-Four  HealthierLife – Health and Recovery Plan (HARP)

Though HealthierLife is an integrated physical and behavioral health program, at Fidelis Care, its administrative operations reside within the Behavioral Health Department, which is part of the Quality Health Care Management Department. The department is staffed by licensed clinical staff as well as paraprofessional associates who can assist with accessing behavioral and physical health services. A provider or member may contact the department through 1-888-FIDELIS (1-888-343-3547) and following the voice prompts to connect directly to Behavioral Health.

All HealthierLife Members will have their HCBS service needs guidelines through the New York State Department of Health approved assessment tool. Members can also self-identify problems and needs through the Fidelis Care Health Risk Assessment. Members, providers or the member’s representatives who feel additional behavioral health needs require assessment or treatment can bring those concerns to their Health Home and/or their Fidelis Care Case Manager. They can assist in determining the screening and assessment tools, treatment and/or community services that are available to fit the HealthierLife member’s needs. Members can also self-refer for behavioral health services.

Behavioral health providers and community services can be located in the Fidelis Care Online Provider Directory. For additional information on Community Support providers, call the Behavioral Health Department, which can assist with identifying appropriate services available.

Fidelis Care encourages the use of validated behavioral health screening tools in primary care settings. In addition to your observations and patient self-report, there are a number of free, valid and reliable screening tools available:

  https://www.oasas.ny.gov/admed/sbirt/index.cfm (Note, this tool requires training before it can be administered)
- Suicide Risk: http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Similarly, it is sound practice for behavioral health providers to routinely evaluate for physical health issues in their patients. The practice guidelines for psychiatric evaluation put forth by the American Psychiatric Association (APA), which include prominently a section on general medical history, can be found here: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/psychevaladults-guide.pdf. Additionally, SAMHSA has published a useful 19-question healthy living questionnaire: http://www.integration.samhsa.gov/clinical-practice/Healthy_Living_Questionnaire2011.pdf.


For detailed information on the Behavioral Health Referrals and Authorization process please refer to Section 21 of the Fidelis Care Provider Manual. https://www.fideliscare.org/Provider/Provider-Resources/Authorization-Grids

PHARMACY

Please visit http://www.fideliscare.org for a comprehensive list of covered drugs and supplies listed on our formulary. Fidelis Care has contracted Caremark (a pharmacy management company) to provide pharmacy services. Contact Caremark directly at 800-345-5413
For additional information on Pharmacy Services please refer to Appendix II of the Fidelis Care Provider Manual.
For information on specialized pharmacy management program, please refer to Section 24.9 Collaboration/Coordination of Care

RENTENTION OF MEDICAL RECORDS

Medical records must be retained for at least ten (10) years. For additional information on medical record retention, please refer to Section 7 of the Fidelis Care Provider Manual, page 7.2.

CONFIDENTIALITY

For information on Confidentiality, please refer to Section 3 of the Fidelis Care Provider Manual, page 3.2.

MEMBER RIGHTS AND RESPONSIBILITIES

HealthierLife Members have the right to:

During the course of any contact with an enrolled member, employees will not encourage an enrollee to dis-enroll because of challenging behavior, complex care needs, or high medical expenses.

Fidelis Care adheres to laws that protect members from discrimination or unfair treatment and does not tolerate discrimination based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. Furthermore, Fidelis Care ensures that:

- Members have the right to be treated with respect, dignity, and in a considerate manner. They have the right to be cared for with respect without regard of health status or medical/genetic history, insurability, sex, race, color, religion, national origin, age, marital status, sexual orientation, medical condition (including physical and mental illness), claims experience, receipt of health care, or disability.
- Members have the right to receive information from a physician or other provider necessary to give informed consent prior to the start of any procedure or treatment.
- Members are ensured confidential handling of information concerning their diagnosis, treatment prognosis, and medical and social history.
- Members have the right to obtain complete current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information shall be made available to an appropriate person on the member’s behalf.
- Members are given the opportunity to participate in decisions involving their health care unless contraindicated. Members are allowed to appoint someone (relative, friend, lawyer) to speak for you if you are unable to speak for yourself about your care and treatment.
• Members are ensured auditory and visual privacy during a visit.

• Members are afforded the opportunity to approve or refuse the release of information except when release is required by law. Members are also given the right to know how Medical Information about them may be used and disclosed and how they may get access to this information from Fidelis.

• Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation entered into the medical record accordingly.

• Members have the right to formulate Advance Directives.

• Members have the right to change Primary Care Physicians.

• Members have a right to reasonable accommodations. Members also have a right to understand their ADA-related rights, to what extent reasonable accommodations are provided, and grievances and appeals related to those rights. Members will be informed of their right to reasonable accommodations and how to obtain reasonable accommodations from the plan and providers, including the process, who decides whether the accommodations will be provided, and the process for appealing any decisions.

• Members have the right to file a complaint with the Plan. Members can complain to the NY State Department of Health or the local Department of Social Services any time they feel they were not treated fairly and without retaliation from the Plan.

• Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

• Members have the right to request a copy of their medical records, and request that they be amended or corrected

• Members have the right to receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood

• If a Member Service Associate does not speak the primary language requested, a member may have access to a language translation service which provides access to foreign language translators.

• Members have the right to disenroll.

Health and Recovery Plan (HealthierLife), members shall not be balanced billed. Should a provider balance bill a member inappropriately, Fidelis Care will investigate the situation and when required, inform the provider to cease the balance billing. Some Members may have applicable spend-down/NAMI for Medicaid.

Fidelis Care has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.

**A Choice of Plans and Providers**
Members will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose an alternative package of Medicaid services through 1) a different HealthierLife Plan or 2) a qualified mainstream plan.

**Continuity of Care**

For all items and services other than nursing facility services, Fidelis Care HealthierLife members can maintain current providers and service levels, including prescription drugs, for the current episode of care at the time of enrollment for up to 90 days after enrollment. Members will not be required to change Health Homes at the time of enrollment.

Fidelis Care will cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care. For services that are part of the traditional Medicaid benefit package, Fidelis Care will reimburse non-contracting providers at least the lesser of the providers' charges or the Medicaid FFS rate, regardless of the setting and type of care for authorized out-of-network services.

**Enrollment Assistance and Options Counseling**

The State will provide HealthierLife-eligible members with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with the independent Enrollment Broker to ensure ongoing outreach, education and support to individuals eligible for HealthierLife.

**MEMBER COMPLAINTS AND APPEALS**

All Fidelis Care members have a right to file a complaint at any time if they are dissatisfied with Fidelis Care, a Fidelis Care provider, or with the care or services they have received. If a complaint involves a physician or provider, a Provider Relations Representative will contact the provider to discuss the complaint. The findings will be reported to the Quality Healthcare Management (QHCM) Department for consideration as to action or disposition.

Members are advised to call Member Services to file a complaint. Fidelis Care will attempt to resolve complaints immediately by taking prompt corrective action and educating members regarding Fidelis Care policies and procedures. The substance of the complaint and the agreed upon disposition will be documented.

Complaints are submitted in writing or recorded by Fidelis Care staff on behalf of members. All complaints are logged and acknowledged by Fidelis Care in writing. Complaints relative to the delivery of healthcare services will be referred to Fidelis Care's QHCM Department for investigation.

A member or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written Complaint Appeal. Complaint Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered healthcare professionals who did not make the initial determination - at least one of whom must be a clinical peer reviewer.

Upon the member's request, Fidelis Care will expedite the complaint process to accommodate the member's needs.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file and in the provider's Total Quality Profile on an annual basis.
NOTE: Members may always file a complaint with the New York State Department of Health and/or the City or respective County.

COMPLAINTS

If a member has a problem or dispute with care or services, the member may file a complaint with Fidelis Care. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to the following procedure. Fidelis Care is always available to assist a member in filing a complaint, complaint appeal, or action appeal. A Member Services Associate can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, Fidelis Care can help with this.

A member has the right to contact the New York State Department of Health about their complaint at 1-800-206-8125 or may write to: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. The member may also contact their local Department of Social Services with a complaint at any time. A member may call the New York State Insurance Department at (1-800-342-3736) if their complaint involves a billing problem.

Filing a Complaint with the Plan:

To file by phone, the member should call Member Services at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30AM to 6:00PM. If the member contacts Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, the member will be notified. The member can write Fidelis Care with his or her complaint or call the Member Services number and request a complaint form. It should be mailed to Attn: Member Services Department, Fidelis Care, 95-25 Queens Boulevard, Rego Park, NY 11374.

If Fidelis Care does not solve the problem right away over the phone or if Fidelis Care receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Fidelis Care will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint, but the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Fidelis Care will send the member a letter with the reasons for the decision. When a delay would risk a member’s health, Fidelis Care will make a decision within forty-eight (48) hours of when Fidelis Care has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Fidelis Care will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Fidelis Care is unable to make a decision about a complaint because we don’t have enough information, a letter will be sent to the member.

Complaint Appeals:

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Fidelis Care. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member will sign and return the form to Fidelis Care. The member may make any needed changes before sending the form back to us.
Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about the complaint.

If Fidelis Care has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member’s health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the member or their designee can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

**FAIR HEARINGS AND ACTION APPEALS**

In some cases, a member may ask for a fair hearing from New York State. A member may request a Fair Hearing with regard to: enrollment/enrollment decisions made by the Local Department of Social Services; the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member may also request a Fair Hearing if they believe that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the fair hearing officer will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

**ACTION APPEALS**

If a member disagrees with Fidelis Care’s decision with a Service Authorization Request, a payment denial, or timeliness of an action taken by Fidelis Care, the member or their designee can file an action appeal. The member has sixty (60) business days after hearing from Fidelis Care to file an appeal. The action appeal must be in writing. If the appeal is by telephone, it must also be made in writing. Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member must sign and return the form to Fidelis Care. The member may make any changes to the form before sending it back to us. After receipt of the action appeal, an acknowledgement letter will be sent within fifteen (15) calendar days.

If Fidelis Care has all the information needed, the member will know our decision within thirty (30) calendar days. If a delay would significantly increase the risk to the member’s health, the member or their designee can request an expedited review of the action appeal, which will be decided within two (2) business days. The timeframe for deciding an action appeal can be extended for up to fourteen (14) calendar days if the member or his/her designee requests one or if Fidelis Care determines that the
extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.

The member will be given the reasons for Fidelis Care's decision and clinical rationale. Fidelis Care will attempt to reach the member with the action appeal decision by phone. If the member is still not satisfied with Fidelis Care's decision, the member or someone on his or her behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125. Filing an action appeal is the member's right, and the Fidelis Care will not retaliate or take any discriminatory action against the member because they filed an action appeal.

An action appeal should be made in writing within sixty (60) business days of receipt of the letter to:

Attn: Quality Health Care Management
Fidelis Care
480 CrossPoint Parkway
Getzville, NY 14068
Phone#: 1-888-FIDELIS – (1-888-343-3547)
Fax#: 1-800-374-9808

EXTERNAL APPEALS

If the plan decides to deny coverage for a medical service the member or the provider asked for because:

It is not medically necessary; the service is experimental or investigational; the out-of-network service requested is not different from a service that is available in our network. The member can ask New York State for an independent External Appeal. It is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan’s benefit package or be an experimental treatment. For Medicaid and CHP members, the fee is waived for an external appeal. Only HBX has a $25 fee for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. Fidelis Care will waive the fee if we determine that paying the fee would be a hardship to the member. If the External Appeal Agent overturns our decision, the fee will be refunded to the member.

Members have four (4) months after receiving the Plan’s final adverse determination (notice of appeal denial) to ask for an external appeal. The member will lose their right to an external appeal for failure to file an application on time. If the member and the plan agreed to skip the plan’s appeal process, the member must ask for the external appeal within four (4) months of when the agreement was made. The member must fill out an application and submit it to the New York State Department of Financial Services. The member and their doctors will have to give information about their medical problem. The external appeal application will list what information will be needed.

The member’s standard external appeal will be decided in thirty (30) days. More time (up to five (5) work days) may be needed if the external appeal reviewer asks for more information. The member and the plan will be notified in writing of the final decision within two (2) work days after the decision is made. The reviewer will decide an expedited appeal in seventy-two (72) hours or less. The member and the plan will be notified immediately by phone or fax. Later, the member will receive written notification of decision made.

A member may request an External Appeal:

1. Call the Department of Financial Services at 1-800-400-8882
2. Go to the Department of Financial Services’ website at www.dfs.ny.gov
3. Contact Fidelis at 1-888-FIDELIS. Member Services will mail or fax the application to the member.
MEDICAID CHILDREN’S EXPANDED BENEFITS

This section of the Fidelis Care Provider Manual provides information to providers serving children, under age 21, for the expanded Medicaid covered services for all children enrolled in Medicaid, as well as the expansion of new child populations eligible for Medicaid Managed Care enrollment.

The expanded benefits include behavioral health (BH) and services for children with medically complex and developmental disability conditions. Children who formerly received 1915 (c) Waiver services who are not also in foster care will enroll effective January 1, 2019, and children in the care of Voluntary Foster Care Agencies will enroll in Medicaid Managed Care starting in July 2019.

The Medicaid Children's Expanded Benefits start to become effective January 1, 2019 and will continue to be implemented through January 1, 2020 in various phases. Expanded benefits include an array of Children's Home and Community Based Services (HCBS) previously received through the 195 (c) waivers in addition to the six new State Plan Amendment Services. HCBS and State Plan Amendment Services are available for all children, under age 21, enrolled in the Fidelis Care Medicaid Managed Care program in all counties of New York State meeting medical necessity and/or eligibility criteria.

This manual is reviewed and will be updated periodically as additional guidance is released regarding later phases of this transition, and contains very specific effective dates for the various benefit changes. The manual version and date of review or revision is included in the footer of this document.

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Section Twenty-Five  Medicaid Children’s Expanded Benefits

MEDICAID CHILDREN’S BENEFITS MODEL OF CARE

Consistent with the vision put forth by the State of New York, Fidelis Care seeks to create an environment to comprehensively meet the needs of children and youth under 21 years of age with Behavioral Health (BH) and Home and Community Based Services (HCBS). This includes addressing the needs of medically fragile children, children with behavioral health diagnoses, children with developmental disabilities, and children in Foster Care (FC). This new set of benefits has been recommended to improve service access and provide earlier intervention for children, youth, and families.

A critical component for these benefits and services is an effective partnership between Fidelis Care and providers to support the delivery system, promote early identification, prevention, and treatment which, in turn, will reduce the need for intensive services, acute levels of care, and out-of-home placements.

In order to support treatment integration, improve health outcomes for children and youth, and lay the groundwork for better health outcomes in adulthood, three (3) key policy steps have been identified:

1. The State will make available via a Medicaid State Plan Amendments (SPAs), **six new services** that were either not available in NYS previously or were only available to children who met narrow eligibility criteria.
2. The State has established a **Level of Care (LOC)** and **Level of Need (LON)** criteria to identify subpopulations of children who are likely to benefit from an array of home and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at-risk by virtue of exposure to adverse events or symptoms leading to functional impairment in their home, school, or community.
3. The State is simplifying **six existing children’s 1915(c) waivers** into one integrated array of HCBS for an expanded number of Medicaid-eligible children allowing them to stay in their home communities to avoid residential and inpatient care.

The vision for this Model of Care is a future where service delivery silos are eliminated and in which MMCOs service providers, care managers, family peers, youth peers, multiple child serving systems of care (e.g., education, child welfare, juvenile justice, developmental disabilities), and State and local government agencies work together to support the physical, social and emotional development of children and youth while increasing health and wellness outcomes during childhood and into adulthood.

CHILDREN’S SERVICE DELIVERY SYSTEM TRANSFORMATION

The following transformational changes have taken place within the children’s service delivery systems:

1. **Health Home Care Management for Children**
   Children eligible for HCBS will be enrolled in a Health Home, unless the child opts-out of Health Home. Health Homes will administer all HCBS assessments through the Uniform Assessment System which will have algorithms to determine functional eligibility criteria. The Health Home will ensure that the child meets all other eligibility criteria for HCBS (i.e., a child must live in a
setting meeting HCBS settings criteria for HCBS (i.e. Target and Risk criteria for LOC and LON populations).

Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or BH needs. Health Home care managers provide person-centered, integrated PH and BH care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

Health Home Care Management is a critical component of the Children’s Medicaid Redesign Plan. Not only will it provide comprehensive, integrated, child and family focused Care Management, but it will also ensure the efficient and effective implementation of the expanded array of State Plan services and HCBS contemplated under the Redesign Plan. Please see the New York State Department of Health Homes Serving Children homepage for more information on the implementation of the program, Health Home standards and requirements for serving children.

2. Transitions of Benefits and Populations into Medicaid Managed Care

Effective January 1, 2019, the following will occur:
- Implement three of six new State Plan Services statewide known as Children and Family Supports and Treatment (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatments and Supports) in Medicaid Managed Care for non-SSI related enrollees under age 21 meeting medical necessity criteria. SSI children can receive these benefits in FFS Medicaid until their services are carved in during the July 1, 2019 phase.

Effective April 1, 2019, the following will occur:
- statewide, the State has removed the exemptions from Medicaid Managed Care enrollment for children in the following HCBS waivers with a physical, emotional or developmental disabilities diagnosis not enrolled in foster care:
  - OMH Serious Emotional Disturbance (SED) 1915(c) waiver (NY.0296)
  - Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
  - Bridges to Health (B2H) Medically Fragile 1915(c) waiver (NY.0471)
  - Bridges to Health (B2H) DD 1915(c) waiver (NY.0470)
  - DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
  - Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176
  - New array of aligned Children’s HCBS including Family Peer Support Services, Youth Peer Support and Training, and Crisis Intervention for HCBS eligible children only
  - All children’s 1915 (c) waivers transition to Health Home (begins October 2018)

Beginning no earlier than July 1, 2019 the following will occur:
- Three year Phase-in of expansions of Level of Care (LOC) eligibility for HCBS begins (within limits of global spending cap)
- The State will remove the exclusion from Medicaid Managed Care enrollment for children in the care of Voluntary Foster Care Agencies
- Remove exemption from mandatory managed care enrollment for children in receipt of HCBS who are also placed in foster care
- Family Peer Support Services (new State Plan Service) added to the Medicaid Managed Care Benefit Package
Current State Plan behavioral health benefits carve in for children under 21 are added to the Medicaid Managed Care Benefit Package

Beginning no earlier than **January 1, 2020**, the following will occur:

- Youth Peer Support and Training and Crisis Intervention (New State Plan Services) will be added to the Medicaid Managed Care Benefit Package

Children/youth who continue to be excluded from enrollment in a managed care plan or who are exempt and choose not to enroll will continue to receive benefits via the fee-for-service (FFS) delivery system.

3. **Transition of State Plan and Demonstration Services into Medicaid Managed Care**

Existing NYS Medicaid State Plan services and HCBS covered under FFS will be included in the managed care benefit package to more fully integrate children and youth’s access to PH and BH care. Under the proposed 1115 Waiver Amendment, beginning January 1, 2019 statewide, Plans will administer some children’s BH services, including three of the six new Medicaid State Plan services and the full array of children’s HCBS as well as the four BH Demonstration services. These services will be administered in conjunction with the Community First Choice Option (CFCO) services, which will be added to the Medicaid managed care plan benefit package at a later date.

The four BH Demonstration services are already included under the 1115 demonstration in managed care:

- Outpatient addiction services,
- Residential addiction services,
- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

NYS’s Medicaid State Plan will be expanded to include the following new State Plan services: (see the current State Plan services manual for a complete description of these services.

- Other Licensed Practitioner (OLP)
- Crisis Intervention
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Family Peer Support Services
- Youth Peer Support and Training

These services will be concurrently transitioned into the Medicaid managed care benefit package and will therefore be available to any Medicaid enrollee under 21 years of age who meets Medical Necessity Criteria (MNC).

4. **Transition of Children’s HCBS to Managed Care**

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1 The State will offer a single HCBS benefit package to all children meeting institutional level of care (LOC) functional criteria. This includes offering State Plan Community First Choice Option (CFCO) services to children who are otherwise eligible for CFCO services but who become eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children not eligible under the State Plan but who meet institutional admission criteria and receive HCBS). More information on CFCO can be found at the following website: [https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm)
Services previously delivered under agency-specific 1915(c) waivers will be aligned and moved under the authority of NYS’s 1115 MRT, MRT Waiver. All reimbursement for children’s HCBS covered in the managed care benefit package will be non-risk for 24 months from the date of inclusion in the MMCO benefit package. The Plan capitation payment will not include children’s HCBS. These will be paid on a non-risk basis. The benefits are listed below (additional detail can be found in the current Draft HCBS Manual):

- Health Home (if not otherwise eligible under the State Plan)
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Habilitation
- Non-Medical Transportation
- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Financial Management services for the Customized Goods and Services (phased in as a pilot)
- Customized Goods and Services (phased in as a pilot)

5. **Transition of Children in the care of a Voluntary Foster Care Agency (VFCA) into Managed Care**

**Beginning July 1, 2019,** children/youth in the care of VFCA's will receive Medicaid benefits through Medicaid Managed Care, unless otherwise exempt or excluded. DOH and OCFS are working to enable contracting between Plans and VFCA's, which includes DOH licensure of VFCA's for providing services by licensed health care practitioners under the Department of Education. The requirements of those licenses, including procedures for obtaining that licensure and the requirements of the licensure are in development.

**DELIVERY OF SERVICE TO MEDICAID (CHILDREN) MEMBERS**

- Each Fidelis Care Medicaid Member has a member identification card on which is the name and telephone number of the member’s Primary Care Physician (PCP).

- To verify eligibility, call 1-888-FIDELIS (1-888-343-3547). To obtain eligibility or status of claims please go to [https://providers.fideliscare.org](https://providers.fideliscare.org) to access our secure Provider Portal.

- Fidelis Care is responsible for administering Medicaid approved children’s expanded benefits for members enrolled in our Medicaid Managed Care plan. In rendering care to Medicaid members, based on your specialty and clinical expertise, you are asked to provide treatment to special populations, including, but, not limited to:

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2 Non-Medical Transportation will be paid Fee-for-Service for eligible children/youth, regardless of whether the child/youth is enrolled in Medicaid Managed Care, to leverage the existing Medicaid Fee-for-Service transportation infrastructure.
MEMBER ELIGIBILITY

Eligible Populations

The Fidelis Care Medicaid Managed Care Expanded Children’s Benefits will be available to individuals who meet all of the following criteria:

- Child and youth Medicaid beneficiaries under 21: who are currently enrolled in Fidelis Care’s Medicaid Managed Care and meet medical necessity requirements for expanded Children’s Benefits including, but not limited to, behavioral health, physical health for medically complex conditions, and those in foster care.

- Children’s HCBS benefits will be available to children who meet NYS Criteria for Level of Care (LOC) and Level of Need (LON) for Serious Emotional Disturbance (SED), Medically Fragile Children (MFC), and Children with Developmental Disabilities (DD). Additional details on the NYS eligibility criteria can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf
SUMMARY OF BENEFITS

The summary of covered benefits are listed in the grid below. This grid indicates the covered services, the current delivery system, and the date in which the service becomes effective with Fidelis Care’s Medicaid Managed Care Expanded Children’s Benefits program.

Table 2: Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21 Included in the Children’s System Transformation.

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<thead>
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<th>Covered Services</th>
<th>Current Delivery System</th>
<th>Fidelis Care’s Medicaid Managed Care – Expanded Children’s Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment (minimum age is 18 for medical necessity for this adult oriented service)</td>
<td>FFS</td>
<td>07/01/2019</td>
</tr>
<tr>
<td>CFCO State Plan Services for children meeting eligibility criteria</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Children’s Crisis Intervention</td>
<td>FFS</td>
<td>04/01/19 – 12/31/19 Demonstration service for children eligible for aligned children’s HCBS 01/01/2020 New State Plan service for children</td>
</tr>
<tr>
<td>Children’s Day Treatment</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed</td>
<td>Current MMC Benefit for individuals age 21 and over</td>
<td>7/1/19</td>
</tr>
<tr>
<td>Continuing day treatment (minimum age is 18 for medical necessity for this adult oriented service)</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>CPST</td>
<td>N/A (New SPA service)</td>
<td>01/01/19 for non SSI, 07/01/19 for SSI related enrollees</td>
</tr>
<tr>
<td>Crisis Intervention Demonstration Service</td>
<td>MMC Demonstration Benefit for all ages</td>
<td>Current MMC Demonstration Benefit for all ages</td>
</tr>
</tbody>
</table>

3 Beginning at a later date, eligibility for CFCO benefits will become available to children who are eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children who meet institutional admission criteria and receive HCBS). These children are not eligible for CFCO under the State Plan but will be eligible for identical benefits under the 1115 Demonstration Waiver Amendment.

4 NYS is exploring the use of EBPs. Pending CMS approval, these services will be billed through CPST and/or OLP, depending upon provider qualifications. Additional guidance will be issued regarding provider designation as well as the rate structure.
## Medicaid Children’s Expanded Benefits

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Current Delivery System</th>
<th>Fidelis Care’s Medicaid Managed Care – Expanded Children’s Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Peer Support Services</td>
<td>FFS/1915(c) Children’s waiver service</td>
<td>04/01/19 – 06/30/19 Demonstration service for children eligible for aligned children’s HCBS 07/01/19 – State Plan service for children</td>
</tr>
<tr>
<td>Health Home Care Management</td>
<td>FFS</td>
<td>07/01/19 for current MMC enrolled children, for current MMC enrolled children 04/01/19 for HCBS waiver children enrolling in MMC 01/01/19 for HCBS waiver children enrolling in MMC</td>
</tr>
<tr>
<td>Inpatient psychiatric services</td>
<td>Current Medicaid Managed Care Benefit</td>
<td>Current Benefit</td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>Licensed Behavioral Health Practitioner (NP-LBHP) Service</td>
<td>MMC Demonstration Benefit for all ages</td>
<td>Current MMC Demonstration Benefit for all ages</td>
</tr>
<tr>
<td>Licensed outpatient clinic services</td>
<td>Current MMC Benefit for non-SSI Medicaid Managed Care enrolled members</td>
<td>Current Benefit for MMC enrolled non-SSI, will carve in for SSI members under 21 years old on 07/01/19</td>
</tr>
<tr>
<td>Medically Managed detoxification (hospital based)</td>
<td>Current Medicaid Managed Care Benefit</td>
<td>Current Benefit</td>
</tr>
<tr>
<td>Medically supervised inpatient detoxification</td>
<td>Current Medicaid Managed Care Benefit</td>
<td>Current Benefit</td>
</tr>
<tr>
<td>Medically supervised outpatient withdrawal</td>
<td>Current Medicaid Managed Care Benefit</td>
<td>Current Benefit</td>
</tr>
<tr>
<td>OASAS Inpatient Rehabilitation Services</td>
<td>Current Medicaid Managed Care Benefit</td>
<td>Current Benefit</td>
</tr>
<tr>
<td>OASAS opioid treatment program (OTP) services</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>OASAS Outpatient and Residential Addiction services</td>
<td>MMC Demonstration Benefit for all ages</td>
<td>Current MMC Demonstration Benefit for all ages</td>
</tr>
<tr>
<td>OASAS Outpatient Rehabilitation Programs</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>OASAS Outpatient Services</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>OMH State Operated Inpatient</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Other Licensed Practitioner (OLP)</td>
<td>N/A (New SPA service)</td>
<td>01/01/19 for non SSI, 07/01/19 for SSI related enrollees</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Current Delivery System</th>
<th>Fidelis Care’s Medicaid Managed Care – Expanded Children’s Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)</td>
<td>FFS</td>
<td>7/1/19</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>N/A (New SPA service)</td>
<td>01/01/19 for non SSI, 07/01/19 for SSI related enrollees</td>
</tr>
<tr>
<td>Rehabilitation Services for residents of community residences</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Residential Rehabilitation Services for Youth (RRSY)</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)</td>
<td>OCFS Foster Care</td>
<td>7/1/19</td>
</tr>
<tr>
<td>Residential Treatment Facility (RTF)</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Teaching Family Home</td>
<td>FFS</td>
<td>TBD</td>
</tr>
<tr>
<td>Youth Peer Support and Training</td>
<td>FFS/1915(c) Children’s Waiver service</td>
<td>04/01/19 – 12/31/19 Demonstration service for children eligible for aligned children’s HCBS 01/01/2020 State Plan Service</td>
</tr>
</tbody>
</table>

### ACCESS AND AVAILABILITY STANDARDS

**Behavioral health (BH) and physical health (PH) services:**

**Table 6:** The following minimum appointment availability standards apply to behavioral health and physical health services:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to residential services, detention discharge, or discharge from justice system placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic</td>
<td>Within 24 hours</td>
<td>Within 1 week</td>
<td>Within 5 business days of request</td>
<td>Within 5 business days of request</td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Emergency</td>
<td>Urgent</td>
<td>Non-urgent</td>
<td>Follow-up to emergency or hospital discharge</td>
<td>Follow-up to residential services, detention discharge, or discharge from justice system placement</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<td>-------------------------</td>
<td>---------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td></td>
<td></td>
<td>2–4 weeks</td>
<td>Within 24 hours</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 business days of request</td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPEP</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASAS Outpatient Clinic</td>
<td></td>
<td>Within 24 hours</td>
<td>Within 1 week of request</td>
<td>Within 5 business days of request</td>
<td>Within 5 business days of request</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Rehab</td>
<td>Upon presentation</td>
<td></td>
<td>Within 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASAS opioid treatment program (OTP) services</td>
<td></td>
<td>Within 24 hours</td>
<td>Within 1 week of request</td>
<td>Within 5 business days of request</td>
<td>Within 5 business days of request</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Within 1 hour</td>
<td></td>
<td></td>
<td>Within 24 hours of Mobile Crisis Intervention response</td>
<td></td>
</tr>
<tr>
<td>CPST</td>
<td></td>
<td>Within 24 hours</td>
<td>Within 1 week of request</td>
<td>Within 72 hours of discharge</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>OLP</td>
<td></td>
<td></td>
<td>Within 24 hours of request</td>
<td>Within 72 hours of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Family Peer Support</td>
<td></td>
<td>Within 24</td>
<td>Within 1 week</td>
<td>Within 72 hours of</td>
<td>Within 72 hours of request</td>
</tr>
</tbody>
</table>

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*25.10*
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to residential services, detention discharge, or discharge from justice system placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>hours of request</td>
<td>week of request</td>
<td></td>
<td>request</td>
<td></td>
</tr>
<tr>
<td>Youth Peer Support and Training</td>
<td></td>
<td></td>
<td></td>
<td>Within 1 week of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>PSR</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 business days of request</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Caregiver/Family Supports and Services</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 business days of request</td>
<td>Within 5 business days of request</td>
</tr>
<tr>
<td>Crisis Respite</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td></td>
<td>Within 24 hours of request</td>
<td></td>
</tr>
<tr>
<td>Planned Respite</td>
<td></td>
<td></td>
<td></td>
<td>Within 1 week of request</td>
<td></td>
</tr>
<tr>
<td>Prevocational Services</td>
<td></td>
<td></td>
<td></td>
<td>Within 2 weeks of request</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td></td>
<td></td>
<td>Within 2 weeks of request</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Community Self-Advocacy Training and Support</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 business days of request</td>
<td>Within 5 business days of request</td>
</tr>
<tr>
<td>Habilitation</td>
<td></td>
<td></td>
<td></td>
<td>Within 2 weeks of request</td>
<td></td>
</tr>
<tr>
<td>Adaptive and Assistive Equipment</td>
<td>Within 24 hours of request</td>
<td>Within 2 weeks of request</td>
<td></td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
</tr>
</tbody>
</table>
### Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to residential services, detention discharge, or discharge from justice system placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility Modifications</td>
<td>Within 24 hours of request</td>
<td>Within 2 weeks of request</td>
<td>Within 24 hours of request</td>
<td>Within 24 hours of request</td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Within 2 weeks of request</td>
<td>Within 24 hours of request</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOSTER CARE INITIAL HEALTH SERVICES - NOTE: FOSTER CARE SERVICES DO NOT BECOME EFFECTIVE UNTIL JULY 1, 2019 AND IS SUBJECT TO ADDITIONAL STATE GUIDANCE**

Table 7 below outlines the time frames for initial health activities, to be completed within 60 days of placement. An “X” in the Mandated Activity column indicates that the activity is required within the indicated time frame.

**Table 7**

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Activity</th>
<th>Mandated Activity</th>
<th>Mandated Time Frame</th>
<th>Who Performs</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hours</td>
<td>Initial screening/ screening for abuse/ neglect</td>
<td>X</td>
<td>X</td>
<td>Health practitioner (preferred) or child welfare caseworker/health staff</td>
</tr>
<tr>
<td>5 Days</td>
<td>Initial determination of capacity to consent for HIV risk assessment &amp; testing</td>
<td>X</td>
<td>X</td>
<td>Child Welfare Caseworker or designated staff</td>
</tr>
<tr>
<td>5 Days</td>
<td>Initial HIV risk assessment for child without capacity to consent</td>
<td>X</td>
<td>X</td>
<td>Child Welfare Caseworker or designated staff</td>
</tr>
<tr>
<td>10 Days</td>
<td>Request consent for release of medical records &amp; treatment</td>
<td>X</td>
<td>X</td>
<td>Child Welfare Caseworker or health staff</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial medical assessment</td>
<td>X</td>
<td>X</td>
<td>Health practitioner</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial dental assessment</td>
<td>X</td>
<td>X</td>
<td>Health practitioner</td>
</tr>
<tr>
<td>30 Days</td>
<td>Initial mental health assessment</td>
<td>X</td>
<td></td>
<td>Mental health practitioner</td>
</tr>
</tbody>
</table>
### Time Frame | Activity | Mandated | Mandated | Who Performs
--- | --- | --- | --- | ---
30 Days | Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate) | X | X | Health practitioner
30 Days | HIV risk assessment for child with possible capacity to consent | X | X | Child Welfare Caseworker or designated staff
30 Days | Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection | X | X | Child Welfare Caseworker or health staff
45 Days | Initial developmental assessment | X | | Health practitioner
45 Days | Initial substance abuse assessment | | | Health practitioner
60 Days | Follow-up health evaluation | | | Health practitioner
60 Days | Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection | X | X | Child Welfare Caseworker or health staff
60 Days | Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing | X | X | Child Welfare Caseworker or health staff

### LANGUAGE LINES

Fidelis Care’s Medicaid Managed Care Plan for Enhanced Children’s Benefits makes resources available (such as language lines) to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Members that require culturally, linguistically, or disability-competent care.

Providers may provide and be reimbursed for translator services using Code T1013. If a translator is not available, a language line or TTY line can be accessed by calling the Fidelis Care Provider Call Center at 1-888-FIDELIS (1-888-343-3547). (TTY line: 1-800-421-1220)
ACCESS TO SPECIALTY CARE

In order to facilitate a smooth transition of HCBS and LTSS authorization for children in receipt of HCBS, Fidelis Care expects Care Management Agencies to submit comprehensive Plans of Care inclusive of HCBS requirements with appropriate signatures in a timely manner to promote continued access to HCBS services. Specifically, Fidelis Care is expecting to receive initial Plans of Care for the following members:

Beginning March 1, 2019: children for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed; and

Beginning June 1, 2019: b) for a child in the care of a LDSS/licensed VFCA, where Plan election has been confirmed by the LDSS/VFCA.

Additional training and communication documents will specify where POCs need to be submitted and what to include to complete the process.

Fidelis Care is developing reporting and procedures to identify children meeting NYS defined criteria for the different categories of HCBS LOC, HCBS LON, Foster Care, Children in the care of a Voluntary Foster Care Agency, HCBS Serious Emotional Disturbance, HCBS Medically Fragile, HCBS Coexisting Developmental Disability and Medically Fragile condition, and HCBS Developmental disability. Upon identification of the defined population via state enrollment rosters (K-codes in the RE field) or other identified channel, members meeting this criteria will be assigned to the Children’s Health and Behavioral health clinical team. This team will work with each member, their family member, providers involved in the member’s care, and other caregivers to determine their clinical needs, including their linkage to a Health Home Care Management agency in order to complete the CANS-NY HCBS eligibility assessment.

Upon HCBS eligibility being determined, the Fidelis Care clinical management team will work closely with the HCBS providers to approve a completed Health Home Plan of care, issue the appropriate level of service determination consistent with requirements regarding choice, and ensure the member is linked to the HCBS provider.

Fidelis Care will work closely with the member’s Health Home Care Manager to ensure specialty services are accessed and meet the requirements specified in the Children’s HCBS POC workflow currently under development with State agencies. HCBS must be managed in compliance with CMS HBCS Final Rule and any applicable State guidance and Fidelis will be requiring the submission of a completed Plan of Care (POC) and conduct a clinical review of this document to ensure it was developed in a person-centered manner, compliant with federal regulations and state guidance, and meets the member’s needs in order to authorize HCBS services that are pursuant to the POC. Claims utilization will be monitored in the form of reporting to identify members receiving, and providers delivering HCBS in patterns that deviate from any approved POC and conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the contents of the POC.

The Fidelis Care clinical management team serves as a resource to obtain information from Health Home and HCBS providers, and additional reports to enhance care coordination and promote adequacy of service plans and quality are under development.

COLLABORATION/COORDINATION OF CARE

Effective working relationships between providers and other treatment partners and service sites is an evidence-based practice, and thus will result in improved member health outcomes, improved continuity
and coordination of care, increased quality, efficiency and effectiveness of services, and increased member satisfaction. All collaboration efforts should be documented in the medical record.

Fidelis Care has a variety of data driven mechanisms to monitor clinical, regulatory, and financial measures for members and providers through claims, authorizations, and care management process measures. Fidelis uses this information to evaluate an enrollee’s health and safety, level of care, identify gaps in care, monitor adequacy of service plans, as well as financial accountability and compliance. Providers involved in the care and treatment of children who may be eligible for HCBS services can expect to be involved in the Fidelis Care Management process with the member, family member, Health Home Care Management Agency, and other caregivers as appropriate.

Fidelis Care meets with regulatory bodies as determined by the State (e.g. DOH, OMH, OCFS and OASAS) to discuss specific issues including, but not limited to, foster care, medically fragile, or other identified special populations. Fidelis Care meets quarterly with the RPC Children and Families Subcommittee in their respective regions. RPCs will be comprised of representatives of children’s MH and SUD service providers, VFCAs, LDSS, peers, families, Health Home leads, schools, Plans and other stakeholders as appropriate. Fidelis Care shall work with the State to ensure that the specialty children populations described in this transition are provided continuity of care without service disruptions or mandatory changes in service providers.

Behavioral health care providers should communicate with the member’s PCP:
1. For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment;
2. When the PCP’s support for a treatment plan would enhance member satisfaction and/or compliance;
3. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and
4. When PCP has requested immediate feedback.

**First Episode Psychosis (FEP)**

The provider, in collaboration with Fidelis Care and the Health Home (when involved), will utilize available data to identify members with FEP. Appropriate resources, such as those available through OnTrack NY (through the Center for Practice Innovations) will be engaged to assure comprehensive and integrated aftercare planning designed to facilitate prompt, extended follow up of these members to identify and address barriers to successful community tenure and avoidance of readmission.

Fidelis Care has a specialized pharmacy management program to promote coordination/collaboration with BH providers, primary care providers, and other specialty provider types.

- Areas of focus include, but not limited to, polypharmacy and metabolic and cardiovascular side effects of psychotropic medications.
- Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost stratified by age group.
- Protocols to monitor the use of psychotropic medications, including the oversight of any child:
  - Under the age of six taking any psychotropic medications;
  - On more than one medication from the same class (antidepressants, antipsychotics, attention-deficit/hyperactivity disorder medications, anxiolytics/hypnotics, mood stabilizers); or
  - On three or more psychotropic medications; in the event that any of these prescribing methods occur.
COORDINATION FOR CHILDREN IN FOSTER CARE

The following procedure describes how Fidelis Care works with the Local Department of Social Services (LDSS) and those providers serving children in Foster Care.

ENROLLMENT

- Fidelis has established a procedure working with children in Foster Care to ensure all notices, welcome letters, and MCO identification cards are sent to the foster care coordinators at the LDSS within 14 days of enrollment. Fidelis Care also provides temporary identification for new enrollees in foster care and transmits this information to the LDSS foster care coordinator by the next business day following the request or as needed to allow immediate access to services.

- For current Fidelis Care enrollees entering Foster Care, Fidelis Care ensures replacement identification cards or alternative documentation requested by the LDSS/VFCA Foster Care Coordinator are processed by the next business day following the request.

DISENROLLMENT

- Upon notice of an enrollee leaving foster care and/or transitioning to another health plan, the Fidelis Care Foster Care Liaison works with the LDSS and any care managers or health care providers to ensure all are aware of the transition so that the service plan can continue to be coordinated to meet the needs of the enrollee. When children in the care of VFCAs start enrolling in Managed Care in January 2019, the Foster Care Liaison will work collaboratively with the VFCA to ensure the child’s service needs are met and that all relevant parties are engaged in the coordination of the enrollee during this transition.

- Upon notice of an enrollee leaving foster care and remaining enrolled in the plan, the Fidelis Care enrollment team will process the notice of the enrollee leaving foster care and will update the member record with the correct responsible party and contact information. Documentation of the end date of foster care is captured in the Member Record.

- Upon discharge from foster care, or disenrollment from the plan, if the child is considered unstable by either the health care provider or the LDSS/VFCA, or has a chronic condition, the Plan Foster Care Liaison shall coordinate with the LDSS/VFCA Foster Care Coordinator(s) and any Health Home Care Managers to ensure that continuity of care plans are in place.

COMMUNICATION SYSTEM

- A shared secure mailbox has been established to promote the efficient and coordinated communication between the Fidelis Care Enrollment, Case Management, and Foster Care Liaison resources and has been in operation since 2013.

- The email address is FCNYFosterCareLDSS@fideliscare.org. The LDSS have been advised to use this email address to notify Fidelis Care of the enrollment and disenrollment of Fidelis enrollees in and out of Foster Care, as well as any other changes such as placement addresses, contact information, and health care needs. The LDSS provides the foster care information to the plan by completing a Managed Care Transmittal form (see next page for example of the form).
Once received, Fidelis Care follows the procedures described above to process the enrollment or disenrollment, ensure notices and replacement identification cards are sent to the correct party, and support linkages to health care needs including care management. The plan Foster care Liaison communicates status and coordination needs back to the LDSS Foster Care coordinator through this secure email.

CONTINUITY OF CARE

For continuity of care purposes, Fidelis Care has procedures in place to allow children to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This requirement will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.

To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. The Plan will be required to pay on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan.

The Plan shall work with the State to ensure that TAY are provided continuity of care without service disruptions or mandatory changes in service providers.

Upon discharge from foster care or disenrollment from the Plan, if the child is considered unstable by either the health care provider or the LDSS/VFCA, or has a chronic condition, the MMCO Foster Care Liaison shall coordinate with the LDSS/VFCA Foster Care Coordinator(s) and any Health Home Care Manager to ensure continuity of care plans are in place. If an enrolled child in foster care is placed in another county, Fidelis (being a statewide plan that operates in all counties in New York State) will allow the child to transition to a new primary care provider and other health care providers without disrupting the care plan that is in place. If an enrolled child in foster care is placed outside of the Fidelis service area, Fidelis will permit the enrollee access to providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.

For 24 months from the date of the transition of the children’s specialty services carve in, for children in FFS in receipt of HCBS at the time of enrollment, as well as children transitioning from a 1915 (c ) waiver, Fidelis will continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of the children’s specialty services newly carved into managed care. Service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed. During the initial 180 days of the transition, Fidelis will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review.

PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

 Expedited and standard requests for prior authorization of services not already authorized as part of a member’s service plan may be submitted through the traditional prior authorization process. Primary care physicians and other providers can call or fax a treatment request that Fidelis Care may use as a basis for authorizing services.
When referring for services covered in the service benefits package, ensure that the provider is contracted and participating in the network. If you have any questions, please contact Fidelis Care.

Members can choose any participating hospital or specialist they wish; however, please contact the member's HealthierLife Care Manager. This will aid the Care Manager in properly coordinating services.

Once a request has been approved by Fidelis Care, authorizations will be issued for each service. Fidelis complies with State Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. The UM protocols, Medical Necessity Criteria guidelines, and admission/service authorization criteria shall be specific to New York State for Behavioral Health and Home and Community Based Service benefits as appropriate and as defined in Table 3 consistent with State guidance. OASAS will identify guidelines that all Plans must use for SUD services. The LOCADTR 3.0 tool will be used for all SUD services.

Specifically, Fidelis has incorporated the following guidance:

- OMH Clinic Standards of Care: [www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html](http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)
- OASAS Clinical Guidance: [https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm](https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm)
- OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013 [https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_f.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_f.pdf)
- OHIP Principles for Medically Fragile Children (Attachment G)

A licensed Behavioral Health Case Manager will be available after regular business hours, from 5:00pm to 8:30am and on weekends and holidays, in order to arrange care and coverage 24 hours a day for physical health and behavioral health care, respectively. Please call 1-877-533-2404.

Providers shall have policies and procedures addressing enrollees who present for unscheduled non-urgent care with aim of promoting enrollee access to appropriate care in the most appropriate setting in order to meet the recovery needs of the person seeking care.

Fidelis Care is responsible for coordinating, arranging, and authorizing payment to providers for the member’s medically and clinically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Fidelis Care's Provider Directory.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Prior Authorization</th>
<th>Concurrent Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic: including initial assessment,</td>
<td>No</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most</td>
<td>MCOs must cover at least 30 visits per calendar year without requiring authorization</td>
</tr>
<tr>
<td>psychosocial assessment, and individual/family</td>
<td></td>
<td></td>
<td>recent edition</td>
<td>and ensure that concurrent review activities do not violate parity law, and be</td>
</tr>
<tr>
<td>/collateral/group psychotherapy, and LBHP</td>
<td></td>
<td></td>
<td></td>
<td>consistent with <a href="https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_f.pdf">OMH Clinic Standards of Care</a>; and <a href="https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm">OASAS Clinical Guidance</a> as applicable.</td>
</tr>
<tr>
<td>Mental Health Clinic Services:</td>
<td>No</td>
<td>No</td>
<td>Milliman Care Guidelines, most</td>
<td>MH clinic visits exclusively for Medication management or psychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>recent edition</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Approval</td>
<td>Coverage</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Assessment, Medication Treatment</td>
<td></td>
<td>recent edition</td>
<td>assessment will not count towards the 30 visits per calendar year and be consistent with <a href="#">OMH Clinic Standards of Care</a></td>
<td></td>
</tr>
<tr>
<td>Psychological or neuropsychological testing</td>
<td>Yes</td>
<td>N/A</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
<td>Yes</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td></td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission Status</td>
<td>No</td>
<td>No</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>PROS Admission: Individualized Recovery Planning</td>
<td>Yes</td>
<td>No</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>PROS Active Rehabilitation</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Services (IPRT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS Guidelines-see Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Psych Emergency</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medicaid Children’s Expanded Benefits

#### Room (CPEP)

<table>
<thead>
<tr>
<th>Service</th>
<th>Inpatient</th>
<th>Psychiatric Services</th>
<th>Milliman Care Guidelines, most recent edition</th>
<th>Internal report of crisis visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or the need for changes in services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Crisis Intervention</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASAS Outpatient Rehabilitation Programs</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>14 service days, then concurrent, and consistent with <a href="https://www.oasas.ny.gov">OASAS Clinical Guidance</a></td>
</tr>
<tr>
<td>OASAS outpatient and opioid treatment program (OTP) services</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>30 Service days, then concurrent, and consistent with <a href="https://www.oasas.ny.gov">OASAS Clinical Guidance</a></td>
</tr>
<tr>
<td>Outpatient and Residential Addiction Services</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>Concurrent review will be consistent with <a href="https://www.oasas.ny.gov">OASAS Clinical Guidance</a></td>
</tr>
<tr>
<td>SUD Outpatient Clinic (non-intensive) OASAS Part 822 Clinic</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0</td>
<td>Internal report of outpatient visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or the need for changes in services and be consistent with <a href="https://www.oasas.ny.gov">OASAS Clinical Guidance</a> as applicable.</td>
</tr>
<tr>
<td>SUD Intensive Outpatient OASAS Part 822 programs</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>14 service days, then concurrent, and consistent with <a href="https://www.oasas.ny.gov">OASAS Clinical Guidance</a></td>
</tr>
<tr>
<td>Medically Supervised Outpatient Withdrawal</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification (OASAS Service)</td>
<td>No*</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>*Providers must notify plan within 48 hours from the admission start time by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a></td>
</tr>
<tr>
<td>Inpatient Rehabilitation Treatment (OASAS Service)</td>
<td>No*</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>*Providers must notify plan within 48 hours from the admission start time by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a></td>
</tr>
<tr>
<td>Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)</td>
<td>No*</td>
<td>Yes</td>
<td>LOCADTR 3.0</td>
<td>*Providers must notify plan within 48 hours from the admission start time by faxing or emailing the OASAS Appendix A Notification Form and OASAS LOCADTR Medical Necessity Tool to 646-829-1421 or <a href="mailto:LOCADTR@fideliscare.org">LOCADTR@fideliscare.org</a></td>
</tr>
</tbody>
</table>
### CLINICAL CRITERIA FOR BEHAVIORAL HEALTH

Comprehensive clinical guidelines specifying medical necessity specific to service types and levels of care can be found in the Fidelis Care Provider Manual Section 21: Behavioral Health (available here: https://www.fideliscare.org/Portals/0/Providers/ProviderManuals/2018-FidelisCare-ProviderManual-Medicaid-English.pdf)

Medically necessary treatments are defined as services that are:

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<table>
<thead>
<tr>
<th>Service Type</th>
<th>Approval Required</th>
<th>Eligibility</th>
<th>Guidelines</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Licensed Practitioner (OLP)</td>
<td>No</td>
<td>Yes</td>
<td>NYS Guidelines</td>
<td>Authorization begins when plan approves the treatment plan and the initial authorization must be inclusive of at least 30 service visits. The Plan will review services at reasonable intervals thereafter consistent with the child’s treatment plan and/or Health Home Plan of Care.</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Supports and Treatment (CPST)</td>
<td>No</td>
<td>Yes</td>
<td>NYS Guidelines</td>
<td>Authorization begins when plan approves the treatment plan and the initial authorization must be inclusive of at least 30 service visits. The Plan will review services at reasonable intervals thereafter consistent with the child’s treatment plan and/or Health Home Plan of Care.</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>No</td>
<td>Yes</td>
<td>NYS Guidelines</td>
<td>Authorization begins when plan approves the treatment plan and the initial authorization must be inclusive of at least 30 service visits. The Plan will review services at reasonable intervals thereafter consistent with the child’s treatment plan and/or Health Home Plan of Care.</td>
</tr>
<tr>
<td>Family Peer Supports and Services (FPSS)</td>
<td>No</td>
<td>Yes</td>
<td>NYS Guidelines</td>
<td>Authorization begins when plan approves the treatment plan and the initial authorization must be inclusive of at least 30 service visits. The Plan will review services at reasonable intervals thereafter consistent with the child’s treatment plan and/or Health Home Plan of Care.</td>
</tr>
<tr>
<td>Youth Peer Support and Training</td>
<td>No</td>
<td>Yes</td>
<td>NYS Guidelines</td>
<td>Authorization begins when plan approves the treatment plan and the initial authorization must be inclusive of at least 30 service visits. The Plan will review services at reasonable intervals thereafter consistent with the child’s treatment plan and/or Health Home Plan of Care.</td>
</tr>
<tr>
<td>Children’s HCBS service array</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
1. Provided for the diagnosis or care and treatment of a disease or condition defined by the standard diagnostic classification system of the current DSM version.

2. Essential for the care and treatment of the behavioral health condition, indicating treatment is essential since no less restrictive level of care can provide the clinical intervention required to ensure the safety and effective treatment of the member;

3. Adequate for the care and treatment of the behavioral health condition indicating treatment is considered adequate if the assessment and treatment plan are clinically appropriate, comprehensive, and active, with timely monitoring and revision;

4. Considered generally acceptable medical practice based on the national standards of clinical practice and current clinical research; and

5. Have a reasonable expectation of being successful in alleviating symptoms and/or improving member functioning.

UTILIZATION MANAGEMENT FOR MEDICALLY FRAGILE CHILDREN

OHIP Principles for Medically Fragile Children

A "medically fragile child" (MFC) is defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria (1) is technologically dependent for life or health sustaining functions, (2) requires a complex medication regimen or medical interventions to maintain or to improve their health status, (3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

Health Plans shall do at least the following with respect to MFC:

A. In accordance with the requirements of C/THP and EPSDT as described in Section 10.4 of the DOH Model Contract, cover all services that assist a MFC in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. Health Plans must continue to cover services until that child achieves age-appropriate functional capacity.

B. Shall not base determinations solely based upon review standards applicable to (or designed for) adults to MFC. Adult standards include, but are not limited to, Medicare rehabilitation standards and the "Medicare 3 hour rule". Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

C. Accommodate unusual stabilization and prolonged discharge plans for MFC, as appropriate. Areas plans must consider when developing and approving discharge plans include, but are not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for a MFC at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for a MFC; the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other inappropriate setting for a MFC, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds or pediatric ventilator units).
MMCOs must develop a person centered discharge plan for the child taking the above situations into consideration.

D. It is Health Plan’s network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility; payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the plan to identify an appropriate provider. MMCOs are required to approve the use of out of network (OON) providers if they do not have a participating provider to address the needs of the child.

E. MMCOs must ensure that MFC receive services from appropriate providers that have the expertise to effectively treat the child and must contract with providers with demonstrated expertise in caring for the MFC. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the MMCO for out-of-network providers when participating providers cannot meet the child’s needs. The MMCO must authorize services as fast as the enrollee’s condition requires and in accordance with established timeframes in the Medicaid Managed Care Model Contract.

QUALITY PROGRAMS

A description of Fidelis Care’s quality management programs and ongoing procedures can be found in the section 10 of the provider manual, refer to the link below:


The Quality Management program will be modified to address the specific requirements related to the populations, benefits, and services covered in the Children’s System Transformation requirements and standard documents. Once finalized, this document will be made available to providers as a separate document. The information below serves to describe the expansion of the Quality Management BH Subcommittee functions to meet the requirements of the Children’s System Transformation.

Children’s Quality Management Subcommittee

Composed of the Medical Director (Co-Chair), the BH Medical Director (Co-Chair), the AVP of Behavioral Health Services, the Director of Behavioral Health Products, the Director of Clinical Services, the Director of Children Clinical Services, the AVP of Quality Management, the Director of and the Director of Behavioral Health and HARP Quality Management (who facilitates the meeting), and the Director of Behavioral Health Product. This committee will also include members, family members, youth and family peer support specialists, and child-serving providers, who will act in an advisory capacity. The purpose of this committee is to provide comprehensive oversight of the Quality Management Program and Plan specifically for Mainstream Medicaid children health and behavioral health services. Committee functions include:

- Oversight of the quality of health and behavioral health services for Mainstream Medicaid children
- Reviews data on all metrics collected on health and behavioral health quality and utilization, and development and monitoring of completion of improvement plans as needed for children and the specific children wavier populations.
- Reviews reports and recommendations from advisory subcommittee, and where appropriate, act on recommendations
• Ensures all planned Medicaid Children Quality Management Program and Improvement Plan activities are carried out
• Oversees the expansion of a State-wide system of care and the integration of additional populations

The Children's UM/CM and Children’s Advisory Committees report to this committee. This committee is accountable to and reports at minimum quarterly to the Quality Management Committee. This committee meets at minimum quarterly.

Children's Utilization and Care Management Subcommittee

Composed of the Medical Director (Co-Chair), the BH Medical Director (Co-Chair), the AVP of Behavioral Health Services, the Director of Behavioral Health Products, the Director of Clinical Services, the Director of Children Clinical Services, The Director of Medical Management, the AVP of Quality Management, the Director of and the Director of Behavioral Health and HARP Quality Management, and the Director of Behavioral Health Product. The purpose of this committee is to monitor, analyze and evaluate Utilization and Care Management process and outcome measurement results for children health and behavioral health services, consistent with the NYSDOH reporting requirements.

The Committee will ensure intervention strategies have measurable outcomes that are recorded in committee minutes. Analyses will include studies of over and underutilization and cost. The Committee performs the following functions:

• Ensure family-driven and youth-guided care planning and care management
• Ensure service planning (supporting service authorization) for the least restrictive, most-integrated environment
• Review and evaluate data on key clinical utilization and care management indicators, and create and monitor completion of action plans
• Ensure all planned Mainstream children health and behavioral health Utilization Management Program and Improvement Plan activities are carried out

The Administrators of the Children’s Clinical UM and CM Program report to this committee. This committee reports to the Behavioral Health Quality Management Subcommittee. The committee meets at minimum monthly.

Children’s Advisory Subcommittees

Composed of youth and family members who have been served in the child welfare and BH system, trained peers with lived experience, children’s service providers, VFCAs, foster/adoptive family members, and other keys stakeholders. The stakeholders shall have expertise across the different child populations and the children services throughout the state. The stakeholders will also reflect the different QARR regions in NYS. The purpose of this committee is to identify and resolve issues related to the management of children’s health and behavioral health benefits. This committee performs the following functions:

• Provide the guidance on crisis intervention, recovery and rehabilitation services, including HCBS and Health Home services
• Assists in the development of level of care specific performance standards, measures, and measurement methodologies, root-cause analyses, QI intervention, and implementation, and plan development
• Provides input on policies, procedures, protocols and guidelines
• Informs about access and availability of regionally based services, including wait times and capacity
• Assists with identifying and devising plans to remove any barriers to care for children
• Reviews and assists with monitoring performance measures for access, service quality, quality of care, utilization, customer service and health plan operations
• Advises on quality improvement initiatives including initiatives aimed at improving the integration of physical and behavioral health care
• Ensures an emphasis is maintained on the clinical outcomes of care
• Identifies regionally-specific challenges and opportunities for performance improvement

All parties in attendance are expected to bring to this committee information, data and their specific perception on all matters presented on the agenda related to children services. These Committees meet at minimum quarterly and will report to the Behavioral Health and Children's Quality Management Committee.

BILLING AND CLAIMS

Timely Filing

All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to Medicaid Managed Care enrollees must be submitted within 90 days. Acceptable reasons for a claim to be submitted late are: litigation, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Instructions for Submitting Claims

The physician’s office should prepare and electronically submit a CMS-1500 claim form. Hospitals, facilities, clinics, and other agencies for whom NY State Children's Health and Behavioral Health Billing Guidance applies should prepare and electronically submit a UB-04 claim form.

Electronic Claims Submission

Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org.

The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

All Medicaid billing guidelines must be followed when submitting your Claims to Fidelis. Physicians must include the National Provider Identifier and Tax Identification Number on all claims.

Fidelis Care receives electronic claims submission, for a complete list of vendors; visit the Fidelis Care website at fideliscare.org

Mailing Address for Direct Paper Claims Submission:

<table>
<thead>
<tr>
<th>CMS-1500 Claims:</th>
<th>UB-04 Claims:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelis Care</td>
<td>Fidelis Care</td>
</tr>
<tr>
<td>PO Box 898</td>
<td>PO Box 806</td>
</tr>
<tr>
<td>Amherst NY 14226-0898</td>
<td>Amherst NY 14226-0806</td>
</tr>
</tbody>
</table>
Balance Billing

**BALANCE BILLING NOTE:**

Participating providers may not under any circumstances bill a Fidelis Care member.

For additional Billing and Claim information, please refer to Section 12 of the Fidelis Care Provider Manual.

**PROVIDER PAYMENT**

The Plan shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. Fidelis Care has procedures in place to ensure rates are consistent with mandated FFS or ‘government’ rate fee schedules for the designated time period.

Fidelis care has procedures in place to ensure rates are consistent with the Medicaid FFS fee schedule for 24 months or as long as New York State mandates (whichever is longer) for the following services/providers:

i. New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports

ii. OASAS clinics (Article 32 certified programs)

iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)

iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide Care Management services that are being transitioned to Health Home, may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

Fidelis Care contracts with OASAS residential programs and has procedures in place to ensure the rates are consistent with the mandated FFS or ‘government’ rate methodology as specified by NYS agencies.

Fidelis Care has procedures in place to ensure that all HCBS services will be paid according to the NYS fee schedule and coding methodology as long as the Plan is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates).

**PROVIDER CREDENTIALING**

Fidelis Care has procedures in place to support the contracting of new providers serving the Children’s population under the Health and Behavioral Health Benefit administration consistent with NYS requirements for credentialing. Upon completion of NYS designation, Fidelis Care receives a list of providers designated by NYS agencies to deliver the expanded array of children’s health and behavioral health services. The Fidelis Care Contract management team leads the initiative of completing new contracts or issuing contract amendments to contracted providers who are designated to expand their service array. The standard facilities contract template describes provider responsibilities related to not employing or contracting with any employee, subcontractor, or agent who has been debarred or suspected by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
When contracting with NYS-designated providers, Fidelis Care does not separately credential individual staff members in their capacity as employees of OCFS licensed Voluntary Foster Care Agencies, OASAS and OMH licensed programs. Fidelis Care continues to accept and collect program integrity related information from these providers, as required in the Medicaid Managed Care Model Contract, and requires providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Additional information on the provider credentialing process can be found in section nine (9) of the provider manual, refer to the link below:

INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH

People with mental illness die younger than the general population, and have more co-occurring conditions such as hypertension, diabetes, heart disease, obesity, tobacco use and asthma. One in five adults with mental illness also have a co-occurring substance use disorder (SUD): Only 20 percent of adults with mental health disorders are seen by mental health specialists and many prefer to receive treatment in primary care settings. The evidence clearly shows that improving health, improving the patient experience, and driving down costs is no longer possible without attending to both physical and behavioral health.

Though Medicaid Managed Care Expanded Children’s Benefits program is an integrated physical and behavioral health program, at Fidelis Care, its administrative operations reside within the Behavioral Health Department, which is part of the Quality Health Care Management Department. The department is staffed by licensed clinical staff as well as paraprofessional associates who can assist with accessing behavioral and physical health services. A provider or member may contact the department through 1-888-FIDELIS (1-888-343-3547) and following the voice prompts to connect directly to Behavioral Health.

Fidelis Care has augmented their BH-medical integration requirements to include the following definitive strategies to promote BH-medical integration for children, including at risk populations defined by the state:

i. The Plan shall deliver orientation and ongoing training to educate its BH and medical staff about co-occurring BH and medical disorders and integrated clinical management principles, including the unique needs of medically fragile children and children involved with child welfare. The training objective is to strengthen the knowledge, skill, expertise, and coordination efforts within the respective outreach, UM, clinical management, pharmacy, and provider relations workforce. Per Section 3.2 of this document, the Plan shall develop and implement a training plan, which at a minimum shall incorporate the topics listed in Attachment E.

ii. The Plan shall expand its business rules regarding screening, referral, and co-management of high risk individuals with both BH and medical conditions. The protocols shall be expanded to include processes to facilitate appropriate sharing of clinical information among providers, LDSS, VFCAs, LGUs and/or SPOAs as needed for coordinated care.

iii. Fidelis promotes provider access to rapid consultation from child and adolescent psychiatrists through the New York State OMH Project TEACH (Training and Education for the Advancement of Children’s Health) Initiative. For more information, please visit the New York State Office of Mental Health Website (clicking this link will cause you to leave the Fidelis Care website) or contact Dr. David Kaye, Project Director at 716- 887–5775
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Behavioral health providers and community services can be located in the Fidelis Care Online Provider Directory. For additional information on Community Support providers, call the Behavioral Health Department, which can assist with identifying appropriate services available.

Fidelis Care encourages the use of validated behavioral health screening tools in primary care settings. In addition to your observations and patient self-report, there are a number of free, valid and reliable screening tools available:

- Children’s specific screening tools for primary care via Project Teach: [http://www.cappcny.org/home/clinical-rating-scales/](http://www.cappcny.org/home/clinical-rating-scales/)

Similarly, it is sound practice for behavioral health providers to routinely evaluate for physical health issues in their patients. The practice guidelines for psychiatric evaluation put forth by the American Psychiatric Association (APA), which include prominently a section on general medical history, can be found here: [https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/psychevaladults-guide.pdf](https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/psychevaladults-guide.pdf)


Further screening tools and best practice information can be found at: [http://www.integration.samhsa.gov/clinical-practice/screening-tools](http://www.integration.samhsa.gov/clinical-practice/screening-tools) and on the Fidelis Care Provider Website in the Provider Manual Appendix IV. [https://www.fideliscare.org/Provider/Provider-Resources/Manuals-And-Forms](https://www.fideliscare.org/Provider/Provider-Resources/Manuals-And-Forms)

For detailed information on the Behavioral Health Referrals and Authorization process please refer to Section 21 of the Fidelis Care Provider Manual. [https://www.fideliscare.org/Portals/0/Providers/ProviderManuals/2018-FidelisCare-ProviderManual-Medicaid-English.pdf](https://www.fideliscare.org/Portals/0/Providers/ProviderManuals/2018-FidelisCare-ProviderManual-Medicaid-English.pdf)

PHARMACY

Please visit [https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services](https://www.fideliscare.org/Provider/Provider-Resources/Pharmacy-Services) for a comprehensive list of covered drugs and supplies listed on our formulary. Fidelis Care has contracted Caremark (a pharmacy management company) to provide pharmacy services. Contact Caremark directly at 800-345-5413.

For additional information on Pharmacy Services, please refer to Appendix II of the Fidelis Care Provider Manual.

For information on specialized pharmacy management program, please refer to Section 25.16 Collaboration/Coordination of Care.
RETENTION OF MEDICAL RECORDS

Medical records must be retained for at least ten (10) years for adults, and six (6) years from the age of majority for children. For additional information on medical record retention, please refer to Section 7 of the Fidelis Care Provider Manual, page 7.2.

CONFIDENTIALITY

For information on Confidentiality, please refer to Section 3 of the Fidelis Care Provider Manual, page 3.2.


MEMBER RIGHTS AND RESPONSIBILITIES

Fidelis Care Medicaid Managed Care (Expanded Children’s Benefits) Members have the right to:

During the course of any contact with an enrolled member, employees will not encourage an enrollee to dis-enroll because of challenging behavior, complex care needs, or high medical expenses.

Fidelis Care adheres to laws that protect members from discrimination or unfair treatment and does not tolerate discrimination based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. Furthermore, as a Fidelis Care member, you have a right to:

- Receive information about Fidelis Care, our services, our practitioners and providers, and member rights and responsibilities. For more information, please visit the Fidelis Care website at https://www.fideliscare.org/ or contact Member Services 24 hours a day, 7 days a week: 1-888-FIDELIS (1-888-343-3547) or fax us at 718-896-6832. TTY users should call 1-800-421-1220.

- Be treated with respect and recognition of your dignity and your right to privacy.

- Have your information remain confidential throughout the Fidelis Care organization. The following are ways Fidelis Care keeps your information confidential:
  - Fidelis Care staff members are prohibited from discussing confidential information in public places, such as elevators or outside of Fidelis Care offices.
  - When discussing your confidential information on the telephone, staff members are required to use appropriate safeguards to confirm they are speaking with someone who has the right to your confidential information.
  - All electronic transmissions contain limited identifiable information and are protected by encryption when sent outside of the organization.
  - Paper documents are stored in secure locked areas and destroyed when no longer needed.

- Participate with practitioners in making decisions about your health care.

- A candid discussion with your practitioners or providers about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
• Voice complaints or appeals about Fidelis Care and the care or services we provide. Complaints may be communicated by contacting Member Services 24 hours a day, 7 days a week: 1-888-FIDELIS (1-888-343-3547) or fax us at 718-896-6832. TTY users should call 1-800-421-1220.

• Make recommendations regarding our Member Rights and Responsibilities Policy.

As a Fidelis Care member, you have a responsibility to:

• Supply information (to the extent possible) that Fidelis Care and its practitioners and providers need in order to provide care.

• Follow plans and instructions for care that you have agreed to with your practitioners.

• Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Medicaid Managed Care (Expanded Children’s Benefits) members shall not be balanced billed. Should a provider balance bill a member inappropriately, Fidelis Care will investigate the situation and when required, inform the provider to cease the balance billing. Some Members may have applicable spend-down/NAMI for Medicaid.

Fidelis Care has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.

A Choice of Plans and Providers

Members will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose an alternative package of Medicaid services through a different Medicaid Managed Care Plan.

MEMBER COMPLAINTS AND APPEALS

All Fidelis Care members have a right to file a complaint at any time if they are dissatisfied with Fidelis Care, a Fidelis Care provider, or with the care or services they have received. If a complaint involves a physician or provider, a Provider Relations Representative will contact the provider to discuss the complaint. The findings will be reported to the Quality Healthcare Management (QHCM) Department for consideration as to action or disposition.

Members are advised to call Member Services to file a complaint. Fidelis Care will attempt to resolve complaints immediately by taking prompt corrective action and educating members regarding Fidelis Care policies and procedures. The substance of the complaint and the agreed upon disposition will be documented.

Complaints are submitted in writing or recorded by Fidelis Care staff on behalf of members. All complaints are logged and acknowledged by Fidelis Care in writing. Complaints relative to the delivery of healthcare services will be referred to Fidelis Care's QHCM Department for investigation.

A member or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written Complaint Appeal. Complaint Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered healthcare
professionals who did not make the initial determination - at least one of whom must be a clinical peer reviewer.

Upon the member’s request, Fidelis Care will expedite the complaint process to accommodate the member’s needs.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file and in the provider's Total Quality Profile on an annual basis.

NOTE: Members may always file a complaint with the New York State Department of Health and/or the City or respective County.

COMPLAINTS

If a member has a problem or dispute with care or services, the member may file a complaint with Fidelis Care. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to the following procedure. Fidelis Care is always available to assist a member in filing a complaint, complaint appeal, or action appeal. A Member Services Associate can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, Fidelis Care can help with this.

A member has the right to contact the New York State Department of Health about their complaint at 1-800-206-8125 or may write to: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. The member may also contact their local Department of Social Services with a complaint at any time. A member may call the New York State Insurance Department at (1-800-342-3736) if their complaint involves a billing problem.

Filing a Complaint with the Plan:

To file by phone, the member should call Member Services at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30AM to 6:00PM. If the member contacts Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, the member will be notified. The member can write Fidelis Care with his or her complaint or call the Member Services number and request a complaint form. It should be mailed to Attn: Member Services Department, Fidelis Care, 95-25 Queens Boulevard, Rego Park, NY 11374.

If Fidelis Care does not solve the problem right away over the phone or if Fidelis Care receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Fidelis Care will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint, but the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Fidelis Care will send the member a letter with the reasons for the decision. When a delay would risk a member’s health, Fidelis Care will make a decision within forty-eight (48) hours of when Fidelis Care has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Fidelis Care will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Fidelis Care is unable to
make a decision about a complaint because we don’t have enough information, a letter will be sent to the member.

Complaint Appeals:

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Fidelis Care. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member will sign and return the form to Fidelis Care. The member may make any needed changes before sending the form back to us.

Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about the complaint.

If Fidelis Care has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member’s health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the member or their designee can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

**FAIR HEARINGS AND ACTION APPEALS**

In some cases, a member may ask for a fair hearing from New York State. A member may request a Fair Hearing with regard to: enrollment/disenrollment decisions made by the Local Department of Social Services; the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member may also request a Fair Hearing if they believe that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the fair hearing officer will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

**ACTION APPEALS**

If a member disagrees with Fidelis Care's decision with a Service Authorization Request, a payment denial, or timeliness of an action taken by Fidelis Care, the member or their designee can file an action
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appeal. The member has sixty (60) business days after hearing from Fidelis Care to file an appeal. The action appeal must be in writing. If the appeal is by telephone, it must also be made in writing. Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member must sign and return the form to Fidelis Care. The member may make any changes to the form before sending it back to us. After receipt of the action appeal, an acknowledgement letter will be sent within fifteen (15) calendar days.

If Fidelis Care has all the information needed, the member will know our decision within thirty (30) calendar days. If a delay would significantly increase the risk to the member’s health, the member or their designee can request an expedited review of the action appeal, which will be decided within two (2) business days. The timeframe for deciding an action appeal can be extended for up to fourteen (14) calendar days if the member or his/her designee requests one or if Fidelis Care determines that the extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.

The member will be given the reasons for Fidelis Care’s decision and clinical rationale. Fidelis Care will attempt to reach the member with the action appeal decision by phone. If the member is still not satisfied with Fidelis Care's decision, the member or someone on his or her behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125. Filing an action appeal is the member's right, and the Fidelis Care will not retaliate or take any discriminatory action against the member because they filed an action appeal.

An action appeal should be made in writing within sixty (60) business days of receipt of the letter to:

Attn: Quality Health Care Management
Fidelis Care
490 CrossPoint Parkway
Getzville, NY  14068
Phone#: 1-888-FIDELIS – (1-888-343-3547)
Fax#: 1-800-374-9808

EXTERNEAL APPEALS

If the plan decides to deny coverage for a medical service the member or the provider asked for because:

It is not medically necessary; the service is experimental or investigational; the out-of-network service requested is not different from a service that is available in our network. The member can ask New York State for an independent External Appeal. It is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan’s benefit package or be an experimental treatment. For Medicaid and CHP members, the fee is waived for an external appeal. Only HBX has a $25 fee for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. Fidelis Care will waive the fee if we determine that paying the fee would be a hardship to the member. If the External Appeal Agent overturns our decision, the fee will be refunded to the member.

Members have four (4) months after receiving the Plan’s final adverse determination (notice of appeal denial) to ask for an external appeal. The member will lose their right to an external appeal for failure to file an application on time. If the member and the plan agreed to skip the plan’s appeal process, the member must ask for the external appeal within four (4) months of when the agreement was made. The member must fill out an application and submit it to the New York State Department of Financial Services. The member and their doctors will have to give information about their medical problem. The external appeal application will list what information will be needed.
The member’s standard external appeal will be decided in thirty (30) days. More time (up to five (5) work days) may be needed if the external appeal reviewer asks for more information. The member and the plan will be notified in writing of the final decision within two (2) work days after the decision is made. The reviewer will decide an expedited appeal in seventy-two (72) hours or less. The member and the plan will be notified immediately by phone or fax. Later, the member will receive written notification of decision made.

A member may request an External Appeal:

1. Call the Department of Financial Services at 1-800-400-8882
2. Go to the Department of Financial Services’ website at www.dfs.ny.gov
3. Contact Fidelis at 1-888-FIDELIS. Member Services will mail or fax the application to the member.

**PROVIDER COMPLAINTS AND APPEALS**

Please refer to section 13 of this manual for additional detailed information

In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition:

i. A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.

ii. A physician certified in addiction treatment must review all inpatient LOC/continuing stay denial for SUD treatment.

iii. Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist.

iv. A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver.
TELEHEALTH and TELEMEDICINE – OCTOBER 2019

This section of the Fidelis Care Provider Manual provides information to providers rendering care via telehealth modalities as defined by the New York State Department of Health to Medicaid Managed Care, Child Health Plus, Medicare Advantage and Dual Advantage, HealthierLife (HARP), Qualified Health Plans (Metal-Level Products), and the Essential Plan. Providers are responsible for the submission of accurate claims that align with the scope of their contracted services with Fidelis Care and this section does not address all issues related to reimbursement for health services provided to Fidelis Care members. Other factors may supplement, modify, or supersede this section. These factors include, but are not limited to: regulatory requirements including state and federal laws, provider agreements, product benefit coverage and/or other reimbursement standards.

General Information

Pursuant to New York State (NYS) Public Health Law (PHL) Article 29-G, as recently amended, and Social Services Law (SSL) Section 367-u, aligned with NYS Medicaid, Fidelis Care has expanded coverage of telehealth services to include:

1. Additional originating and distant sites;
2. Additional telehealth applications (store-and-forward technology, and remote patient monitoring); and
3. Additional practitioner types.

This section of the Fidelis Care Provider Manual outlines updated telehealth coverage and reimbursement policy. This information is intended to serve only as a general reference regarding Fidelis Care’s coverage and reimbursement for the modality of telehealth delivery of benefits that are already covered in the applicable insurance products. This section does not specify or permit the reimbursement of benefits not otherwise covered in the benefit package and does not address all issues related to reimbursement for health care services provided to Fidelis Care enrollees. Providers should refer to (at a minimum) sections three, seven, and twelve of the provider manual that describe guidelines for billing, claims submission, and defined standards required of providers participating with Fidelis Care.

The following information applies to Article 28 facilities and private practitioners effective March 1, 2019. As additional state guidance is issued from The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, Fidelis Care’s policies will be reviewed and updated in accordance with new information as it becomes available.

Definition of Telehealth

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Fidelis Care member. Telephone conversations, e-mail or text messages, and facsimile transmissions between a practitioner and a Fidelis Care member or between two practitioners are not considered telehealth and are not reimbursable. In addition, the acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable.

While Fidelis Care has aligned with NYS Medicaid coverage expansion of telehealth services, such telehealth services should not be used by a provider if they may result in any reduction to the quality of care required to be provided to a Fidelis Care member or if such service could adversely impact the member. Telehealth is designed to improve access to needed services and to improve member health.
Telehealth is not available solely for the convenience of the practitioner when a face-to-face visit is more appropriate and/or preferred by the member.

**Originating Site**

The **originating site** is where the member is located at the time health care services are delivered to him/her by means of telehealth. The originating site must be located within the fifty United States or United States’ territories. Originating sites previously included facilities licensed under Article 28 (general hospitals, nursing homes, and diagnostic and treatment centers) and private physician’s or dentist's offices located within the state of New York.

The list of allowable originating sites reads as follows:

1. Facilities licensed under Article 28 of the PHL (general hospitals, nursing homes, and diagnostic and treatment centers);
2. Facilities licensed under Article 40 of the PHL (hospice programs);
3. Facilities as defined in Subdivision 6 of Section 1.03 of the Mental Hygiene Law (MHL) (includes clinics certified under Articles 16, 31 and 32);
4. Certified and non-certified day and residential programs funded or operated by OPWDD;
5. Private physician's or dentist's offices located within the state of New York;
6. Any type of adult care facility licensed under Title 2 of Article 7 of the SSL;
7. Public, private and charter elementary and secondary schools located within the state of New York;
8. School-age child care programs located within the state of New York;
9. Child daycare centers located within the state of New York; and
10. The member's place of residence located within the state of New York or other temporary location within or outside the state of New York.

Additionally, consistent with CMS guidelines, authorized originating sites also include:

1. Rural Health Clinics
2. Federally Qualified Health Centers
3. Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
4. Skilled Nursing Facilities
5. Community Mental Health Centers
6. Renal Dialysis Facilities
7. Homes of beneficiaries with End-Stage Renal Disease getting home dialysis
8. Mobile Stroke Units

**Distant Site**

The **distant site** is any secure location within the fifty United States or United States’ territories where the telehealth provider is located while delivering health care services by means of telehealth. Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent (including, but not limited to 45 CFR Parts 160 and 164 [HIPAA Security Rules]; 42 CFR Part 2; PHL Article 27-F; and MHL Section 33.13).
Telehealth Applications (Telemedicine, Store-and-Forward, Remote Patient Monitoring)

Fidelis Care has covered both remote patient monitoring provided by Certified Home Health Agencies (CHHAs) for their patients and telemedicine for a number of years. At this time, Fidelis Care is expanding coverage of telehealth to include store-and-forward technology, additional originating sites, and additional practitioners.

Telemedicine

Telemedicine uses two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site. The totality of the communication of information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.

Store-and-Forward Technology

Store-and-forward technology involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.

1. Store-and-forward technology aids in diagnoses when live video or face-to-face contact is not readily available or not necessary.
2. Pre-recorded videos and/or static digital images (e.g., pictures), excluding radiology, must be specific to the member's condition as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, blood pressure, heart rate, weight, blood sugar, blood oxygen levels and electrocardiogram readings. RPM may include follow-up on previously transmitted data conducted through communication technologies or by telephone. Follow-up is included in the monthly time component.

The following considerations apply to RPM:

1. Medical conditions that may be treated/monitored by means of RPM include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.
2. RPM must be ordered and billed by a physician, nurse practitioner or midwife, with whom the member has or has entered into a substantial and ongoing relationship. RPM can also be provided and billed by an Article-28 clinic, when ordered by one of the previously mentioned qualified practitioners.
3. Members must be seen in-person by their practitioner, as needed, for follow-up care.
4. RPM must be medically necessary and shall be discontinued when the member's condition is determined to be stable/controlled.

5. Payment for RPM while a member is receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to PHL Section 3614 (3-c)(a) – (d) and will only be made to that same CHHA.

**Telehealth Providers**

This section addresses the telehealth payment policy for the following provider types:

1. Physicians;
2. Physician assistants;
3. Dentists;
4. Nurse practitioners;
5. Registered professional nurses (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of RPM);
6. Podiatrists;
7. Optometrists;
8. Psychologists;
9. Social workers;
10. Speech language pathologists;
11. Audiologists;
12. Midwives;
13. Physical therapists;
14. Occupational therapists;
15. Certified diabetes educators;
16. Certified asthma educators;
17. Genetic counselors;
18. Credentialed alcoholism and substance abuse counselors (CASAC) credentialed by OASAS or by a credentialing entity approved by such office pursuant to Section 19.07 of the MHL;
19. Providers authorized to provide services and service coordination under the Early Intervention (EI) Program pursuant to Article 25 of PHL (Note: The EI Program will issue program-specific guidance regarding the use of and reimbursement for EI services delivered via telehealth.)
20. Hospitals licensed under Article 28 of PHL, including residential health care facilities serving special needs populations;
21. Home care services agencies licensed under Article 36 of PHL;
22. Hospices licensed under Article 40 of PHL;

The following applies to practitioners providing services via telehealth:

1. Practitioners providing services via telehealth must be licensed or certified, currently registered in accordance with NYS Education Law or other applicable law, participating in a Fidelis Care product that reimburses for telehealth and enrolled in NYS Medicaid.
2. Telehealth services must be delivered by providers acting within their scope of practice.
3. Reimbursement will be made in accordance with existing policy related to supervision and billing rules and requirements. Notwithstanding, this policy does not address all issues related to reimbursement in a particular case, and other factors affecting reimbursement may supplement, modify, or supersede this policy.
4. When services are provided by an Article 28 facility, the telehealth practitioner must be credentialed and privileged at both the originating and distant sites in accordance with Section 2805-u of PHL. The law can be viewed at the following link:
Confidentiality

All services delivered via telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to: 45 CFR Parts 160 and 164 (HIPAA Security Rules); 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Additionally:

1. HIPAA requires that a written "business associate agreement" (BAA), or contract that provides for privacy and security of protected health information (PHI) be in place between the telehealth provider and the supporting telehealth vendor.
2. Privacy must be maintained during all patient-practitioner interactions.
3. All existing confidentiality requirements that apply to medical records (including, but not limited to: 45 CFR Part 160 and 164; 42 CFR Part 2; PHL Article 27-F, and MHL Section 33.13) shall apply to services delivered by telehealth, including the actual transmission of service, any recordings made during the telehealth encounter, and any other electronic records.

Patient Rights and Consents

The practitioner shall provide the member with basic information about the services that he/she will be receiving via telehealth and the member shall provide his/her consent to participate in services utilizing this technology. Telehealth sessions/services shall not be recorded without the member's consent. Culturally competent translation and/or interpretation services must be provided when the member and distant practitioner do not speak the same language. If the member is receiving ongoing treatment via telehealth, the member must be informed of the following patient rights policies at the initial encounter. Documentation in the medical record must reflect that the member was made aware of the policies outlined below.

Patient rights policies must ensure that members receiving telehealth services:

1. Have the right to refuse to participate in services delivered via telehealth and must be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
2. Are informed and made aware of the role of the practitioner at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care;
3. Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed;
4. Have the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;
5. Have the right to be informed of all parties who will be present at each end of the telehealth transmission; and
6. Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

Failure of Transmission

All telehealth providers must have a written procedure detailing a contingency plan in the case of a failure of transmission or other technical difficulty that renders the service undeliverable via telehealth. Policies
and procedures must be available upon audit. If the service is undelivered due to a failure of transmission or other technical difficulty, a claim should not be submitted.

Billing Rules for Telehealth Services

<table>
<thead>
<tr>
<th>Modifiers to be Used When Billing for Telehealth Services</th>
<th>Description</th>
<th>Note/Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system</td>
<td>Note: Modifier 95 may only be appended to the specific services covered by Medicaid and listed in Appendix P of the AMA's CPT Professional Edition 2018 Codebook. The CPT codes listed in Appendix P are for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio-visual telecommunication system.</td>
</tr>
<tr>
<td>GT</td>
<td>Via interactive audio and video telecommunication systems</td>
<td>Note: Modifier GT is only for use with those services provided via synchronous telemedicine for which modifier 95 cannot be used.</td>
</tr>
<tr>
<td>GQ</td>
<td>Via asynchronous telecommunications system</td>
<td>Note: Modifier GQ is for use with Store-and-Forward technology.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation &amp; management (E&amp;M) service by the same physician or other qualified health care professional on the same day as a procedure or other service</td>
<td>Example: The member has a psychiatric consultation via telemedicine on the same day as a primary care E&amp;M service at the originating site. The E&amp;M service should be appended with the 25 modifier.</td>
</tr>
</tbody>
</table>

Place of Service (POS) Code to be Used when Billing for Telehealth Services

<table>
<thead>
<tr>
<th>POS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>The location where health services and health-related services are provided or received, through telehealth telecommunication technology. When billing telehealth services, providers must bill with place of service code 02 and continue to bill modifier 95, GT or GQ.</td>
</tr>
</tbody>
</table>

General Billing Guidelines

Generally, Fidelis Care follows NYS Medicaid FFS billing guidance and methodologies for Article 28 facility based payments, including the allowable and disallowable combinations of service delivery subject to reimbursement. Additionally, Fidelis Care’s billing guidelines adhere to industry standards as defined by the Center for Medicare and Medicaid Services (CMS); National Correct Coding Initiative (NCCI); National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); the American Medical Association's (AMA) Current Procedural Terminology Manual (CPT-4); Healthcare common Procedure Coding System (HCPCS); and International Classification of Diseases 10th Revision (ICD10).

In addition, only one clinic payment will be made when both the originating site and the distant site are part of the same provider billing entity. In such cases, only the originating site should bill Fidelis Care for the telemedicine encounter. The CPT code billed should be appended with the applicable modifier (GT or GQ).
95). (e.g., Hospital X has multiple sites for primary and specialty care. A member at one of the primary care sites requires a telemedicine consultation with a specialist located at a distant site within the system of Hospital X.)

For individuals with Medicare and Medicaid, if Medicare covers the telehealth encounter, Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by state law. If a service is within Medicare's scope of benefits (e.g., physician), but Medicare does not cover the service when provided via telehealth, Medicaid will defer to Medicare's decision and will not cover the telehealth encounter at this time.

For additional billing and claiming guidance, please see Section Twelve part 1 and 2 of the Fidelis Care Provider Manual.