ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

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PROVIDER GUIDELINE

2025

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Contents

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1. ELIGIBILITY

The Puerto Rico Medicaid Program (PRMP) defines that a person is eligible for the Puerto Rico Government Health Plan (Plan Vital) if he/she is certified in the **Decision Notification form** (formerly known as MA-10). This person will be referred to hereinafter as a "Potential Enrollee." The Potential Enrollee may access covered services using the Decision Notification form as a temporary enrollee ID card from the certification date, even if the person has not received an actual enrollee ID card. Only Medicaid, Children's Health Insurance Program (CHIP), and Commonwealth enrollees receive a Decision Notification form and may access covered services. On November 15, 2020, CMS approved changes to the indigence level tables, to provide coverage to the population due to the COVID-19 pandemic. These changes make it possible for more people to qualify for Medicaid coverage. This temporary coverage will be valid until October 31, 2023.

MSO of Puerto Rico, LLC does not object not to provide a Referral or Prior Authorization for a covered service because of an objection on moral or religious grounds. However, if, the MSO of Puerto Rico, or a provider elects not to provide, not to reimburse for, or not to provide a Referral

or Prior Authorization for a covered service because of an objection on moral or religious grounds, the plan shall:

1.1.1 Notify the ASES within one hundred and twenty (120) Calendar Days before adopting the policy with respect to any service.

1.1.1.1 MMM Holdings acknowledges that such objections will be factored into the calculation of rates paid to the Contractor and, when made during a contract period, may serve as grounds for recalculation of the rates paid.

1.1.1.2 If, MMM Holdings, MSO of Puerto Rico, LLC and/or its subsidiary company do not cover counseling or referral services because of moral or religious objections and choose not to furnish information to enrollees on how and where to obtain such services, ASES must provide that information to the Enrollees.

1.1.2 Notify the member within ninety (90) Calendar Days after adopting the policy with respect to any service; and

1.1.3 Notify member and Potential Enrollees before and during Enrollment.

Providers that object to provide a referral or to render a covered services because of an objection on moral or religious grounds, must notify the MSO of Puerto Rico for the plan to follow the communication process defined above.

1.2 Effective Date

The effective date of eligibility for Medicaid and CHIP eligible beneficiaries is specified on the Decision Notification form. The date specified on the Decision Notification form may be a

retroactive date of eligibility which is up to three (3) months before the first day of the month in which the potential enrollee submits the eligibility application to the Medicaid Program Office. Only the services for Medicaid and CHIP populations can be retroactively covered. Retroactive eligibility is calculated independently for each month.

The date of effectiveness for the Commonwealth of Puerto Rico's population is the date in which they are certified in the Medicaid Program. The Commonwealth population does not have the benefit of retroactive coverage.

The effective date of eligibility for beneficiaries that have recertified is the date immediately following the expiration of the twelve (12) months period.

Public employees and pensioners will be eligible to enroll in MMM Multi Health in accordance with policies determined by the Government of Puerto Rico, and their effective date of eligibility will be determined based on those policies. The Puerto Rico Medicaid Program (PRMP) and ASES play no role in determining eligibility for public employees and pensioners.

1.3 Termination of Eligibility

Disenrollment occurs only when the Puerto Rico Medicaid Program (PRMP) determines that an Enrollee is no longer eligible for the GHP (*Plan Vital*); or when Disenrollment is requested by the MCO or Enrollee and approved by ASES. The Foster Care Population and Domestic Violence Population may not disenroll from their Auto-Enrolled GHP Plan.

A beneficiary of Medicaid, the Children's Health Insurance Program (CHIP), or another beneficiary who is determined ineligible for MMM Multi Health, after a redetermination made by the Puerto Rico Medicaid Program, will remain eligible to receive covered medical services under MMM

Multi Health up to the date the negative re-determination decision was made. This date will be specified in the Decision Notification form issued by the Puerto Rico Medicaid Program after the negative re-determination decision is made.

An enrollee who is a public employee or pensioner shall remain eligible until the Commonwealth agency disenrolls the beneficiary from MMM Multi Health, as long as the person maintains the applicable premium payment up to date.

1.4 The duty of Eligibility Verification

All contracted providers under MMM Multi Health shall validate a patient's eligibility with their enrollee ID. It also provides the patients coverage history and access to print the Certificate of Eligibility. The verification of eligibility warrants that all network providers will verify the eligibility of enrollees before providing covered services. This verification of eligibility is a condition for receiving payment. It's required that the provider verifies the enrollee's eligibility before providing services or making a referral. The systems that support the eligibility verification process are:

InnovaMD Access – (www.innovaMD.com)

MSO Provider Call Center telephone numbers:

787-993-2317 (Metro Area)

1-866-676-6060 (toll free)

Monday through Friday, 7:00 a.m. to 7:00 p.m.

2. ENROLLMENT AND DISENROLLMENT

2.1 Effective Date of Enrollment

Upon receiving notices for enrollment, the Contractor shall comply with the Auto-Enrollment process and issue a notice informing the Enrollee of the Primary Medical Group (PMG) and Primary Care Provider (PCP) they are assigned to and their rights to change the PMG or PCP without cause during the applicable Open Enrollment Period established by ASES. Each year, such changes may be requested through ASES's designated enrollment counselor. Beneficiaries can change their Managed Care Organization (MCO) with cause at any time through the Enrollment Counselor chosen by ASES.

The notice of enrollment issued by the Contractor will clearly state the effective date of enrollment. This will inform that the enrollee is entitled to receive covered services through the Contractor, and of his or her limited right to cancel enrollment and to select a different PCP or to switch PMGs. It will also encourage the Enrollee to pursue this option if he or she is dissatisfied with care or services.

All enrollees must be notified at least annually of their voluntary disenrollment rights. Such notification must explain the process for exercising this disenrollment right, as well as the alternatives available to the Enrollee based on their specific circumstances.

If a Medicaid or CHIP eligible person or enrollee loses eligibility for MMM Multi Health, they will be treated as a new enrollee soon after re-enrollment.

Upon notification of recertification from the Puerto Rico Medicaid Program (PRMP), MMM Multi Health will automatically enroll the person, with enrollment effective as of the new eligibility effective date.

2.2 Dual Eligible Enrollees

It is the dually eligible enrollees' responsibility to keep their certification updated with the Medicaid Puerto Rico Program (PRMP). They must attend their annual recertification appointment and inform the health plan about any changes to their eligibility for Medicaid.

At the time of enrollment, MMM Multi Health will provide potential enrollees who are Medicaid-eligible and are also eligible for Medicare Part A, or Part A and Part B ("Dual Eligible Enrollees") with the information about their covered services and copayments. Members of the Commonwealth population who are Medicare eligible will not be considered Dual Eligible Enrollees.

For dual eligible enrollees who receive Medicare Part A only, MMM Multi Health will provide regular coverage, excluding services covered under Medicare Part A (hospitalization). However, MMM Multihealth will cover hospitalization services after the Medicare Part A coverage limit has been reached:

1. MMM Multihealth will not cover copayments or coinsurance under Medicare Part A.
2. Once dual beneficiaries spend their hospitalization benefit under Medicare, they will pay copayments or coinsurance applicable to hospitalization under *Plan Vital*.

2.3 Termination Enrollment

The enrollment term will be a period of twelve (12) consecutive months for all MMM Multi Health enrollees, except in cases in which the Puerto Rico Medicaid Program (PRMP) has designated an

eligibility redetermination period shorter than twelve (12) months for an enrollee who is a Medicaid or CHIP Eligible; that same period will also be considered the enrollee's termination of enrollment. Such a shortened eligibility redetermination period may apply, at the discretion of the Puerto Rico Medicaid Program (PRMP), when an enrollee is pregnant, homeless, or anticipates a change in status.

2.4 Auto-enrollment

MMM Multi Health will receive from the Puerto Rico Medicaid Program (PRMP) the eligibility record including the assigned PCP and PMG. If the potential beneficiary does not select a PCP and PMG, MMM Multi Health will execute the Auto-Enrollment process that will include Auto-Assignment of a PMG and a PCP. A new Enrollee who is a Dependent of a current MMM Multi Health enrollee will be automatically assigned to the same PMG as his or her parent or spouse who is a current MMM Multi Health Enrollee.

2.5 Newborn Enrollees

MMM Multi Health will mail a Newborn enrollment packet to the expectant mother instructing her to register the newborn with the Puerto Rico Medicaid Program (PRMP) within ninety (90) calendar days of birth by providing evidence of the newborn's birth and birth certificate; notifying her that the newborn will be auto-enrolled in MMM Multi Health; informing her that unless she visits MMM Multi Health office to select a PMG and PCP, the child will be auto-assigned to the mother's PMG and to a PCP who is a pediatrician; and informing her that she will have ninety (90) calendar days after the child's birth to disenroll the child from the Plan or to change the child's PMG and PCP, without cause. If the mother has not made a PCP and PMG selection at the time

of the child's birth, MMM Multi Health will, within one (1) Business Day of receiving the eligibility file, auto-assign the newborn to a PCP who is a pediatrician and to the mother's PMG.

2.6 Re-enrollment Procedure

MMM Multi Health will inform enrollees who are Medicaid and CHIP Eligible, and members of the Commonwealth population of an impending redetermination through written notices. Such notices will be provided ninety (90) calendar days, sixty (60) calendar days, and thirty (30) calendar days before the scheduled date of the redetermination. The notice will inform the enrollee that, if he or she is recertified, their term of enrollment in the plan will automatically renew; but, upon the effective date of recertification, he or she will have a ninety (90) calendar-day period in which he or she may disenroll from the plan without cause or may change his or her PMG and/or PCP selection without cause. The notice will advise Enrollees that Disenrollment from the MCO will terminate the access to health services from The Government Health Plan (Plan Vital) for not attending their certification appointment.

2.7 Disenrollment

Disenrollment occurs when the Medicaid Program (PRMP) determines that an enrollee is no longer eligible for MMM Multi Health; or when it's requested and approved by Medicaid. Disenrollment will be affected by Medicaid and will issue notification to MMM Multi Health. Such notice will be delivered via file transfer to MMM Multi Health daily with information on potential enrollees within five (5) business days of making a final determination on disenrollment.

Disenrollment decisions are the responsibility of the Puerto Rico Medicaid Program (PRMP) however, the notice of Disenrollment to enrollees will be issued by MMM Multi Health. MMM Multi Health will issue such notice in person or via traditional mail to the enrollee within five (5) business days of a final disenrollment decision. Each notice of disenrollment will include information concerning:

- The effective date of disenrollment;
- The reason for the disenrollment;
- The enrollee's appeal rights, including the availability of the Grievance System and of ASES's Administrative Law Hearing process, as provided by Act 72 of September 7, 1993.
- The right to re-enroll in MMM Multi Health upon receiving a recertification from the Puerto Rico Medicaid Program (PRMP)

If applicable; disenrollment will occur according to the following timeframes:

1. Disenrollment will take effect upon the effective date of disenrollment specified in the Puerto Rico Medicaid Program (PRMP) notice to MMM Multi Health that an enrollee is no longer eligible.
2. If the Puerto Rico Medicaid Program notifies MMM Multi Health of disenrollment on or before the last working day of the month in which eligibility ends, the disenrollment will be effective on the termination date received in the eligibility file.
3. When disenrollment is effectuated at the request of MMM Multi Health or of the enrollee's, disenrollment will take effect no later than the first day of the second month following the month that MMM Multi Health or enrollee requested the disenrollment.

4. If ASES fails to decide on MMM Multi Health or enrollee's request before this date, the disenrollment will be deemed granted.
5. If the enrollee requests reconsideration of a disenrollment through the MMM Multi Health Grievance System, the Grievance System process will be completed in time to permit the disenrollment (if approved) to take effect in accordance with this timeframe. Otherwise, the effective date of disenrollment would be:
    a) When the enrollee is hospitalized, ASES will postpone the effective date of disenrollment so that it occurs on the last day of the month in which the enrollee is discharged from the hospital, or the last day of the month following the month in which disenrollment would otherwise be effective, whichever occurs earlier.
    b) During the month in which the enrollee is in the second or third trimester of pregnancy, ASES will postpone the effective date of disenrollment so that it occurs on the date of delivery.
    c) During the month in which an enrollee is diagnosed with a terminal condition, ASES will postpone the effective date of disenrollment so that it occurs on the last day of the following month.
    d) For the public employees and pensioners who are other eligible persons referred, disenrollment will occur according to the timeframes set forth in a Normative Letter issued by ASES annually.

2.8 Disenrollment initiated by the enrollee:

An enrollee may request disenrollment from the Government Health Plan (Plan Vital) without cause during the ninety (90) calendar days following the effective date of enrollment with the Health Plan or the date that the Health Plan sends a notice of the Enrollment, whichever is later. An enrollee may request disenrollment without cause every twelve (12) months thereafter.

An enrollee may request disenrollment from *Plan Vital* for cause at any time. The following constitute cause for disenrollment by the Enrollee:

1. If the beneficiary has died or has moved out of Puerto Rico, making them ineligible for Medicaid or CHIP or not eligible for Plan Vital;
2. The Enrollee needs related services to be performed at the same time, and not all related services are available within the Network. The Enrollee's PCP or another Provider in the Preferred Provider Network has determined that receiving service separately would subject the Enrollee to unnecessary risk;
3. Poor quality of care; or
4. Lack of Access to Covered Services, or lack of Providers experienced in dealing with the Enrollee's health care needs.

The Puerto Rico Medicaid Program (PRMP) shall make the final decision on enrollee requests for disenrollment. An enrollee wishing to request disenrollment must submit a written request to ASES or to the Health Plan. If the request is made to the Health Plan, the plan shall forward the request to the Puerto Rico Medicaid Program (PRMP) and copy to ASES within ten (10) business days of receipt of the request, with a recommendation of the action to be taken. The Puerto Rico Medicaid Program (PRMP) will notify the final decision to the MCO via daily electronic files.

The following are acceptable reasons for the Health Plan to request Disenrollment:

1. The Enrollee's continued enrollment in *Plan Vital* seriously impairs the ability to provide services to either this particular Enrollee or other Enrollees;
2. The Enrollee demonstrates a pattern of disruptive or abusive behavior that is not caused by a presenting illness;
3. The Enrollee's use of services constitutes Fraud, Waste or Abuse (for example, the Enrollee has loaned his or her Enrollee ID Card to other persons to seek services);
4. The Enrollee has moved out of Puerto Rico;
5. The Enrollee is placed in a long-term care nursing facility or intermediate care facility for the developmentally disabled;
6. The Enrollee's Medicaid or CHIP eligibility category changes to a category ineligible for *Plan Vital*; or
7. The Enrollee has died or has been incarcerated, thereby making him or her ineligible for Medicaid or CHIP or otherwise ineligible for *Plan Vital*.
8. If you are disenrolled from your Health Plan, you will lose access to services under *Plan Vital*.

Disenrollment (cancellations) requested by *Plan Vital* Beneficiaries:

1. Beneficiaries of *Plan Vital* can request the disenrollment in writing, by:
    - Visiting one of our regional offices
    - Sending the written request, along with a copy of a valid identification to the fax: **1-844-330-9330**
    - They can also send an email to

i. Fullfilment-at-EnrollmentPSG@mmmhc.com

- OR send regular mail to the following address:

PO Box 72010

San Juan, PR 00936-7710

2. Requests received at the Regional Offices or Member Services Department will be sent to the distribution list email.
3. The Enrollment Department will send the requests to the central office of the Puerto Rico Medicaid Program (PRMP) for processing.
4. The official disenrollment will be received electronically from the Puerto Rico Medicaid Program (PRMP) in the eligibility files.

***** IMPORTANT *****

The process of requesting a voluntary cancellation does not apply to the Vital X population. (Population under the Adoption program or population under the Gender Violence program).

2.9 Request Appeal Standard or Expedited

The Enrollee, the Enrollee's Authorized Representative, or the Provider acting on behalf of the enrollee, with the Enrollee's written consent, may file an Appeal within sixty (60) Calendar Days from the date on the Contractor's Notice of Adverse Benefit Determination. Appeals may be filed orally by contacting the Vital Plan Call Center toll-free at 1-844-336-3331. For the hearing impaired, TTY telephone services are available by calling 787-999-4411. Our Representatives are available Monday through Friday from 7:00 am to 7:00 pm. You may write to us at AGPLANVITAL@MMMHC.COM or via facsimile: 1-844-990-1990. You may also write to the

following address: MMM Multihealth Appeals & Grievances Department PO Box 72010 San Juan PR 00936-7710.

The Requirements of the Appeal Process will:

1. Handle all types of appeals, including expedited appeals, unless otherwise established.
2. The appeals process provides the enrollee; the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, reasonable time to present evidence and allegations of fact or law, in person, as well as in written. MMM Multihealth shall inform the enrollee of the time available to file an expedited appeal.
3. The appeals process provides the enrollee, the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, opportunity, before and during the Appeals process, to review the enrollee's case file, including medical records, and any other documents and records considered during the appeal and provide copies of documents contained therein without charge.
4. The appeals process includes as parties to the appeal the enrollee, the enrollee's authorized representative, the provider acting on behalf of the enrollee with the enrollee's written consent, or the legal representative of the estate of a deceased enrollee's estate.
5. MMM Multihealth resolves each standard appeal and provides written notice of the disposition, as expeditiously as the enrollee's health condition requires, but no more than thirty (30) calendar days from the date MMM Multihealth receives the appeal.

6. MMM Multihealth establishes and maintain an expedited review process for appeals, when the MMM Multihealth determines (based on a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The enrollee, the enrollee's authorized representative, or the provider acting on behalf of the enrollee with the enrollee's written consent, may file an **Expedited Grievance,** either orally or in writing.
7. MMM Multihealth resolve each **Expedited Grievance** and provide a written notice of disposition, as expeditiously as the enrollee's health condition requires, but no longer than **twenty-four (24)** hours after the MMM Multihealth receives the **Grievances** and makes reasonable efforts to provide oral notice.

3. ENROLLEE RIGHTS AND RESPONSIBILITIES

3.1 Selection of Providers by the Enrollee

When a person signs up with MMM Multi Health, LLC ("MMM Multi Health"), they must choose a Doctor or "Primary Care Physician" (PCP). The PCP is the main person to see for health care. This includes checkups, treatment for colds and flu, health concerns and screenings. The PCP can find and treat health problems early. He or she will have the patient's medical records. The PCP has the complete visibility about health care. The PCP keeps track of all the care the patient gets.

***** Important *** - The process of selecting a PCP/PMG DOES NOT APPLY to the Vital X population. (Foster Care program or Gender Violence program).**

The following practitioners can be considered Primary Care Physicians (PCPs):

- General Practitioners;
- Family Physicians;
- Pediatricians;
- Gynecologists/Obstetricians;
- Internal Medicine Specialists

The patient must choose a PCP for each Beneficiary member of the family. The family members can have different PCPs. Female patients over age 12, can also choose a Gynecologist to be their PCP. If pregnant, the patient's PCP can be their Gynecologist/Obstetrician during pregnancy. When pregnancy ends, the patient returns to their regular Doctor. The Gynecologist will continue attending gynecological needs.

A patient may choose a Pediatrician or a Family Physician for their newborn or MMM Multihealth will assign one.

To choose a PCP, the enrollee must call MMM Multi Health at 1-844-336-3331 (Toll free), TTY 787-999-4411 (For the hearing impaired). **If the enrollee does not select a PCP, MMM Multi Health will assign one thru the auto enrollment process.**

A Primary Medical Group (PMG) is a group of doctors that coordinate health care services and work with the Health Plan to make the patient get the care they need. Enrollees' ID card shows the name of the PCP and the name and number of the PMG.

3.2 How can a patient see their PCP?

If a patient needs an appointment, they must call their PCP and arrange an appointment. It is important to keep appointments with the PCP. If that is not possible, for any reason, the patient

must call the PCP's office right away to let them know. The patient should get to know the new PCP, especially if they've been getting care or treatment from a different doctor. If the patient is feeling good, they should call to get a follow-up checkup with the PCP.

A. Before going to the first appointment, it is important that the patients;

1. Ask their past doctor to give them their medical record(s) at no cost and bring those medical records to the new PCP during the first visit. The medical record will help the new PCP to learn about the patient's health.
2. Call the PCP to schedule an appointment.
3. Have their ID card ready when initiating the call.
4. Identify themselves as MMM Multihealth Beneficiaries and provide their ID number.
5. Write down appointment date and time. As new patients, the Provider may ask them to come early.
6. Make a list of questions or concerns they want to clarify with the Doctor, considering any health problems they are experiencing.
7. If they need a ride to the appointment and have no other way to get there, the patient should call MMM Multihealth or their local Municipality. They can help you get a ride.

B. Appointment Date:

1. Bring a list of all medicines and questions for the Doctor.
2. Patients should be on time for the visit. If they cannot keep the appointment, they should call the PCP to get a new time.

3. Patients must take their ID card with them. You, as a PCP, may make a copy of it.

3.3 Preferential Turns:

The policy of requiring Network Providers to give priority in treating Enrollees from the island municipalities of Vieques and Culebra, so that they may be seen by a Provider within a reasonable time after arriving at the Provider's office. This priority treatment is necessary because of the greater travel time required for their residents to seek medical attention.

3.4 Advance Directives:

This information includes the rights of Enrollees to file directly with ASES or with the Puerto Rico Office of the Patient Advocate about an Advance Directive. In compliance with 42 CFR 438.6 (i), Law No. 160 of November 17, 2001, and 42 CFR 489.100, MMM Multihealth will provide these policies and procedures written at a fourth (4th) grade reading level in English and Spanish to all Enrollees eighteen (18) years of age and older and shall advise enrollees such Advance Directives will be included in each Enrollee's Medical Record and will advice:

1. Their rights under Puerto Rico laws, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive; MMM Multihealth written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience. The right to receive emergency services within twenty-four (24) hours, seven (7) days of week.
2. The Enrollee's right to file complaints concerning noncompliance with Advance Directive requirements directly with ASES or the Puerto Rico Office of the Patient Advocate. The information must include a description of Puerto Rico law reflecting

changes in laws as soon as possible and no later than ninety (90) calendar days after the effective change.

3. MMM Multihealth educates its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Enrollees, and the staff's responsibility to educate Enrollees about this tool and assist them in making use of it.
4. MMM Multihealth educates Enrollees about their ability to direct their care using Advance Directives and specifically designates which staff members or Network Providers are responsible for providing this education.
5. MMM Multihealth provides Enrollees with at least thirty (30) calendar days written notice of any significant change in policies concerning Enrollees' disenrollment rights, right to change PMG or PCP, or any significant change to any of the items listed in Enrollee Rights and Responsibilities, regardless of whether ASES or MMM Multihealth caused the change to take place.
6. Evidence of current Advanced Directives is noted in a prominent place in the patient's record.
7. Advance Directives pertaining to treatment preferences and the designation of a surrogate decision-maker if a person should become unable to make medical decisions on their own behalf. Advanced directives generally may be a living will, power of attorney, or healthcare proxy:

    a) Actionable Medical Orders:

Written instructions regarding initiation, continuation, withholding, or withdrawal of a form of life-sustaining treatment.

b) Living Wills:

Legal documents denoting preferences for life-sustaining treatment and end of life care.

c) Surrogate Decision Maker:

A written document designating someone else to make future medical treatment choice.

d) Oral Statements:

Conversations with relatives or friends about life-sustaining treatments and end of life care documented in the medical record.

Patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year.

8. MMM Multihealth will have written policies and procedures regarding the rights of Enrollees and will comply with any applicable federal and Puerto Rico laws and regulations that pertain to Enrollee rights, including those set forth in 42 CFR 438.100, and in the Puerto Rico Patient's Bill of Rights Act 194 of August 25, 2000 (as amended); the Puerto Rico Mental Health Law of October 2, 2000, as amended and implemented; and Law 77 of July 24, 2013 which was created the Office of the Patient Advocate. These rights will be included in the Enrollee Handbook. At a minimum, policies and procedures will specify Enrollee's right to:

a) Receive information pursuant to 42 CFR 438.10;

b) Be treated with respect and with due consideration for the Enrollee's dignity and privacy;

c) Have all medical records and personal information confidential;

d) Receive information on available treatment options and alternatives, presented appropriately to Enrollee's condition and ability to understand;

e) Participate in decisions regarding his or her healthcare, including the right to refuse treatment;

f) Be free from any form of restraint or reclusion as a means of coercion, discipline, convenience, or retaliation, as specified in 42 CFR 482.13(e) and other federal regulations on the use of restraints and reclusion;

g) Request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, Subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;

h) Choose an Authorized Representative to be involved as appropriate in making care decisions;

i) Provide informed consent;

j) Be furnished with healthcare services in accordance with 42 CFR 438.206 through 438.210;

k) Exercise his or her rights, including those related to filing a grievance or appeal, and that exercising these rights will not adversely affect the way the Enrollee is treated;

l) Receive information about covered services and how to access covered services and Network Providers;

m) Be free from harassment by MMM Multihealth or its Network Providers with respect to contractual disputes between MMM Multihealth and its Providers;

n) Participate in the understanding of physical and behavioral health problems developing mutually agreed-upon treatment goals;

o) Not be held liable for MMM Multihealth debts in the event of insolvency; not be held liable for the covered services provided to the Enrollee for which ASES does not pay MMM Multihealth; not be held liable for covered services provided to the Enrollee for which ASES or MMM Multihealth does not pay the Provider that furnishes the services; and not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are more than the amount the Enrollee would owe if MMM Multihealth provided the services directly. Only be responsible for cost-sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and as permitted by the Puerto Rico Medicaid and CHIP State Plans and Puerto Rico law as applicable to the Enrollee.

3.5 The Right to change the Primary Medical Group (PMG) and Primary Care Physician (PCP).

During the ninety (90) calendar days period the Enrollee can change his/her auto assigned PMG and PCP. MMM Multihealth can offer counseling and assistance to the Enrollee in selecting a different PCP and PMG. MMM Multihealth will advise certain Enrollees to choose a Physician other than, or in addition to, a general practice Physician as their PCP, as follows:

1. Female Enrollees will be recommended to choose an Obstetrician / Gynecologist as a PCP;
2. Enrollees under twenty-one (21) years of age will be recommended to choose a Pediatrician as a PCP; Enrollees with chronic conditions including heart, kidney failure, or diabetes will be recommended to choose an Internist as PCP.

MMM Multihealth provides to all new Enrollees an Enrollee ID card made of durable plastic material. The card is mailed to the Enrollee via surface mail within five (5) calendar days of sending the Notice of Enrollment. The Enrollee ID card must, at a minimum, include the following information:

a) The MMM Multihealth logo;
b) Enrollee's Name and Last Name;
c) Enrollee's Date of birth;
d) A designation of the Enrollee as a Medicaid Eligible, CHIP Eligible, or another eligible person;
e) Enrollee's Medicaid or CHIP identification number, if applicable;
f) Enrollee's Plan Group number, when applicable;
g) Enrollee's eligibility for MMM Multihealth as a dependent;

h) Enrollee's relationship with the principal Enrollee;

i) Effective Date of Enrollment in MMM Multihealth;

j) Master Patient Identifier (MPI) (if applicable);

k) Co-payment levels for various services outside the Enrollee's Preferred Provider Network (PPN) and the assurance that no copayment will be charged for a Medicaid Eligible person and for CHIP children under twenty-one (21) years under any circumstances;

l) PCP and PMG names;

m) The name and telephone number(s) of MMM Multihealth;

n) The twenty-four (24) hour, seven (7) day a week toll-free MMM Multihealth service line of medical advice service phone number;

o) A notice that the Enrollee ID card may under no circumstances be used by a person other than the identified Enrollee;

p) Instructions to obtain emergency services.

3.6 Right to Enrollee Privacy Health Insurance Portability and Accountability Act (HIPAA)

The Beneficiary's health information is confidential. The law says that the Puerto Rico Health Insurance Administration (ASES) and MMM Multihealth must protect your health information. ASES and MMM Multihealth can share your information for your medical care, to pay your health claims and run the healthcare program. But we can't share Beneficiary's information with other

people unless the Beneficiary authorizes it, or the use or disclosure is allowed by HIPAA Law. If you want to know more about what information we have, how we can share it, or what to do if you don't want your health information shared with certain people, call MMM Multihealth:

Enrollee Services:
1-844-336-3331 (Toll free)
787-999-4411 TTY (Hearing impaired)
Monday through Friday
From 7:00 a.m. to 7:00 p.m.

3.7 Right to Second Opinion

All beneficiaries under Vital Plan coverage have the right to request a medical second opinion;

MMM MH shall provide a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery, or alternative treatments of a health condition when requested by any Enrollee, or by a parent, guardian, or other person exercising a custodial responsibility over the Enrollee.

The second opinion shall be provided by a qualified Network Provider, or, if a Network Provider is unavailable, the Contractor (MMM MH) shall arrange for the Enrollee to obtain a second opinion from an Out-of-Network Provider.

The second opinion shall be provided at no cost to the Enrollee.

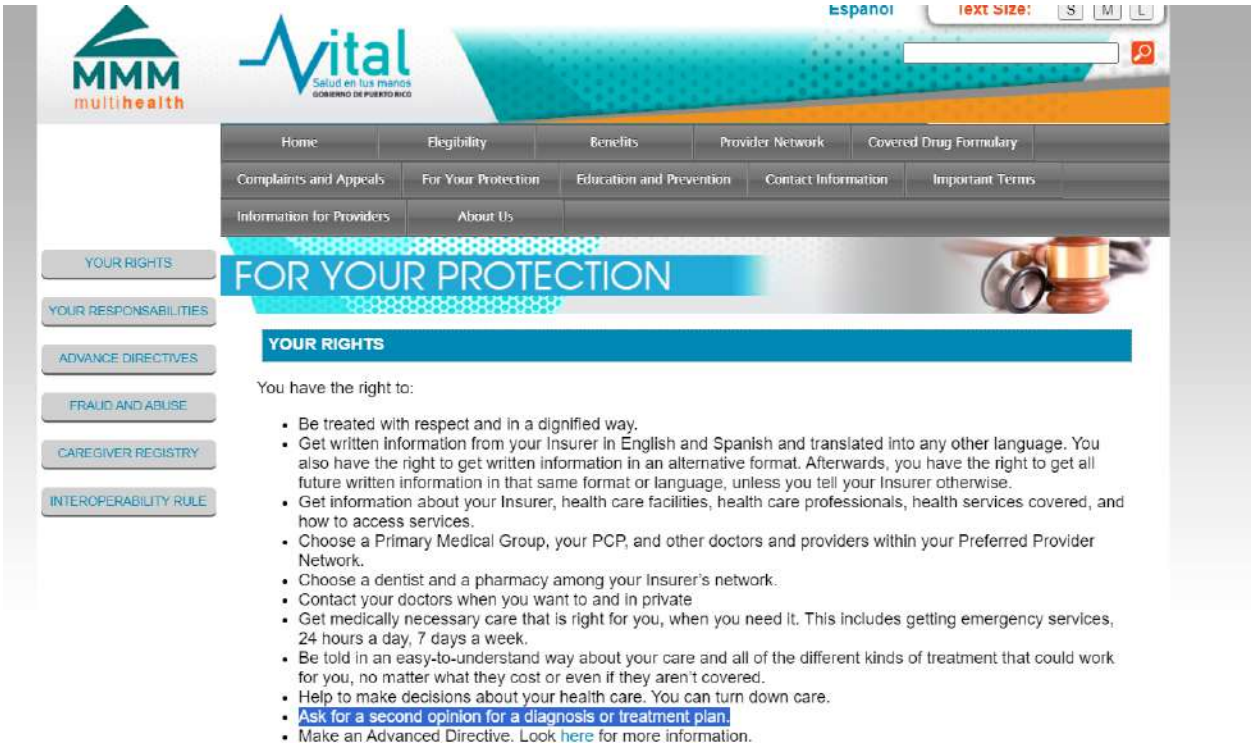
The primary care physician must provide the necessary referrals so that the beneficiary can obtain a second opinion, as needed.

MMM MH has this additional information about Second Opinion on the website
https://www.multihealth-vital.com/eng/protection.html

Beneficiary Handbook

Provider's guideline

Internal Policies and Procedure



3.8 Co-payments:

Do you have to pay copays for a PCP, Specialist, Emergency Room visit, Hospital stay, or other type of service? Not sure? Check the chart below, look at your ID card or call:

MMM Multihealth at 1-844-336-3331 (Toll free),

TTY: 787-999-4411(For the hearing impaired).

1. No co-payments can be charged to the Federal and CHIP population for the treatment of any Emergency Medical Condition or Psychiatric Emergency;

2. No copayments shall be charged for Medicaid and CHIP children under eighteen (18) years under any circumstances.

3. By using MMM Multihealth Medical consultation line, the Enrollee may avoid a co-payment for such services.

The following chart shows a breakdown with the amounts you must pay, according to the services received and the type of coverage you have as MMM Multihealth Enrollee:

BENEFIT PACKAGES, CO-PAYS & CO-INSURANCE - effective on January 2023 *											
BENEFIT PACKAGES &SERVICES FOR MENTAL HEALTH (MH), SUBSTANCE USE DISORDER (SUD), MEDICAL/SURGICAL (M/S)	**Federal**				**CHIPs**		**Commonwealth**				***ELA**
	100	110	120	130	220	230	300	310	320	330	400
HOSPITALIZATION SERVICES	$0	$0	$0	$0	$0	$0	$15	$15	$15	$20	$50
Admissions	$0	$0	$0	$0	$0	$0	$15	$15	$15	$20	$50
Nursery	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Behavioral health hospitalizations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Detoxification Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Inpatient behavioral Health Services in an Institution for Mental Disease (IMD)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
BEHAVIORAL HEALTH SERVICES											
Evaluation, screening, and treatment of individual, couples, families, and groups	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outpatient services with psychiatrist, psychologist, and social workers	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Hospital services for substances and alcohol abuse disorders	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outpatient services for substance and alcohol abuse disorders	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Intensive outpatient services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Emergency or crisis intervention services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Long-lasting injected medicine clinics	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Escort/professional assistance and ambulance services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prevention and secondary-education services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Treatment of attention deficit disorder	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Substance abuse treatment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Opiate addiction treatment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Partial hospitalization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Electroconvulsive Therapy (EC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Psychological / Neurosicological testing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
PREVENTIVE HEALTH SERVICES											
Well baby care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Immunizations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hearing Exams	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Evaluation and nutritional screening	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Laboratory and Clinical Tests	$0	$0	$0	$0	$0	$0	$2	$2	$5	$6	20%
Nutritional, oral and physical health education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Reproductive health/family planning	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annual physical exam for diabetics	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health certificates	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

DIAGNOSTIC TEST SERVICES	$0	$0	$0	$0	$0	$0	$2	$2	$5	$6	40%
OUTPATIENT REHABILITATION SERVICES											
Physical therapy	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$5
Occupational therapy	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$5
Speech therapy	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$5
EMERGENCY ROOM (ER)											
Emergency Room (ER) Visit	$0	$0	$0	$0	$0	$0	$2	$10	$15	$20	$20
Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)	$0	$4	$5	$8	$0	$0	$20	$20	$25	$30	$20
Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)	$0	$2	$3	$4	$0	$0	$20	$20	$25	$30	$20
Trauma	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MEDICAL AND SURGICAL SERVICES											
EPSDT/early and periodic screening, diag, treatment <21	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Primary care physician visits including nursing services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$3
Specialist treatment	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$7
Sub-specialist treatment	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$10
Physician home visits	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$10
Respiratory therapy	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$5
Anesthesia services (except of epidural)	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	$5
Radiology services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Pathology services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Surgery	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Outpatient surgery facility services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%

Nursing services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Sterilization	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Prosthetics	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Ostomy equipment	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Blood transfusion and blood plasma services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Services to patients with Level 1 or Level 2 chronic renal disease	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Skin, bone and corneal transplants	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Veklury (remedesivir) for COVID-18	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Breast reconstruction after mastectomy	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Surgical procedures to treat morbid obesity	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Mechanical respirators and ventilators	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Durable Medical Equipment	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Emergency Transportation Services	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Maternity and Pre-natal services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OTHER SERVICES											
High-Tech Laboratories**	$0	$0	$0	$0	$0	$0	$2	$2	$5	$5	20%
Special Diagnostic Tests**	$0	$0	$0	$0	$0	$0	$2	$2	$5	$6	40%
DENTAL SERVICES											
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$0	$0	$0	$0	$0	$2	$2	$3	$5	$3
Restorative	$0	$0	$0	$0	$0	$0	$2	$2	$5	$6	$10
PHARMACY SERVICES											
Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5
Preferred (Adult)****	$0	$1	$2	$3	$0	$0	$3	$3	$5	$5	$5
Non-Preferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10
Non-Preferred (Adult)****	$0	$3	$4	$6	$0	$0	$8	$8	$10	$10	$10

KEYS:
√=Covered by MCO for the specified benefit package

NA=Not covered by MCO for the specified benefit package

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drug

PA=Preauthorization required.

*****IMPORTANT*****

***Copayments and/or coinsurances does not apply to children under 21 years old neither to pregnant women. Copayments and/or coinsurances within the Preferred Provider Network are $0.00.**

**** Code 400 in the column labeled as ELA, refers to the population that subscribes to the plan as employees of the Government of Puerto Rico.**

***** Copayments and/or coinsurances apply to each medication included in the prescription.**

****** Copayments and/or coinsurances will apply to diagnostic tests. No copayments nor coinsurances will apply any preventive test**

4. SERVICES COVERED BY MMM MULTIHEALTH

4.1 Medical Necessity

Based on generally accepted medical practices specific to the medical or Behavioral Health condition of the Enrollee at the time of treatment, Medically Necessary Services are those that relate to the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; or the ability to attain, maintain, or regain functional capacity. The scope of Medically Necessary Services must not be any more restrictive than that of Puerto Rico's Medicaid program. Additionally, Medically Necessary services must be:

1. Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Enrollee is medical condition.
2. Compatible with the standards of acceptable medical practice in the community.
3. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.

4. Not provided solely for the convenience of the Enrollee or the convenience of the Provider or hospital.
5. Not primarily custodial care (for example, foster care).

In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly treatment, service, or setting available.

4.2 Experimental or Cosmetic Procedures

In no instance will MMM Multihealth cover experimental or cosmetic procedures, except as required by the Puerto Rico Patient's Bill of Rights Act or any other Federal or Puerto Rico law or regulation. Breast reconstruction after a mastectomy and surgical procedures that are determined to be Medically Necessary to treat morbid obesity will not be regarded as cosmetic procedures.

4.3 Covered Services

4.3.1 Preventive Services

1. Medically Necessary laboratory exams and diagnostic tests:
    a. Prostate and gynecological cancer screening
    b. Sigmoidoscopy and colonoscopy for colon cancer detection in adults
2. Provide the following Preventive Services as Covered Services under the Healthy Child Care Program:
    - Vaccines
    - Eye exam
    - Hearing Exam

- Evaluation and nutritional screening
- One (1) annual comprehensive evaluation by a certified Provider.

3. Other services, as needed, during the first two (2) years of the child's life.

4.3.2 Diagnostic Test Services

Diagnostic and testing services for Enrollees under age twenty-one (21) required by EPSDT, as defined in Section 1905(r) of the Social Security Act. Clinical labs, including but not limited to, any laboratory order for disease diagnostic purposes, even if the final diagnosis is a condition or disease whose treatment is not a Covered Service.

1. Hi-tech Labs
2. X-rays
3. Electrocardiograms
4. Radiation therapy (Prior Authorization required)
5. Pathology
6. Arterial gases and Pulmonary Function Test
7. Electroencephalograms
8. Diagnostic services for Enrollees who present learning disorder symptoms
9. Services related to a diagnostic code included in the Diagnostic and Statistical Manual of Mental Disorders ("DSM IV or DSM V").

The following will not be considered diagnostic test services covered under *Plan Vital.*

1. Polysomnography studies
2. Clinical labs processed outside of Puerto Rico

4.3.3 Outpatient Rehabilitation Services

1. Medically Necessary outpatient rehabilitation services for Enrollees under age twenty-one (21), as required by EPSDT, Section 1905(r) of the Social Security Act.
2. Physical therapy (limited to maximum of fifteen (15) treatments per Enrollee condition per year unless Prior Authorization of an additional fifteen (15) treatments is indicated by an orthopedist, physiatrist or chiropractor.
3. Occupational therapy, without limitations.
4. Speech therapy, without limitations

4.3.4 Medical & Surgical Services

MMM Multihealth will provide the following medical and surgical services as Covered Services:

1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, as defined in Section 1905(r) of the Social Security Act.
2. Primary Care Physician visits, including nursing services.
3. Specialist treatment once referred by the selected PCP if outside of the Enrollee's PPN.
4. Sub-specialist treatment once referred by the selected PCP if outside of the Enrollee's PPN.
5. Physician home visits when Medically Necessary.
6. Respiratory therapy, without limitations.
7. Anesthesia services (except for epidural anesthesia).
8. Radiology services
9. Pathology services

10. Surgery
11. Outpatient surgery facility services
12. Nursing services
13. Voluntary sterilization of men and women of legal age and sound mind, if they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent.
14. Prosthetics, including the supply of all extremities of the human body including therapeutic ocular prosthetics, segmental instrument tray, and spine fusion in scoliosis and vertebral surgery.
15. Ostomy equipment for outpatient-level optimized patients.
16. Blood transfusion and blood plasma services, without limitations, including the following:
    a) Autologous and irradiated blood.
    b) Monoclonal factor IX with the Referral of a certified hematologist.
    c) Intermediate purity concentrated antihemophilic factor (Factor VIII).
    d) Monoclonal type antihemophilic factor with a certified hematologist's authorization.
    e) Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization.
17. Chronic renal disease Levels 1 and 2 are defined as follows:
    a) Level 1: GFR (Glomerular Filtration – ml/min. per 1.73m² per corporal area surface) over 90; slight damage when protein is present in the urine.

b) Level 2: GFR between 60 and 89, a slight decrease in kidney function.

c) When GFR decreases to less than 60 ml/min per 1.73 m^2, the Enrollee must be referred to a nephrologist for proper management. The Enrollee will be registered for Special Coverage.

18. While cosmetic procedures will be excluded from Covered Services, breast reconstruction after a mastectomy and surgical procedures Medically Necessary to treat morbid obesity will not be considered cosmetic procedures.

19. Mechanical respirators and ventilators with oxygen supplies are covered without limits as required by local law to enrollees under age twenty-one (21). All Durable Medical Equipment (DME) is not covered, however, DME may be covered on a case-by-case basis under an exceptions process.

20. Abortions are covered in the following instances:

a) Life of the mother would be in danger if the fetus is carried to term;

b) When the pregnancy is a result of rape or incest; and

c) Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.

4.3.5 Emergency Transportation Services

1. MMM Multihealth shall provide Emergency Transportation Services, including but not limited to, maritime and ground transportation, in emergency situations as Covered Services.

2. Emergency transportation services will be available twenty-four (24) hours a day, seven (7) days per week throughout Puerto Rico.

3. Emergency transportation services do not require Prior Authorization.

4. Ensure that adequate emergency transportation is available to transport any Enrollees experiencing an Emergency Medical Conditions or a Psychiatric Emergency, or whose conditions require emergency transportation because of their geographical location.

5. The Contractor may not impose limits on what constitutes an Emergency based on lists of diagnoses or symptoms.

6. Aerial emergency transportation services are provided and paid for by ASES under a separate contract.

7. In any case in which an Enrollee is transported by ambulance to a facility that is not a Network Provider, and, after being stabilized, is transported by ambulance to a facility that is a Network Provider, all emergency transportation costs, provided that they are justified by prudent layperson standards, will be borne by MMM Multihealth.

8. Emergency transportation services will be subject to periodic reviews and/or audits by applicable governmental agencies and ASES to ensure quality of services.

4.3.6 Emergency Service

A. Emergency Services will include the following without limitations:

1. Emergency room visits, including medical attention and routine and necessary services.

2. Trauma services

3. Operating room uses
4. Respiratory therapy
5. Specialist and sub-specialist treatment when required by the emergency room physician.
6. Anesthesia
7. Surgical material
8. Laboratory tests and X-rays
9. Post-Stabilization Services.
10. Care as necessary in the case of a Psychiatric Emergency in an emergency room setting.
11. Drugs, medicine, and intravenous solutions used in the emergency room.
12. Transfusion of blood and blood plasma services, without limitations, including:
    a. Autologous and irradiated blood;
    b. Monoclonal factor IX with a certified hematologist referral.
    c. Intermediate purity concentrated anti-hemophilic factor (Factor VIII);
    d. Monoclonal type anti-hemophilic factor with a certified hematologist's authorization.
    e. Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization.

B. Emergency Services Within and Outside Puerto Rico

1. For all Enrollees, and notwithstanding whether the emergency room is a Network Provider.

2. For Medicaid and CHIP Eligible, in Puerto Rico or in the US, when the services are Medically Necessary and could not be anticipated, notwithstanding that emergency rooms outside of Puerto Rico are not Network Providers.

4.3.7 Maternity & Pre-Natal Services

Plan Vital will provide the following maternity and prenatal services as Covered Services:

1. Pregnancy testing.
2. Medical services, during pregnancy and postpartum.
3. Physician and nurse obstetrical services during vaginal and caesarean section deliveries and services to address any complication that arises during the delivery.
4. Treatment of conditions attributable to the pregnancy or delivery, when medically recommended.
5. Hospitalization for a period of at least forty-eight (48) hours in cases of vaginal delivery, and at least ninety-six hours (96) in cases of Caesarean section.
6. Anesthesia, excluding epidural.
7. Incubator use, without limitations.
8. Fetal monitoring services, during hospitalization only.
9. Nursery room/routine care for newborns.
10. Circumcision and dilatation services for newborns.
11. Transportation of newborns to tertiary facilities when necessary.
12. Pediatrician assistance during delivery.
13. Delivery services provided in freestanding birth centers.

14. MMM Multihealth will implement a prenatal and maternal program, aimed at preventing complications during and after pregnancy, and advancing the objective of lowering the incidence of low birth weight and premature deliveries. The program will include, at a minimum, the following components:

    a) A prenatal care card, used to document services utilized

    b) Counseling regarding HIV testing

    c) Pregnancy testing

    d) A RhoGAM injection for all pregnant women who have a negative RH factor according to the established protocol.

    e) Alcohol screening of pregnant women with the 4P-Plus instrument or CAGE Test.

    f) Smoking cessation counseling and treatment.

    g) Postpartum depression screening using the Edinburgh postnatal depression scale. Postpartum counseling and Referral to the WIC program.

    h) Dental evaluation during the second trimester of gestation.

    i) Educational workshops regarding prenatal care topics (importance of prenatal medical visits and postpartum care), breastfeeding, stages of childbirth, oral and Behavioral Health, family planning, and newborn care, among others.

15. MMM Multihealth will ensure that eighty-five percent (85%) of pregnant Enrollees receive services under the Prenatal and Maternal Program. MMM Multihealth will

submit its Prenatal and Maternal Program wellness plan to ASES and will submit reports quarterly concerning the usage of services under this program.

16. MMM Multihealth will provide reproductive health and family planning counseling. Such services will be provided voluntarily and confidentially including circumstances where the Enrollee is under age eighteen (18). Family planning services will include, at a minimum, the following:
    a) Education and counseling necessary to make informed choices and understand contraceptive methods;
    b) Pregnancy testing;
    c) Diagnosis and treatment of sexually transmitted infections; Infertility assessment;
    d) Oral contraceptive medications, but only when prescribed for the purpose of treating menstrual dysfunction and other hormonal conditions;
    e) Information on the family planning services available through the Health Department.

4.3.8 Post-Stabilization Services

MMM Vital will cover Post-Stabilization Services obtained from any Provider, regardless of whether the Provider is in the General Network or PPN, that are administered to maintain the Enrollee's stabilized condition for one (1) hour while awaiting response on a Prior Authorization request. The attending Emergency Room physician or other treating Provider will be responsible for determining whether the Enrollee is sufficiently stabilized for transfer

or discharge. That determination will be binding for MMM Vital with respect to its responsibility for coverage and payment.

4.3.9 Hospitalization Services

MMM Vital will provide hospitalization services, including the following:

1. Access to a nursery.
2. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year).
3. Access to an isolation room for physical or Behavioral Health reasons.
4. Food, including specialized nutrition services.
5. Regular nursing services.
6. Specialized room use, such as operation, surgical, recovery, treatment and maternity, without limitations;
7. Drugs, medicine, and contrast agents, without limitations.
8. Availability of materials such as bandages, gauze, plaster, or any other therapeutic or healing material.
9. Therapeutic and maintenance care services, including the use of the necessary equipment to offer the service.
10. Specialized diagnostic tests, such as electrocardiograms, electroencephalograms, arterial gases, and other specialized tests that are available at the hospital and necessary during the Enrollee's hospitalization.
11. Supply of oxygen, anesthetics, and other gases including administration.
12. Respiratory therapy, without limitations;

13. Rehabilitation services while Enrollee is hospitalized, including physical, occupational, and speech therapy. Service not covered is authorized by medical necessity.
14. Outpatient surgery facility use.
15. Blood transfusion and blood plasma services, without limitations, including:
    a. Autologous and irradiated blood.
    b. Monoclonal factor IX with the Referral of a certified hematologist.
    c. Intermediate purity concentrated antihemophilic factor (Factor VIII).
    d. Monoclonal type antihemophilic factor with a certified hematologist's authorization.
    e. Activated prothrombin complex (Auto flex and Feiba) with a certified hematologist's authorization.

4.3.10 Dental Services

MMM Multihealth will provide the following dental services as Covered Services:

1. All **preventive** and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement.
2. Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21).
3. Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy.
4. **Diagnostic and preventive** dental services for Adults.
5. Restorative dental services for Adults.
6. One (1) comprehensive oral exam per year.
7. One (1) periodical exam every six (6) months.
8. One (1) defined problem-limited oral exam.

9. One (1) full series of intra-oral radiographies, including **bitewings**, every three (3) years.
10. One (1) initial periapical intra-oral radiography.
11. Up to five (5) additional periapical/intra-oral.
12. One (1) single film-bite radiography per year.
13. One (1) two-film bite radiography per year.
14. One (1) panoramic radiography every three (3) years.
15. One (1) Adult cleanse every six (6) months.
16. One (1) child cleanse every six (6) months.
17. **One (1) Topical fluoride varnish application** every six (6) months for enrollees under twenty-one (21) years old.
18. One (1) topical fluoride application – (excluding varnish) **for beneficiaries under nineteen (19) years old.**
19. Fissure sealants **one (1) per tooth, per lifetime** for beneficiaries up to fourteen (14) years old (including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies).
20. Amalgam restoration**s.**
21. Resin restorations**.**
22. Root canal **treatments for anterior and premolar teeth.**
23. Palliative treatment**.**
24. **Dental extractions, removal of impacted teeth and removal of residual tooth roots.**

25. Surgical incisions for drainage.

26. Adjunctive General Services**, including sedations and hospital calls for enrollees up to twenty one (21) years old or adults with special care needs.**

4.3.11 Basic Behavioral Health Services

A. Covered Behavioral Health Services include the following:

1. Evaluation, screening, and treatment of individuals, couples, families, and groups.
2. Outpatient services with psychiatrists, psychologists, social workers, and substance abuse counselors.
3. Hospital or outpatient services for substance and alcohol abuse disorders.
4. Mental health outpatient services in Primary Medical Groups
5. Mental health clinical consultations and assessments in Primary Health Hospital Facilities
6. Behavioral Health hospitalization.
7. Intensive outpatient services.
8. Immediate access to Emergency or crisis intervention Services twenty-four (24) hours a day, seven (7) days a Week (services outside of Puerto Rico available only for Medicaid and CHIP Eligible).
9. Detoxification services for Enrollees intoxicated with illegal substances, whether because of substance abuse, a suicide attempt, or accidental poisoning.
10. Long lasting injected medicine clinics.
11. Escort/professional assistance and ambulance services when needed.
12. Prevention and secondary-education services.

13. Pharmacy coverage and access to medicine for a maximum of twenty-four (24) hours, in compliance with Act No. 408;
14. Medically Necessary clinical laboratories.
15. Treatment for Enrollees diagnosed with attention deficit disorder (with or without hyperactivity). This includes, but is not limited to, neurologist visits and tests related to this diagnosis's treatment.
16. Substance abuse treatment.
17. Psychiatric and psychological consultations for inpatients.

B. The following services are **excluded** from all Basic Coverage:

1. Expenses for personal comfort materials or services, such as, telephone use, television, or toiletries;
2. Services rendered by close family relatives (parents, children, siblings, grandparents, grandchildren, or spouses);
3. Weight control treatment (obesity or weight gain) for esthetic reasons. As noted, procedures determined to be Medically Necessary to address morbid obesity will not be excluded;
4. Sports medicine, music therapy, and natural medicine;
5. Services, diagnostic testing, or treatment ordered or rendered by naturopaths, naturists, chiropractors, iridologists, or osteopaths;
6. Health Certificates, except as provided in (Preventive Services);
7. Epidural anesthesia services;

8. Chronic pain treatment, if it is determined that the pain has a psychological or psychosomatic origin by a medical professional;
9. Educational tests or services;
10. Peritoneal dialysis or hemodialysis services (covered under Special Coverage, not Basic Coverage);
11. Hospice care;
12. Services received outside the territorial limits of Puerto Rico, except as provided in (Emergency Transportation) and (Emergency Services);
13. Expenses incurred for the treatment of conditions resulting from services not covered under MMM Multihealth (maintenance prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered);
14. Judicially ordered evaluations for legal purposes; Psychological, psychometric, and psychiatric tests and evaluations to obtain employment or insurance, or for purposes of litigation;
15. Travel expenses, even when ordered by the Primary Care Physician;
16. Eyeglasses, contact lenses and hearing aids;
17. Acupuncture services;
18. Rent or purchase of durable medical equipment, wheelchairs, or any other transportation method for the handicapped, either manual or electric, and any expense for the repair or alteration of said equipment, except when the patient's life depends on this service;

19. Sex change procedures;

20. Organ transplants and

21. Tuboplasty and Vasovasostomy or any other procedure to restore procreation.

C. <u>The following are **excluded** from maternity and pre-natal covered services:</u>

1. Outpatient use of fetal monitor;
2. Treatment services for infertility and/or related to conception by artificial means;
3. Services, treatments, or hospitalizations as a result of a provoked non-therapeutic abortion or associated complications are not covered. The following are considered to be provoked abortions:
    a) Dilatation and curettage
    b) Dilatation and expulsion
    c) Intra-amniotic injection
    d) One or more vaginal suppositories (e.g., Prostaglandin) with or without cervical dilatation (e.g., Laminar), including hospital admission and visits, fetus birth, and afterbirth
    e) One or more vaginal suppositories (e.g., Prostaglandin) with dilatation and curettage/or evacuation
    f) One or more vaginal suppositories (e.g., Prostaglandin) with hysterectomy (omitted medical expulsion.
4. Differential diagnostic interventions up to the confirmation of pregnancy are not covered. Any procedure after the confirmation of pregnancy will be at the *Vital* own risk.

5. Hospitalization for services that would normally be considered outpatient services or for diagnostic purposes only is not a Covered Service under the *Vital*.

D. The following drugs are **excluded** from the pharmacy services benefit:

1. Medications delivered directly to Enrollees by a Provider that does not have a pharmacy license, except for medications that are traditionally administered in a doctor's office, such as injections.

E. Psychiatric Emergencies

1. MMM Multihealth will not deny payment for treatment of an Emergency Medical Condition or a Psychiatric Emergency, including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in the definition of Emergency Medical Condition or a Psychiatric Emergency in this Contract and in 42 CFR 438.114(a).

2. MMM Multihealth will not refuse to cover an Emergency Medical Condition or a Psychiatric Emergency on the ground that the emergency room Provider, hospital, or fiscal Agent did not notify the Enrollee's PCP or MMM Multihealth of the Enrollee's screening or treatment following the Enrollee's arrival for Emergency.

3. Care as necessary in the case of a Psychiatric Emergency in an emergency room setting.

F. Substance abuse treatment

1. MMM Multihealth will provide appropriate services for Enrollees in need of Buprenorphine treatment due to of a diagnosis of opiate addiction cover all services related to assessment, treatment, and monitoring of opiate addiction including:

a) Prescriptions for Buprenorphine or any other medically A list of CPTET Centers and community-based organizations that administer these medications is included as Attachment [4] to this Contract appropriate medications included on the PDL

b) Comprehensive medical examination

c) Extended office visits

d) Brief office visit Code

e) Psychiatric Diagnostic Interview Exam – New Patient

f) Individual Therapy with Medical Evaluation and Management.

g) Pharmacologic Management

h) Drug Urine Toxicology

i) Blood Test Basic Metabolic Panel

j) Blood Test CBC

k) TB Test – Skin (CPT Code 86580), but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction.

l) HIV Test, but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction.

m) Hepatitis Panel, but only in conjunction with the prescription of Buprenorphine for the treatment of opiate addiction.

n) Individual Counseling

o) Group Counseling

p) Mental Health Assessment by Non-Physician Professional

q) Alcohol and substance abuse Services, Treatment Plan Development and Modification

2. MMM Multihealth will have Providers trained and certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide opiate addiction treatment. The training and certification of the Providers by SAMHSA may be evidenced with either (1) a copy of the letter issued by SAMHSA to the Provider certifying his/her training and certification or (2) a copy of the Controlled Substance Registration Certification issued by the Drug Enforcement Administration with the identification number assigned to the Provider by SAMHSA. Evidence of SAMHSA certification will be included in the Provider's Credentialing file maintained by MMM Multihealth.

3. MMM Multihealth will establish and strengthen relationships (if needed, through memoranda of understanding) with ASSMCA, ADFAN, the Office of the Women's Advocate, and other government or nonprofit entities, in order to improve the delivery of Behavioral Health Services.

4.3.12 Special Cover

1. The Special Coverage benefit is designed to provide services for beneficiaries with special care needs as a cause of serious illness.

2. The mental and physical health services that the autistic population needs to access specialists such as gastroenterologists, neurologists, allergists and dentists, are offered through the Special Coverage.

3. Services provided under the Special Cover will be subject to a pre-authorization from the Vital Plan.

4. The Special Coverage includes the following services that will be provided to beneficiaries who only have medical needs to treat the condition for which they qualify for this coverage:

    a) Intensive care or coronary services without limitations.

    b) Maxillary surgery

    c) Neurosurgical or cardiovascular procedures, including pacemakers, valves and any other artificial instrument or device (require pre-authorization).

    d) Peritoneal dialysis, hemodialysis, and related services (reauthorization required).

    e) Clinical or pathological laboratory tests that need to be sent outside of Puerto Rico for processing (requires pre-authorization).

    f) Services in the Neonatal Intensive Care Unit, without limitations.

    g) Radioisotopes, chemotherapies, radiotherapies, and cobalt treatments.

    h) Treatment for gastrointestinal conditions, allergies, and nutrition services for autistic patients.

5. Diagnostic procedures and tests when medically necessary require pre-authorization:

    a) Computed tomography

b) MRI test

c) Cardiac catheterizations

d) *Holter* test

e) *Doppler* test

f) *Stress Test*

g) Lithotripsy

h) Electromyography

i) Topographic Test for Computerized Emission (SPECT)

j) Orthopantomography Test (OPG)

k) Impedance Plethysmography

l) Neurological, cerebrovascular, and cardiovascular procedures, invasive and non-invasive.

m) Nuclear imaging Endoscopic diagnostics

n) Endoscopic diagnostics

o) General studies

6. Up to fifteen (15) additional physical-therapeutic treatments (beyond what is provided by the Basic Coverage) per beneficiary per year when indicated by an orthopedist or a doctor after a requested preauthorization has been approved.

7. General anesthesia, including dental treatments for children with special conditions.

8. Hyperbaric Chamber

9. Immunosuppressive drugs and clinical laboratories for beneficiaries who require follow-up treatment after surgery or transplantation, to ensure the stability of the beneficiary's health and for emergencies that may occur after surgery.

10. Treatment for the following conditions after laboratory results are confirmed and a diagnosis has been established:

    a) HIV positive and/or acquired immunodeficiency syndrome (AIDS) (inpatient or outpatient services are included. A referral or pre-authorization is not required for the beneficiary to attend visits or treatments at the Department of Health's Regional Immunology Clinics or any other certified provider.)
    b) Tuberculosis
    c) Leprosy
    d) Lupus
    e) Cystic fibrosis
    f) Cancer
    g) Hemophilia
    h) Children with special conditions, including the conditions prescribed in the Code Manual for Children with a Special Needs Diagnosis (see annex 13), except asthma and diabetes, which are included in the Condition Management, Psychiatric Disorder and Intellectual Disabilities program.

i) Scleroderma

j) Multiple sclerosis

k) Pulmonary Hypertension

l) Conditions as causes of self-made harm or as result of crime or negligence by a beneficiary.

m) Chronic kidney conditions at a level of 3, 4 and 5. (Levels 1 and 2 are included in the Basic Cover). These levels of kidney conditions are defined as follows:

    i. Level 3 – Glomerular filtration (GFR-ml/min. per1.73m² per body surface area) between 30 and 59, a moderate decrease in kidney functionality.

    ii. Level 4 – GFR between 15 and 29 is considered a severe decrease in kidney functionality.

    iii. Level 5 – GFR below 15 is considered kidney failure, likely requiring dialysis or a kidney transplant.

n. Aplastic Anemia

o. Rheumatoid Arthritis

p. Autism

q. Neonatal Hearing Screening

r. PCD- Primary Ciliary Dyskinesia

s. Inflammatory Bowel Disease

t. Amyotrophic Lateral Sclerosis

u. CHF- Congestive Heart Failure – Stage III & IV

v. PKU- Phenylketonuria

w. Hepatitis C

x. Cleft Palate /Cleft lip

y. Post-Transplant

11. Medicines needed for outpatient treatment of tuberculosis, leprosy and hepatitis C are included in the special cover. It also includes medicines for outpatient treatment or hospitalization of beneficiaries diagnosed with AIDS or beneficiaries with HIV, except for protease inhibitors that will be provided by the CPTET centers. Costs incurred for hepatitis C medication are not part of the applicable premium rates and will be disbursed by ASES.

4.3.13 Pharmacy Services

1. Services provided by pharmacies under MMM Multihealth, including the following:
    a) All costs related to prescription drugs for beneficiaries, except when the copayment applies.
    b) Drugs that are covered under Vital Plan.
    c) Preferred Drug List (PDL) serve as a guide for providers in making decisions about drugs in cost-effective coverage.
2. Among them is the following:
    a) Physical Health
    b) Dental
    c) Nephrology
    d) Ob/Gyn

e) Oncology

f) HIV / AIDS

g) Physical Health Subform

h) Integrated Emergency Form (FEI)

i) Mental health:

- Mental Health Subform

j) Non-Preferred Drug List (NPDL)

k) In instances, some exceptions to the process, drugs that are not included in the PDL or the NPDL.

3. MMM Multihealth will not impose restrictions beyond those established in the FMC, LME or any other medication form approved by ASES.

4. Hormonal drugs covered by the Vital Plan will be covered to beneficiaries regardless of gender. Hormonal medicines will be covered to participants over the age of 18. You can receive your prescribed hormone treatments through your Primary Physician.

A. Role of Pharmacy Benefit Manager

1. Pharmacy services are administered primarily by a Pharmacy Benefit Manager ("PBM") under contract with ASES. MMM Multihealth will work with the PBM as well as the Pharmacy Program Administrator ("PPA") selected by ASES in order to ensure the successful provision of pharmacy services.

2. Among other measures, to enhance cooperation with the PBM, *Plan Vital* will:

a) Work with the PBM to improve Information flow and to develop protocols for Information-sharing.

b) Establish, in consultation with the PBM, the procedures to transfer funds for the payment of Claims to the pharmacy network according to the payments cycle specified by the PBM.

c) Coordinate with the PBM to establish customer service protocols concerning pharmacy services.

d) Collaborate with ASES to facilitate a smooth transition, since the PBM, PPA, and rebate contracts will take effect after April 1, 2015, which is the Implementation Date of this Contract.

B. Medication for Treatment of HIV / AIDS

1. The following HIV/AIDS medications are excluded from the ASES PDL: Viread®, Emtriva®, Truvada®, Fuzeon®, Atripla®, Epzicom®, Selzentry®, Intelence®, Triumeq®, Genvoya®, Odefsey®, Descovy®, Juluca®, Biktarvy®, Trogarzo®, Isentress®, Edurant®, Complera®, and Stribild®.
2. Because of an agreement between the Health Department and ASES, Enrollees diagnosed with HIV/AIDS may access the medications listed above through Health Department clinics. MMM Multihealth is not At Risk for the coverage of these medications.
3. Inform Providers to refer Enrollees for whom these medications are Medically Necessary to Centers for the Prevention and Treatment of Communicable Diseases (CPTETs) or community-based organizations, where the beneficiary may

be screened to determine whether the Enrollee is eligible for the AIDS Drug Assistance Program (ADAP).

4. A list of CPTET Centers and community-based organizations that administer these medications is included as Attachment [4] to this Contract.

C. Formulary Management Program

1. Select two (2) members of its staff to serve on a cross-functional committee, the Pharmacy Benefit Financial Committee, tasked with rebate maximization. The Committee will evaluate recommendations regarding the PDL, from the P&T Committee and the PPA, and will ultimately develop and review the PDL from time to time under the direction of ASES and the PPA.

2. MMM Multihealth will select a member of its staff to serve on a cross-functional subcommittee tasked with rebate maximization. The subcommittee will take recommendations on the PDL from the P&T Committee and will ultimately create and manage the PDL.

4.3.14 Wellness Plan

1. In order to advance the goals of strengthening Preventive Services, providing integrated physical, behavioral health, and dental services to all eligible persons, and educating Enrollees on health and wellness, MMM Multihealth will develop a Wellness Plan.

2. The Wellness Plan will include a strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health Department, the Department of the Family, and the Department of Education. The

Wellness Plan will incorporate strategies to reach all Enrollees including those living in remote areas ~~of MMM Multihealth's Service Regions.~~

3. The Wellness Plan will present strategies for encouraging Enrollees to:
    a. Seek an annual health checkup;
    b. Appropriately use the services of *Plan Vital,* including Enrollee Service Line.
    c. Seek women's health screenings including mammograms, pap smears, cervical screenings, and tests for sexually transmitted infections;
    d. Maintain a healthy body weight, through good nutrition and exercise;
    e. Seek an annual dental exam;
    f. Seek behavioral health screening;
    g. Attend to the medical and developmental needs of children and adolescents, including vaccinations.
    h. Receive education regarding the diagnosis and treatment of high-risk diagnoses including:
        i. Depression;
        ii. Schizophrenia;
        iii. Bipolar disorders;
        iv. Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder;
        v. Substance abuse.
        vi. Anxiety disorders.

4. MMM Multihealth will ensure that its Wellness Plan reaches, at a minimum, eighty-five percent (85%) of MMM Multihealth Enrollees. To achieve the eighty-five percent (85%) goal, MMM Multihealth will, in compliance with the requirements of HIPAA and the rules and regulations thereunder, utilize wellness advertisements, campaigns and/or seminars, including without limitation, health fairs, educational activities, visits to enrollees, and others.

4.3.15 Coverage and Benefits related to COVID-19

- MMM Multihealth has taken all necessary measures to guarantee that patients, health care facilities, and clinical labs in Puerto Rico are ready to respond to the COVID-19.
- MMM Multihealth will cover lab services ordered by a physician.
- For this service, the beneficiary will not need to make any copayment, regardless the type of coverage they have.
- The vaccine will have no cost for beneficiaries and service providers for the period established by the CDC.

A. Important aspects of the Medicaid and the CHIP data sheet:

- MMM Multihealth will cover testing and diagnostic services, as well as laboratory and X ray services. It will furnish hospital services for inpatient and outpatient beneficiaries.
- Hospital care coverage will be provided to children and pregnant women enrolled in the CHIP program. Specific questions on covered benefits should be addressed to the corresponding Medicaid and CHIP state agency.

B. Telehealth Code, Virtual Check In, E-Visits COVID-19

1. Telemedicine health records must be kept in the same way other health records are kept.
2. Specific documentation required will vary according to interaction level.
3. Health care facility that uses telemedicine information in order to make decisions on the patient's treatment shall comply with all standards;
4. Medical record must include:
    - Aspect that needs evaluation
    - Informed consent
    - Event documentation (regardless the media used)
    - Authentication of record entries.

C. Billing codes for the COVID-19 vaccine

1. Providers will have the right to bill for vaccine-related services, which includes inoculation, specific information about the conservation of the vaccine, information to patient, and tracking to coordinate the second dose, as well as the booster dose.
2. The vaccine administration fee will be standard for all duly certified and registered providers who also comply with the COVID-19 vaccine requirements set upon by the Centers for Disease Control and Prevention (CDC) and the Puerto Rico Health Department.
3. Based on the information provided by CMS, ASES has established the rates and codes for the administration of vaccines against COVID-19 and the booster for the adult and pediatric population.

D. Laboratory testing for laboratories to test patients for COVID-19

1. Administrative Order No. 451 (OA 451) of the Secretary of Health, issued on June 16, 2020, establishes specific instructions for the payment of COVID-19 tests for the duration of the emergency caused by the pandemic. The Center for Medicare & Medicaid Services (CMS) has also issued guidance on Medicaid coverage and the Children's Health Insurance Program (CHIP), which requires states to that cover, without cost sharing, all diagnostic and screening tests that are consistent with the recommendations of the Centers for Disease Control and Prevention (CDC).
2. The ASES establishes that providers must issue Vital beneficiaries with the necessary medical orders to satisfy screening tests that meet the exposure conditions and/or risks established by the Puerto Rico Department of Health and/or those indicated by the CDC or CMS.
3. Issuing medical orders for diagnostic tests that are not in this framework and that meet other individual needs for social activity, entertainment, or leisure activities, entails an inappropriate use of the medical resources available in the country. Therefore, all providers must exercise their medical judgment strictly based on access to medically necessary services and the current reality of the COVID-19 pandemic.
4. In addition, the inappropriate practice of issuing medical orders without a determination of valid medical necessity may lead to audits by insurers and/or regulatory agencies that provide federal funds for Medicaid-Vital services.
5. ASES advises that all tests that meet the medical necessity requirement, as stipulated in OA 451 and/or the criteria established by the CDC adopted by CMS, duly issued by

the medical provider, must be payable to the clinical laboratories participating in the Vital Plan, free of copayments and deductibles for the beneficiary.

6. The ASES has determined that the Vital Government Health Plan will cover eight (8) home tests (OTC, over the counter) per person for its insured population.
7. After exhausting the benefit of the eight (8) tests, the beneficiary may access additional tests with a medical order. The doctor is responsible for conducting a clinical evaluation to determine the beneficiary's medical need for the use of the COVID-19 home test when issuing said order.

5. PHARMACY

The MMM Multihealth Pharmacy department works in close coordination with the Pharmacy Benefits Administrator (PBM) hired by ASES to ensure that the pharmacy services provided to its enrolled beneficiaries are based on the highest quality standards, and that the maintenance of operations is in compliance with the requirements of ASES, CMS and any other applicable law or statute.

To facilitate claims processing, MMM Multihealth will send to the PBM a daily report of the eligibility data of the beneficiaries and providers. The PBM is responsible for administering claims processing, facilitate the formulary management process, review, and analyze the use of drugs, and manage the pharmacy network. MMM Multihealth works with the PBM as well, as with the Pharmacy Program Administrator (PPA).

Both entities (PBM & PPA) are selected by ASES, to ensure quality in providing pharmacy services. MMM Multihealth is obliged to accept the terms and conditions of the contract ASES granted to the PBM and the PPA.

MMM Multihealth Clinical Pharmacy operations are carried out by a team of experienced professionals in *Plan Vital* including doctors in pharmacy and certified pharmacy technicians highly trained to handle clinical interventions and to effectively establish communication with providers involved in health care.

The MMM Multihealth Pharmacy Operations team consists of the:

- Clinical Pharmacy Unit: responsible for the evaluation and resolution of received coverage determination requests.
- Pharmacy Utilization Unit: dedicated to continuous drug utilization review and to support pharmacy initiatives such as under and over utilization, polypharmacy, and the use of high-risk medications, among others.

MMM Multihealth has a pharmacy drug utilization specialist dedicated to continuously review the Drug Utilization, in order to coordinate with the PBM topics to be discussed with medical groups in educational activities through the PBM Academic Detailing program, as well as MMM Multihealth visits to physician offices by its Clinical Practice Consultants (CPC). In these activities, topics as polypharmacy and its implications and appropriate use of medicines are discussed. The

drug utilization analysis also allows us to establish programs for the optimum treatment of patient conditions such as asthma, depression, diabetes and cholesterol among others, and to identify opportunities for establishing a discipline that allows us to offer our beneficiaries a Pharmacy Benefit Program that assures the quality and effectiveness of the drug therapy.

5.1. Pharmacy Covered Services

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MMM Multihealth provides pharmacy services, including the following:

1. All costs related to prescribed medications for Enrollees, excluding the enrollee's Copayment where applicable.
2. Preferred Drug List (PDL) and Non-Preferred Drug List (NPDL) covered by *Plan Vital*, where ASES can assign different co-payment levels and/or utilization management edits within the drugs under your pharmacy coverage.
3. An exception request may be used for (i) medications included in the PDL that are subject to utilization management edits (such as step therapy, quantity or dose limits, or prior authorization requirements), when the prescriber wishes to bypass such restrictions, (ii) non-preferred medications (NPDL) that are not included in the PDL, or (iii) if the prescriber demonstrates that none of the alternatives in the PDL and NPDL are not clinically viable for the patient..
4. If the prescribed drug is included in the PDL, the drug will be managed following clinical protocols approved and established by ASES. If the prescriber wishes to bypass the utilization managements edits, is required to submit a clinical justification that

established the clinical reasons of why the requested drug is medically necessary for the patient.

5. If the prescribed drug is not included in the PDL, but it is included in the NPDL is prescribed, the drug will be managed as an exception request. All evaluations must have evidence of medical necessity and will have to be justified by the patient's prescribing physician.
    a) Prescribing physician will provide evidence of contraindication to all the alternatives within the PDL. The MCO will request a copy of the patient's medical history that validates the presented contraindication to all the PDL alternatives or physician should provide scientific evidence that substantiates that the utilization of the PDL alternatives would represent serious health repercussions to the patients' health; or
    b) Patient has experienced serious adverse reactions to all the alternatives in the PDL; or
    c) Patient has experienced therapeutic failure to all the alternatives in the PDL due to ineffectiveness of therapy or because it would adversely affect the patient's condition or illness.
6. If a drug is not included in the PDL nor the NPDL is prescribed, the drug will be managed as an exception request. All evaluations will have to evidence medical necessity and will have to be justified by the patient's prescribing physician.
    a) Prescribing physician will have to evidence contraindication for all for the alternatives within the PDL and the NPDL.

b) The MCO will request a copy of the patient's medical history that validates the presented contraindication to all the PDL and NPDL alternatives, or physician should provide scientific evidence that substantiates that the utilization of the PDL and NPDL alternatives would represent serious health repercussion to the patients' health.

c) Patients have experienced serious adverse reactions to all the alternatives of the PDL and the NPDL. or

d) Patient has experienced therapeutic failure to all the alternatives in the PDL and the NPDL due to ineffectiveness of therapy or because it would adversely affect the patient's condition or illness

7. MMM Multihealth should not impose restrictions on available prescription drugs beyond those stated in the PDL, NPDL or any other drug formulary approved by ASES.

5.2 Drugs Excluded from Pharmacy Benefit Services

1. Medications to promote fertility, medications for cosmetic purposes or hair growth uses, medication for weight control (anorexia, weight loss or weight gain), medications for the relief of cough and cold symptoms, most of the vitamins and minerals, non-prescription medicines or over the counter (OTC) medications, unless the drug is specifically included in the Vital Plan coverage.
    - Treatment indicated for psoriasis, acne, rosacea, or vitiligo are NOT considered cosmetics.

2. Drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
3. Drugs that are not prescribed for a medically accepted indication.
4. Drugs that are prescribed for the purpose of treating a condition not covered under Plan Vital.
5. Medications delivered directly to Enrollees by a Provider that does not have a pharmacy license, except for medications that are traditionally administered in a doctor's office, such as injections.

5.3 Relevant Information to Our Providers

Prescriptions ordered under the Pharmacy Benefit services are subject to the following utilization controls:

1. Some prescription drugs may be subject to prior authorization, which will be implemented and managed in its majority by MMM Multihealth or by the PBM, according to policies and procedures established by the ASES Pharmacy and Therapeutic Committee (P&T) and decided upon in consultation with MMM Multihealth, when applicable.
2. MMM Multihealth ensures that Prior Authorizations for pharmacy services are provided for the Enrollees in the following timeframes, including outside of normal business hours.
    a) The decision whether to grant a Prior Authorization for a prescription must not exceed twenty-four (24) hours from the time of the Enrollee's Service Authorization Request is received for any Covered Service. However, incomplete requests that do not include all the standard information needed

to make a determination, will be returned to the pharmacy receiving the request, prescribing physician or health care provider by fax or e-mail, for completion as soon as practicable, and within 24 hours. If the request does not contain the appropriate information, this information will be requested from the prescribing physician who will have up to seventy-two (72) additional hours for submitting the additional information.

b) The minimum standard information required for the evaluation of drug is the following:

i. Prescription

ii. A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication

iii. Expected duration of treatment, as required by the protocol for the medication.

iv. For controlled drugs the request (written prescription) must comply with, but not limited to, the following Pharmacy Law Requirements:

- Prescription date
- Patient's full name and address
- Patient's age
- Prescriber's full name, address, phone number, license number
- Drug name, dosage form, strength, and quantity

- Drug's direction for use
- Prescriber's DEA registration number if a controlled drug is prescribed

c) In an emergency, MMM Multihealth must authorize at least a 72-hour supply of the requested drug as long as the drug is statutorily excluded from coverage. An emergency means that a lack of access to the requested drug may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. MMM Multihealth must evaluate the request to determine, based on the information presented, whether the patient is in an emergency. Such evaluations must be conducted using appropriate clinical judgment and shall not be used to deny a 72-hour emergency supply of the requested drug if an emergency does in fact exist.

3. Prescriptions written by a Provider who is outside the Preferred Provider Network (PPN) may be filled only upon a Countersignature from the Enrollee's PCP, or another assigned PCP from the Primary Medical Group (PMG).
4. MMM Multihealth uses bioequivalent drugs approved by the Food and Drug Administration ("FDA"), provided they are classified as "AB" and authorized by regulations, branded medications with a bioequivalent generic available will be covered through the exception process in compliance with conditions established by this process. Nonetheless, MMM Multihealth will not refuse to cover a drug solely because the bioequivalent drug is unavailable; nor will they impose an additional payment on the Enrollee because the bioequivalent is unavailable.

MMM Multihealth observes the following timeframe limits with respect to prescribed drugs:

1. Medication for chronic conditions will be covered for a maximum of thirty (30) Calendar Days and for additional time, where Medically Necessary.

   Medication for acute Conditions will be covered for a maximum of fifteen (15) Calendar Days. For severe mental health conditions, prescribed by a contracted mental health provider, they will be covered for a maximum of thirty (30) calendar days, upon a Provider's recommendation, a minimum of fifteen (15) Calendar Days will be prescribed in order to reevaluate compliance and tolerance. According to the ASES cover According to the ASES cover, a prescription may be refilled up to five (5) times.
2. For maintenance drugs that require Prior Authorization, the Prior Authorization will be effective for the time specified by the physician or for six (6) months, unless there are contra-indications or side effects.
3. The prescribing Provider will re-evaluate pharmacotherapy as to compliance, tolerance, and dosage within ninety (90) Calendar Days of having prescribed a maintenance drug. Dosage changes will not require Prior Authorization but are subject to review by clinical staff. Changes in the drug used may require Prior Authorization.

Special considerations, including cooperation with Puerto Rico governmental entities other than ASES, govern coverage of medications for the following conditions:

1. Some contraceptive medications are provided by MMM Multihealth, but only for the treatment of menstrual dysfunction and other hormonal conditions. Contraceptives prescribed for family planning purposes will be provided through PREVEN clinics.

2. Medications prescribed for children with special health needs that have a chronic condition:
    a) Will be covered for thirty (30) calendar days, and if necessary up to five (5) refills of the original prescription, according to medical opinion of a certified Provider.
    b) When medically necessary, additional prescriptions will be covered.
3. Prescription Drugs must be dispensed by a pharmacy under contract with the PBM that is duly authorized under the laws of Puerto Rico and is freely selected by the Enrollee. The PBM maintains responsibility for ensuring that the pharmacy services network complies with the terms specified by ASES.
4. Prescribed drugs must be dispensed according to the date and time as established by the Puerto Rico Pharmacy Law, when the enrollee submits the prescription for dispensation.

5.4 Formulary Management Program

A. What is the *Preferred Drug List (PDL) of Plan Vital*?

The Health Insurance Administration (ASES) is the agency responsible for establishing and reviewing the drug coverage of Plan Vital. Under the pharmacy benefit covered drugs can be identified in the Preferred Drug List (PDL). In addition, the pharmacy coverage has a Non-Preferred Drug List as an alternative when the drugs on the PDL are not preferred for our beneficiaries. *Plan Vital's* pharmacy benefit coverage establishes the use of a mandatory bioequivalent generic as the first option and the use of generics classified “AB” by the Food and Drug Administration (FDA) is required.

The brand name, for drugs that have a bioequivalent generic available, is mentioned in the PDL just as reference.

B. How is the GHIP list of covered drugs created?

ASES, through its Pharmacy and Therapeutics (P&T) Committee reviews the PDL and NPDL drugs. MMM Multihealth has representation in the Pharmacy and Therapeutic Committee to provide clinical recommendations of the medications to be included in the PDL or NDPL and those medications excluded from ASES Drugs Formulary. All changes are published in MMM Multihealth Web: www.MultiHealth-vital.com

C. What does the Non-Preferred Drug List (NPDL) include?

Is a List of medications that are not included in the PDL, but that have been evaluated by ASES' Pharmacy and Therapeutics (P&T) Committee. Medications that are not included in the NPDL, may still be covered under an Exception Request, unless statutorily excluded.

D. Can the PDL and NPDL change?

Yes, the PDL and NPDL lists changes from time to time. All changes are published on our websites and Providers portal: www.MultiHealth-vital.com

5.5 Exception Request process

Physicians are encouraged to prescribe drugs that are in the Preferred Covered Drug List of *Plan Vital* (PDL) whenever possible.

1. MMM Multihealth will cover drugs not included in the PDL but are included in the Non Preferred Drug List formulary (NPDL), through the exception process:

    a) If a prescribed drug is not in the PDL but is in the NPDL at the point of sale, the pharmacy will receive the following reject message:

    - **75 - Prior Authorization Required**

    b) **.. For Exceptions PA Fax 1.866.349.0514 PA required for this drug.. Drug on Non Preferred Drug List (Non PDL). Exception request required. Validate other alternatives in PDL before proceeding.** If after validation the pharmacy decides to proceed with the evaluation of the prescribed drug, the request must contain the following standard information:

        - Prescription
        - A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication.
        - Expected duration of treatment, as required by the protocol for the medication.

    c) The prescribing physician must provide a written and signed supporting statement based on clinical evidence that the requested prescription drug is medically necessary to treat the member's disease or medical condition. If the physician is requesting and NPDL alternative, the physician's supporting

statement must indicate that the requested prescription drug should be approved based on the following:

- All PDL alternatives for the requested drug are contraindicated with drugs that the patient is already taking. The MCO must request that the patient's medical records show such contraindication, or that the prescribing physician provide scientific literature showing the strong possibility of serious adverse health effects as a result of taking the PDL alternatives; or
- Patient has experienced serious adverse reactions to the alternative drugs in the PDL or;
- Therapeutic failures of all alternatives in the PDL, either because those alternatives were ineffective or would adversely affect the patient's health or condition.

d) Incomplete requests will be returned to the doctor by fax, or email to complete within twenty-four (24) hours.

e) The result of the determination will be notified within twenty-four (24) hours to the beneficiary, the pharmacy and the prescribing physician.

f) In an emergency, the MCO may authorize at least one seventy-two (72) hour supply of the requested drug as long as it is not a drug excluded by regulation.

- An emergency means that: the lack of access to the requested medicine can endanger the life or health of the beneficiary or the ability to recover their functions.

g) If a request lacks additional information to complete the evaluation, the doctor will be notified that the insurer will grant seventy-two (72) hours to submit the information.

h) If the additional information is not submitted within seventy-two (72) hours, the request may be inactivated unless prior to the expiration of time the MCO confirms that the available information is enough to make a determination.

i) If it is inactivated, the pharmacy and the prescribing physician will be notified in writing.

j) Appropriate additional information includes but is not limited to:

- Diagnosis
- Data or medical history of relevant patient
- Documentation of prior use to other alternatives of therapies or medications (including therapies, time of use and Clinical results).
- Medical justification such as: contraindication to the alternatives available in the PDL, adverse reaction to the medications in the form, evidence of therapeutic failure to the alternatives, medication not covered in the form for a specific diagnosis Laboratory result, if required in the protocol.

2. MMM Multihealth shall cover a drug that is not included on the PDL or NPDL, provided that the drug is not in an experimental stage and that the drug has been approved by the FDA for the treatment of a specific condition.

a) If a drug that is not in the PDL or the NPDL is prescribed and processed at the pharmacy, the pharmacy will receive the following rejection message:

b) ***70 - Product Service Not Covered*** If after validation the pharmacy decides to proceed with the evaluation of the prescribed drug, it must contain the following standard information:

- Prescription
- A supporting statement setting forth the clinical justification and medical necessity for the prescribed medication
- Expected duration of treatment, as required by the protocol for the medication.

c) The prescribing physician must provide written and signed clinical justification stating the clinical reason or reasons why the requested medication is clinically necessary to treat the beneficiary's disease or medical condition. If the physician is requesting an alternative not listed on PDL or NPPDL, the physician's supporting statement must indicate that the requested prescription drug should be approved based on the following:

- All PDL and NPDL alternatives for the requested drugs are contraindicated with drugs that the patient is already taking. The MCO must request that the patient's medical records to show such contraindication, or that the prescribing physician provide scientific literature showing the strong possibility of serious adverse health effects as a result of taking the PDL and NPDL alternatives; or

- Patient has experienced serious adverse reactions to the alternative drugs available in the PDL and the NPDL; or
- Therapeutic failures of all the alternatives in the PDL and the NPDL, either because those alternatives were ineffective or would adversely affect the patient's health or condition.

d) Incomplete requests will be returned to the doctor by fax, or email to complete within twenty-four (24) hours.

e) The result of the determination will be notified within twenty-four (24) hours to the beneficiary, the pharmacy and the prescribing doctor.

f) In an emergency, the MCO may authorize at least one seventy-two (72) hour supply of the requested drug as long as it is not a drug excluded by regulation.

- An emergency means that: the lack of access to the requested medicine can endanger the life or health of the beneficiary or the ability to recover their functions.

g. If a request is received but additional information is needed to complete the evaluation, the doctor will be notified that the insurer will grant seventy-two (72) hours to submit the information.

h. If the additional information is not submitted within seventy-two (72) hours, the request may be inactivated unless prior to the expiration of time the MCO confirms that the available information is sufficient to make a determination.

i. If it is inactivated, the pharmacy and the prescribing physician will be notified in writing.

j. Appropriate additional information includes but are not limited to:

- Diagnosis
- Relevant patient Data or medical history
- Documentation of prior use to other alternatives of therapies or medications (including therapies, time of use and clinical results)
- Medical justification for the requested drug such as: contraindication to the alternatives available in the PDL, patient has experienced or would experience adverse reaction to the medications in the PDL , evidence of therapeutic failure after available alternatives on PDL were attempted, medication not covered in the form for a specific diagnosis.
- Laboratory results, if required in the protocol

k. MMM Multihealth covers drugs that are not included in the PDL or in the NPDL as long as the drug is not in an experimental phase and has been approved by the Food and Drug Administration (FDA) for the treatment of the beneficiary's health condition.

5.6 Fraud Investigations

The MMM Multihealth Pharmacy Department has a high commitment to support the comprehensive Corporate Compliance Department plan for the prevention, detection, and correction of possible cases of fraud, waste or abuse related to the pharmacy benefit.

If any case is identified or referred to the Department by an employee, beneficiary, pharmacy or doctor, its information will be shared with the MMM Multihealth Compliance Department to determine the actions to be taken on these cases.

Regularly, utilization analysis is conducted to identify any pattern that may represent fraud, waste, or abuse, such as *Controlled substances utilization;* Doctor/Pharmacy Shopping (prescriptions of controlled substance medications, prescribed by multiple physicians and/or dispensed by multiple pharmacies for the same beneficiary)

MMM Multihealth has established **reporting mechanisms** such as:

- Ethics-Point Hotline (1-844-356-3956);
- Email address (VITALSIU@mmmhc.com) for Providers, Subcontractors, Beneficiaries and public. Individuals or entities may anonymously report fraud, waste, abuse or misconduct.

Nobody must be subjected to any form of retaliation based solely on the good faith or honest intention of reporting a suspected violation.

5.7 Pharmacy Department Contact Information

PHARMACY CLINICAL UNIT	
Pharmacy Clinical Call Center (Prior Authorizations of Medications)	
Telephone Numbers	• 1-844-880-8820 (TOLL FREE) • 787-523-2829

Fax for Physical Health	• 1-866-349-0514
Fax for Mental Health	• 1-844-990-9940
Fax for J Codes	• 787-300-4897
Internet:	
MMM Multihealth	www.multihealth-vital.com
InnovaMD	www.innovaMD.com

6. QUALITY IMPROVEMENT AND PERFORMANCE PROGRAM

The Quality Improvement and Performance Program provides a structure for the delivery of quality care to all enrollees with the primary goal of improving health status or, in instances where the enrollee's health is not amenable to improvement, maintaining the enrollee's current health status by implementing measures to prevent any further deterioration of his or her health status.

6.1 Objectives

1) Measurable compliance and detailed goal setting for quality improvement activities and performance improvement projects.
2) Continuous quality assessment and probing to promote tangible and required performance improvement.

3) Targeted efforts to minimize encountered barriers that impede full continuum of care, in order to drive improved healthcare outcomes for our population.
4) Maintain partnerships with stakeholders that will maximize the plan's capability to provide adequate healthcare services and benefits.

6.2 Quality Assessment Performance Improvement Program

The Quality Assessment Performance Improvement (QAPI) Program was established specifying quality measurements and performance improvement activities based on clinically sound, nationally developed, and accepted criteria standards, and taking into consideration the latest available research in the area of quality assurance. Some of the elements that comprise the QAPI Program will be described in the subsequent sections.

6.3 Advisory Board

The Advisory Board consist of representatives from all of Plan Vital populations of MMM Multihealth, such as enrollees, family members and providers, among others, that convenes on a quarterly basis. The participants of the Advisory Board shall serve to advice and contribute to the resolution of issues related to service delivery, the quality of all covered services (for example, physical health and behavioral health), enrollee rights and responsibilities, resolution of enrollee grievances and appeals, and the needs of groups represented by the participants of the Advisory Board pertaining to the Puerto Rico Medicaid Program. MMM Multihealth will promote an equitable representation of the Advisory Board's participants in terms of race, gender, special populations, and Puerto Rico's geographic areas in *Plan Vital*. MMM Multihealth shall advise ASES ten calendar days in advance of meetings to be held and maintain a record of all attempts to

invite and include its representatives in the meetings, the attendees and the activities discussed during the Advisory Board meetings. The Board attendance roster and minutes are made available to ASES ten calendar days following the meeting date. The Advisory Board's participants shall actively contribute to the discussions; none shall dominate proceedings, in order to foster an inclusive and participative environment.

6.4 Performance Improvement Projects

The Performance Improvements Projects (PIPs) are consistent with the statutes of the Federal and State government, the regulations and the requirements of Quality Assessment and Performance Improvement Program pursuant to 42 CFR 438.330. The main purpose of the PIPs is to achieve a favorable and positive effect on health outcomes and satisfaction of the enrollee. The projects are designed to achieve, through measurements and continuous interventions, significant improvements in clinical care for the assessment of kidney health and identify the early stages of kidney disease, increase the detection of depression, anxiety and substance use disorders and improve outcomes for beneficiaries with diabetes and in administrative areas of EPSDT (Early and Periodic Screening, Diagnostic and Treatment) and the integration of Physical and Behavioral Health.

E. Steps for designing a program for the improvement of performance:

1) Select the need according to the current and desired situation with the purpose of achieving a measurable benefit to the member.
2) Set goals and objectives that are specific, measurable, achievable, results-oriented and time based for implementation SMART objectives).

3) Create quality indicators that allow the tracking of performance and improvements or select standardized indicators of performance such as HEDIS® and the Adult and Child Core Measures (ACCM).
4) Execute interventions designed to achieve the improvement in quality.
5) Evaluate the effectiveness of interventions.
6) Plan and initiate activities for increasing or sustaining improvement.
7) Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.
8) Collect and analyze appropriately, accurate and valid data that demonstrate the improvement in quality.

For more information about the protocols of the External Quality Review Organization (EQRO) you may access: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

6.5 Emergency Room Quality Initiative Program

MMM Multihealth designed an Emergency Rooms (ER) Quality Initiative Program to proactively identify high users of emergency services for non-emergency situations; it includes strategies which allow early interventions, in order to ensure appropriate utilization of services and resources.

The ER Quality Initiative Program includes the following components:

1) A system for tracking, monitoring, and reporting high users of ER services for non-emergency situations.

2) Criteria for defining non-emergency situations.
3) Educational components to inform the enrollees about the proper use of ER services and how to access ER services; to inform the Primary Care Physicians (PCPs) about identifying high users or potential high users of ER services and how to refer them to the program.
4) Protocols for the identification of high users of inappropriate ER services, for referring them to Care Management for needs assessments and possible identification of other more appropriate services and resources.
5) Quarterly Emergency Rooms Utilization Reports.
6) Process for assuring the provision of physical and behavioral health services in an appropriate setting upon identification of the need.
7) Processes to evaluate the ER Quality Initiative Program effectiveness, identify areas of opportunities, and modify the program, as needed, in order to improve service utilization.
8) Rapid cycle continuous improvement process that includes evaluating the effectiveness of interventions and their adjustment over the period of the initiative.

6.6 Health Care Improvement Program

The Health Care Improvement Program was developed to improve the quality of services provided to the enrollees of MMM Multihealth. This Quality Incentive Program is part of the Quality Assessment Performance Improvement ("QAPI") program. It includes:

1) Initiatives to educate providers regarding the program requirements.
2) Strategies to ensure and monitor compliance with the program.

MMM Multihealth shall submit data to ASES for standardized performance measures, within specified timelines and according to the established procedures, data collection and reporting, when requested.

The Health Care Improvement Program, as required by ASES, evaluates the following three (3) categories of performance indicators:

1) Chronic Conditions Initiative
2) Healthy People Initiative
3) Emergency Room High Utilizers Initiative

B. Below a brief description of each category and respective metrics:

Chronic Conditions Initiative	Focused on improving the health of beneficiaries with specific chronic conditions and reducing utilization associated with avoidable health complications.
	Medicaid/Federal, State and CHIP Population
	• Diabetes • Asthma
	Medicaid/Federal and State Population
	• Severe Heart Failure • Hypertension • Chronic Obstructive Disease (COPD) • Chronic Depression
Healthy Population Initiative	These focus on preventive medical care. They also include populations identified as having high-cost conditions and chronic conditions.
	Healthy Population

	• Breast Cancer Screening - (BCS) • Cervical Cancer Screening - (CCS) • Controlled Blood Pressure - (CBP) • Diabetes Screening in Patients with Schizophrenia or Bipolar Disorder Using Antipsychotics – (SSD) • Follow-up after Hospitalization for Mental Health Illness - (FUH)
	Access to Care and Other Use
	• Access to Preventive Care in Adults – (AAP) • Oral Evaluation of Dental Services – (OEV) • Prenatal and Postpartum Care – (PPC) • Preventive visit the first 30 months of life (W30) • Preventive Visit of Children and Adolescents (WCV)
Emergency Room Quality Initiative	Developed to reduce inappropriate use of emergency room services for non-emergency situations and enable early intervention to ensure appropriate use of resources and services.

6.7 Wellness Program

MMM Multihealth designed a Wellness Program to strengthen Preventive Services and to provide integrated Physical, Behavioral Health and Dental services to all participants while educating enrollees on health and wellness. These programs include strategies to promote educational efforts and disease prevention. It incorporates approaches to reach all enrollees including those living in remote areas. Educational activities are offered by duly licensed professionals, who are knowledgeable enough in the specific areas to be addressed.

Some of the practices that MMM Multihealth wants to encourage its members to perform as part of their health care and issues prevention includes:

1. Annual health checkup.
2. Women's health screening such as mammograms, pap smears and cervical screenings.
3. Colorectal cancer screening
4. Receive the COVID-19 vaccine and take other preventive measures:
5. Properly use of GHP services, including the GHP service line:
6. Annual dental exam.
7. Attend to the medical and developmental needs of children and adolescents.
8. Behavioral Health screening
9. Receive education and treatment on high-risk diagnoses including Depression; Schizophrenia; bipolar disorders; Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; Substance abuse; and anxiety disorders.

6.8 Provider and Enrollee Satisfaction Surveys

Satisfaction surveys are performed annually for Providers and Enrollees. The satisfaction surveys for Enrollees are the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Experience of Care and Health Outcomes (ECHO) survey instruments. As the satisfaction surveys for Enrollees, the Provider's satisfaction survey is performed by an independent entity, thus maintaining the required confidentiality. The results of the surveys are shared with ASES and are also available to the enrollees and providers, upon

request. Those results are used to monitor the service delivery and quality, and to develop quality strategies.

6.9 External Quality Review

In compliance with Federal requirements at 42 CFR 438.358, ASES will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the quality outcomes, timeliness of, and access to the covered services. MMM Multihealth has developed and established analytical activities to assess the quality of care and services provided to Enrollees, and to identify areas of opportunities. The EQRO shall also audit MMM Multihealth performance, Performance Improvement Projects (PIP's), and performance measure program against quality standards based on CMS criteria.

7. ADMINISTRATIVE AND CLINICAL FUNCTION

7.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

A. <u>Purpose</u>

To provide guidance to our contracted physicians on EPSDT service requirements and periodicity schedule in accordance with preventive health guidelines based on the American Academy of Pediatrics (AAP)/Bright Futures Standards of Care and the Department of Health Pediatric Service Guidelines 2021, and by contractual agreement between *Plan Vital* and MMM Multihealth. The scope also includes the provision for providers EPSDT education with service requirements, compliance, and surveillance of quality measures.

A. <u>Scope</u>

This policy applies to all MMM Multihealth Network Providers that provide routine care for Medicaid or CHIP eligible members 0 to the first month of the 21st year birthday of age.

B. Definitions

1. Bright Futures

Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally based approach to address children's health care needs in the context of family and the Department of Health of Puerto Rico have adapted the Bright Futures periodicity schedule to help guide health care providers for pediatric preventive care. (Please see attached schedule).

2. EPSDT **-** The EPSDT acronym stands for:

- **E**arly: identifying problems early, starting at birth
- **P**eriodic: checking children's health at periodic, age-appropriate intervals;
- **S**creening: providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems based on approved guidelines.
- **D**iagnosis: performing diagnostic tests to follow up when a risk is identified,
- **T**reatment: control, correct or reduce health problems found.

3. The EPSDT Program

Is the child health component of Medicaid designed to addresses physical, mental, and developmental health needs? EPSDT is a mandatory set of services and benefits for all individuals 0 to the first month of the 21st year birthday of age, who are enrolled

in Medicaid. All services must be directed to prevent, treat, or ameliorate physical, mental or developmental problems or conditions offered by certified providers, in sufficient amount, duration and scope on basis of medical necessity. EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow up. Its service includes screening, vision, hearing and dental services, as well as all other medically necessary mandatory and optional services listed in the *Plan Vital* contract requirements, to correct or ameliorate defects and physical and mental illness and condition identified in an EPSDT periodical screening.

C. <u>Responsibilities</u>

1. Health Services Department:

a) The Chief Medical Officer (CMO) is responsible for the medical activities of the medical directors and providers, while ensuring appropriate use of medical guidelines in the operations.

b) The Vice President of Clinical Operations (VP) is ultimately responsible for the Care Management process along with strategic corporate goals.

c) The Directors and Managers are responsible for the day-to-day operations and establishment of improvement plans as deemed appropriate.

d) The Manager and Supervisor are responsible for supervising the staff and ensuring proper execution of the policy and procedure.

e) The Care Management Staff is responsible for assisting Providers as detailed by the policy and procedure and maintaining case documentation available for audit processes.

2. Contracting & Provider Relations**:**

a) The President is ultimately responsible for overseeing the Contracting process.

b) The VP of Contracting Department is responsible for overseeing the Contracting processes.

c) The Contracting Provider Network Performance and Compliance Director are responsible for the day-to-day operations of the monitoring of Network adequacy.

d) The Contracting and Provider Relations Director is responsible for the day-to-day operations of the Contracting processes.

e) The AVP of Contracting is responsible for overseeing the Contracting processes of Specialists, Hospital and Ancillary Services.

f) The Contracting Representatives are responsible for negotiating contracts with Primary Care Providers, Specialist, Behavioral Health practitioners and organizational providers.

D. <u>Procedures</u>

1. Provider Contractual requirements

a) Primary Medical Group (PMG) and the Primary Care Physician (PCP) must implement process to ensure age-appropriate screening and care coordination when member needs are identified. Providers are encouraged to

utilize the *Plan Vital* approved standard screening tools and chats, and complete training in the use of those tools. The Managed Care Organization (MCO) will establish a monitoring process and implement interventions for those PMG and PCP that are not in compliance.

b) Health Care Provider responsibilities for EPSDT per CMS and ASES requirements are stipulated in the Network Providers and Medical Group contracts.

c) The Department of Health's Pediatric Preventive Services Guidelines 2018, along with required policy for follow-up for appointments and or missed appointments process are shared with PCP.

d) PCP providers must ensure that member receive required health screening in compliance with the schedule. The service intervals represent the minimum requirements, and any services determined by the PCP to be medically necessary must be provided, regardless of the interval.

e) Proper coding requirements to ensure accurate reporting are also provided.

f) Requirements are documented in this policy as reference for Medical Management and the Provider & Contracting department.

g) Contracts also stipulate that EPSDT services are provided without cost.

h) Each Municipality in Puerto Rico has a variety of free transportation services available to assist members in getting to their medical appointments for non-emergency services. The Provider office can assist members contacting the local Municipal office. If such service is unavailable, PCP may refer these

members to the Care Management Program for evaluation and coordination, as needed.

C. Following EPSDT and Department of Health Pediatric Preventive Services 2018 requirements, checkups and services must include**:**

a) A comprehensive health and developmental history, including assessment of both physical, and mental, emotional and behavioral development, including substance abuse disorders;

b) Measurements (height, weight, body mass index; including head circumference for infants);

c) Early detection, referral and treatment for mental and substance use using age-appropriate screening tools (MCHAT, ASQ, CRAFFT, PHQ-9 and other approved assessments);

d) An assessment of nutritional status to assist EPSDT members whose health status may improve with nutrition intervention that may include:

- Initial comprehensive nutritional evaluation as well as nutritional follow up and assistance up to complete 5 years old;
- Providing the required formulary and assessments necessary for initiation in the WIC Program to those children that requires special nutritional and supplement assistance;
- Nutritional assessments provided by a contracted registered dietician, when ordered by the PCP;

- These assessments should be done as part of the EPSDT screenings specified in the EPSDT Periodicity Schedule and on inter-periodic basis as determined necessary by the PCP.

e) A comprehensive unclothed physical exam;

f) Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices (ACIP). The vaccines themselves are provided and paid for by the Department of Health Immunization Program for the Medicaid and CHIP Eligible. The vaccine is provided and paid for by the Contractor for the Other Eligible Persons in *Plan Vital*. The MCO will cover the cost related to the vaccine administration, under the fee schedule established by ASES for EPSDT member until 18 years of age. The MCO will cover the cost related to the vaccine and the vaccine administration to all EPSDT members 0 to the first month of the 21st year birthday of age.

g) Laboratory tests; provider must ensure that members receive required health screening in compliance with schedule. The service intervals represent minimum requirements, and any services determined by PCP to be medically necessary must be provided regardless of interval.

h) Lead screening for the detection of the presence of lead toxicity. The screening shall consist of two (2) components: verbal risk assessment and lead blood screening. The verbal risk assessment must be completed at each EPSDT visit done at nine (9) months of age and at ages one (1), two (2), three (3), four (4), five (5) and seven (7) years of age. Regardless of risk, the PCP shall order blood

lead screening test for all EPSDT-Eligible children at ages twelve (12) and twenty-four (24) months of age. If at the age 6 years there is no record of a previous blood test, a blood test should be ordered.

i) PMG and PCP must implement protocols for: care coordination for members with elevated blood lead levels to ensure timely follow-up and retesting and coordination and transitioning of a child who has an elevated blood level to another specialist provider, as necessary.

j) Health education is a required component of screening services and includes anticipatory guidance. Health education and counseling to parents/guardians as well as children are required and designed to assist in understanding what to expect in terms of the child's development, and to provide information about the benefits of healthy lifestyles, practices, and accident and disease prevention in the following topics:

- Breast feeding
- Car seat safety
- Smoke free environment
- Accidents and injury prevention
- UV protection
- Physical activity
- Health diet
- Prevention of STDs and HIV
- Clinical oral exam

- Tooth cavity risk assessment
- Dental radiographic assessment
- Prophylaxis and topical fluoride
- Fluoride supplementation

k) Periodical vision screening with diagnosis and treatment services for visual defects, including eyeglasses;

l) Tuberculosis testing as applicable;

m) Periodic hearing screening including diagnosis and treatment services including devices for communication augmentation and cochlear implants;

n) Appropriate oral health screening, as soon as the eruption of the first tooth and no later than twelve (12) months, intended to maintain oral health and to identify oral pathology, including tooth decay and/or oral lesions, conducted by the primary care physician and dental specialists. Services will also include fluoride banish, dental emergency services for pain relief, infection treatment and tooth restoration. Providers must comply with the Preventive Dental Periodicity Schedule. Other dental services may be covered in accordance to the plan's benefit and medical necessity.

o) Family Planning Services will be provided to sexually active adolescents on childbearing age. Those services include orientation and education on pregnancy and sexually transmitted diseases prevention. Access to contraception methods is available under the Family Planning Program established in all regions.

p) Other services – Case management service is available through the Plan's Case Management Program where all children with special needs undergo a special registration according to the identified medical diagnosis. The registry will provide access to necessary care, without the need of a PCP referral from specialized providers, clinics, surgical and medical procedure, laboratories, and all necessary tests as well as medication.

q) Medical supplies, including diabetes test strips, when medically necessary, for children 0 to the first month of the 21st year birthday of age.

r) Organ transplants are not under the current benefits for enrollees under *Plan Vital* except for corneal, bone and skin transplant. When such services are necessary, coordination with the Department of Health is done by the Plan's Care Management team to access them through the Catastrophic Funds. Those Catastrophic Funds are identified to cover services not currently under the scope of benefits of *Plan Vital* but that could be clinically necessary, such as organ transplants, services out of Puerto Rico including United States territory, medical equipment such as adapted car seats and nutritional supplements to complementary dietary restrictions for special conditions.

s) EPSDT allows coverage for items or services which are medically necessary and are not otherwise covered by Medicaid. EPSDT Special Services may be preventive, diagnostic, treatment, or rehabilitative.

t) Physicians should provide these services in a culturally and linguistically competent manner, taking into account cultural beliefs and/or language barriers or limitations, and ethnically diverse groups.

E. Provider Outreach and Education Regarding EPSDT

1. Providers will be oriented on the following*:*

a) EPSDT Policies and Procedures;

b) The periodicity schedule and the depth and breadth of services;

c) EPSDT benefits, preventive and evidence base practices and services guidelines;

d) The importance of comprehensive preventive health and developmental history care visits that will include medical history, physical exam, developmental measurements, preventive laboratories, autism, and depression screening and tracking system to ensure compliance.

e) New enrollee under CHIP eligible children should be seen within the first 90 days in the ambulatory setting and within the first 24 hours in the hospital setting;

f) EPSDT member identification, outreach and tracking activities;

g) Quality, measures and understanding and tracking HEDIS applicable parameters;

h) That services are provided without cost, including referrals to WIC, Early Health Start and other Department of Health's Early Interventions Programs;

i) Non-emergency transportation to promote access to needed preventive, diagnosis and treatment services is coordinated, if needed.

2. Providers in the Plan are notified of the EPSDT program through the following strategies:
    a) New Provider Kit for newly contracted providers with information regarding how the EPSDT Program works with the members.
    b) *Plan Vital* Provider Guideline
    c) *Plan Vital* Provider Website
    d) Medical Office Notes
    e) Provider outreach visits by Provider Network Account Executives
    f) Monthly report of children who are due for health screens and or immunizations.
3. The Provider Network Account Executive will conduct orientation sessions for EPSDT providers and offer ongoing support regarding the administration of EPSDT preventive care, billing and claims processes for EPSDT, the required components of a complete EPSDT screening, and the importance of outreach and education to EPSDT eligible members and their families.

G. Appointment Scheduling and Tracking

1. Utilizing their current appointment system, Providers are responsible for providing timely access to EPSDT services. Monthly reports to Providers will supplement the efforts in identifying members needing care and requiring appointments.

2. Missed appointments must be tracked for rescheduling to ensure periodicity schedules are met.
3. Particular priority should be given for initial health and screening visits for newly enrolled CHIP Eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns within the Hospital Setting.

H. Provider Compliance

1. Provider compliance will be monitored through:
    a) PCP reports on members needing or past due for EPSDT Services;
    b) Random EPSDT Claims Audits
    c) Medical records audits
    d) CMS-416 report requirements
2. These EPSDT elements are part of the physician incentive program.

7.2 Prenatal Program

A. Prenatal Program Purpose and Scope

Our Prenatal Program has been developed to address overarching Maternal & Child Health concerns. The Prenatal Program will address a wide range of conditions, risk factors, health behaviors, and health system determinants that can affect the health, wellness, and quality of life of women and their children. Although slight progress has been achieved, Puerto Rico's rate of premature births continues to be unacceptably high. Low birth weight and elevated elective cesarean sections are also of concern. The main goal is to emphasize prevention, continuity of care, and coordination of care at all times in their path to health or recovery.

Program standards were developed according to ASES contractual requirements, American College of Obstetricians and Gynecologists (ACOG) guidelines for pre and postnatal care, as well as other national guidelines for obstetrics practice for Medicaid enrollees.

B. Program Enrollment

Per ASES Contractual requirements, all pregnant women will be included in Special Obstetrical (OB) Coverage. The PCP or OB/Gyn may refer an eligible enrollee by utilizing the appropriate electronic tools applying the OB Special Coverage criteria. Received referrals will be routed to the clinical management software platform for review:

1. Cases can also be identified when an enrollee is required to obtain a preauthorization for a specific set of clinical services, prescription drugs or procedures as requested by the PCP or Specialist.
2. Upon receipt of referral, Case Management Nurses are alerted that a new case is ready for review.
3. Case Management nurses assigned to the Special OB Coverage Program will conduct an eligibility criterion review to confirm if the meets the clinical criteria for admission to the program.
4. In the event that the referral does not meet with any of the required criteria, a denial letter will be sent to the enrollee and to the PCP indicating reasons for denial.
5. If the referral meets all criteria, the enrollee will be registered in the program within 72 hours. Approval letters will be sent to the Provider and Enrollee for appropriate notification.

6. Coverage will be provided retroactively to the Estimated Date of Conception, as determined by the Physician.
7. Enrollee eligibility will be extended if eligibility review period falls within the 2nd or 3rd trimesters.
8. Registered enrollees will be referred to the Prenatal Wellness & Care Management Program for interventions based on initial stratification, such as age, medical history documented by the Ob/Gyn and current status of the disease or conditions.
9. Any pregnant *Plan Vital* enrollee who visits the Ob/Gyn for prenatal care should begin receiving care as quickly as possible, preferably the same day.
10. The pregnant enrollee must be referred to the Special OB Coverage if not currently included.
11. One hundred percent (100%) of enrollees included in the Special OB Coverage will be provided with an educational packet on the importance of pre and post-natal care as well as EPSDT requirements for their child.

C. <u>Prenatal and Postpartum Services</u>

All enrollees enrolled in the Special OB Coverage are guaranteed access to contracted Ob/Gyms for their pre and postnatal healthcare services. Physicians who specialize in Obstetrics and Gynecology shall provide comprehensive prenatal care services in accordance with generally accepted standards of professional practices, as outlined by the AAP and ACOG.

Prenatal diagnostic and treatment services shall include but not be limited to the following:

1. Comprehensive assessment - An initial comprehensive assessment including history, review of systems, and physical examination.
2. Standard and special laboratory tests - Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.

Pregnant women with medical, obstetrical or psychosocial problems may require more frequent visits or a referral to specialized perinatal services. This need is best determined by the prenatal care provider considering the individual needs of the woman, nature and severity of her problems, and her care and treatment plan. Of particular importance are pregnant women that meet criteria for 17-P, to help reduce her probabilities of having a repeat preterm delivery gestation.

Given the correlation between poor oral health and pregnancy outcomes, the OB/Gym shall assess the woman's oral healthcare needs during the first prenatal care visit. Pregnant women identified as having a current oral health problem should be referred to a dentist as soon as possible. Pregnant women should have a dental visit during the second trimester. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy.

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule between the 21st and the 56th day after delivery, (approximately 4 – 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7 - 14 days of delivery). The visit should include an interval

history and a physical examination to evaluate the enrollee's status and how she is adapted to the newborn.

The visit shall include, but not be limited to the following:

1. Pregnancy testing
2. A pre-natal care card, used to document services utilized
3. Medical services, during pregnancy and post-partum
4. HIV testing and Counseling during the 1st and 3rd trimesters
5. Dental evaluation during the second trimester of gestation.
6. A RhoGAM injection for all pregnant women who have a negative RH factor according to the established protocol.
7. Alcohol screening of pregnant women with the 4P-Plus instrument
8. Smoking cessation counseling and treatment
9. Physician and nurse obstetrical services during vaginal and caesarean section deliveries and services to address any complication that arises during the delivery.
10. Treatment of conditions attributable to the pregnancy or delivery, when medically recommended.
11. Hospitalization for a period of at least forty-eight (48) hours in cases of vaginal delivery, and at least ninety-six hours (96) in cases of caesarean section.
12. Anesthesia, excluding epidural
13. Incubator use, without limitations
14. Fetal monitoring services, during hospitalization only

15. Nursery room routine care for newborns
16. Circumcision and dilatation services for newborns
17. Transportation of newborns to tertiary facilities when necessary
18. Pediatrician assistance during delivery
19. Delivery services provided in free-standing birth centers, if available
20. Post-partum depression screening using the Edinburgh post-natal depression scale.
21. Post-partum counseling and referral to the WIC program
22. Voluntary and confidential reproductive health and family planning counseling, including circumstances where the Enrollee is under the age of eighteen (18).
23. Family planning services will provide education and counseling to assist women to make informed choices and understand contraceptive methods.
24. Enrollees seeking prescribed family planning services should be advised on the methods available through the Puerto Rico Health Department.

D. <u>Prenatal Wellness & Care Management Program</u>

The Prenatal Wellness & Care Management Program will provide an array of strategies and interventions for pregnant *Plan Vital* enrollees.

Dedicated team approaches may include telephonic coaching, face to face counseling, educational workshops, and peer support groups.

Population Health strategies will be applied in enrollee communications to advise on topics such as:

1. The importance of prenatal and post-partum care,
2. Breastfeeding,
3. Stages of childbirth,
4. Oral health,
5. Family planning,
6. Newborn care,
7. Behavioral health topics such as:
    a) domestic violence,
    b) post-partum depression,
    c) tobacco cessation,
    d) alcohol use/abstinence and substance abuse,
    e) parenting,
    f) HIV screening and prevention,
    g) Socio-emotional screening in children, among others.

Field-based teams will provide opportunities to participate in pre and postnatal wellness sessions within collaborating agencies, physician offices or other community settings.

All enrollees included in the Special OB Coverage will receive an educational packet on the importance of pre and post-natal care as well as EPSDT requirements for their child.

High risk enrollees will be offered the Prenatal Care Management program to address their particular health and wellness needs and concerns and help improve pregnancy outcomes. A dedicated team of telephonic Prenatal Care nurses will conduct a standardized comprehensive prenatal care assessment for both maternal and fetal risks, at the earliest

point of pregnancy for enrollees enrolled in the Prenatal Care Management Program. Risk assessment includes, but is not limited to:

1. Analysis of individual characteristics affecting a pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors.
2. Pregnant enrollees receiving 17P will be provided with intensive prenatal care management follow-up to assist in coordinating their services, educating on the risks associated to preterm delivery, as well as to promote compliance with treatment.

Identification of behavioral health risks is an integral part of the assessment and as such will be administered to all enrollees in the Prenatal Care Management Program. Assessments will include:

1) 4P Plus
2) Edinburgh

Completed assessments will be used to develop the enrollees' comprehensive individual care plan. Individual care plans will be jointly developed with enrollees, addressing the problems identified as a result of the initial and ongoing risk assessments.

Women identified with behavioral health concerns will be referred for to MMM Multihealth Mental Health Services to coordinate services. Referrals will be tracked for reporting as contractually required.

Prenatal Program participants will be offered counseling about the risks of smoking during pregnancy. Those that report that they are active smokers will be offered telephonic coaching about smoking cessation or will be referred to the Smoking Cessation Line *(¡Déjalo Ya!)* of the

Puerto Rico Department of Health. Participants that require more intensive counseling will be referred to the Behavioral Health Services Department.

Based on enrollee risk and care plan, prenatal care nurses shall provide pre and postnatal education based on an assessment of the pregnant woman's individual needs. Prenatal care nurses will focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and linguistic needs of the enrollee as well as her gestational history. The plan will be routinely updated with the pregnant woman, her family and the appropriate enrollees of the healthcare team, as needed.

E. Program Monitoring

As contractually required, MMM Multihealth will submit Quarterly Reports to ASES indicating:

1. Number of pregnant women enrolled in *Plan Vital* by trimester and age
2. Number of pregnant women enrolled in *Plan Vital* by trimester and age who received HIV tests.
3. Number of pregnant women screened for substance abuse with the 4P Plus screening tool; as well as the number of cases referred to behavioral health providers for smoking cessation counseling and treatment.
4. Number of pregnant women in postpartum care screened for depression with the Edinburgh screening tool; as well as the number of cases referred to the behavioral health provider with an Edinburgh score of 10 or above.
5. Number of pregnant women who received educational interventions.

MMM Multihealth will collaborate with Primary Medical Groups and Ob/Gyns to develop effective outreach interventions to serve pregnant women and women in reproductive age. Through population health strategies, telephonic case management and access to pre and post-natal care services through the contracted network, an ample array of interventions will be implemented to help meet contractual outreach requirements. Strategies may include:

1. Educational materials
2. Workshops and Educational Sessions
3. Presentations at the Primary Care Setting
4. Collaborations with state agencies such as WIC and Early Head Start, and other private or public community-based organizations.
5. Message Campaigns within the infrastructure of the *Plan Vital* Service Line or the Triage Line

7.3 Wellness Program

The Wellness Program is developed in order to advance the goals of strengthening Preventive Services, providing integrated physical and behavioral health to all enrollees on health and wellness. Following the contract between *Administración de Seguros de Salud de Puerto Rico (ASES)* and MMM Multihealth, LLC.

The Wellness Program must reach 85% of the government health plan enrollees. A key element for the success of the wellness initiatives is the establishment of a multidisciplinary team. This team provides targeted interventions based on population needs (children, adolescents, adults, and older adults). The interventions have been designed to support and promote the integration

of physical and behavioral health in a variety of settings and outreach events. These outreach initiatives were offered using diverse educational strategies, such as:

1. Group interventions
2. Workshops
3. Health fairs
4. Health clinics
5. Population health campaigns or events
6. Social Media, traditional media outlets

An important part of these interventions is to work in collaboration with government agencies in order to maximize our mutual efforts effort and to support each other for the benefit of the members in the Region. This collaboration will be focused on the establishments of intervention strategies that would support the integration of the mental and physical health. Specifically, the wellness program will coordinate join efforts with the following agencies:

1. Puerto Rico Health Department
2. Auxiliary Secretariat for Health Promotion
3. Family Services Department
4. Puerto Rico Department of Education
5. ASES
6. *Programa de Asistencia Médica* (Medicaid)
7. Municipalities
8. Community Based Organizations

The Wellness Program uses the following process in diverse scenarios to foster collaborations that would benefit different population groups with a variety of topics and interventions:

Topic	Population Group	Government Agency Collaboration	Scenarios
Annual health checkup (including EPSDT for childcare) • Preventive screening and care • Developmental screening • Risk assessments (physical and behavioral health) • Immunization	• Children • Adolescents	• PR Department of Health • Department of the Family • Department of Education • Non-Profit organizations such as: American Heart Association	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community – based and faith-based organizations
Appropriate use of services* • Emergency Room • Nurse helping line • Importance of visiting the Primary care Physician • Service lines *Among others	• Adult	• PR Department of Health • Department of the Family • ASSMCA	• Medical Provider Offices (Co-location Facility) • Government agencies (Medicaid office, WIC, etc.) • Community-based and faith-based organizations
*Physical Health: • Asthma • Diabetes • Hypertension	• Adult • Adolescents • Children	• PR Department of Health • Department of the Family • Department of Education	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start,

Topic	Population Group	Government Agency Collaboration	Scenarios
• Non-intentional injuries • Flu • Dengue • COVID-19 *Among others		• Non-Profit organizations such as: American Heart Association	Medicaid office, etc.) • Community-based and faith-based organizations
Women's health (mammograms, pap smears, cervical screenings)	• Women	• PR Department of Health • Department of the Family • Non-Profit Organizations (Ex. Susan G. Komen, American Heart Association)	• Medical Provider Offices (Co-location Facility) • Government agencies (Medicaid office, WIC, etc.) • Community-based and faith-based organizations
Sexually Transmitted Diseases	• Adults • Adolescents	• PR Department of Health • Department of the Family • Department of Education • WIC • Colleges and Universities	• Medical Provider Offices • Government agencies (School, Medicaid office, etc.) • Co-location Facility • Community-based and faith-based organizations
Weight management, nutrition and physical activity	• Adults • Adolescents • Children	• PR Department of Health • Department of the Family • Department of Education • Department of Sports and Recreations	• Medical Provider Offices • Government agencies (School, Head Start, Medicaid office, etc.) • Co-location Facility

Topic	Population Group	Government Agency Collaboration	Scenarios
			• Community-based and faith-based organizations
Reproductive health and family planning	• Adults • Adolescents	• PR Department of Health • Department of the Family • Department of Education • Colleges and Universities	• Medical Provider Offices (Co-location Facility) • Government agencies • (School, Medicaid office, WIC, etc.) • Community-based and faith-based organizations
Annual dental exam	• Adults • Adolescents • Children	• PR Department of Health • Department of the Family • Department of Education	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community-based and faith-based organizations
Behavioral Health • Stress Management • Self-esteem • Bullying	• Adults • Adolescents • Children	• PR Department of Health • Department of the Family • Department of Education • ASSMCA	• Medical Provider Offices (Co-location Facility) • Government agencies (School, Head Start, Medicaid office, etc.) • Community-based and faith-based organizations
Behavioral Health (specific and high-risk diagnoses)	• Adults • Adolescents	• PR Department of Health • Department of the Family	• Medical Provider Offices (Co-location Facilities)

Topic	Population Group	Government Agency Collaboration	Scenarios
• Depression • Bipolar disorders • Schizophrenia • Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder • Anxiety disorders • Substance Abuse • Autism		• Department of Education • ASSMCA • Non Profit Organizations ; *La Alianza de Autismo de PR*	• Reverse Co-location Facility • Community-based and faith-based organizations

A. <u>Emergency Room Program</u>

The Emergency Room Program is designed to identify high users of Emergency Services (including behavioral health) for non-emergency situations and to allow for early interventions in order to ensure appropriate utilization of services and resources. The program offered detailed activities and interventions such as:

1. Educational campaign to educate beneficiaries about healthcare options available to then when primary care physician isn't available.
2. One on One care management interventions
3. Primary care physician (PCP) interventions on identifying high users or potential high users of ER services.

The Emergency Room Program is aimed at decreasing of the Emergency Room (ER) visit rate.

7.4 Care Management Program

A. <u>Evaluation Process</u>

1. Purpose

The insurance counts on a full staff of nurses and other professionals capable to provide the support through our Management Programs to all the beneficiaries registered under the Special Coverage. These programs are made to also provide support to the beneficiary that receives clinical care. Talk to your beneficiaries, in regards the Special Coverage and invite them to participate and register. These programs are designed with a holistic focus, which helps the beneficiary to take control of their condition, in order to accomplish their health goals.

2. Goals

The Case Management Program goals are the following:

a) To provide support and education to the identified beneficiaries with chronic and complex conditions.

b) Program is developed with a holistic focus addressed to promote health changes on habits and lifestyle.

c) Made as an alliance for the care coordination, when necessary.

d) Integrates tools for the physical and mental health screening as part of the standard, in order to define the care plan.

e) Developed an individualized care plan for each participant.

3. Scope

The Case Management Program provides multiples alternatives for the care management for the identified beneficiaries as high risk. An assigned Case Manager will make interventions based on the individualized Care Plan.

Our philosophy on Care Management is the focus under a Multidisciplinary level with the collaboration of Professional Nurses, Social Workers, and Psychologist, in order to optimize the beneficiary participation under the program.

7.5 Special Coverage Protocol

A. Goals

Plan Vital determines that all beneficiary, who had been diagnosed with any of the fifteen (24) conditions stablished by ASES, has the right to request Special Coverage Registration. The Special Coverage offers the registered beneficiary major access to the required services to manage their condition, in order to have a clinical control and a better quality of life. It's important to advise them of the application process and their details, in regards the Special Coverage Registration. Should you like more detailed information, please referred to Normative Letter 15-1112.

B. Identification of Eligible Beneficiaries

The process to register a beneficiary under the Special Coverage Registration is simple, only if you complete the Special Coverage Registration Form (attached), breakdown and meet the determined clinical criteria for each condition and should include the required supporting documentation. The application for registration can be send by a Specialist Provider or by a Primary Care Physician (PCP). On HIV cases, the registration form can also be sent by the Case Manager from the Immunology Center that the beneficiary attends too.

Once the insurance receives the Special Coverage Form fully completed with proper documentation, it would provide approval or denial determination at the Registry, and

additional information will be requested. The insurance will maintain telephonic communication with the beneficiary and to keep them informed, in regards the application status. The insurance will also notify the Provider that requested special coverage, in regards the final case determination. As soon the case is approved, the beneficiary will receive a Special Coverage Certification Letter. This document will include information related on the effectivity of the Special Coverage and the services which has access. In case that the enrollment at the Registry was requested by a Specialist, the insurance will notify the beneficiary's Primary Care Physician by phone and also by sending a letter about the application's final determination. The Insurer must make a final determination about the subscription to the Special Coverage Registry within a period of 72 hours.

For your knowledge, the time is considered from the moment is received the documentation required for each condition defined on the Special Coverage Table.

Once the provider sends the required information, the case will be reviewed and approved; the Special Coverage will have a retroactive effective date, to the date that the Specialist had stablished with the diagnostic or the pathology date.

C. Plan of Individual care and treatment

Within program of management of care, health professional, specialized nurses develop a plan of care individualized for each beneficiary participant. This professional Team, integrated tools of tanning and of physical and mental health, as part of the criteria for defining the individualized care plan.

D. Conditions which registered under the Special Coverage

The conditions that are registered under the Special Coverage are defined on the Attachment 7 of the MCO & ASES contract. These conditions are:

1. Aplastic Anemia
2. Albinism
3. Rheumatoid Arthritis
4. Autism – Temporary& Permanent
5. Cancer
6. Congenital Hearing Screening
7. Chronic Renal Disease (Stage 3-5)
8. Scleroderma
9. Multiple Sclerosis and Amyotrophic Lateral Sclerosis
10. Cystic Fibrosis
11. Hemophilia
12. Leprosy
13. Systemic Lupus Erythematous
14. Children with special health conditions (Please note that on some cases diagnoses are considered as temporary conditions, including:
    1. Cleft Palate and Cleft Lip
15. PKU – Phenylketonuria – (Adults)
16. PKU – Phenylketonuria – (Children)
17. HIV/ AIDS
18. Pulmonar Hypertension

19. CHF- Stage III-Stage IV

20. Post- Transplant

21. Tuberculosis

22. End Stage Renal Disease (ESRD)

23. Hepatitis C

24. PCD – Primary Ciliary Dyskinesia

25. Inflammatory Bowel Disease (EII):

25.4.4.2 Crohn's Disease

25.4.4.3 Ulcerative Colitis

25.5 Indeterminate Colitis

26. Obstetrics

26.4.4 **The effective period of the Registry**

ASES defines the Special Coverage conditions as **Persistent** or **Temporary** Conditions. These definitions and conditions are the ones that determines the effective time of the Special Coverage.

1. Persistent Conditions

These are complex conditions which are expected that the beneficiary keeps registered while continue been eligible under *Plan Vital*. This means that the Certification that the beneficiary receives will have a registration initial date; however, it will not have a termination date. The conditions defined as persistent are the following:

a) Aplastic Anemia

b) Albinism

c) Rheumatoid Arthritis

d) Autism

e) Tuberculosis (Tb)

f) Chronic Kidney Disease (Stage 3-5)

g) Scleroderma

h) Multiple Sclerosis & Amyotrophic Lateral Sclerosis

i) Cystic Fibrosis

j) Hemophilia

k) Leprosy

l) Systemic Lupus Erythematosus

m) Phenylketonuria – PKU - Adult

n) Phenylketonuria – PKU - Children

o) Children with special health conditions (Please note that on some cases diagnoses are considered as temporary conditions).

p) HIV/AIDS

q) Pulmonary Hypertension

r) PCD – Primary Ciliary Dyskinesia

2. <u>Temporary Conditions</u>

These conditions are different than the persistent, which has a defined period. This period is defined based on a treatment plan which the specialist generates for the beneficiary due to the condition. If beneficiary requires an additional period to complete their treatment; you or the Specialist will need to send the required documentation prior

the Registry expiration date, to inquire a coverage extension period. These conditions defined as temporary are the following:

1. Cancer
2. Some conditions associated with children with health care necessities.
    a. Cleft Palate and Cleft Lip
    b. Congenital Hearing Loss
3. CHF – Stage III & IV
4. Congenital Hearing Screening
5. Hepatitis C
6. Obstetrician

Some of the services that require pre-authorization, even though if beneficiary is under a Special Coverage are the following:

1. Computerized Tomography (CT scan)
2. Magnetic Resonance Imaging (MRI)
3. Cardiac Catheterizations
4. Lithotripsy
5. Electromyography
6. SPECT
7. Orthopantomography
8. Other neurological, cerebrovascular, and cardiovascular procedures (Invasive & Non-Invasive)
9. Nuclear Imaging

10. Diagnostic Endoscopy
11. Genetic Studies
12. Pathologic and clinical laboratories Test that needs to be process outside of Puerto Rico

26.4.5 Special Coverage - Obstetric Registry

To enroll a beneficiary on the Obstetric Registry, the provider will need to complete the Registry OB Form (attached on this statement). This form can be completed and send by the Primary Care Physician (PCP) or by the Obstetric Gynecologist. As part of the enrollment process, each application should have the OB form and positive pregnancy evidence (laboratory result or sonogram).

As soon as the case is registered, the beneficiary will receive by mail a Certification of the Obstetric Registry. This document will include the effective coverage date and a description of the services that will have access.

7.6. Complex Management Program

A. Intervention Process:

The Complex Management Program has a staff of nurses and other health care professionals, in order to provide the support for all the beneficiaries that are identified with chronic conditions and are eligible to participate on the Program. These are the following conditions:

a. Asthma
b. Diabetes Mellitus type 1 & 2
c. Congestive Heart Failure (CHF)
d. Hypertension

e. Morbid Obesity

f. Chronic Renal Disease 1& 2

Beneficiaries are categorized on three (3) sub-stratification levels using algorithms that are incorporated by the Individualized General Assessment and available medical documentation.

The Stratification levels represents the severity of the beneficiary's condition, a scale is used indicating (1) Low, (2) Medium, (3) High, and (4) Severe, it measures the intensity of the interactions in each beneficiary; these can also include phone call, educative material provided, etc.

B. Mental Health Integration

As part of the Process, every beneficiary enrolled on the Program, a PHQ-9 estimate (tool that helps identified symptoms related to Depression) will be completed. If a result indicates Depression symptoms, beneficiary will be referred to the Mental Health Department for proper assessment.

Recommendation is provided to the beneficiaries to inform the Primary Care Physicians, related to their health condition and treatment. The Complex Management Program is the link between the beneficiary and the physician, in order to promote the adherence on the treatment plan. The Program promotes the following:

1. <u>Plan of Individual Care and Treatment</u>

Within program of management of care, health professional, specialized nurses develop a plan of care individualized for each beneficiary participant. This professional Team,

integrated tools of training and of physical and mental health, as part of the criteria for defining the individualized care plan.

2. Monitoring

    a) Beneficiary Auto management, in regards his condition.

    b) Preventive Health

3. Management

    a) Comorbidities

    b) Education regarding healthy lifestyles

    c) Education regarding Medication Adherence

    d) Mental Health Referrals, if necessary

C. Definitions

1. Eligible Beneficiaries: Beneficiaries identified that have the criteria to participate on the Program.
2. Voluntary Process: Is a process which the beneficiary decides to enroll on the Disease Management Program.
3. Refuse**:** Process that the beneficiary refuses to participate on the Complex Management Program.
4. Care Management: A health care professional evaluates, plans, and coordinate the necessary services to satisfy the beneficiary's necessities.

7.7 Clinical Guidelines:

Within our Care Management Program, we adopt and utilize practical clinical guidelines, nationally approved (**Milliman Care Guidelines** and **Sanford Guidelines**). These guidelines are of

support for Physicians and Case Managers, as part of the evaluation and determination of a case, in those cases that are required.

7.8 Organizational Structure

The professional personnel of the Care Management Program are made up by doctors, nurses, social workers, nutritionist, and health educators among others. Administrative official's beneficiaries support all functions.

A. Roles and Responsibilities

1. Medical Directors: Supervises development of clinical guides, resolution of clinical problems and implementation of doctor's education related to the Program.
2. Social Worker: helps with the implementation of referral at social level as well home evaluation as necessary.
3. Nutritionist**:** Evaluated nutritional needs and creates individualized nutritional plans for the beneficiaries.
4. Health Educator**:** Develops, implement and evaluated participant's educational activities and identifies resources and community organizations regarding comorbid such as diabetes, CHF, Cardiovascular disorders, etc.
5. Care Manager: Evaluates, facilitates, plans and advocates for health needs individually, including identification and management solutions providing alternative care, coordination of resources and beneficiaries referrals.
6. Respiratory Therapists**:** Evaluates the needs and create the care plans for those beneficiaries with chronic conditions, for example: Asthma, COPD, etc.

7. Data Analyst**:** Monitors and identifies possible candidates through data. Supervises and evaluated results from program activities and determines results. Helps out with the production of reports and evaluated claims data.

8. Outcomes Measures**:** Care Management Programs uses indicators to determine the success of the beneficiaries and professional interventions. Through a yearly revision process, the points of reference are identified, and goals of the following year are established.

    - The indicators are measured against objectives in an annual base
    - Program indicators include cost and quality.

9. For more information, please contact the Provider Services Line at:

787-993-2317 (Metro Area) or 1-866-676-6060 (free of charge);

Monday through Friday from 7:00 a.m. until 7:00 p.m.

Also, you may contact us by email to the following:

CareManagementPSG@mmmhc.com

B. Health Support Program

The Following Table represents additional Care Management Support Programs:

Health Support Program	General Description
Smoking Cessation Program	Designed to help beneficiaries who wish to stop using snuff product to prevent relapse.

Making Contact	Medical advice line, available, 24 hours a day, 7 days a week, 365 days a year.
Wound Care	Helps to improve healings rates of chronic wounds, reduce amputations and disability, thus greatly improving the quality of life of those it serves.

7.9 Wound Care Program

As part of our commitment to continue to improve the services of the beneficiaries of *PlanVital*, we count with a team dedicated to support the process of pre-authorization and coordination of those services.

1. We promote the best practices in skin care in order to optimize the healing prognosis of the patient and compliance with the treatment.
2. Helps to increase the quality of life of the beneficiary.
3. Reduces the prospecting of amputations and impairment.
4. Decreases hospital admissions and the use of emergency rooms.

Within our Wound Care Program, we adopt and utilize practical clinical guidelines, nationally approved (**Milliman Care Guidelines** and **Sandford**). These guidelines support Physicians and Case Managers, as part of the evaluation and determination of a case, if required.

All requests of pre-authorizations must be sent via fax: 787 300-5519. If you require more information, you may call Provider Services department: 787 993-2317 (Metro) 1-866-676-6060

(toll free) Monday-Friday from 7:00 a.m. - 7:00 p.m. You may also reach us via e-mail: CareManagementpsg@mmmhc.com, and deliver images as part of any required evidence to: PAU-PSG-Wound-Care-Photo@mmmmhc.com.

8. CODING AND CLINICAL DOCUMENTATION

8.1Clinical documentation and coding practice

The following information includes key documentation and medical coding guides to help our providers; however, the coding and documentation requirements are not limited to the content of this document. Each provider is responsible for reviewing contractual agreements, applying official guidelines and resources to their daily medical practice and being updated on current changes.

8.2 General concepts in clinical documentation

"If it is not documented, it did not happen" is a principle in the field of medical care (CMS, 2015). Medical documentation is a key instrument used in the planning, evaluation, and coordination of patient care both in the hospital and outpatient settings. The contents of the medical record are essential for patient care, accreditation and for reimbursement purposes. Each encounter should detail the information relevant to patient care, documentation of the performance of billable services and should serve as a legal document that describes a course of treatment. Periodic audits, whether internal or external, ensure that the record adequately serves these purposes and complies with federal and state regulations (Grider, 2011). Regardless of the format, electronic (EHR) or manuscript, everything documented in the patient's file must be readable to another reader, reliable, accurate, complete, consistent, clear and timely (Hess, 2015).

A. <u>Please consider the following key points (First Coast, 2006)</u>

1. The plan expects documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable period of time (24-48 hrs.) are acceptable for the purpose of clarification, correction of errors, an addition of initially unavailable information and, if certain unusual circumstances prevent the generation of the note at the time from service. Late entries must comply with the guidelines in the addendum:
    a. The date the registry is modified.
    b. The details of the modified information.
    c. A statement that the entry is an attachment to the medical record (an attachment should not be added to the medical record without identifying it as such).
    d. The date of the service modification.
    e. Legible name and signature of the provider writing the addendum.
2. The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can make an inference about their origin. These corrections or additions must be dated, preferably timed, and be initiated or signed legibly.
3. The notes must include the patient's name and the date of service on each page. The name, credentials, license number and signature of the provider must also be present.
4. Each encounter (note) must be independent, that is, the services performed must be documented from the beginning. Late written explanations will be considered (see

the guides in the appendix above). These only serve to clarify and cannot be used to add and authenticate billed and undocumented services at the time of service or to retroactively justify medical necessity. For that, the medical file must be kept with the original entry that confirms that the service was provided and was medically necessary.

5. Do not use codes in clinical documents; write the diagnosis and service in medical terminology (words) and standard abbreviations instead. Check and call your EHR operator if the program does not describe the diagnosis or procedure in a complete and acceptable format.
6. Common in EHR; Do not copy and paste medical information from encounter to encounter. Patient care must be verified individually to ensure accuracy, avoiding medical errors and excessive payments.
7. Documentation should clearly describe any other information required by the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology Codes (CPT), Coding System for Common Care Procedures (HCPCS), or International Classification of Diseases Codes (ICD-10).

B. **Follow these additional guidelines for notes written by editors (office staff) or dictated:**

1. The name, signature, dictation, and date / time of the writer must be present in the note.
2. The provider must review what is documented by the person who writes and make a statement that indicates whether they agree with the documentation.

C. Follow these additional guides for medical students / residents:

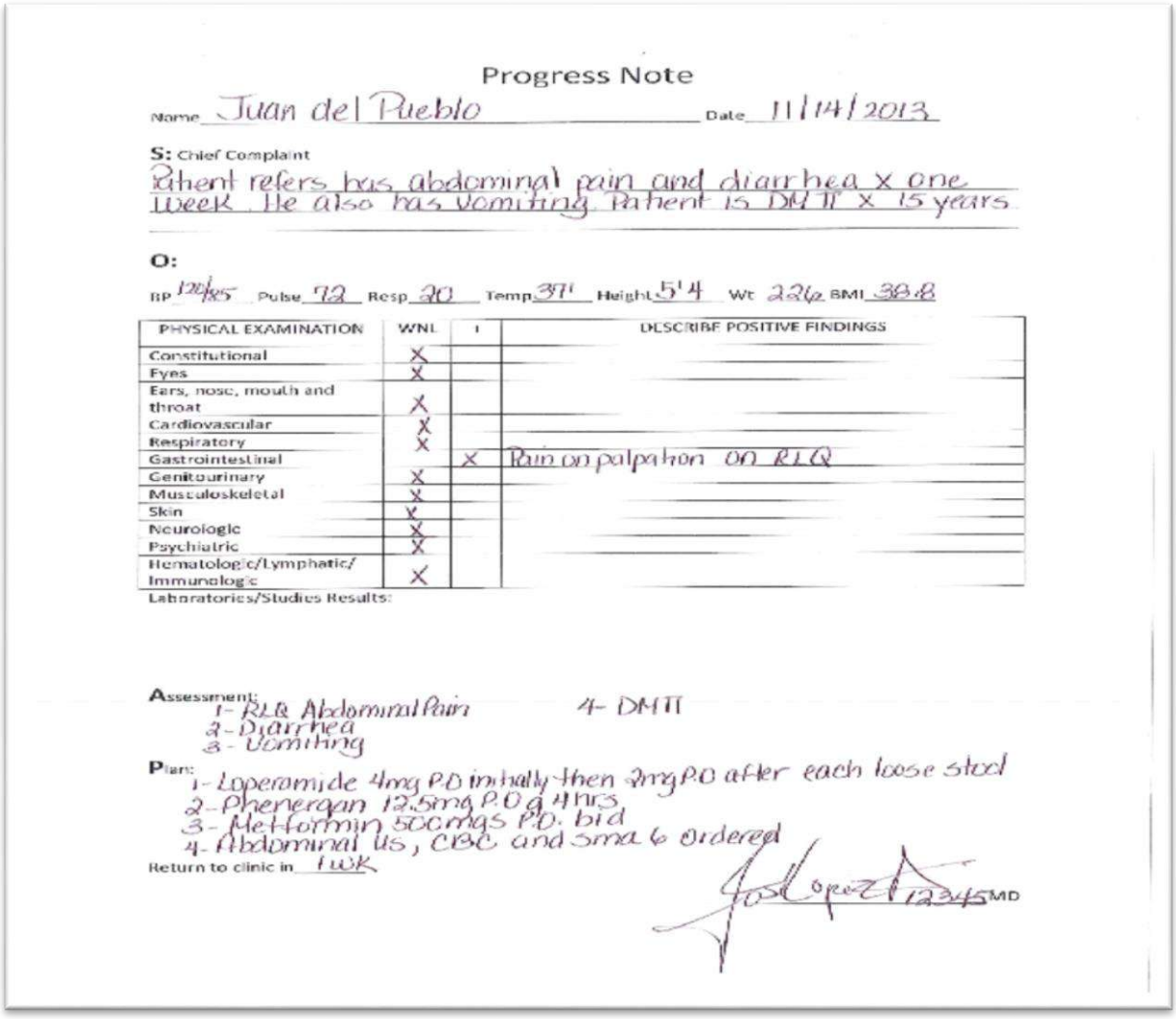
1. CMS requires that the teaching physician be physically present during the critical or key parts of the service. Here are some important guides, but see the Medicare Claims Processing Manual, chapter 12 for more information:
    a. Make sure the care provided is reasonable and necessary.
    b. Review the care provided by the resident during or immediately after each visit. This should include a review of the patient's medical history, the resident's findings on the physical exam, the patient's diagnosis, and the treatment plan (i.e., the record of tests and therapies) and a statement that indicates whether he agrees with resident documentation.
    c. Document the extension of their own participation in the review and direction of the services provided to each patient.
    d. The entry must be signed and dated by the teaching physician.

D. <u>Additional documentation guides for evaluation and management (E/M):</u>

1. Chief complaint.
2. Relevant medical history, past, social and family.
3. Relevant physical examination; any abnormal findings must be described.
4. Any revised objective information or interpretation of findings in laboratories or imaging studies.
5. Evaluation, clinical impression, or diagnosis.
6. Care plan for each diagnosis.

7. Patient progress, response and changes in treatment and diagnostic review should be documented.
8. Time must be documented; especially the time spent in counseling or care coordination.
9. The documentation must clearly describe any other information required by CMS, CPT, HCPCS or ICD-10. (See image I).

Image I: Example of compliance progress note



Progress Note

Name Juan del Pueblo Date 11/14/2013

S: Chief Complaint

Patient refers has abdominal pain and diarrhea x one week. He also has vomiting. Patient is DM II x 15 years.

O:

BP 120/85 Pulse 72 Resp 20 Temp 37° Height 5'4 Wt 226 BMI 38.8

PHYSICAL EXAMINATION	WNL	I	DESCRIBE POSITIVE FINDINGS
Constitutional	X		
Eyes	X		
Ears, nose, mouth and throat	X		
Cardiovascular	X		
Respiratory	X		
Gastrointestinal		X	Pain on palpation on RLQ
Genitourinary	X		
Musculoskeletal	X		
Skin	X		
Neurologic	X		
Psychiatric	X		
Hematologic/Lymphatic/ Immunologic	X		

Laboratories/Studies Results:

Assessment:

1- RLQ Abdominal Pain 4- DM II
2- Diarrhea
3- Vomiting

Plan:

1- Loperamide 4mg P.O initially then 2mg P.O after each loose stool
2- Phenergan 12.5mg P.O q 4hrs
3- Metformin 500mgs P.O. bid
4- Abdominal US, CBC and Sma 6 ordered

Return to clinic in 1wk

Jose Lopez 12345 MD

E. Importance of medical documentation

Documentation is an important aspect in patient care and is used to:

1. Coordinate services.
2. Promote communication between doctors and health professionals.
3. Provide correct and sufficient services.
4. Improve patient care.
5. Comply with federal and state rules.

6. Support the information submitted through billing.

7. Reduce inappropriate payments.

F. Requirements for good documentation

Correct:	That the information is of the patient that is indicated, not of another.
Exact:	That the results are related to the condition,
Legible:	Let the writing be understood,
Egg white:	Express what you really mean,
Complete:	All typecasts full and if you do not apply write n/a,
Timely:	That the cases are referred in time and that effective action is taken,

G. Basic documentation required in a clinical note of a visit

1. The document must be legible and in standard words or abbreviations.

    a. At a minimum, the medical record must:

    - Be written so that anyone who has access to it can read it without interpretation errors, including the patient
    - Written in pen (in the case of manual files).

- Written in clear language.
- It cannot have alterations. The use of corrective ink is prohibited.

2. Patient's and provider's name
    a. In case that a progress note is extensive and takes more than one page, the patient's name should appear on all pages.
    b. There must be continuity in the progress note, that is, the sequential order must be easily identifiable in a progress note consisting of several documents or pages.
3. Date of service
    a. It should appear on all pages that occupy the information of that encounter.
4. Chief complaint
    a. In the case of electronic records, we must avoid using the phrase "Nonclinical visit". This type of assertion indicates that this note was made for a reason that does not include a clinical evaluation. A good grade could be invalídated just for this.
5. Evaluation and management of the condition
    a. Any condition that coexists in the meeting and / or everything that affects the care or management of the main condition must be included.
6. Sign and provider's credential (MD)
7. It should reflect that it comes from a face-to-face encounter with the patient.
    a. For an encounter to be validated as face to face, it must have the following aspects:

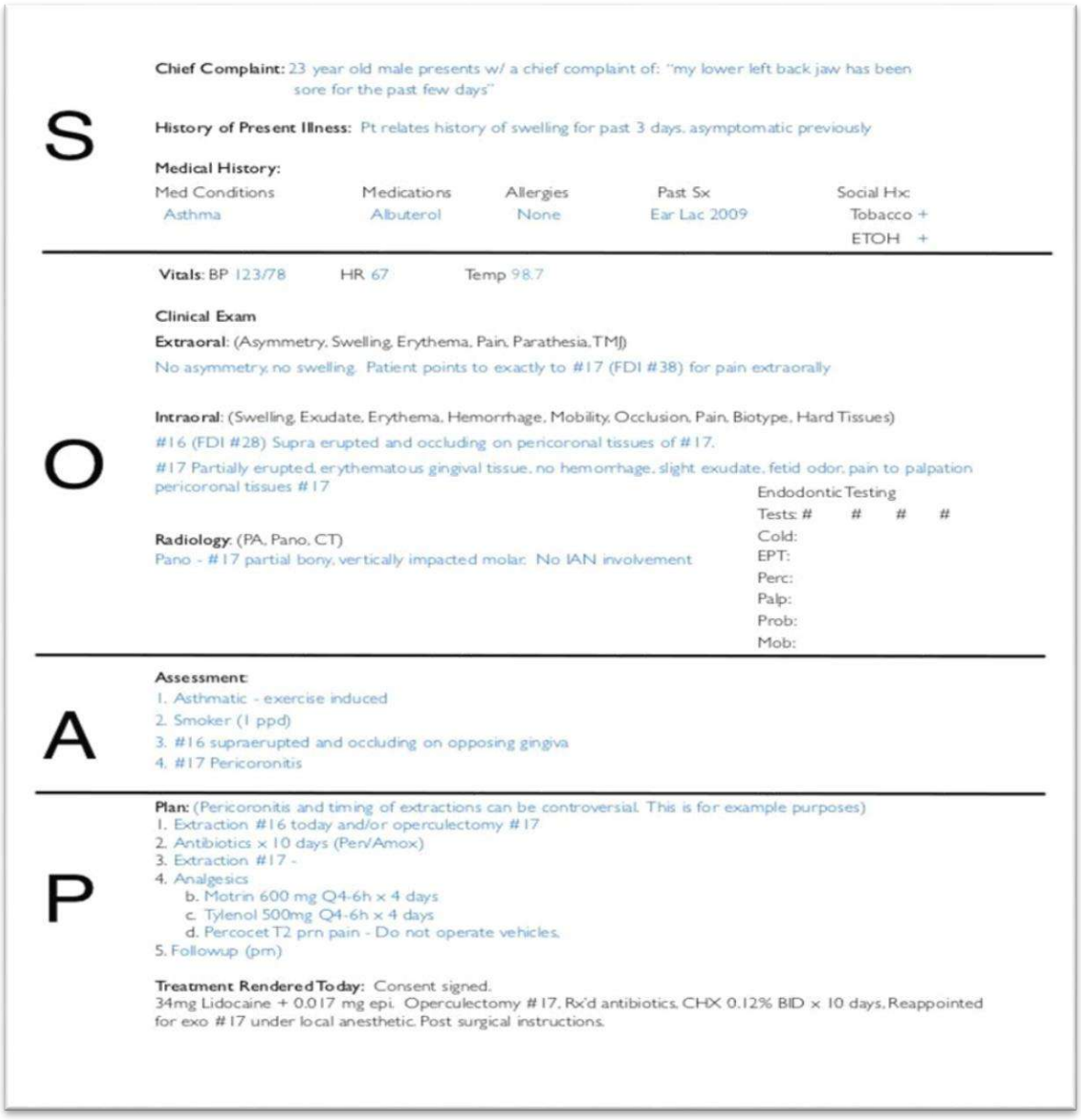
- Reason for the encounter
- Vitals
- Physical examination

8. It must follow ICD-10-CM, CPT, HCPCS, and CMS official guides.

H. Documentation Format

There are several documentation formats but the simplest, and that meets the necessary requirements is the SOAP format. The SOAP format is a way in which medical professionals provide clear and concise documentation of a patient's care. It is used by a variety of providers, including doctors, nurses, emergency medical technicians and mental health providers. The SOAP format is intended to examine the well-being and progress of a patient from various perspectives, ultimately providing the best possible care. (See Image II)

Image II – Example of the SOAP format



S

Chief Complaint: 23 year old male presents w/ a chief complaint of: "my lower left back jaw has been sore for the past few days"

History of Present Illness: Pt relates history of swelling for past 3 days, asymptomatic previously

Medical History:

Med Conditions	Medications	Allergies	Past Sx	Social Hx
Asthma	Albuterol	None	Ear Lac 2009	Tobacco +
				ETOH +

O

Vitals: BP 123/78 HR 67 Temp 98.7

Clinical Exam

Extraoral: (Asymmetry, Swelling, Erythema, Pain, Parathesia, TMJ)

No asymmetry, no swelling. Patient points to exactly to #17 (FDI #38) for pain extraorally

Intraoral: (Swelling, Exudate, Erythema, Hemorrhage, Mobility, Occlusion, Pain, Biotype, Hard Tissues)

#16 (FDI #28) Supra erupted and occluding on pericoronal tissues of #17.

#17 Partially erupted, erythematous gingival tissue, no hemorrhage, slight exudate, fetid odor, pain to palpation pericoronal tissues #17

Radiology: (PA, Pano, CT)

Pano - #17 partial bony, vertically impacted molar. No IAN involvement

Endodontic Testing

Tests: #	#	#	#
Cold:			
EPT:			
Perc:			
Palp:			
Prob:			
Mob:			

A

Assessment:

1. Asthmatic - exercise induced
2. Smoker (1 ppd)
3. #16 supraerupted and occluding on opposing gingiva
4. #17 Pericoronitis

P

Plan: (Pericoronitis and timing of extractions can be controversial. This is for example purposes)

1. Extraction #16 today and/or operculectomy #17
2. Antibiotics x 10 days (Pen/Amox)
3. Extraction #17 -
4. Analgesics
   b. Motrin 600 mg Q4-6h x 4 days
   c. Tylenol 500mg Q4-6h x 4 days
   d. Percocet T2 prn pain - Do not operate vehicles.
5. Followup (prn)

Treatment Rendered Today: Consent signed.
34mg Lidocaine + 0.017 mg epi. Operculectomy #17, Rx'd antibiotics, CHX 0.12% BID x 10 days, Reappointed for exo #17 under local anesthetic. Post surgical instructions.

I. Steps to complete the SOAP format

1. Subjective

a) Tell the story from the patient's perspective. Who is he? How can its current state be described?

b) Write down the patient's first complaint. During this stage, you should detail how the patient describes what he feels. Do not leave anything out, since everything can be important.

c) List the specific complaints of the patient. Did it come suddenly or were there warning signs? Was I injured? If so, how and when? Where was it when it happened? Find out if there is something to do at the time of the injury or incident to improve or change your symptoms.

d) Include the patient's medical history. This is important because one seemingly unrelated case can lead to another. If his main complaint, for example, is depression, a head injury or previous encounter with depression is relevant.

e) Make a list of medications he is currently taking or have stopped taking.

2. Objective

a) Give your point of view. What was your first impression of the patient? Did he seem alert and able to answer the questions? Does his story make sense to you? If you were at the scene, what was your impression of the incident?

b) Document the patient's vital signs, or in the case of a mental consultation, a report of his current mental state.

c) Write down everything you discover during the physical exam, if the complaint is of a physical nature. If the complaint is of a mental nature, take note of everything you find while spending time with the patient.

d) Document the general observations you have, such as the patient's behavior, the behavior and status of anyone who comes with him, how he is dressed, or if he appears to be under the influence of drugs or alcohol.

3. Assessment

a) Determine your conclusions based on your encounter with the patient.

b) Write down your possible diagnosis or diagnoses.

c) Synthesize objective and subjective information in relation to the patient, keeping it brief.

4. Plan

a) Develop an action plan. What do you think should be the next step taken in your treatment?

b) Participate in the next stage. If necessary, refer the patient to a specialist or schedule a follow-up appointment.

c) Design the approach you will use in treating this patient and write why you have chosen this route.

J. Documentation issues

Despite all the recommendations and guidelines, there are situations in which the documentation could be invalidated or is treated incorrectly. The most common problems found in the documentation are the following:

1. Omissions of acts and documentation - Remember that “what was not documented did not happen”. There is an old belief among doctors that states

that future claims are avoided by writing the least possible in a medical history. This belief is wrong since omissions are as serious as express errors.

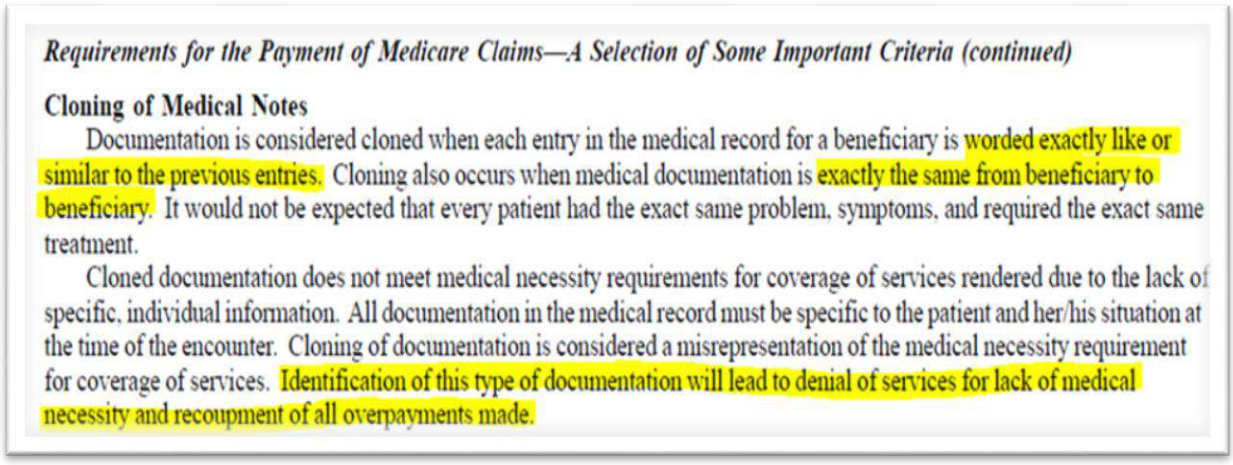
2. Delays in documenting the action taken - The longer it takes to document what happened in a meeting, the less detail you will remember. In the same way, the data will be less reliable.
3. Contraindications (medications vs. condition)
4. Lack of supervision: Patient/Personnel - A medical record should not be left unsupervised as it contains highly sensitive information.
5. Lack of supervision: Patient/Staff – A medical record should not be left unsupervised as it contains highly sensitive information.
6. Inconsistency in information: medical notes vs. Nursing.
7. Diet instructions, physical activity - Many times these indications are part of the management of the conditions and are not documented.
8. Lack of readability of information.
9. Apparent or real alterations (different ink, write about what is written, omit information).
10. Inappropriate corrections (cross out incorrectly, not written).
11. Lack of evidence of who makes the correction.
12. Lack of evidence of when the correction is made.
13. Use of unapproved abbreviations

K. Electronic record

The electronic record is an effective tool since it facilitates the readability of the information and, most of the time, contains an established format that, if used properly, meets the necessary requirements for the note to be appropriate.

However, there is one major challenge that we must take into consideration, the "copy and paste". Avoid copy-paste. This practice CMS is called "cloning". Do not bring information from past visits to the current encounter (except for data that remains such as demographics or histories). If you do, update the information. It is common to find repeated information from meeting to meeting throughout the year: same vital, repeated medications, same diagnoses. Conditions have also been found that have been eradicated documented as active. (See Image III)

Imagen III First Coast (CMS) copy-paste Newsletter 3rd quarter 2006



Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

8.3 General concepts of billing and coding

International Classification of Diseases 10th Rev. (ICD-10)

ICD-10 is an approved coding set for entities covered by the Health Insurance Portability and Accountability Act (HIPAA). The clinical modification of the coding set (ICD-10-CM) is used to

report diseases, disorders, symptoms and medical conditions. The Procedure Coding System (ICD-10-PCS) is used to inform hospitalization services (Hospital Part A) - hospitals under DRG contracts. Both coding systems include official guidelines for coding and reporting that suppliers must apply in their coding and documentation practices.

In addition to the General Concepts in Clinical Documentation above, for ICD-10-CM coding, the provider must document for each encounter:

1. Complete evaluation, coexisting diagnoses that include the main condition and its complications / manifestations.
2. The way in which the diagnosis is being addressed, treated, monitored and / or evaluated.
3. Do not code or report the diagnosis indicated as "suspicious" ("rule out" - R / O) or other similar terms that indicate uncertainty. Rather, code signs, symptoms, abnormal test results or another reason for the encounter. Please refer to Section II. H of ICD-10-CM Official Guidelines for Coding and Reporting for special instructions for facilities and hospitalized patients.
4. Always code the final result of a diagnostic test or procedure. If the final result is "normal", code the signs and / or symptoms.
5. Always code the postoperative diagnosis of a medical procedure. Do not code the preoperative diagnosis as it can be changed once the procedure is performed.

ICD-10-CM organization

1. The ICD-10-CM consists of several parts:

a) **Special guidelines** - In this section you will find general guides (applicable to the whole book) and guides by chapter. It is important that you read them since the information offered in this part is not found anywhere else in the ICD-10 and directly affects the way in which it will be coded.

b) **Index (Volume II)** - It is in strict alphabetical order. In this section the search is by condition, not by anatomical system. Here we will translate the diagnosis from words to codes. The given code has to be confirmed in the tabular listing.

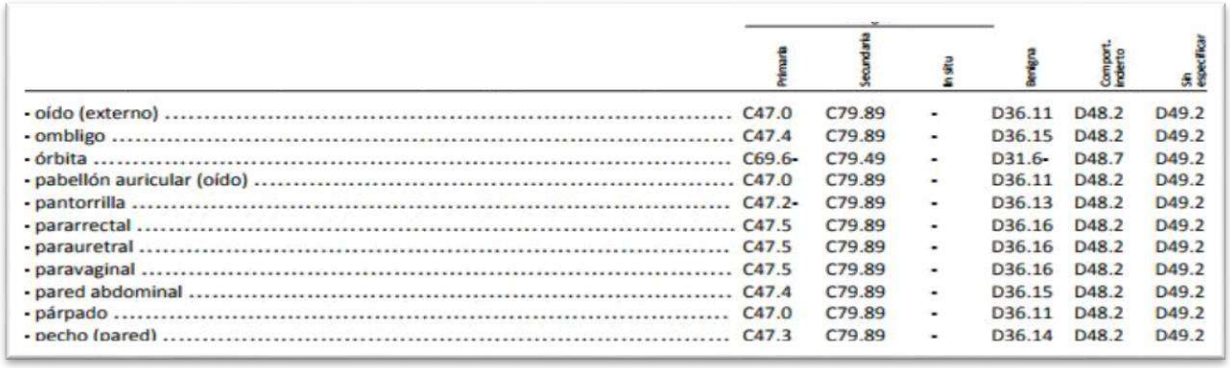
c) **Table of Neoplasms** - In it we will find the codes associated with some type of cancer: primary, secondary (metastasis), in situ, benign, of uncertain or unspecific behavior. It is also designed in strict alphabetical order. In the vertical direction we will find the anatomical systems and vertically the type of neoplasm. (See table 1).

d) **Table of drugs and chemicals (for adverse effects and poisoning)** - This table contains, in alphabetical order, everything that could cause some kind of adverse effect. Vertically there are drugs and chemicals and horizontally the type of adverse effect or poisoning: accidental (unintentional) poisoning, intentional poisoning (self-harm), assault or criminal poisoning, indeterminate poisoning, adverse effect (therapeutic cause poisoning), under dosing (see Table II).

e) **Tabular List (Volume I)** - List of codes where the code suggested by the index will be confirmed. In this section, you should be aware of additional symbols

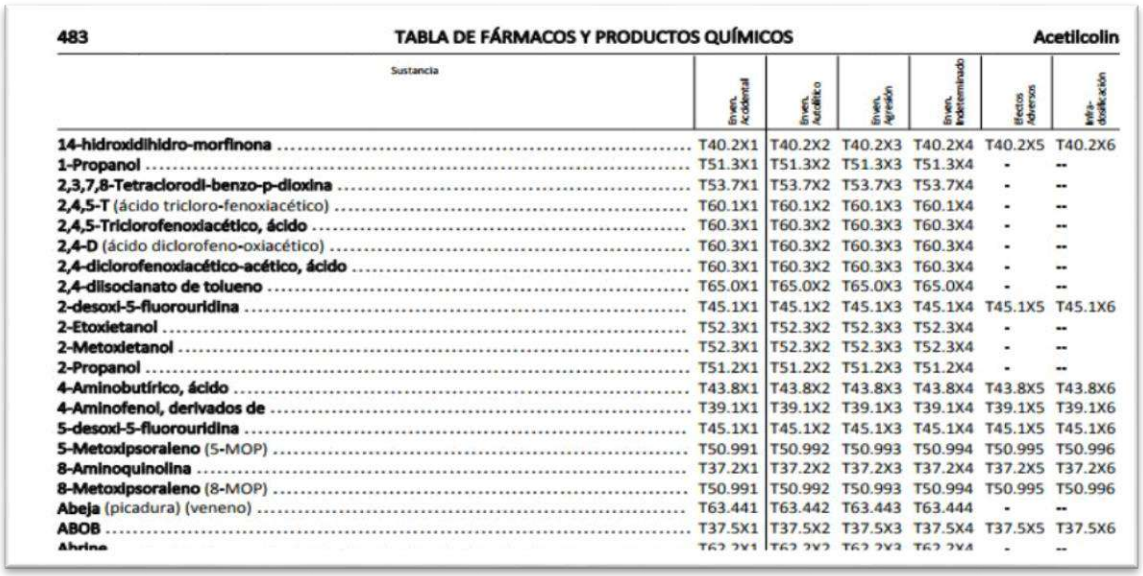
and instructions applicable to that code or category. You will only see these instructions in this section.

Table I – Table of neoplasms



	Primaria	Secundaria	In situ	Benigna	Comport. incierto	Sin especificar
- oído (externo)	C47.0	C79.89	-	D36.11	D48.2	D49.2
- ombligo	C47.4	C79.89	-	D36.15	D48.2	D49.2
- órbita	C69.6-	C79.49	-	D31.6-	D48.7	D49.2
- pabellón auricular (oído)	C47.0	C79.89	-	D36.11	D48.2	D49.2
- pantorrilla	C47.2-	C79.89	-	D36.13	D48.2	D49.2
- pararrectal	C47.5	C79.89	-	D36.16	D48.2	D49.2
- parauretral	C47.5	C79.89	-	D36.16	D48.2	D49.2
- paravaginal	C47.5	C79.89	-	D36.16	D48.2	D49.2
- pared abdominal	C47.4	C79.89	-	D36.15	D48.2	D49.2
- párpado	C47.0	C79.89	-	D36.11	D48.2	D49.2
- pecho (pared)	C47.3	C79.89	-	D36.14	D48.2	D49.2

Table II – Table of adverse effects and poisoning



483 TABLA DE FÁRMACOS Y PRODUCTOS QUÍMICOS Acetilcolin

Sustancia	Enven. Accidental	Enven. Autolítico	Enven. Agresión	Enven. Indeterminado	Efectos Adversos	Infra-dosificación
14-hidroxidihidro-morfinona	T40.2X1	T40.2X2	T40.2X3	T40.2X4	T40.2X5	T40.2X6
1-Propanol	T51.3X1	T51.3X2	T51.3X3	T51.3X4	-	--
2,3,7,8-Tetraclorodi-benzo-p-dioxina	T53.7X1	T53.7X2	T53.7X3	T53.7X4	-	--
2,4,5-T (ácido tricloro-fenoxiacético)	T60.1X1	T60.1X2	T60.1X3	T60.1X4	-	--
2,4,5-Triclorofenoxiacético, ácido	T60.3X1	T60.3X2	T60.3X3	T60.3X4	-	--
2,4-D (ácido diclorofeno-oxiacético)	T60.3X1	T60.3X2	T60.3X3	T60.3X4	-	--
2,4-diclorofenoxiacético-acético, ácido	T60.3X1	T60.3X2	T60.3X3	T60.3X4	-	--
2,4-diisocianato de tolueno	T65.0X1	T65.0X2	T65.0X3	T65.0X4	-	--
2-desoxi-5-fluorouridina	T45.1X1	T45.1X2	T45.1X3	T45.1X4	T45.1X5	T45.1X6
2-Etoxietanol	T52.3X1	T52.3X2	T52.3X3	T52.3X4	-	--
2-Metoxietanol	T52.3X1	T52.3X2	T52.3X3	T52.3X4	-	--
2-Propanol	T51.2X1	T51.2X2	T51.2X3	T51.2X4	-	--
4-Aminobutírico, ácido	T43.8X1	T43.8X2	T43.8X3	T43.8X4	T43.8X5	T43.8X6
4-Aminofenol, derivados de	T39.1X1	T39.1X2	T39.1X3	T39.1X4	T39.1X5	T39.1X6
5-desoxi-5-fluorouridina	T45.1X1	T45.1X2	T45.1X3	T45.1X4	T45.1X5	T45.1X6
5-Metoxipsoraleno (5-MOP)	T50.991	T50.992	T50.993	T50.994	T50.995	T50.996
8-Aminoquinolina	T37.2X1	T37.2X2	T37.2X3	T37.2X4	T37.2X5	T37.2X6
8-Metoxipsoraleno (8-MOP)	T50.991	T50.992	T50.993	T50.994	T50.995	T50.996
Abeja (picadura) (veneno)	T63.441	T63.442	T63.443	T63.444	-	--
ABOB	T37.5X1	T37.5X2	T37.5X3	T37.5X4	T37.5X5	T37.5X6
Abrina	T62.2X1	T62.2X2	T62.2X3	T62.2X4	-	--

Code structure

The ICD-10-CM codes may contain three to seven characters, the first three being considered the category, and the following as subcategories. All codes begin with a letter.

A. Steps to code correctly

Here are some steps that will be useful when coding a diagnosis:

1. Identify the reason for the visit - By this we mean the main reason why the patient has attended his office or arrived at a facility. This will be your primary diagnosis.
    a. Remember: If the reason for the visit includes signs and symptoms associated with a condition managed and documented at the same encounter, you should only code the condition.
2. Identify the main term in the diagnosis.
3. Locate the main term in the ICD-10 index.
4. Review any sub-term under the main term in the index.
5. Follow any reference instructions, such as see, abbreviations, cross references, symbols, and square brackets.
6. Verify the code selected in the tabular list.
7. Go to the category to make sure of additional instructions.
8. Assign the code to the highest level of specificity that the documented diagnostic information carries.
9. Code the diagnosis using all the identified elements. Let's look at the following example:

a) A patient with high blood pressure and history of tobacco use - He is reoriented that he should leave table salt completely and follow the instructions including taking his antihypertensive medications.

Step 1 - Search in the index

Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) I10
- with
- - heart involvement (conditions in I51.4- I51.9 due to hypertension) —*see* Hypertension, heart
- - kidney involvement —*see* Hypertension, kidney
- benign, intracranial G93.2
- borderline R03.0
- cardiorenal (disease) I13.10
- - with heart failure I13.0
- - - with stage 1 through stage 4 chronic kidney disease I13.0
- - - with stage 5 or end stage renal disease I13.2
- - without heart failure I13.10
- - - with stage 1 through stage 4 chronic kidney disease I13.10
- - - with stage 5 or end stage renal disease I13.11
- cardiovascular
- - disease (arteriosclerotic) (sclerotic) —*see* Hypertension, heart
- - renal (disease) —*see* Hypertension, cardiorenal
- chronic venous —*see* Hypertension, venous (chronic)
- complicating
- - childbirth (labor) O10.92
- - - with
- - - - heart disease O10.12
- - - - - with renal disease O10.32
- - - - renal disease O10.22

Step 2 - Confirm in the tabular list

I10 Essential (primary) hypertension

Includes: high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

Excludes1: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

Excludes2: essential (primary) hypertension involving vessels of brain (I60-I69)
essential (primary) hypertension involving vessels of eye (H35.0-)

Step 3 - Check for additional instructions at the beginning of the category

Hypertensive diseases (I10-I15)

Use additional code to identify:
exposure to environmental tobacco smoke (Z77.22)
history of tobacco use (Z87.891)
occupational exposure to environmental tobacco smoke (Z57.31)

- In this case we would code I10 and Z87.891.

Relationship between documentation and coding

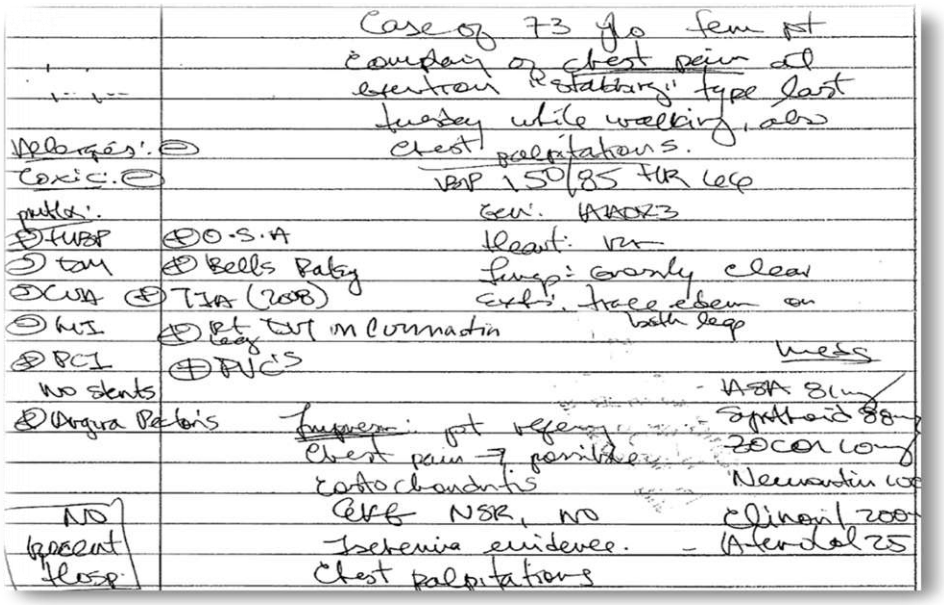
Proper documentation and at the highest level of specificity will result in adequate and appropriate coding that describes the patient's conditions at their highest level.

Example:

Mr. Pedro goes to his office to monitor his diabetes condition with stage 4 chronic kidney disease. He also has hypertension with heart failure. These diagnoses were made with clinical information including labs, radiological studies and specialist referrals in face to face encounters during past visits. However, you document only diabetes (without complication) and hypertension (without heart failure). Your coder will send in the bill the codes of diabetes without complication (E11.9) and essential hypertension (I10) instead of the codes associated with the conditions that Don Pedro really has but were not documented. This does not mean that Mr. Pedro does not have the complicated conditions or that he will not spend for them. This will result in a smaller allocation of funds in Mr. Pedro's *fund*, based on the diagnostic information received, which will not be sufficient to support the real conditions of this patient.

Example documentation with areas of opportunity

- Notice the following progress note for a moment:



Understanding, for this analysis, that this note has the patient's identifiers, the date of service and the signature and credentials of the provider; Even so, we can identify several areas of improvement in it:

1. Readability - This note lacks clear legibility in all its parts.
2. Format - There is no orderly consistency in the exposed data.
3. Medications - There is treatment without associated conditions.
    a. Neurontin
    b. Synthroid
4. Conditions - There is documentation of acute and other associated conditions.
    a. CVA (Cerebrovascular accident)
    b. MI (Myocardial Infarction)
    c. Chest pain, palpitations, costochondritis, angina pectoris
5. Ambiguous documentation – RT leg DVT en Coumadin

a. There is no specification of whether the condition is chronic or history. Remember that chronicity cannot be inferred by the existence of a treatment. The word "chronic" must be documented.

Recommendations for greater specificity when coding

A. What do you need to document?

The basic concepts to document (depending on the condition) are the following:

1. Laterality (right, left, bilateral)
2. Specificity about the anatomical site
3. Trimester and weeks of gestation
4. Type of diabetes
    - You must also indicate if you use insulin and / or oral medications
5. Know the complications or comorbidity conditions
6. Describe if severe, acute or chronic or know other parameters

Recommendations for greater specificity when coding neoplasms

1. Behavior (Primary, secondary, benign, in situ)
2. Laterality
3. Specify anatomical site
4. Other conditions associated with malignancy (anemia, dehydration, among others).
5. Complications associated with the neoplasm
6. Active treatment

a. If the patient does not receive treatment for any reason, for example their age, it must be documented.
b. If the patient does not receive treatment because they refuses it, it must be documented.

Recommendations for greater specificity when coding diabetes

1. Type (I, II, secondary).
    a. If no documentation of the type of diabetes is found, it must be coded as type II.
2. Control
    a. Inadequate control
    b. Out of control
    c. Poorly controlled
    d. Hypoglycemia
    e. Hyperglycemia
3. Use of insulin (if applicable)
4. Manifestations

Recommendations for greater specificity when coding substance abuse and / or dependence use

1. This section is categorized by hierarchies: use, abuse, and dependence; being dependence the most serious.
2. If the patient has more than one condition in the hierarchy, code only the most serious. For example, if the patient uses and abuses a substance, code only the abuse.

3. Identify the type of drug or substance.
4. Describe the frequency of use or if it is in remission.
5. In the case of nicotine, describe the mode of use: cigarettes, tobacco, pipe, among others.
6. Identify any withdrawal syndrome
7. Identify any associated condition. For example, alcoholic cirrhosis.
8. Identify any associated mental disorder
9. Describe management and / or treatment

Recommendations for greater specificity when coding depression

1. Episode documentation
    a. Single
    b. Recurrent
    c. In remission
        - Partial
        - Complete
2. Severity documentation
    a. Mild
    b. Moderate
    c. Severe
        - Without psychotic events
        - With psychotic events

3. Any associated condition or diagnosis
4. Management and / or treatment
    a. In case that the condition is in remission does not require treatment.

Recommendations for greater specificity when coding Heart Failure

1. Document severity
    a. Acute
    b. Chronic
    c. Acute on Chronic
2. Document type
    a. Systolic
    b. Diastolic
    c. Combined
3. Caused or associated by:
    a. Hypertension
    b. Surgery
    c. Valvular disease
    d. Rheumatic heart disease
        - Endocarditis (valvitis), Pericarditis o Miocarditis
    e. Other (specify)
4. Management and / or treatment

Recommendations for greater specificity when coding Chronic Kidney Disease (CKD)

1. Document CKD Stage

a. Chronic Kidney Disease, stage 1

b. Chronic Kidney Disease, stage 2 (mild)

c. Chronic Kidney Disease, stage 3 (moderate)

1. Chronic Kidney Disease, stage 3A (eGFR between 45 y 59)

2. Chronic Kidney Disease, stage 3B (eGFR between 30 y 44)

d. Chronic Kidney Disease, stage 4 (severe)

e. Chronic Kidney Disease, stage 5

f. End Stage Renal Disease (ESRD)

2. Indicate any causative condition such as diabetes or hypertension

3. Document if the patient is dialysis dependent or has a fistula, even if he is not dialyzing at the moment.

a. Chronic Renal Failure documented without stage will be code as Chronic Kidney Disease, unspecified.

4. Management and / or treatment

Recommendations for greater specificity when coding pregnancy

1. Specify trimester

a. First (less than 14 weeks, 0 days)

b. Second (from 14 weeks, 0 days since less than 28 weeks, 0 days)

c. Third (from 28 weeks, 0 days, until birth)

2. Specify *preterm labor / delivery*

3. Gestational diabetes needs documentation specifying the diet or control with insulin.

Recommendations for greater specificity when coding newborns

1. Birth:
    a. At hospital
        - Natural birth
        - Caesarean section
    b. Outside hospital
2. Document any condition of the mother that affected the newborn
3. Specify the gestational age and weight of the newborn
4. Specify congenital and / or acquired conditions

Recommendations for greater specificity when coding asthma

1. Type
    a. Mild persistent
    b. Moderate persistent
    c. Severe persistent
    d. Other (Specify)
2. Condition status
    a. Acute
    b. With status asthmaticus
    c. Without complications
3. Associated conditions (if any)
4. Management and / or treatment

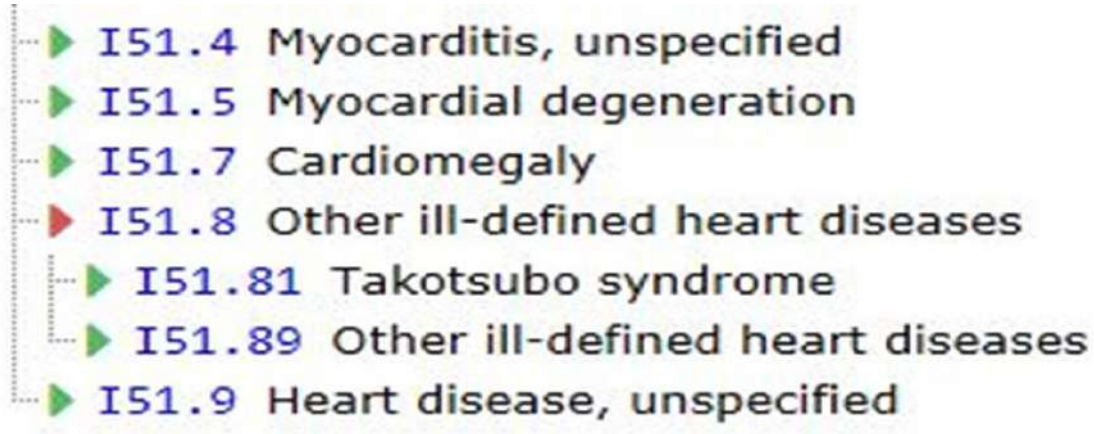
Recommendations to obtain greater specificity when coding hypertension

1. For this condition there are some important guides that you should know:

a. Assume cause and effect between CKD codes (N18-) and HTN.

b. Do not assume cause and effect between heart conditions, except for CHF (see image VI) unless you document it as such. Example: "hypertensive cardiomegaly".

Image VI - Cardiac conditions that cannot be assumed to be related to HTN, unless the provider document it



2. Document the type of hypertension

   a. Essential

   b. With cardiac complications

      - Without heart failure
      - With heart failure

   c. With renal complications

      - CKD stage I-IV
      - CKD stage V or ESRD

   d. Combined (with cardiac and renal complications)

- Without heart failure and with CKD stage I-IV
- With heart failure and with CKD stage I-IV
- Without heart failure and with CKD stage V o ESRD
- With heart failure and with CKD stage V o ESRD

e. Secondary

- You must indicate the causative condition

f. Due to pregnancy

g. Urgency or hypertensive emergency (more frequent in hospital)

3. Document the pressure tap and the result
4. Management and / or treatment

Recommendations to evaluate performance in your practice

1. Develop an internal compliance program
2. Develop a documentation policy in the medical record
3. Create a standard format for your records
4. Perform internal audits
5. Select a sample of records to review
6. Use the results of the audit to improve your practice.

Reminder

The basis of the entire coding process is the documentation. Clear and concise documentation, written to the highest level of specificity possible, will result in a healthy practice, in compliance and with the necessary elements to offer the patient a quality and excellence service. Everything depends on you.

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9. INTEGRATED MODEL OF MENTAL HEALTH AND PRIMARY MEDICINE

9.1 Collocation Model

The current contract between MMM Holdings and ASES establishes the Collocation Guidelines that focus on the full integration of physical and mental health and requires the placement of a psychologist or other type of provider of mental health in each Primary Medical Group (PMG).

Each participating PMG must have a mental health provider, as indicated. Depending on the size of the group, it will be the number of weekly hours required from the mental health provider. PMG's with a total of 1,000 lives or less will require a total of 4 contact hours by a mental health provider. PMG's with more than 1,000 lives are required to increase an additional 4 hours for every 1,000 lives assigned. The PMG must provide an office space for the mental health provider to carry out its interventions with members.

The mental health provider shall be present and available to provide evaluation, identification, consultation, and mental health services to members. The mental health provider may also carry out short interventions (between 4 to 6 sessions) or as required. Through this model, physicians, mental health providers, and other members of the health team collaborate in the provision of an integrated care plan for members. In this context, communication between physicians and mental health providers is one of the most important steps for collaboration and integration.

Some of the situations that can be addressed by the mental health provider, in collaboration with the member's primary physician are; members with signs of depression or anxiety, members with chronic conditions, members with problems of adherence to medical treatment, members with developmental, behavioral or psychiatric conditions, members who face stressful events such as

losing another significant one, divorce, who are caregivers, members with family, school or work situation stressors, identification and referral of members with drug, alcohol or tobacco. (In this case they should evaluate and refer to the next level of care).

If a GMP does not comply with the co-location model, as required, may be subject to sanctions and penalties, which vary from the notification of non-compliance to the cancellation of the Medical Group contract.

Primary Medical Group Assigned Membership	**Minimum amount of required weekly hours of mental provider in PMGs**
1,000 members or les	4 weekly hours
1,001 a 2,000 members	8 weekly hours
2,001 a 3,000 members	Twelve weekly hours
3,001 a 4,000 members	16 weekly hours
4,001 a 5,000 members	20 weekly hours
5,001 a 6,000 members	24 weekly hours
6,001 a 7,000 members	28 weekly hours
7,001 a 8,000 members	32 weekly hours
8,001 a 9,000 members	36 weekly hours
9,001 a 10,000 members	40 weekly hours

In developing the full integration of physical and behavioral health, ASES also requires the placement of a psychologist or other type of behavioral health provider in the Inpatient setting (physical hospitals). The Emergencies Room shall be responsible for identifying beneficiaries' needs and coordinating proper access to both physical and behavioral health services. The co-location program should be incorporated to the inpatient setting staffing, intending to provide

continuity of services, based on the provision of integrated plan to patients as stated in Puerto Rico Mental Code, Law No. 408 of October 2, 2000, as amended, and the Puerto Rico Patients' Rights and Responsibilities. The Behavioral Health Provider shall be present and available to provide assessment, screening, consultation, and other behavioral health services. Through this model, physicians, behavioral health providers and other members of health teams collaborate in the provision of an integrated care plan to patients. In this context, communication between physicians and behavioral health providers is one of the most important steps to collaboration and integration.

Situations that may be address by behavioral health person in collaboration with the medical staff may include, but are not limited to:

- Patients with signs of depression or anxiety
- Patients in the high cost/ high need program
- Patients with chronic conditions
- Patients who present problems with adherence to medical treatment
- Patients with developmental, behavioral, psychiatric conditions
- Patients who confront stressful events such as losing a significant other, divorce, care giving or others
- Patient with family, school, or work-related situational stressors
- Identification and referral of patients with drugs, alcohol, or smoking additions
- Patients referred as high emergency room utilizers associated to behavioral health conditions.

- Patients seeking behavioral services at their own initiative.
- Education to patients, community, or staff

Required Co-location of Staff per Inpatient Setting:

Any patient who is hospitalized for acute services in general hospitals and during his stay requires, due to medical recommendation, psychologist, or other type of behavioral health provider evaluation; the MCO must guarantee access to behavioral health provider's service. The multidisciplinary team should have in his team these professionals, either on call daily or within his faculty.

A corrective action plan (CAP) will be required if any PMG or inpatient setting does not comply with the required co-location level.

9.2 Reverse Collocation

In accordance with the provisions of the Puerto Rico Mental Health Code, Law No. 408 of October 2, 2000, as amended, and the Puerto Rico Patient's Bill of Rights and Responsibilities, the Government Health Plan (GHP) is committed to promoting mental and physical health integration, to improve program effectiveness and quality of life for enrollees.

Reverse Co-location is an integrated care model in which physical health services are available to Enrollees being treated in Behavioral Health settings.

It has been known that patients with co-morbid conditions that include chronic or acute medical conditions and behavioral health diagnoses are at higher risk for increased utilization and costs in health care. Persons with serious mental illness have high levels of medical co-

morbidity compared to the general population, as well as increased risk for diabetes, obesity, and high cholesterol due to the use of some second-generation antipsychotic medications (Milbank Memorial Fund, 2010)

Under this model, a physician is located part-time or full-time in a mental health facility for the purpose of monitoring the physical health of patients. Affiliates under the Severe Mental Illness Registry (SMI) will benefit from this integration by having their physical and mental health needs taken care of in the same facility. Those patients who are officially under the SMI will receive all primary care medical services at the mental health facility. Members with mental health conditions who visit the facility can also receive medical consultations, however, the doctor can only prescribe limited prescriptions and refer these members to their Primary Medical Group (PMG) for proper follow-up.

In the development of the full integration of physical and mental health, ASES requires the placement of a medical doctor in each of the following mental health scenarios:

- Ambulatory Services Units must have at least one collocated PCP 5 days per week for 4 hours.
- Addiction Services Units must have at least one collocated PCP 3 days per week for 4 hours.
- Psychiatric Hospitals are required to have at least one PCP on call daily.
- Partial Hospitalization Units must have at least one collocated PCP 2 days per week for 4 hours.
- Stabilization units must have one PCP for consultation (on call) daily.

If the mental health facility does not comply with the Reverse Collocation Model, as required, it may be subject to sanctions and penalties that vary from notification of non-compliance to cancellation of the contract.

9.3 Social Services and Determinants of Health Department (SS&DoHD)

The SS&DoHD has the purpose of addressing social determinants of health (SDoH), community health issues and social needs through group interventions and direct social interventions. Social Work staff works with members and their relatives or caregivers to remove barriers, promote social justice as well as obtain better health outcomes and quality of life. Cases are evaluated and managed individually so the interventions can be adjusted to each beneficiaries' needs and priorities. The SS&DoHD offers a voluntary and opt out service. Referrals sources for those services may be community resources, hospital staff, physicians, internal Departments, members, relatives, caregivers, medical groups, internal reports, among others.

The SS&DoHD has two approaches to address member's SDoH issues where licensed Social Workers perform a holistic assessment in order to establish an accurate plan of care. For both scenarios within the SS&DoHD, the assessment tool is based on the biopsychosocial model; differences of approaches implemented are related to the level of care that the situation represents. Telephone Assessments are done by Social Workers from the Outreach Unit and Face to Face Assessments are done by Social Work Case

Managers (SWCM). If further management needs are identified during the telephone assessment, the member is referred to a SWCM for a Home Visit Coordination.

Cases that represent greater complexity will be able to benefit from more comprehensive evaluation and long-term case management (Face to Face interventions). Referral sources such as providers, health care professionals, support systems or member's self-referral can be considered a complex need that can benefit from face-to-face interventions. Referrals with less complexity will be managed through telephone interventions with a shorter biopsychosocial assessment within a shorter time frame. These referrals are usually received by reports such as AHA and HRA.

The SWCM understands the community and the needs of the targeted members. They are fully integrated in the community and assigned by region to go to where the member is, serving as an advocate and liaison for the member and their support system. The SS&DoHD has an Island wide directory of resources that permit the identification of available services to attend primary SDoH needs identified and this tool is available for all Social Work Staff so any given situation can be promptly addressed with available resources. Social Work Case Managers as well as the Social Workers from the Outreach Unit act as part of a multidisciplinary care team while providing information that complements or strengthens the interventions of the centralized care plan in other Clinical Programs through the identification of SDoH needs and barriers identified during the evaluation and intervention process.

The SS&DoHD provides the following benefits and services for our members:

- Visits to community agencies, hospitals, providers, PMG's, PCP offices, clinics, and members residence to address their needs, this applies to members managed by SWCM.
- Collaboration with clinical programs to manage member's identified SDoH.
- Coordination of agreements with appropriate community agencies and programs that will ensure continuity of care and the proper use of community resources.
- A holistic assessment of a member's condition and available support system and resources in the community.
- Manage the members who present medical service needs, isolation, lack of support, or social welfare related service needs. The Social Work staff will determine the need of psychosocial, psychiatric, therapeutic, or medical evaluations, including referrals and coordination of immediate services.
- Interactions with families and individuals to assess their priorities, needs and find social service programs or community resources that can assist them.

- Development and implementation of a care plan with specified goals and interventions to manage and address member's social and clinical needs.

- Evidence the corresponding follow up to referrals, coordinations and agreements to monitor the care plan progress and ensure appropriate timelines in managing member's identified problems.
- Care Team discussions to offer, as well as obtain recommendations and feedback to provide the most achievable care plan.
- Complete interventions and interactions with the family, primary care physician, caregivers, and other member's support systems in member's health care management.
- Extend services and referrals to include member's family.
- Support member's Emergency Planning.
- Integration of case management or social services functions into the member's care, home safety and discharge planning processes.
- Address social emergencies to the appropriate Government Agencies immediately.

The following inclusion criteria are established to identify the most vulnerable members:

Social Factors

- Homelessness
- Inability for self-care due to:
    - No available caregiver
    - No family or relative's support
    - Nutrition or meal prep issues

- Subhuman living conditions (extremely inappropriate living conditions for any human being to preserve health and wellbeing)
- Self-neglect with health care:
    - No clinical follow up
    - Do not follow clinical recommendations (diet, instructions, treatment, or medication)
- Transportation Issues for medical care or to cover their basic needs
- Unsafe home situation:
    - Requires furniture movement
    - Electrical issues
    - Inappropriate spaces for their care and safety
    - Promote Community Health
- Financial issues for follow up care

Clinical Factors (at least one social criterion is required)

- Need coordination of clinical services
    - Multiple admissions
    - Multiple Emergency Room visits due to inappropriate care or lack of resources (financial and humans)
    - Multiple Readmissions
    - Inadequate wound care management
    - No medications or follow up care due to financial issues
    - No medication adherence

- No adherence to treatment

The SS&DoHD has the goal to empower and support members regaining optimal health while promoting empowerment, increasing knowledge about community resources, and facilitating access to them, addressing clinical needs with the appropriate providers and settings in a cost-effective manner.

10. UTILIZATION MANAGEMENT

An initiative of MMM Multihealth that seeks to ensure that the Covered Services provided to Members meet the standards and requirements established by the Contract or a similar program developed or established by ASES, and in accordance with them. MMM Multihealth will provide assistance to members and providers to ensure the proper use of resources. MMM Multihealth will have written utilization management policies and procedures included in the Provider Guidelines.

10.1 Authorizations and Referrals

MMM Multihealth will not require a Referral from a PCP when an Enrollee seeks care from a Provider who is part of the MMM Multihealth Preferred Provider Network (PPN). In case where the provider is not in the PPN, the Primary Care Provider (PCP) must submit an electronic referral request to the Specialist Contracted Provider. MSO will offer to the PCP the alternative of generating the electronic referral through InnovaMD web page and IVR, at no expense to the provider. The PCP should provide a copy of the referral to the patient. A Referral from the PCP will be required:

1. For the Enrollee to access specialty care and services within the MMM Multihealth General Network but outside the PPN.
2. For the Enrollee to access an Out-of-Network Provider (except for Emergency Services).
3. A Referral for either the General Network or out-of-network services must be provided during the same visit with the PCP but no later than twenty-four (24) hours of the Enrollee's request.
4. When a Provider fails or refuses to provide the Referral within specified period (24 hours) l an Administrative Referral will be issued by MMM Multihealth, according to established process.
5. Neither MMM Multihealth nor any Provider may impose a requirement that Referrals be submitted for the approval of committees, boards, Medical Directors, etc. MMM Multihealth will strictly enforce this directive and will issue Administrative Referrals whenever it deems medically necessary.

6.If the Provider Access requirements of this Contract cannot be met within the PPN within thirty (30) calendar days of the Enrollee's request for the Covered Service, the PMG will refer the Enrollee to a specialist within the General Network, without the imposition of Copayments. However, the Enrollee will return to the PPN specialist once the PPN specialist is available to treat the Enrollee.

7. MMM Multihealth will ensure that PMGs comply with the rules stated in this Section concerning Referrals, so that Enrollees are not forced to change PMGs in order to obtain needed Referrals.,

8. If the referral system developed by MMM Multihealth requires the use of electronic means, said system will be installed in the provider's office.
9. The referral request is included in case you need to fill it out manually, (please see the document in annex # 4).

The referral is valid for a 90 days period from the issued date.

10.2 Timeliness of Prior Authorization

MMM Multihealth will ensure that Prior Authorization is provided for the Enrollee in the following timeframes, including on holidays and outside of normal business hours:

1. The decision to grant or deny a Prior Authorization must not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for all Covered Services; except that, where MMM Multihealth or the Enrollee's Provider determines that the Enrollee's life or health could be endangered by a delay in accessing services, Prior Authorization must be provided as expeditiously as the Enrollee's health requires, and no later than twenty-four (24) hours from the Service Authorization Request.
2. MMM Multihealth may, in its discretion, grant an extension of the time allowed for Prior Authorization decisions for up to fourteen (14) Calendar Days, where: The Enrollee, or the Provider, requests the extension; or MMM Multihealth justifies to ASES a need for the extension in order to collect additional Information, such that the extension is in the Enrollee's best interest.

3. If the timeframe is extended, MMM Multihealth must give the Enrollee written notice of the reason behind granting the extension and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

The notice of the determination must be sent as expeditiously as the Enrollee's health condition requires and no later than the expiration date of the extension.

4. For services that require Prior-Authorization by MMM Multihealth, the Service Authorization Request will be submitted promptly by the Provider for the MMM Multihealth's approval, so that Prior Authorization may be provided within the timeframe.
5. MMM Multihealth will submit to ASES Utilization Management clinical criteria to be used for services requiring Prior Authorization. ASES will previously approve in writing such Utilization Management clinical criteria.
6. MMM Multihealth will ensure that the PMG complies with the rules laid down in this section on referral, so that beneficiaries are not obliged to change the PMG to obtain a referral.
7. Any denial, unreasonable delay, or rationing of Medically Necessary Services to Enrollees is expressly prohibited. MMM Multihealth will ensure compliance with this prohibition from Network Providers or any other entity related to the provision of Behavioral Health Services to *Plan Vital* Enrollees. Should MMM Multihealth violate this prohibition, MMM Multihealth will be subject to the provisions of Article VI, Section 6 of Act 72 and 42 CFR 438 Subpart I (Sanctions).

8. MMM Multihealth will employ appropriately licensed professionals to supervise all Prior Authorization decisions and will specify the type of personnel responsible for each type of Prior Authorization in its policies and procedures. Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a Provider who possesses the appropriate clinical expertise for treating the Enrollee's condition. For Authorization Requests for dental services, only licensed dentists are authorized to make such decisions,
9. Neither a Referral nor Prior Authorization will be required for any Emergency Service, no matter whether the Provider is within the PPN, and notwithstanding whether there is ultimately a determination that the condition for which the Enrollee sought treatment in the emergency room was not an Emergency Medical Condition or Psychiatric Emergency.
10. MMM Multihealth will not require a Prior Authorization or a Referral for dental services except for maxillofacial surgery, which requires Prior Authorization from a PCP.
11. MMM Multihealth will require Prior Authorization for filling a drug prescription for certain drugs specified on the FMC. Require a Countersignature from the Enrollee's PCP to fill a prescription written by a Provider who is not in the PPN. Any required Prior Authorization or Countersignature for pharmacy services will be conducted within the timeframes provided.

10.3 InnovaMD

InnovaMD is a Care Coordination Platform that has been designed to join patients, providers and partners allowing them to work together. InnovaMD uses a highly secure, powerful and efficient

network platform that serves as a rendezvous point for all sectors within the healthcare industry. Upon joining, members of InnovaMD have the liberty of exchanging medical and administrative information instantly, while operating under strict regulations that guarantee compliance privacy and confidentiality.

Through a formula based on increased interoperability coupled with the effective flow of medical information, InnovaMD becomes an extremely valuable tool that keeps the healthcare industry well prepared while providing patients with high quality services, so they receive the best quality treatment.

InnovaMD is also the preferred communication channel between the providers and the MSO.

A. <u>Benefits</u>

1. Enables the providers to manage their medical panel more efficiently by using the **Beneficiary Center** functionality.
2. Facilitates an efficient communication platform among the group of health professionals who work with the patient.
3. Search and filter options are available across all enhanced applications allowing intuitive and uniform use.
4. Capability to manage multiple sessions of selected beneficiaries during the creation and submission of services, encounters, etc.
5. Integrated functionalities to request services such as Referrals and Pre-authorizations.
6. **Info Center** serves as a centralized repository of administrative documents (Document Center), Clinical Guidelines, Learning Modules (Learning Center), Reports (My Documents).

7. Providers have more options to grant their office staff access to InnovaMD transitioning their initial role from contacts to delegates, so they can work on behalf of them.
8. Logged user is displayed more information regarding their role or roles within InnovaMD to facilitate switching between them.
9. Both PCP and Group Administrators can benefit of the availability of the Beneficiary Center functionality.
10. PCPs can enter additional contact information of their beneficiary's profile.
11. Secure and personalized access to clinical and financial information.
12. Streamlined, secure and confidential communication with the provider.
13. Protects patient's clinical information as required by HIPAA regulations.

B. <u>Available Application Tools and Functionalities</u>

The following is a list of some of the tools and functionalities available to contracted providers:

1. **Beneficiary Center** – allows PCPs to manage their medical panel more efficiently by having an easy access to a Clinical Profile and requests services such as Referrals, Pre-authorizations, etc. for one or more beneficiaries simultaneously.
2. **Beneficiary Eligibility** - allows all providers to validate patient eligibility by searching with the Beneficiary ID and obtaining Demographic Information, Benefit Plan Information, Patient Coverage Information, Eligibility History and access to print the Certificate of Eligibility.

3. **Practice Center** – allow all providers to centralized view of services referred by their practice.
4. **Providers Directories** – allows all providers' access to all active and contracted network providers. Providers can filter by Company, Product, Doctors and Health Care Professionals, Medical Facilities. Searches can be performed Service Facility (Specialty), Name, Location, Zip Code, etc. Results include information such as office addresses, office telephone and map and other details.
5. **Clinical Viewer** - allows providers access through InnovaMD using the Clinical functionality. This functionality has the capability to transmit electronically clinical information among a variety of health care systems to consolidate clinical data that gains a new meaning in patient treatments and medical outcomes by improving the care offered by MMM.

   Provide an up-to-date and accurate summary related to the beneficiaries clinical. Data.

   Allows the provider direct access to information related to laboratory results, X-rays, meetings, etc. of patients, and reduces the delays in receiving laboratory results from their patients.

   Avoid duplication of therapies, doses, tests, and procedures.

   Ensures clarity and accuracy in diagnoses and prescriptions.

   It is aligned with the requirements of the Federal Government in the handling of the electronic medical record.

6. **Office Advantage** – providers can view and manage incentives corresponding to their office staff. Also, allows office staff to view a dashboard that contains information about their payments of incentives received for use InnovaMD.
7. **Office Advantage Rewards** – office staff can view and redeem prizes to use InnovaMD portal.
8. **ICD-10 Aid Tool** – facilitates providers and staff while performing search with coding translation.
9. **Formulary Search** – provides the drugs covered by the plan according to the category and / or name of the drug selected.
10. **Claims Status** - allows the providers to search and view al claims status.
11. **Document Center** – providers can view and search their Documents, Clinical Guidelines, General Documents and Digital Publications published.
12. **Learning Center** – providers can view lessons published.
13. **News** – providers can view and search for important news published.
14. **Events** – providers can view upcoming events and they can register if required.
15. **Quality Improvement Monthly Statement (QIMS)**

    a) Allows providers to:

    - View Raw Quality Rating - the result of part C, part D and the Overall. Also, allow providers to view a chart YOY (Year over Year): this chart compares provider performance based on their star result at this time in time compared to last year.

- View Raw Rating Progress YTD (Year to Day): this chart shows how their execution has moved between Part C & Part D.
- View all measures in evaluation for the Rating Year and which of them are classified in Below Target, On Target and Display Measure.

b) Displays a list of non-compliance beneficiaries for selected measure. Other non-compliance measures for selected beneficiaries are displayed.

c) Save and Print statement.

d) Export statement in Excel format.

16. Hospital Census – this functionality allows providers to follow up patients during and after an admission in a hospital level. In addition, they can identify if the patients were admitted, discharged, or readmitted.

a) Providers can view the following:

- List of beneficiaries admitted
- List of beneficiaries discharged
- List of beneficiaries readmitted
- Type of hospital contract with the plan
- Clinical notes transcribed on admission by the MSO auditor
- Export Census in Excel document

b) Benefits:

- Provides updated and accurate overview regarding the beneficiary clinical data.

- Allows the provider to directly access information regarding the patients results directly from the laboratories, x-rays, etc. and reduces delay in receiving these results from their patients.
- Avoids duplicity of therapies, doses, tests, and procedures.
- Ensures the accuracy and clarity of diagnoses and prescriptions.
- Is aligned with Federal Government requirements in the management of electronic health records.

C. <u>For more information visit the:</u>

1. **InnovaMD portal at www.innovamd.com, or**
2. **Contact InnovaMD Support Team at:**

   Monday to Friday
   7:00 a.m. a 7:00 p.m.
   787-993-2317 or 1-866-676-6060 or
3. **by email at** InnovaMDAlert@mmmhc.com.

10.4 Provider Call Center

The health plan providers of the Government of Puerto Rico (Vital Plan) have available the services of our call center which is open from Monday to Friday 7:00 a.m. to 7:00 p.m. The call center offers services related to eligibility verification, claims status, pre-authorizations, payments among others, and serves primary service providers, specialists, health professionals, ancillary services facilities, dentists and hospitals. Telephone numbers are included below to access the representatives of the provider call center.

Provider Call Center	**787-993-2317 (Metro Area)** **1-866-676-6060 (Toll Free)**
Dental Provider Call Center	787-993-2317 (Metro Area) 1-866-676-6060 (Toll Free)

10.5 Interactive Voice System (IVR) Services

The interactive voice system (IVR) is available to our entire provider network. Through this system, providers can obtain automated information 24 hours a day, 7 days a week. It is convenient, easy to use and fast. In addition, the system provides the information that is needed at once in a confidential manner. The services available through this system are verification of eligibility, payments and preauthorizations, among others.

10.6 InnovaMD Support Group

The InnovaMD portal is an excellent tool for sharing health information of assigned lives with other providers within the health industry. The portal has been developed in a highly secure and efficient platform complying with strict regulations that guarantee compliance with privacy and confidentiality.

Participant providers can validate the beneficiary's eligibility, create, review, and print referrals and pre-authorizations. In addition, they can check their payment history, review, and print news, forms, and guides, among others.

The use of the portal is free of charge and is available 24 hours a day, 7 days a week, and can be accessed at www.innovamd.com.

To offer a complete service, we have technical staff in the InnovaMD Support Group. This dedicated staff offers to our providers, technical support, guidance, education and all the necessary support during the registration and navigation process through our portal. This team's service is offered Monday to Friday from 8:00 a.m. to 6:00 p.m. and you can contact them through our Provider Call Center.

10.7 Electronic Health Record (EHR)

Providers need to comply the following ASES requirements:

1. **Use a Certified Electronic Health Record**.

   The CEHRT must have the latest certification form the Office of National Coordinator (ONC) and has been updated to the 2015 Edition Cures Update.

   To verify if the EHR that you are using in your office is certified, you can validate accessing the following link: https://chpl.healthit.gov/#/search

2. **Electronic Prescribing Software:**

   The EHR system must have electronic prescribing software in place within a reasonable timeframe after the Effective Date of the Contract, which shall not exceed one (1) year from such Effective Date.

3. **Interoperability:**

   Promote health information exchange through interoperable CEHRT and implementing enabling HIT/HIE infrastructure. Data maintained must be made available to facilitate the creation and maintenance of cumulative health records and must permit third-party applications to retrieve adjudicated claims, encounter data, clinical data, including

laboratory results and information about outpatient drug coverage and updates to such information, if applicable. Any third-party application's connection to an API must be consistent with the HIPAA Security Rule.

4. **Meet the Program requirements for Promoting Interoperability for Medicaid providers.**

11. INPATIENT UTILIZATION MANAGEMENT

11.1 Vision

The main objective is to ensure excellence in the provision of necessary medical services with the highest sense of responsibility and cooperation between providers and company facilities.

11.2 General Description

The management of inpatient medical use is a process designed to monitor a set of integrated components, including but not limited to:

a. Case Number Notification

b. Admission Review

c. Concurrent Review

d. Retrospective Review

e. Discharge Planning

f. Individual Case Management

The administration of MMM Multihealth's Provider network for *Plan Vital* was delegated to inHealth Management, LLC. This includes medical review, inpatient utilization processes and

authorization of hospital stays at acute and subacute levels for adult and pediatric patients, as well as acute inpatient and partial mental health care.

The Inpatient Utilization Review Department at inHealth Management, LLC, works with medical providers to determine medical necessity, cost-effectiveness and quality of services provided at inpatient settings.

Any determination of medical necessity is carried out in accordance with generally accepted standards in medical practice, including those identified in the Clinical Management Guidelines (based on updated medical evidence), the clinical suitability of the service or procedure, properly documented clinical evidence, current industry standards and existing contractual agreements.

The process covers inpatient services rendered in acute and subacute levels of care, including the transition between these and the patient's home. The purpose is that our beneficiaries achieve an optimal recovery in the required and appropriate level of care to maximize their medical coverage benefits.

11.3 Goals

1. Evaluate all case admitted to a hospital facility by concurrently or retrospectively review.
2. Apply medical necessity criterion according to the criteria described in this manual.
3. Promote effective communication between hospital facility, physicians, and other service providers in order to identify potential needs of beneficiaries during the admission period.
4. Promote a highly effective and efficient discharge planning.
5. Identify deviations and preventable events that might impair the health or optimal recovery of beneficiaries.

11.4 Inpatient Utilization Review Program Description

This program is designed to evaluate all inpatient admissions concurrently and retrospectively in all inpatient facilities. The following principles govern the program:

1. The Chief Medical Officer, AIMD, Vice President of Clinical Operations and other components of the department are responsible for administrating the program's review process and hospital inpatient utilization.
2. The policies and procedures designed by the Inpatient Utilization Review Department are revised and approved by the Vice President of inHealth Management, LLC who reserves the right to periodically review these policies and procedures.
3. The department is responsible for determining medical necessity of services in accordance with the criteria mentioned in this guide.
4. All clinical/medical determination are supported by updated evidence, based on medical care guidelines.
5. MMM Holdings, LLC and Inhealth Management, LLC currently have the MCG guidelines that are used in the evaluation of concurrent and retrospective cases admitted in facilities.
6. The Inpatient Utilization Review Department is also responsible for identifying trends in overutilization or low utilization by monitoring referrals, encounter data, pharmacy data, assessment of records and requests for authorizations.
7. inHealth Management, LLC assigns the responsibility of concurrent and retrospective review process to highly qualified professionals (clinicals auditors) with extensive clinical experience in hospital settings or utilization management. The clinicals auditors receive

direct support from the AIMD, who makes the final decision to approve or on the contrary, make an adverse determination.

8. InHealth Management, LLC reserves the right to reassign Clinical Auditor staff to contracted hospital facilities. This process of change of route or facility is performed at the discretion and need of the company, depending on its operational needs.
9. Any service that has been determined as not medically necessary or not covered under the enrollee's existing contract will be adverse determined. Likewise, adverse determinations for contractual and/or administrative reasons.
10. Providers will have the right and opportunity to appeal any adverse determination through MMM Multihealth Appeals and Grievances (A&G) Department for *Plan Vital*. The provider must comply with the case pre-deviation and discussion processes as indicated in this manual in order to proceed with the evaluation of an appeal.
11. All service providers have the right to file an appeal starting 30 days after closing the case. To apply for an appeal, a hospital provider must submit all documentation complete (true and exact copy of medical records, a letter indicating reasons why non-compliance days should be validated) to the Appeals and Grievance Department. The appeal must be signed by a licensed physician to practice medicine in the Commonwealth of Puerto Rico.
12. At inHealth Management, LLC we are committed to providing outstanding medical services. We work closely with utilization departments of medical institutions and with patients' physician during the admission period, to provide the greatest benefit to the patient. To achieve this, our utilization management decisions are based on medical

necessity and timeliness of services provided based on the application of clinical care guidelines authorized by the company at the time of review.

13. InHealth Management, LLC does not compensate employees assigned to the review and management of utilization for denying services and does not provide financial incentives for approving or denying requested services.

11.5 Organization:

A. <u>Associate Inpatient Medical Director (AIMD)</u>

1. Health professional specialized in the field of medicine, certified and licensed by the Board of Medical Examiners to practice medicine in Puerto Rico.
2. Our AIMD are specialist in internal medicine. We also have various specialists and sub-specialists that support medical decisions and determinations during the utilization review process of inpatient cases.
3. The AIMD is the only person in charge of highlighting and determining clinical non-compliant days regarding services or a hospital stay.
4. All decisions are supported by utilizing medical management guidelines approved by inHealth Management, LLC at the time of review or when a service is provided.

B. <u>Clinicals Auditor</u>

1. A healthcare professional specialized in nursing with two (2) years minimum experience in a clinical area, certified and licensed as a General Nurse or Nurse Specialist by the Nursing Board of Puerto Rico to practice nursing in Puerto Rico.
2. Our auditors are highly qualified professionals with clinical expertise who have been

certified and trained in the use of company-approved medical care guidelines.

3. Our auditor staff carries out the concurrent and retrospective audit process validating provided medical care based on the documentation provided in the medical record.
4. Clinical Auditor staff may approve services as long as they comply with all criteria authorized in the medical care guidelines at the time of review or when services are provided.
5. The Auditor can approve services in the first instance.
6. Auditor staff is responsible for detecting administrative and medical treatment deviations. All clinical criteria are referred to the AIMD for corresponding action.

11.6 Definition of Concepts

A. <u>Concurrent Review Process</u>

1. The process in which Clinical Auditor assigned to the institution physically evaluate the medical record at the hospital facility or remotely through the electronic medical record during the patient's stay. It is defined as concurrent, the review of medical records that occur prior to the date of discharge.
2. The Clinical Auditor must have contact with the medical record at least one occasion to be considered a concurrent review prior to the patient's discharge.

B. Deviation Notification Process

1. Intermediate communication phase during the Concurrent Review process between the Clinical Auditor, hospital facility and admitting physician.

2. The Clinical Auditor will verbally inform the staff assigned by the hospital or admitting physician, as well as provide a written notification of any type of clinical or administrative deviation that must be corrected immediately by the hospital or admitting physician.
3. The objective of the process is to maintain the flow of information by promoting the clinical discussion of cases, to facilitate their management and minimize possible adverse determinations to the hospital or physician at the time of closing the case.
4. Once the case is available for closing, the Clinical Auditor will evaluate the case entirely; after the days in non-compliance have been identified a Case Discussion letter will be sent indicating all the days.
5. The facility will have a period not exceeding 90 calendar days after the date of discharge, to present the file to the Clinical Auditor without an administrative penalty for exceeding the established time frame.
6. If an expired case is presented 90 calendar days after the discharge date, it will not be reviewed by the Clinical Auditor. The case will be closed with the recommendation of an administrative adverse determination.
7. This process does not apply to retrospective case review.

C. Retrospective Review Process

1. Process through which the Clinical Auditors physically evaluate the medical record at the hospital facility after the discharge date. It is defined as retrospective, any revision or first contact with a medical record by our Clinical Auditors after the discharge date. During this process, the patient is physically absent from the hospital

facility due to discharge, transfer to another institution, discharge against medical recommendation or death.

2. The hospital facility has a period lasting no longer than ninety (90) calendar days from the discharge date to submit the record to our auditors for evaluation to avoid an administrative penalty for exceeding the established period.
3. If an expired case is presented 90 calendar days after the discharge date, it will not be reviewed by the auditor. The case will be closed with the recommendation of an administrative adverse determination.
4. The Deviation Notification Process does not apply to retrospective review cases.

D. Discharge Planning Process

1. The discharge planning process analyzes the patient's bio-psychosocial needs in a holistic manner during the hospital admission. This analysis is performed by a healthcare professional.
2. The hospital provider and admitting physician are responsible for initiating, developing, and implementing this process.
3. Any deviation from the hospital provider that delays this process and extends a patient's stay may cause an administrative adverse determination of payment for excess days.
4. The hospital provider is responsible for providing all patients with written instructions upon discharge, including the Important Discharge Notice as per CMS and ASES regulations.
5. The hospital provider will provide all patients a discharge summary from their

hospitalization. It is the patient's responsibility to share the discharge summary with their Primary Care Physician (PCP).

6. As long as there is an agreement between the parties, an MSO of PR, LLC discharge planner can access the patient and family to help coordinate the discharge planning process including medication reconciliation, health education, follow-up appointments with their PCP or specialist and, any services that require coordination with the healthcare plan at the time of discharge.

11.7 Medical Care Guidelines

Since the 1990s, clinical guidelines have been developed and published to promote the adoption of the best evidence in clinical practice.

1. The guides are typically published by national associations, professional societies and government agencies and, therefore, their recommendations are based on consensus, they include multiple evidence-based options and do not necessarily adhere to specific practices or local health service benefit systems.
2. Clinical guidelines are used by the doctor and other health professionals to treat patients with specific diagnoses or conditions according to evidence-supported medicine.
3. ASES endorses the use of these guides in the review of medical records to support the authorization of services. Currently, with the patient in mind, the guideline used and approved by inHealth Management, LLC is MCG.
4. This guideline is used to assist in identifying the best practices accepted in medicine and to improve patient care based on updated medical criteria and supported by the state of

knowledge of science and practice prevailing in medicine.

5. All the staff of the Inpatient Utilization Management Department has been properly instructed in the use and application of the guidelines. Guidelines and staff training are reviewed periodically.
6. inHealth Management, LLC reserves the right to select the medical care guidelines based on business needs and in benefit of the member.

11.8 Policy for Admissions Notification and Medical Discharge: Acute level, SNF and Rehab (Non-coverage service)

A. <u>Admissions:</u>

1. Hospital provider is responsible for notifying all admissions to our coordinators daily through the following telephone numbers: 1-833-950-4360. They can notify admissions and discharges via fax to 787 – 999 - 1744 or by email inpatient@inHealthpr.com using the form provided.
2. The form provided for the notification of admissions and discharge must include Beneficiary ID, Beneficiary Full Name, Admitting Physician Full Name, Admission Diagnosis Code (ICD-10), Admission Date, Discharge Date, Patient's Room Number, Type of Admission and final disposition include expired patient.
3. The provider has a maximum of three (3) calendar days from the admission date to notify the admission to inHealth Management, LLC Inpatient Utilization Review Department in order to request a case number.
4. inHealth Management, LLC Inpatient Utilization Review Department will verify member eligibility with the plan for the corresponding dates in which services were

provided. If they are eligible, the coordinator from inHealth Management, LLC will notify the case number to the hospital provider, either by telephone, by fax or email within twenty-four (24) hours of the hospital provider's request. inHealth Management, LLC is not responsible for the payment of services rendered if the enrollee is not eligible at the moment the services were provided.

5. The assigned case number does not guarantee payment of admission; it is subject to the review of medical records by Clinical Auditor.
6. Notification of Decision (Notice of Decision - Application for Medical Benefits) known as MA-10 must be presented with the following documentation: notification of action on application or reassessment, admission fact sheet, beneficiary ID number, beneficiary first and last name, full name of admitting physician, admission diagnosis code (ICD10), admission date, discharge date, room number and type of admission. The hospital facility has a period no longer than fifteen (15) business days from the date of issuance, the date of action on application or reassessment for the admission notification.
7. The hospital facility has a period no longer than 90 calendar days to report the admission from the date of discharge and/or adverse determination of any medical insurance (Medicare, Medicaid, Private Plan, etc.).
8. inHealth Management, LLC is not responsible for payment for services provided to a member when the member is not eligible on the date of service.

B. Discharges:

1. The hospital provider is responsible for notifying InHealth Management all Government Health Plan patients discharges within a period of time no greater than two (2) calendar days from the patients discharge date, through the same numbers previously mentioned.

2. CMS will assure beneficiaries obtain a high-quality medical attention. InHealth Management, LLC will guarantee that the patient receives adequate services during the admission and after discharge.

3. As part of the process, the hospital provider will notify the discharge and will send a discharge summary electronically and/or through Innova MD. The patient's disposition includes the notification of the patient who died during the stay in the hospital. The discharge disposition will be notified by email inpatient@inHealthpr.com or via fax 787-999-1744.

C. Notification Hours:

Office hours are Monday through Friday, from 7:30 a.m. to 4:30 p.m.

Admissions and discharges can be notified on weekends via fax to 787 – 999 - 1744 or by email inpatient@inHealthpr.com using the form provided. The reference number for reported admissions notified on weekends will be offered the next business day.

11.9 Newborns Notification Policy

1. Hospitals must complete the established form for notification of births and newborns in a period not exceeding 24 working hours and send it to the following address inpatient@inHealthpr.com or to the fax number 787 – 999 - 1744.

2. The hospital staff may contact the MMM Multihealth Inpatient Department at 1-833-950-4360 , to clarify questions or concerns regarding the notification process of newborns.
3. Inpatient Department will place the form in the Dakota file in the Compliance PSG-Audit and Reporting folder and then choose the Newborn Notification all the information collected in a period of 24 working hours or less.
4. Staff from the Medical Services Department will then submit to ASES the information collected over a period of 24 working hours or less.

11.10 Assessment of Clinical Records Policy in Contracted Hospital Facility

1. The hospital provider is responsible for providing and assuring adequate physical facilities so that the auditors can comply with the medical record review process Monday through Friday from 8:00 a.m. to 5:00 p.m.
2. The hospital provider is responsible for having hospital staff accessible to assist and attend the auditors during scheduled visits as agreed by inHealth Management, LLC and the contracted hospital.
3. Our auditors will be assigned to the facility for concurrent review based on the volume of members admitted in the institution.
4. The hospital provider is responsible for complying with the previously mentioned processes to avoid delay in the concurrent review process or an increase in retrospective case reviews.
5. The healthcare provider must submit a census or list of hospitalized cases of all MMM

Multihealth enrollees to inHealth Management, LLC auditors' staff on or before 8:30 a.m. of each business day. The census must include all postpartum cases and babies born to these, as well as babies in good health that are in the Nursery.

6. The hospital provider should notify all new admissions and all discharges to auditors' staff.
7. The concurrent review process for admitted cases should be initiated on the first day of hospitalization.
8. The hospital provider is responsible for presenting the auditors with 100% of all admitted cases during the auditor's visits to the facilities, including Emergency Room admission cases.
9. Cases that are not presented by the hospital provider to our auditors' staff will be subject to adverse determination if the record's medical documentation does not justify the days incurred.
10. Admissions by non-participating providers of inHealth Management, LLC could be adverse determined entirely after the stabilization period, providing it's not an emergency, if the service is not transferred to a participating physician from inHealth Management, LLC Network.
11. The non-participating physician will perform the transfer of care process, to a participating physician within the facility.
12. Participating hospital staff will cooperate with inHealth Management, LLC that non-participating physicians effectively transfer medical services to another participating physician of inHealth Management, LLC Network without affecting services or the patient's continuity of care.

11.11 Inpatient Concurrent Review Policy for Acute and Sub-acute Level of Care

1. Concurrently reviewed cases will be evaluated by the auditors who will discuss all clinical deviations with the AIMD. Afterwards, the AIMD will apply the medical care guidelines established and notified by the company for final determination.
2. The process of determining medical necessity by concurrent review will continue in accordance to the policies and procedures as set out in this manual.
3. The priority in the evaluation of medical records on behalf of the plan will be the concurrent review process followed by the retrospective review process.

11.12 Deviation Notification Policy

1. Intermediate phase of communication during the concurrence process between the Clinical Auditor, hospital provider and/or admitting physician.
2. The deviation notification process may be applied to the hospital provider, the medical provider, or both parties. The process will depend on whether the deviation is administrative, clinical or a combination of both.
3. After the verbal and written notification by the Clinical Auditor to the personnel assigned by the hospital, of a possible deviation (adverse determination), the hospital provider will provide additional clinical information justifying the stay.
4. This information must be notified to Clinical Auditor with supporting clinical or administrative documentation for final determination of approval or adverse determination of the days.

11.13 Assessment of Retrospective Admissions Policy

1. Retrospective review is considered to be any case that has not been presented during the patient's stay.
2. Clinical Auditor review the medical record after the discharge date.
3. The hospital facility will have a period lasting no longer than ninety (90) calendar days from the patient's discharge date to present the case to the auditors without penalty of an administrative adverse determination for exceeding the assigned time frame.
4. This process may be subject to current written contractual agreements between both parties (InHealth Management, LLC, and the contracted institution) at the moment the services were rendered.
5. The Clinical Auditor or coordinator will verify the eligibility of the retrospective case and notify the hospital provider the dates services were provided.
6. If a case is presented after the assigned ninety (90) calendar days period from the discharge date, the case will not be reviewed. Will proceed with an administrative adverse determination.
7. In retrospective cases admitted in the hospital facility with Original Medicare or other healthcare plan adverse determination, the provider must present our Clinical Auditor with the adverse determination letter as evidence in order to initiate the retrospective review process.
8. The hospital provider has a period lasting no more than ninety (90) calendar days of receiving the Original Medicare or another healthcare plan denial to present the case to the Clinical Auditor.

9. If a record is presented after the assigned period of receiving the Original Medicare or another healthcare plan adverse determination, the case will not be audited. We will proceed to close the record indicating an administrative denial.
10. The process of determining medical necessity during the closing of retrospective admissions will continue in accordance to the criteria as set out in this manual.

11.14 Noncompliant Admission Days or Level of Care Adjustments Policy

1. The Clinical Auditor is responsible for initiating the evaluation of the medical record and identifying possible deviations that affect the management or stay of a patient by applying the medical care guidelines approved by InHealth Management, LLC, at the time the services were provided.
2. The Clinical Auditor will only take into consideration the evidence documented in the clinical file at the moment of the evaluation.
3. The deviation notification process will be activated and notified verbally as well as written to the hospital provider, admitting physician or personnel assigned by the institution. It is the hospital's responsibility to initiate the communication process with its medical staff to promote the flow of information, legible documentation, and availability of information that will support the member's hospital stay and the level of care provided.
4. The Clinical Auditor will consider only the evidence documented in the medical record at the time of assessment.
5. The Clinical Auditor will have discussions with the AIMD in regard to all potential deviations that may cause non-compliance days, services or medical visits of

subspecialist.

6. At the time of closing the case, a Clinical Auditor will receive the medical record in its entirety and coded so that the corresponding medical use review process can be carried out.
7. During the closing process, the Clinical Auditor will notify the provider of days in clinical non-compliance and/or level adjustment. The hospital provider will have ten (10) calendar days from the time the case is placed under discussion, to present evidence, so that the case can be completed.
8. It is the provider's responsibility to complete the case discussion process on or before ten (10) calendar days. The Clinical Auditor will complete the review process and deliver to the supplier the letter and/or final notification report indicating the days approved or denied as of the date of closing of the file.
    a. Stratification of the adverse determination (Administrative Adverse Determination Reasons): Some reasons for adverse determinations but not limited to:
        i. A physician’s payment for professional services will not be affected due to administrative adverse determination denied to the hospital provider.
        ii. Delays in answering consultations that may impact additional length of stay. Consultations should be answered in 24 hours.
        iii. Omission or delays of pharmaceutical administration or procedures ordered by an authorized physician that may incite prolonged bed

days.

iv. Omissions of treatment that may produce complication in the condition and therefore increase length of stay.

v. Non-Available Services in hospital facility that involve coordination with another facility, therefore may prolong the stay, or may interfere with a decision for discharge.

vi. Sudden clinical changes in members condition previously documented in the medical file and no action was taken by the facility health staff.

vii. No availability of needed specialty consultants.

viii. Lack of hospital discharge plan that may cause prolonged hospital to stay.

ix. Does not meet the appropriate level of care according to the Medical Care Guidelines use and approved by MMM Holdings, LLC.

x. No availability of hospital beds, therefore, members are kept in the Emergency Room.

b. Stratification of the adverse determination (Clinical adverse determination Reason): Some reasons for adverse determinations but not limited to:

i. Physician visits not completed or not documented on medical file, subsequent to 24 hours from the auditing day.

ii. Clinical record does not reflect relevant medical documentation of the severity of condition and intensity of treatment.

iii. Not providing an adequate level of care or a level of care that is not

appropriate according to the Medical Care Guidelines approved by MMM Holdings, LLC.

9. If the provider does not present clinical evidence within ten (10) calendar days justifying the stay and level of care, the adverse determination of days or level adjustment will prevail.
10. The Clinical Auditor will refer any clinical questions to the AIMD through the electronic InHealth system. The AIMD will apply clinical criteria using as a reference the clinical care guidelines established by the company for its final determination.
11. If the deviation notification process and/or case discussion process is not carried out between the hospital, medical provider, and the Clinical Auditor and there is no documentation supporting or justifying the member's hospital stay and level of care, the determination of adverse determination days or the adjustment in level of care will prevail.
12. The Clinical Auditor will complete the case review process and deliver to the provider the final notification letter or a summary report of completed cases indicating approved or adverse determined days on the date medical file is closed.
13. The process of notification and discussion of deviations identified in these files will not proceed in cases evaluated retrospectively.

11.15 Closure of Medically Discharged Case Policy

1. The hospital provider will present the cases with medical discharge to the Clinical Auditor for closure, in a period no greater than ninety (90) calendar days from the discharge date.
2. This process may be subject to valid written contractual agreements between both

parties (InHealth Management, LLC and the contracted institution) at the time the services were rendered.

3. The Clinical Auditor will deliver written notification to the hospital provider indicating authorized days, non-compliance days or adjustments in levels of care.
4. If the hospital provider does not present the discharged cases to the Clinical Auditor within a ninety (90) calendar day's period from the case's discharge date, the case will be administratively closed due to an adverse determination.

11.16 Concurrent Review Process to Prolonged Admission Stay at Emergency Room Policy

1. This process only applies to providers that have a contractual agreement with MSO that establishes contracting services under the Emergency Room.
2. Assessment criteria and current notification policies from InHealth Management, LLC inpatient utilization review department, deviation notification policies, the retrospective case review policy, and policies relating to notification of non-compliance days or adjustment in levels of care will be applied.
3. The Clinical Auditor will execute the scope of contractual clauses providing medical services to the patient. The approval or adverse determination of services for not meeting the criteria established at the emergency room , adjustments in level of care or subspecialist medical visits will be subject to the services rendered according to the patient clinical needs.
4. For hospital facilities that MSO contracts with per diem rates who do not have a written and valid contract or other contractual agreements at the time the services

were provided, the days that the patient remains in emergency room facilities without being transferred to the patient's appropriate level of care as recommended in the medical orders, will be denied due to administrative contractual reasons.

5. Any hospital provider without an Emergency Room contract will have until 11:59 p.m. of the admission day to transfer the patient to the appropriate level of care recommended in the medical order to avoid an adverse administrative contractual determination.
6. Admissions with prolonged emergency room stays will not be able to exceed the conditions stipulated in the contract. Excess days will be determined as adverse administrative contractual reason.

11.17 Notification of Medical Consultations policy: Specialists or Sub-Specialists

1. The hospital provider will have a period of no more than twenty-four (24) hours from the date and hour of the medical order for the medical consultant to evaluate the patient.
2. If the consultant exceeds the established twenty-four (24) hours period in evaluating the patient and makes recommendations or adjustments that alter the treatment or the patient's hospital stay, then the excess days incurred waiting for the consultant's evaluation will be adverse determined to the hospital provider due to administrative reasons.
3. This process may be subject to valid written contractual agreements between the

contracted hospital provider and MSO at the time the services were rendered.

11.18 Report of events HAC & SRAE Policy

1. Sentinel events, HAC and SRAE are defined as any preventable clinical event that occurs during a patient's hospitalization and that was not identified as a condition Present on Admission (POA) as defined by the CMS and ASES Manual.
2. A mechanism for the prevention of payment will be generated for hospitalization days and services incurred by these preventable events.
3. The hospital provider will allow personnel access to medical files for investigation of Sentinel, HAC or SRAE within five (5) business days from the moment when the event occurred, to allow the healthcare plan to respond within a ten (10) day period, as established by CMS and ASES. The event will also be notified by the hospital provider to InHealth Management, LLC Clinical Auditor.
4. The hospital provider will be accessible to attend and discuss the case with a representative from InHealth Management, LLC and/or MMM Holdings, LLC if it is required in order to discuss the case and observations.
5. Sentinel events or Serious Reportable Adverse Events will be evaluated in every concurrent and retrospective case review.
6. For more information regarding regulations related to Sentinel events, POA's, HAC or SRAE, please visit the following link where you will also find an updated list of conditions considered SRAE: https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalAcqCond

7. MSO reserves the right to implement Sentinel events, HAC or SRAE Policies, as per existing regulations or new changes from CMS.

11.19 Hospital Diagnosed Special Conditions Report Policy

1. Special conditions are defined as all congenital and chronic conditions that require specialized medical care as defined by the Government Health Plan Vital (see list) and have been diagnosed during the period of hospital admissions.
2. The hospital provider shall allow the Clinical Auditor access to the medical record, other relevant data, and studies to support and certify the diagnosis of the condition; this will permit the healthcare plan to report it to the members PCP and ASES.
3. The PCP or Specialist will proceed to request special ASES coverage that corresponds to the beneficiary as required.
4. The cases with special conditions will be evaluated by the Clinical Auditor in any review concurrently and retrospectively when the case is appropriate. (As it applies).
    - Special conditions list:
        - Adults with Phenylketonuria
        - Amyotrophic Sclerosis (ALS)
        - Aplastic Anemia
        - Autism
        - Cancer
        - Child with special conditions
        - Chronic Renal Failure (Stage 3, 4 & 5)
        - Cystic Fibrosis

- Hemophilia
- HIV/AIDS
- Leprosy
- Lupus
- Multiple Sclerosis
- Obstetrical Patients
- Post-transplant status
- Pulmonary Hypertension
- Rheumatoid Arthritis
- Scleroderma
- Tuberculosis
- Hepatitis C
- CHF-Stage III y IV
- Deafness in Neonates
- Primary Ciliary Dyskinesia (PCP
- VHI/ AIDS

11.20 Consultations, Procedures and Study request for non-participating Providers

1. MMM Vital must receive from non-participating providers a request for authorization for professional and technical components of the procedure if it is eliminated from the contract of per diem, capitated, etc. In the case from the hospital for all services, studies,

consults, and procedures for enrollees, MMM Vital must administer, review, clinically determine and inform the decision to non-participating providers in a timely manner to ensure that all applications are being coordinated and carried out, thereby ensuring the enrollee's well-being.

2. The non-participating provider or hospital facility must fax the request for authorization to 787-999-1744, prior to providing the services, except when the service is considered an emergency. It must include at least medical orders, diagnostics, procedure codes, patient demographic information, facility where the procedure will be performed or the service will be provided, contact information of the requesting provider, NPI and the fax number to which the document with the authorization or adverse determination of services will be sent.
3. Inpatient department coordinators shall send the received documents immediately to the Clinical Auditor, assigned utilization management supervisor and the AIMD.
4. The AIMD must decide within twenty-four (24) hours based solely on clinical criteria. In cases where there are contracted physicians who can perform such services or procedures, the AIMD may recommend the change to a contracted provider.
5. The inpatient department coordinator must immediately generate an official letter through the electronic system and send it to the requesting provider.
6. Providers can request an expedite appeal for an adverse decision following the established calendar days and process established by InHealth Management, LLC.
7. Providers must send the written authorization to the Claims Department.

12. PROVIDER NETWORK AND CONTRACTOR PROCESS

12.1. Sanctions or fines applicable in cases of non-compliance

ASES will review each executed Provider Contract against the approved model of Provider Contracts. ASES reserves the right to cancel Provider Contracts or to impose sanctions or fees against MMM Multihealth for the omission of clauses required in the contracts with Providers. The Credentialing Department verifies excluded providers and the Medicare/Medicaid Opt-Out list, on monthly basis, prints and files copy of the reports available in the following links:

- http://oig.hhs.gov/fraud/exclusions/supplement_archive.asp
- http://medicare.fcso.com/Opt_out/

If a Credentialing Department becomes aware that a provider has been excluded or has opted out, the Credentialing Auditor informs the Network Operation Departments start the process of removing that provider from *Vital* network. The specific reasons to consider the exclusion of a provider are as follow:

- 1001.201 - Conviction relating to program or healthcare fraud.
- 1001.301 - Conviction relating to obstruction of an investigation.
- 1001.401 - Conviction relating to controlled substances.
- 1001.501 - License revocation or suspension.
- 1001.601 - Exclusion or suspension under a Federal or State healthcare program.
- 1001.701 - Excessive claims or furnishing of unnecessary or substandard items and services.
- 1001.801- Failure of HMOs (Health Maintenance Organization) and CMPs (Civil Money Penalty) to furnish medically necessary items and services.

- 1001.901 - False or improper claims.
- 1001.951 - Fraud and kickbacks and other prohibited activities.
- 1001.952 - Exceptions.
- 1001.1001 - Exclusion of entities owned or controlled by a sanctioned person.
- 1001.1051 - Exclusion of individuals with ownership or control interest in sanctioned entities.
- 1001.1101 - Failure to provide payment information.
- 1001.1301 - Failure to grant immediate access.
- 1001.1401 - Violations of PPS corrective action.
- 1001.1501 - Default of health education loan or scholarship obligations.
- 1001.1601 - Violations of the limitations on physician charges.
- 1001.1701 - Billing for services of assistant at surgery during cataract operations.

MMM Multihealth will not make a payment to any Provider who has been barred from participation based on existing Medicare, Medicaid, or CHIP sanctions, except for Emergency Services.

12.2 Provider Qualifications

Network Providers that *Vital* Enrollees may access without any requirement of a Referral or Prior Authorization; provide services to *Vital* Enrollees without imposing any Copayments; and meet the Network requirements described in Article 9 of this Contract. *Vital* will comply with the requirements specified in 42 C.F.R. §438.207(c), §438.214 and all applicable Puerto Rico requirements regarding Provider Networks.

Provider Qualifications and Categories

Primary Care Physician, Specialist & Ancillary	
Physician	1. A person with a license to practice medicine as an M.D. in Puerto Rico, whether as a PCP or in the area of specialty under which he or she will provide medical services through a contract with the GHP; and is a Provider enrolled in the Puerto Rico Medicaid Program; and has a valid registration number from the Drug Enforcement Agency and the Certificate of Controlled Substances of Puerto Rico, if required in his or her practice. PCP Example: • General Medicine • Internal Medicine • Geriatric Medicine • Family Medicine • Pediatric Medicine 2. Other specialties considered Primary Care under special circumstance are: • Obstetrics & Gynecology • Hematology • Nephrology
Ancillary	• Federal Qualified Health Centers (FQHC) • Hospital • Rural Health Clinic (RHC) • Non-Hospital Providing Facility • Schools of Medicine • Detoxification Facility • Short-Term Intervention Center

	• X-ray Facilities • Clinical Laboratories • Providers and facilities for Behavioral Health Services • Specialized Service Providers • Urgent care centers and emergency rooms • Any other providers or facilities needed to offer covered services, except for pharmacies, considering specific healthcare needs of the service region.
Specialist	• Ophthalmologists • Radiologists • Endocrinologists • Nephrologists • Pulmonologists • Otolaryngologists (ENT) • Cardiologists • Urologists • Gastroenterologists • Rheumatologists • Dermatologists • Oncologists • Neurologists • Infectious Diseases Specialists • Orthopedists • Physiatrists (Physical & Rehabilitative Medicine) • General Surgeons • Podiatrists
Other Providers	• Optometrists • Chiropractors

	• Speech Therapists • Nutritionists • Physical therapists
Behavioral Health Providers	• Psychiatrists • Clinical or Counseling Psychologist • Social workers (MSW) • Certified Addiction Counselors • Behavioral Health Facilities

12.3 Preferred Provider Network (PPN) Standards

A Preferred Provider Network ("PPN") refers to a group of contracted Network Providers that *Vital* Enrollees may access without the requirement of a referral from their PCP. An added benefit to the Enrollees is that by using a PPN provider there are no co-pays that the enrollee is responsible for. The PPN is composed of physician specialists, clinical laboratories, radiology facilities, hospitals and services to *VITAL* beneficiaries. The objectives of the PPN model are to increase access to Providers, improve timely receipt of services, improve the quality of enrollee care, enhance continuity of care, and facilitate effective exchange of Personal Health Information between providers and MMM Multihealth. The PPN can be divided in two categories:

1. A general PPN contracted by MMM Multihealth available to all enrollees.
2. A more limited PPN contracted directly through the individual Primary Medical Group (PMGs). The particular PMG can be accessed by the enrollees who selected a PCP participating in such PMG.

Through the MMM Multihealth PPN, Enrollees will be allowed to receive services from all Providers within the PPN without Referral from their PCP. Enrollees who receive a prescription

from a PPN Provider are allowed to fill the prescription without the requirement of a countersignature from their PCP.

In addition to the general PPN, Enrollees within a PMG that has its own PPN, can access such Providers without the need of a referral from their PCP as well as acquiring a prescription without the countersignature of their PCP. Providers within the PMG PPN could be co-located at the PMG facilities.

Through this PPN model MMM Multihealth shall improve access to care while improving the quality of services in a cost-effective manner. *Vital* is an integrated program that includes both Physical and Behavioral Health Services and must also explain the concepts of Primary Medical Groups and Preferred Provider Networks. The General Network will be comprised of all Providers available to Enrollees including those Providers who are designated as PPN and those Providers who are included in the general or particular PMG PPN.

12.4 Provider Credentialing

A. <u>Provider Enrollment as Medicaid Providers</u>

According the PRHIA-ASES contract requirement, MSO needs to verify that all Providers for *Plan de Salud Vital* are Medicaid-enrolled Providers consistent with the Provider disclosure, screening, and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b).

If provider isn't enrolled as Medicaid Provider, the process cannot start with MSO Credentialing Department. First, the provider needs to comply and meet the Medicaid enrollment requirement before beginning the initial credentialing process.

All requests of initial credentialing process without Medicaid Enrollment will be automatic rejected by MSO Credentialing Department.

ASES will issue to MSO a list of providers who have applied and who have been approved weekly. We will use this list to update our records to validate which network providers have registered properly in Puerto Rico. All providers must ensure Medicaid registry revalidation with the state every 5 years.

B. Standard for Credentialing and Re-credentialing

1. Credentialing is required for:

All physicians who provide services to the MMM Multihealth Enrollees and all other types of Providers who provide services to the MMM Multihealth Enrollees, and all other types of Providers who are permitted to practice independently under Puerto Rico law including but not limited to: hospitals, X-ray facilities, clinical laboratories, and ambulatory service Providers.

2. Credentialing is not required for:

Providers who are permitted to furnish services only under the direct supervision of another practitioner; Hospital-based Providers who provide services to Enrollees Incident to hospital services.

C. Professionals / suppliers who are invited and / or wish to be part of the network of MSO providers for Vital, must:

1. Comply first with the enrollment requirement through the Health Insurance Administration (ASES) and the Medicaid program in accordance with the mandates of state and federal laws.

2. Send to the Network Management Department a complete initial application with all required credentials for the evaluation process to participating in the network. A complete application consists of current documents and is defined with the following credentials:
    - Electronically signed application form from requesting provider
    - Evidence of enrollment in the Medicaid program
    - DEA Certificate
    - Malpractice insurance
    - ASSMCA certificate
    - License issued by the Department of Health of Puerto Rico.
3. Practitioners/Providers will not be included in the network until the credentialing process is completed.

D. Selection will be based on several factors including but not limited to:

1. Enrollee needs, including accessibility and availability
2. Network needs
3. Successful completion of the credentialing process
4. If the application is approved by the Network Management Department and all the documentation is received in force, MSO may begin 45 calendar days for the initial credentialing process.
5. For you to obtain a determination from the Credentials Committee, the application and all requires documents must have 45 calendar days or less for initial credentialing and 180 days for recredentialization.

6. Health professionals and / or providers will not be included as participating providers until the initial credentialing process is completed and it is validated that they have the quality standards to be participants in the Vital plan network.

MSO will not discriminate against any physician based on certification or specialty, race, color, ethnic/national identity, gender, genetic information, age, languages, sexual orientation, HIPAA, disabilities, or the type of procedures in which the practitioner specializes.

Nondiscrimination Oversight review is done proactively, and through an ongoing monitoring process. Credentialing Committee members sign an attestation that they do not practice discrimination during the credentialing process, and the Credentialing Department monitors practitioner complaints for allegations of discrimination and reports their findings to the QIC.

Network Adequacy reports are generated on an annual basis. After analysis, a moratorium on specific provider classification may be in effect if there is no need for that specific provider in the network. Thereafter the moratorium of new PCP physicians (General Practitioner (GP), Internal Medicine (IM), and Family Practice (FP), Geriatric, Pediatric and Obstetrics & Gynecology (OB-GYN) will be waived considering the following:

1. The requesting PCP will become part of an MSO Group, and all his contracting documentation has been approved by the MSO.
2. Non-Contracted PCP provides services in an underserved area where his specialty is required (Applies only to IM and FP providers).
3. In instances when provider receives, inherits, or buys a practice from a retiring physician who is currently a member of MSO.

MSO through verifies information for credentialing and re-credentialing by using oral, written, and Internet data. Primary source verification includes:

1. Participation in the Medicaid Program
2. A current valid license to practice in Puerto Rico (Good Standing)
3. Evidence of education and training
4. Information from the NPDB
5. Any information regarding sanctions and/or limitations to licensure
6. Any sanction or Opt-Out activity by Medicare
7. DEA Certificate
8. AMSSCA Certificate

MSO or any of its contracted providers will not contract with or employ any individual who has been excluded from participation in the federal and state programs.

MSO will recredential all providers within 36 months through a recredentialing cycle according to the contract and CMS Guidelines. When primary source verification has not been received after 15 days of the receipt of application, the provider will be notified. A provider will not be credentialed if after 45 days from the date the application was received the primary source verification of education and license has not been received. A letter will be sent to the provider notifying the decision and advising to resubmit another application.

A physician will have the right to review information, excluding the NPDB, submitted by an outside primary source to MSO of Puerto Rico in support of his/her credentialing and re-credentialing process and to correct any erroneous information.

Upon request, all practitioners have the right to be informed of the status of their credentialing and re-credentialing applications. Practitioners receive notification of these rights and how to contact the Provider Contact Center, as stated on the credentialing application.

12.5 Credentialing Committee Review and Decision Process

All credentialing time factors must comply within the 45 days for the initial credentialing and 180 days required at the time of the Credentialing Committee decision. For those files reviewed by the Credentialing Committee, under Categories I, II, or III, primary source verification, malpractice history, sanction activity, a practitioner's health status, any history of loss or limitation of privileges or disciplinary activity is reviewed for both credentialing and re-credentialing. Site visit results are only considered for Primary Care Physicians with 10 lives or more and Psychiatrists with more than 3 claims in the last 12 months. Practitioners with less than 10 lives or 3 claims, when applicable, are excluded and a letter for this exclusion will be included in the re-credentialing file. Quality of Care results are considered for all organizational providers when the Quality Department performed this because of an appeal and grievances referral. Practitioner applications that are assessed by the credentialing staff as "clean" files are identified as Category I are reviewed and approved by the Credentialing Committee. For Categories II and III, the committee reviews any positive responses on the Practitioner Questionnaire regarding health issues which may show that the practitioner is physically or psychologically unable to perform the essential functions of the position with or without accommodation, and malpractice claims resulting in individual judgments of $100,000 or less will be carefully reviewed by the credentialing committee medical directors. The Credentialing Committee may recommend approval without conditions, approval with conditions, deny participation, or defer the decision

for further investigation. All applicants receive written notice within 5 calendar days after the Credentialing Committee has rendered a final decision.

12.6 Provider Education and Training

The Provider Education Department is responsible to provide initial onboarding orientation (through MSO University) to new contacted providers. In addition, it is responsible to offer twenty (20) continuing education credit hours, divided into five (5) hours per quarter to our Vital plan providers. This education will be provided in conjunction with the insurers contracted for Plan Vital.

We use various methodologies when furnishing provider training sessions, including web-based sessions, group workshops, face-to-face individualized education, communications, newsletters, magazines, education modules and office visits to providers and PMGs.

The unit also documents provider participation in continuing education to ASES to evidence that provider education and training requirements have been met.

12.7 Delegation

Delegation is a formal process by which MSO gives a provider group or an entity (delegate) the authority to perform certain functions on its behalf, in a manner consistent with the applicable regulations.

This process may involve delegation of credentialing responsibilities such as: information gathering, verification of some or all the credentialing elements, or it can include delegation of the entire credentialing process, including decision-making. Other processes that may be

delegated are pre-authorizations for medical service, and claims processing, among others. It should also be noted that a function may be fully or partially delegated.

The decision of what function may be considered for delegation is determined by the type of contract a provider group has with MSO, as well as the ability of the provider group or an entity to perform the function.

Although the MSO can delegate the authority to perform a function, it cannot delegate the responsibility. If a provider wants to delegate any services, such delegation must be preapproved by the MSO and set forth in a separate addendum that shall include the following requirements:

1. Specify delegated activities, reporting responsibilities, and performance guarantees.
2. The organization evaluates the entity's ability to perform the delegated activities prior to delegation. The organization must document that it has approved the entity's policies and procedures with respect to the delegated function.
3. Written arrangements must provide for revocation of the delegation activities and reporting requirements in instances where the delegate has not performed satisfactorily.
4. Specify that the performance of the parties is monitored by the MSO on an ongoing basis.

All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare and Medicaid laws, regulations, reporting requirements, and CMS instructions.

The MSO Delegation Oversight Program incorporates the following requirements, at minimum:

1. Evaluation of the entity’s ability to perform the delegated or administrative activities prior to delegation.

2. The MSO Delegation Oversight Audit Team will conduct on-site audits to review activities performed by delegated entities.
3. Site reviews shall be conducted in accordance with regulatory requirements and MSO and Health Plan policies, procedures, and performance standards.
4. Audit results will be reported to the Health Plan Delegation Oversight Committee.
5. MSO of Puerto Rico requires the delegated entity to enter into a written, mutually agreed upon contract or agreement.
6. MSO of Puerto Rico will assess the entity's ability to perform delegated or administrative functions on an ongoing basis, by monitoring entity in an annual audit, and through regular monitoring reports.
7. MSO of Puerto Rico uses a delegated audit tool to assess and assure entity compliance with regulatory requirements.
8. MSO of Puerto Rico requires non-performing entities to submit a Corrective Action Plan (CAP). A CAP is a formal written response that identifies all entity deficiencies cited during the audit and/or monitoring activity. The CAP addresses each deficiency and outlines the corrective action(s) required from the entity.
9. If a delegated entity remains non-compliant with MSO requirements, the MSO retains the right to take final actions which may include but are not limited to:
    a. Monetary Penalties
    b. Revocation of delegation of all or parts of delegated or administrative functions.
    c. Contract termination.

For more detailed information on delegation, you may contact MSO. If you are a provider that belongs to one of our delegated entities, some of the processes described in this manual may change. Therefore, we suggest you refer to the procedures of your entity.

12.8. Confidentiality

All information obtained in the credentialing process is kept confidential. Credentialing documents, committee minutes, and peer review files are kept in confidentially manner. Only appropriate MSO staff has access to these documents.

12.9. Reinstallation Process

MSO does not have a reinstallation process. Once a sanction is removed or has expired and the provider wants to participate in the network, the provider needs to present a new request to the Contracting and Provider Relations Department. The request must be approved by the Evaluation Committee. If the Committee accepts the provider, then the contracting and credentialing process will start.

Regulatory References

a. 42 CFR §422.204(b)(2); Manual Ch.6 – Section 60.3

b. 42 CFR §422.204(b)(2)(iii); Manual Ch.6 – Section 20.2

c. 42 CFR §422.204(b) (1); Manual Ch.6 – Section 70

d. 42 CFR §422.205: Manual Ch. 6 – Section 50

e. NCQA 2010 Credentialing Standards

12.10. Definitions

1. **Primary Care Physician (PCP)** - A Doctor of Medicine (M.D.) or osteopathy (D.O). The Plan's primary care physicians are limited to General Practitioner (GP), Internal Medicine (IM), Family Practice (FP), Pediatrician, and Obstetrician Gynecologist. The PCP possesses skills, and knowledge, which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to their patients.
2. **Physician Specialist** - Doctor of Medicine (MDs), Doctors of Osteopathy (DOs), who provide specialty care services including, but not limited to geriatricians, surgeons, obstetricians/gynecologists, cardiologists, anesthesiologists, emergency medicine physicians, pathologists and radiologists, psychiatrists and physicians who are certified in addiction medicine.
3. **Behavioral Health Specialist –** Doctoral and/or master level psychologist who is state certified or state licensed; masters level clinical social worker for applicable network(s) who is state certified or state licensed; masters level social worker who is state certified or state licensed; masters level clinical nurse specialist or psychiatric nurse practitioner who is nationally or state certified and state licensed; addiction medicine specialist and other behavioral health specialists who are licensed, certified, or registered by the state to practice independently. Behavioral Specialists represent the contribution of the behavioral sciences to medicine and encompasses a broad field of knowledge and practice.

4. **Chiropractor -** Doctor of Chiropractic (DC) that provides care for musculoskeletal conditions using manipulation as a primary intervention that includes articulations of the spinal column and the neuro-musculoskeletal system.
5. **Podiatrist -** Doctor of Podiatric Medicine (DPM) who diagnose and treat, surgically, ailments of the foot, and those anatomical structures of the leg governing the functions of the foot. As well, he/she administers and prescribes drugs.
6. **Dental Specialist -** Doctor of Dental Surgery (DDS) and Doctor of Dental Medicine (DMD) who provide specialty dental care services including dental anesthesiologists, oral & maxillofacial pathologists, oral maxillofacial surgeons, oral maxillofacial radiologists, and orthodontists.
7. **Physical Therapist (PT)** - Master level trained who is state certified or state licensed; is qualified to work as a general practitioner in physical therapy and may be contracted as an independent practitioner in private practice, hospitals, rehabilitation centers, geriatric centers, sports medicine centers, health promotion programs, private practice, community programs, and others. Physical therapists provide services to individuals and populations to develop maintain and restore maximum movement and functional ability.
8. **Credentialing Clean File** - A complete credentialing application where all practitioner specific criteria are met and there is no malpractice history, no disciplinary action or sanction activity, or other negative information obtained during the verification process and, when applicable, a passing site visit score.
9. **180 Day Rule**- When the provider file is presented to the Credentialing Committee the application must be processed within six months.

12.11 Procedure

The Credentialing Department contacts practitioner approved in Evaluation Committee. In case that the provider informs a specialty change within the 45 days of the credentialing process, the Credentialing Department orient the provider to request a new application with the specialty change.

The complete file with all primary verifications and CMS requirements includes a complete practitioner application signed and dated, and includes, but is not limited to reasons for any inability to perform the essential functions of the position, with or without accommodations, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitations of privileges or disciplinary activity, attestation by the applicant to the correctness and completeness of the application, licensure documentation of a current Certificate of Good Standing, evidence of current adequate malpractice insurance ($100,000/300,000) on practitioner application or copy of certificate, evidence of NPI number (Provider application serves as attestation) query results, a copy of OIG and GSA query results, documentation of Medicare Opt out and Sanction status on the Clarification Verification Form (Attachment B), a copy of Board Certification query results (if applicable), primary Source Verification of Education, Practitioner Application Attestation of clinical privileges at hospital, a copy of current DEA license, results of query of the NPDB and HIPDB report, results of query of the Sex Offender and/or Child Abuse Registry, work history attestation – more than 5 years of experience and no more than 6 months of work history gap, provider acceptance/rejection form, Initial Credentialing Checklist.

The OIG (Office of Inspector General)/GSA (General Services Administration) /Medicare Exclusion lists are reviewed to identify all providers excluded for any of the following reasons:

1. Conviction relating to program or healthcare fraud.
2. Conviction relating to controlled substances.
3. License revocation or suspension.
4. Exclusion or suspension under a Federal or State healthcare program.
5. Excessive claims or furnishing of unnecessary or substandard items and services.
6. Failure of HMOs and CMPs to furnish medically necessary items and services.
7. False or improper claims.
8. Fraud and kickbacks and other prohibited activities.
9. Exclusion of entities owned or controlled by a sanctioned person.
10. Exclusion of individuals with ownership or control interest in Sanctioned entities.
11. Conviction relating to obstruction of an investigation.
12. Failure to provide payment information.
13. Failure to grant immediate access.
14. Violations of PPS corrective action.
15. Default of health education loan or scholarship obligations.
16. Violations of the limitations on physician charges.
17. Billing for services of assistant at surgery during cataract.

If all documentation is complete as per ASES (Health Insurance Administration) / CMS (Centers for Medicare & Medicaid Services) requirements and all primary source verification, the Credentialing Department submits the credentialing application with Acceptance/Rejection form to the Credentialing Chairman for approval.

All requesting providers receive notification of determination, within 2 calendar days, from the Credentialing Committee. If the Credentialing Committee denies an application, the provider receives a letter with the denial reason. To appeal, the provider needs to submit the appeal request in written within 30 days of the Credentialing Committee denial letter.

To appeal, the provider must submit a written request within 30 days from the date reject letter received.

All provider appeals will be discussed in the Appeals Committee for final decision.

12.12 Program Integrity Plan Development

The complete file with all primary verifications and CMS requirements includes a complete practitioner application signed and dated, and includes, but is not limited to, the Conflict-of-Interest Form. It is required that the provider/practitioner completes the Conflict of Interest Form reporting all people who have a 5 percent or greater (direct or indirect) ownership in a supplier, if and only if, the supplier applicant or provider is a corporation (whatever for profit or nonprofit), officers and directors of the supplier / applicant / provider, all managing employees or the supplier/applicant/ provider (including secretary, reception, amongst others), supplier/applicant/provider (all who have managing control), all individuals with a partnership interest in the supplier / applicant / provider, regardless of the percentage of ownership the partner has and/or authorized delegate officials. It is required that organizations report corporations (profit or nonprofit), partnerships and limited partnerships, limited liability companies, charitable and/or religious organizations and Governmental and/or tribal organizations.

The findings or each Conflict of Interest, based on the previous, is delivered to the Fraud, Waste and Abuse Department (Manager) of MMM Multihealth for the corresponding process.

This validation applies for every credentialing and re-credentialing practitioner or staff in the organizational providers. As an ongoing monitoring, the OIG monthly exclusions and reinstating list are validated against the provider data base to guarantee that no excluded provider continues as participant provider. These processes include nonparticipant providers to avoid making payments until reinstatement, if applicable.

Regulatory References

a. 42 CFR §55.104
b. 42 CFR §55.105
c. 42 CFR §55.106

12.13 Monitoring of Licenses and Credentials

MSO has established policies for ongoing monitoring of the license and credentials of Vital participating providers. The credentials are updated annually and consist, as a minimum, of the following documents: JLDMPR / SARAFS license, DEA license, medical malpractice insurance and ASSMCA license. The purpose of this measure is to guarantee that all MSO contracted providers comply with Federal and State regulations.

The ongoing monitoring process is a different process of quality and does not replace the process of initial credentialing and recredentialing. All participating providers must ensure that they keep their licenses and credentials valid and update with MSO and will be notified 60 days in advance

to indicate them the specific documents that must be updated with us and the expiration date for each credentialing document. Providers can send us their credentials via any of following:

USPS Mail: Credentialing Department

PO Box 71500

San Juan, P.R. 00936-8014

Email: credentialingupdates@mso-pr.com

For MSO and the Credentialing Department it is essential to comply with all the regulations from ASES and CMS. Non-compliance with these requirements could cause contract cancellation for network providers.

12.14 Provider Enrollment Portal (PEP)

As part of compliance with the provisions of the Affordable Care Act of 2010 (ACA), it establishes that state Medicaid agencies must register with the Medicaid Management Information System (MMIS). As of April 2020, the Puerto Rico Medicaid program (PRMP) will require that all providers who provide health services to the Medicaid population must register in the Provider Enrollment Portal (PEP). This requirement applies to any provider that provides, bills, orders, refers, and / or prescribes any health service to a Medicaid beneficiary under *Plan Vital* and / or Medicare Advantage *Platino*. To access, visit the following link, https:///www.medicaid.pr.gov/.

A. What can happen if I do not register or do not register all my locations on the Medicaid PEP Portal?

Under the Registration of Providers in the Medicaid Portal (PEP), the following rules for Service Billing are effective since August 1, 2021:

1. If the provider sends an appeal or dispute for denial of service due to lack of registration in Medicaid, and in effect has not obtained Medicaid ID, the invoice might remain denied since registration is compulsory according to the federal law of the “Affordable Care Act 2010”.
2. If the provider registers later, their eligibility with Medicaid will only apply 90 days retroactive to the date of registration, therefore, only in the case of exceptions established by Medicaid, the invoice can be reprocessed for payment, as long as it complies with the corresponding billing rules.
3. If the Rendering Provider is not the same as the Billing Provider, the invoice must include the Rendering NPI and the Billing NPI, and both providers must be registered and approved in the PEP. If the Billing Provider is registered and the Rendering Provider is not, or vice versa, the payment of the claim could be affected.
4. Medicaid assigns a unique number by location and by type of record, so the claim must identify the location where the service was provided. If you did not record the location where you provide service at the time of billing, the claim payment could be affected.
5. For Medicaid to identify that the service location is registered, requires that the claim include the NPI of the Billing Provider, the taxonomy and the Zip Code +
4. In cases where entering the Rendering is applicable, it is required to include the Rendering NPI, taxonomy, and the ZIP Code + 4 of these providers.

6. (Field) Billing Provider Address: If the provider that renders the service is the same provider that bills, they must report in this field of the claim the location that was registered in the PEP (loop 2010AA segment N3 and N4) with the ZIP Code +4. A P.O. Box cannot be entered in this field. If you need to report a P.O. Box, use the Pay-To Address field.

FIELD	LOOP	SEGMENT	FIELD NAME	NOTES
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code	Enter ZIP Code + 4 that corresponds to the physical address registered in the PEP. Please do not enter the default suffix 9998.
83	2000A	PRV03	Provider Taxonomy Code	Enter the Taxonomy code registered in the PEP.

1. (Field) Service Facility Location Address: If the provider that renders the service is different from the provider that bills, report in this field of the claim (loop 2310C segment N3 and N4) the location that you registered in the PEP associated with that group, with your Zip Code +4. You cannot enter a P.O. Box in this field. If you need to report a P.O. Box, use the Pay-To Address field.

FIELD	LOOP	SEGMENT	FIELD NAME	NOTES
273	2310C	N4	Service Facility Location City, State, ZIP Code	Enter the ZIP Code + 4 that corresponds to the physical address registered in the PEP. Please do not enter default suffix 9998.
265	2310B	PRV03	Provider Taxonomy Code	Rendering Provider Taxonomy Code that is used for claims submitted with NPI.

13.PCP's RESPONSIBILITIES, DUTIES AND OBLIGATIONS

Provider Type	Explanation
PCP Services	1) Physical exams will be provided for Enrollees ages twenty-one (21) and over within thirty (30) Calendar Days of the Enrollee's request for the service, considering both the medical and Behavioral Health need and condition. 2) Routine physical exams for minors under twenty-one (21) years of age. 3) Routine evaluations for Primary Care will be provided within thirty (30) Calendar Days, unless the Enrollee requests a later time. 4) Covered Services will be provided within fourteen (14) Calendar Days following the request for service. 5) The PCP is required to inform and distribute Information to Enrollee patients about instructions on Advance Directives and is also required to notify Enrollees of any changes in Federal or Puerto Rico law relating to Advance Directives, no more than ninety (90) Calendar Days after the effective date of such change. 6) Preferential Turns for residents of Vieques and Culebra Island municipalities. Preferential Turns refer to a policy of requiring Providers to give priority in treating Enrollees from these island municipalities, so that a physician may see them within a reasonable time after arriving in the Provider's office. This priority treatment is necessary because of the

	greater travel time required for the residents to seek medical attention. This requirement was established in Laws No. 86 enacted on August 16, 1997 (Arts. 1 through 4) and Law No. 200 enacted on August 5, 2004 (Arts. 1 through 5). 7) Primary care services or consultations Monday through Saturday of each week, from 8:00 a.m. to 6:00 p.m. The PMG will not have to comply with this requirement during the following Holidays: ➢ January 1st, ➢ January 6th, ➢ Good Friday, ➢ Thanksgiving Day, and ➢ December 25th. 8) The primary medical group (GMP) has the exclusive power to decide whether or not to provide primary care services during the holidays mentioned above. 9) The in-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes. A prescription phoned in by a practitioner will be filled within ninety (90) minutes. ASES highly recommends that the Providers implement an electronic prescribing system. 10) Primary Medical outpatient appointments for urgent conditions will be available within twenty-four (24) hours.

	11) Offer VITAL beneficiaries the same treatment offered to beneficiaries who have private (commercial) health plans in reference to appointments and times to receive a health care treatment or consultation. ASES prohibits network providers from offering different appointments and times to beneficiaries eligible for VITAL. 12) Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *Vital* enrollees. 13) It is prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 14) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 15) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. 16) Needs full compliance with reverse co-location and co-location terms. 17) Appeal of a denial that is based on lack of Medical Necessity. *Vital* will not take any punitive action against a Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.

BENEFICIARIES WITH POSITIVE HEPATITIS C TEST

1. MMM Multihealth request to Primary Providers (PCP), screening testing for Hepatitis C, at least once in life for all adults 18 and older and pregnant women during each pregnancy.

2 . Also, perform regular tests on people with risk factors, including injecting drug users.

3 .The standard coding for hepatitis C screening tests is as follows:

Description	CPT Code	
HCV Antibody test with reflex Quantitative HCV RNA test	86804	Bill by Laboratory when HCV Antibody Testing results Negative
HCV Antibody Testing	86803	Bill by Laboratory when HCV Antibody Testing result Positive
RNA (qualitative and quantitative	87522	Bill together with HCV Antibody Testing when positive

4 . MMM Multihealth will instruct network providers under *Plan Vital* in the following:

a) Identify patients with a confirmed HCV diagnosis.

	b) Once the providers identify beneficiaries with this diagnosis, beneficiaries will be guided about the importance of taking the test. 5. MMM Multihealth will establish an educational plan with the primary providers, to begin to carry out these screening tests with agility for the entire population 18 years of age and older. 6. MSO of Puerto Rico sent to all Vital Plan Providers a Flowchart (Please see the Flowchart in Annex # 2) and an event itinerary (Please see the itinerary in Annex # 3) developed by ASES with the purpose of instructing them on how to direct and instruct the beneficiaries after taking the Hepatitis C test if the results are positive. 7.If the PCP suspect the beneficiary has Hepatitis C, he must order an "HCV reflex test". With this order, the laboratory will automatically perform the HCV RNA Test in those cases in which the antibody test is positive. This avoid that the beneficiary has to repeat his visit to the laboratory and can begin his treatment as soon as possible. 8.If the beneficiary diagnosis is positive to Hepatitis C, the PCP must refer the patient to a specialist. 9. After evaluation of positive test for hepatitis C, the specialist provider will determine if the beneficiary is a candidate for the use of the drug for 8 weeks.

	10. The prescribing Provider must send the prescription and the completed authorization request form to the patient's health Insurance company, in order to advance the approval process. 11.The original prescription must be delivered to the beneficiary, or sent electronically to the pharmacy, for dispatch. MMM Healthcare's fax number is 1-844-997-9950. 12. In case of absolute contraindication to Mavyret, the most cost-effective therapy will be evaluated under the exception mechanism. In addition, the beneficiary may receive assistance through the *Abbvie Contigo* program. 13. It will be the provider's responsibility to inform the beneficiary about the benefit of the *Abbvie Contigo* Program and support them in enrolling in it by calling at 1-855-266-8446 (8:00 am to 6:00 pm). This program is designed to support the beneficiary during their treatment. **COVID-19** 1.ASES urges medical providers, vaccination centers, primary facilities, pharmacies, and other appropriate health facilities to orient themselves and become certified as providers of the COVID-19 vaccine. Full information on the requirements for certification and signing of the agreement with CDC can be found at the following Department of Health address. http://www.salud.gov.pr/pages/coronavirus.aspx

Specialist Services	1) Be provided within thirty (30) Calendar Days of the Enrollee's original request for service. 2) Provider who is a member of the PPN will prohibit the Provider from collecting Co-Payments from *Vital* Enrollees. 3) Preferential Turns for residents of the island municipalities of Vieques and Culebra. Preferential Turns refers to a policy of requiring Providers to give priority in treating Enrollees from these island municipalities, so that a physician may see them within a reasonable time after arriving in the Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for the residents to seek medical attention. This requirement was established in Laws No. 86 enacted on August 16, 1997 (Arts. 1 through 4) and Law No. 200 enacted on August 5, 2004 (Arts. 1 through 5). 4) The in-person prescription fill time (ready for pickup) will be no longer than forty (40) minutes. A prescription phoned in by a practitioner will be filled within ninety (90) minutes. ASES highly recommends that the Providers implement an electronic prescribing system. 5) Network Providers are prohibiting from having different hours and schedules for *Vital* Enrollees than what is offered to commercial Enrollees.

6) Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *Vital* Enrollees.

7) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract.

8) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.

9) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.

10) Appeal of a denial that is based on lack of Medical Necessity. The *Vital* do not take any punitive action with Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.

BENEFICIARIES WITH POSITIVE HEPATITIS C TEST

1) After evaluation of positive test for hepatitis C from beneficiary's, the PCP refer them to the specialist provider which will determine, if the beneficiary is a candidate for the use of the drug for 8 weeks.

	2) The Specialist Provider must send the prescription and the completed authorization request form to the patient's health Insurance company, in order to advance the approval process. 3) The original prescription must be delivered to the beneficiary, or sent electronically to the pharmacy, for dispatch. MMM Healthcare's fax number is 1-844-997-9950. 4) In case of absolute contraindication to Mavyret, the most cost-effective therapy will be evaluated under the exception mechanism. 5) In addition, the beneficiary may receive assistance through the *Abbvie Contigo* program.
Dental Services	1) Be provided within sixty (60) Calendar Days following the request unless the Enrollee requests a later date. 2) Provider who is a member of the PPN will prohibit the Provider from collecting Co-Payments from *Vital* Enrollees. 3) Preferential Turns for residents of the island municipalities of Vieques and Culebra. Preferential Turns refers to a policy of requiring Providers to give priority in treating Enrollees from these island municipalities, so that a physician may see them within a reasonable time after arriving in the Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for the residents to seek medical attention. This requirement was

	established in Laws No. 86 enacted on August 16, 1997 (Arts. 1 through 4) and Law No. 200 enacted on August 5, 2004 (Arts. 1 through 5). 4) Dental outpatient appointments for urgent conditions will be available within twenty-four (24) hours. 5) Network Providers are prohibiting from having different hours and schedules for *Vital* Enrollees than what is offered to commercial Enrollees. 6) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 7) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 8) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Hospitals and Emergency Rooms	1) Placing a lower priority on *Vital* Enrollees than on other patients, and from referring *Vital* Enrollees to other facilities for reasons of economic convenience. Contracts sanctions penalizing this practice. 2) Emergency Services will be provided, including Access to an appropriate level of care, within twenty-four (24) hours of the service request.

	3) Network Providers are prohibiting from having different hours and schedules for *Vital* Enrollees than what is offered to commercial Enrollees. 4) Hospitalization or extended services that exceed thirty (30) Calendar Days, the Provider may bill and collect payments for services rendered to the Enrollee at least once per month. 5) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 6) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 7) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Urgent care services	1) Will have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time), in order to provide Enrollees greater Access to their PCPs and to urgent care services in each Service Region. 2) Network Providers are prohibiting from having different hours and schedules for *Vital* Enrollees than what is offered to commercial Enrollees.

	3) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 4) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 5) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.
Diagnostic Laboratory	1) Diagnostic imaging and other testing appointments will be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time. 2) If a "walk-in" rather than an appointment system is used, the Enrollee wait time will be consistent with severity of the clinical need. 3) Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency, but no longer than forty-eight (48) hours. 4) Network Providers are prohibiting from having different hours and schedules for *Vital* Enrollees than what is offered to commercial Enrollees.

	5) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 6) Copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request. 7) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. 8) All Providers must be in compliance with Fast Transmission of Results Policy in Timeliness and Completeness or Claim Matched. The results shall send to MMM Multihealth no later than 3 days and at least 90% of results must send to MMM Multihealth. A 5% penalty will apply to those noncompliance providers after 90 days of claims submitted. A penalty of 5% may apply to these suppliers in default, after 90 days of the claims submitted.
Behavioral Health	1) Behavioral Health Services will be provided within fourteen (14) Calendar Day following the request unless the Enrollee requests a later date. 2) Behavioral Healthcare outpatient appointments for urgent conditions will be available within twenty-four (24) hours.

	3) Crisis services, face-to-face appointments will be available within two (2) hours; and Detoxification services will be provided immediately according to clinical necessity. 4) Network Providers are not allowed to have hours and schedules for *Plan Vital* Enrollees that are different from what is offered to commercial Enrollees. Providers cannot establish specific days for the delivery of Referrals and requests for Prior Authorization for *Vital* Enrollees. 5) Establish extended hours in the Mental Health facilities. It's required for Behavioral Health Facilities to have opening hours covering twelve (12) hours per day, seven (7) days per Week and will have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist. 6) It's prohibited to deny medically necessary services to *Vital* enrollees as established in the contract. 7) Offer equitable treatment for VITAL beneficiaries for the delivery of referrals and pre-authorization requests. Suppliers cannot set specific days for referral delivery or pre-authorization requests to VITAL beneficiaries. 8) All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration will be protected by MMM Multihealth from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E.

	9) Needs full compliance with reverse co-location and co-location terms. 10) Appeal of a denial that is based on lack of Medical Necessity. Plan *Vital* will not take any punitive action against a Provider who requests a Grievance, Appeal or an Administrative Law Hearing or supports an Enrollee's Grievance, Appeal or Administrative Law Hearing.

14. Compliance

14.1 Compliance Program

MMM Multihealth Vital has established Compliance and Integrity (Fraud, Waste, and Abuse "FWA") Programs to ensure that the organization and its first tier, downstream, and related entities conduct business in a manner that materially complies with applicable federal and state laws and regulations. In addition, the organization is subject to statutes and regulations required by multiple federal and local resources.

The Compliance Program has been designed in accordance with relevant and applicable requirements of the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA), *Administración de Seguros de Salud* (ASES), the Office of the Advocate for Patient Bill of Rights of the Commonwealth of Puerto Rico, the Offices of State Insurance Commissioners, among others. The main objective is to comply with reporting requirements, identify risk areas, prevent FWA, misconduct, operational inefficiencies and enhance operational functions, improve the quality of healthcare service, and decrease the cost of healthcare.

The Compliance Program is intended to provide a framework for compliance efforts on an individual, departmental, and enterprise-wide basis and to apply to all personnel and functions. Detailed policies and procedures, and work plans developed by individual departments shall fit within the scope of this Program. This Program provides for the existence of a Compliance Officer (CO) who has the overall responsibility and accountability for compliance matters. However, every Provider, Employee, Client, Contractor, Subcontractor, or Agent remains responsible and accountable for their compliance with applicable laws and regulations as well as MMM Multihealth Vitals' policies and procedures.

The Compliance Program contains policies and procedures relative to the business of MMM Multihealth Vital, and all its Beneficiaries. This Compliance Program is not intended to serve as the Compliance Program for clients, Providers or contractors of MMM Multihealth Vital; they should adopt their own program. MMM Multihealth Vital does not assume the responsibility of developing a Compliance Program for their clients. However, it is the responsibility of Clients, Contractors, Subcontractors and Delegated Entities to report any non-compliance issues, FWA incidents, and violations of law to MMM Multihealth Vital in a timely manner.

14.1.1 Training and Education

MMM Multihealth Vital acknowledges that the Compliance Program can only be effective if communicated and explained to company personnel, Providers, Contractors, and Subcontractors on a routine basis and in a manner that clearly explains its requirements. To that end, MMM Multihealth Vital requires all personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by MMM Multihealth Vital and each of its beneficiaries based on the needs and requirements of each

beneficiary. Employees are trained early in their employment, annually and more often if required based on regulatory and contractual changes.

Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies, and procedures set forth in this Compliance Program, and corporate ethics. Training programs also include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards. All formal training undertaken as part of the Compliance Program is documented.

The essential components of the program are:

1. Establish standard processes and operating systems;
2. Inform in a continuous and timely manner the Board of Directors, Compliance Officer and Compliance Committee of MMM Multihealth Vital, applicable state and federal regulatory entities, the progress of the program, effectiveness, incidents or risks detected and the corrective actions taken;
3. Train and educate Employees, Providers, Contractors, Subcontractors and Delated Entities on regulatory aspects;
4. Maintain effective lines of communication that allow free access, without fear of retaliation, the alternative of reporting anonymously and confidentially the incidents of non-compliance through;

    a) "Hot line"

    - 1-844-256-3953 (providers, beneficiaries)

b) Mailboxes established in the facilities of MMM Multihealth Vital so that reports can be deposited;

c) Emails:
   - VitalSIU@mmmhc.com

d) Through the website:
   - www.psg.ethicspoint.com (beneficiaries and providers)

e) Written reports can be sent to;

Ave. Chardón 350
Suite 500
Torre Chardón
San Juan, P.R.
00918-2101

MMM Multihealth
P.O. BOX 72010
San Juan P.R.
00936-7710

f) If you send it via regular mail, the envelope should indicate the word "Confidential".

g) All the mechanisms described above are administered under strict confidentiality measures.

5. Establishment of Policies and Procedures;
6. Adoption of disciplinary procedures;
7. Auditing and Monitoring;
8. Prevention, Detection and Investigation of incidents related to FWA;
9. Request and monitoring of Corrective Action Plans (CAP);
10. Report incidents to MMM Multihealth Vital executives and state and federal regulatory entities;

11. Continuous verification of individuals and entities that are excluded from federal programs through the "OIG" and "GSA (SAM)" lists;
12. Ensure that the Privacy, Security and Confidentiality of protected health information (PHI or PII), regulated under the HIPAA law, is maintained;
13. Zero tolerance for discrimination, at all levels and business relationships, including but not limited to Providers, Employees, Contractors, Subcontractors and Delegated Entities;
14. Continuous collaboration in the efforts outlined by federal agencies to recover funds impacted in the health area for FWA;
15. Ensure fair and quality treatment of the beneficiaries, among other aspects.
16. Maintain a healthy and well-being environment at all times.

14.4 Fraud, Waste & Abuse (FWA):

MMM Multihealth, complies with its responsibility to implement and manage a Medicaid Program Integrity Plan (PIP) for the *Vital Plan.* MMM Multihealth has developed a Compliance and Program Integrity Plan (Fraud, Waste and Abuse (FWA) as well as policies and procedures with the purpose of establishing guidelines to reduce FWA, enhance healthcare Provider operations and improve the quality of services.

The Medicaid PIP will assist MMM Multihealth in fulfilling its legal duty to provide quality care, refrain from submitting false and inaccurate claims or cost information to the *Administración de Seguros de Salud* (ASES), the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA), Office of

the Advocate for Patients' Bill of Rights of the Commonwealth of Puerto Rico, the State Insurance Commissioner's Office, among others.

14.4.1 Definitions:

1. **Fraud -** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
2. **Waste –** Waste occurs when someone makes careless or extravagant expenditures, incurs unnecessary expenses, or grossly mismanages resources. This activity results in unnecessary costs. It may or may not provide the person with personal gain. Waste is almost always a result of poor management decisions and practices or poor accounting controls.
3. **Agent -** means any person who has been delegated the authority to obligate or act on behalf of a Provider.
4. **Abuse -** means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.
5. **Anonymous –** Given without name or other identifying information.
6. **Confidential –** Revealed in the expectation that anything done or revealed will be kept private. Reported concerns are kept private to the extent permitted by law.

7. **Medicaid Compliance Officer (CO) –** CO oversees the compliance and program Integrity, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization.
8. **Corrective Action Plan (CAP) –** A written notification outlining the mandatory steps to be implemented to maintain compliance with state, federal, NCQA, URAC and/or MMM Multihealth designated requirements.
9. **Downstream Entity** - Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
10. **False Claims Act –** This act permits individuals to help reduce fraud against the federal government by allowing them to bring "whistleblowers" lawsuits on behalf of the government (known as "qui tam" suits) against groups or other individuals that are defrauding the government through programs, agencies, or contracts.
11. **Ethics –** The discipline of dealing with what is good and bad and with moral duty and obligation.
12. **FWA reporting mechanisms** – Ways an Employee, Provider, Enrollee/Beneficiary or other may report allegations of FWA to MMM Multihealth. Reports can be made anonymously and are kept confidential to the extent permitted by law.
13. **HIPAA** – Health Insurance Portability and Accountability Act.

14. **Integrity –** The adherence to a moral code, reflected in honesty and harmony in what one thinks, says and does.
15. **Retaliation–** A negative consequence for something done in good faith. This can include things like demotion, hostility, adverse changes in job requirements or other undesirable actions by an Employer, Supervisor or Coworker. Retaliation against an Employee for a good faith action is strictly prohibited.
16. **Unbundling –** A fraudulent practice in which Provider services are broken down to their individual components, resulting in a higher payment by the payor.
17. **Upcoding** – A practice of assigning a billing or diagnosis code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive the right to access their medical records, request an amendment to their records and receive a list of individuals and/or entities to whom MMM Multihealth has disclosed their information.
18. **Whistleblower –** A person who files an action under the False Claims Act is informally called a whistleblower. A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public.
19. **Contract -** means the written agreement between ASES and MMM Multihealth for the Vital Plan; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

20. **Conviction or Convicted -** means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
21. **Disclosing Entity -** means a Medicaid Provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
22. **Exclusion -** means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
23. **Group of Practitioners** - means two or more health care practitioners who practice their profession at a common location (whether they share common facilities, common supporting staff, or common equipment).
24. **Immediately -** means within twenty-four (24) hours.
25. **Indirect ownership interest** - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
26. **Program Integrity Plan (PIP) -** means the program, processes and policies that each Contactor has implemented to comply with integrity requirements. The PIP shall be developed in accordance with federal regulations and these guidelines.
27. **Provider Contract -** means any written contract between MMM Multihealth and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.

28. **Stakeholder -** means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid Beneficiaries.

29. **Suspension -** means that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

30. **Termination:**

    a) Medicaid or CHIP Provider, a State Medicaid program or CHIP has taken an action to revoke the Provider's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

    b) Medicare Provider, supplier or eligible professional, the Medicare program has revoked the Provider or supplier's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

    c) In all three programs, there is no expectation on the part of the Provider or supplier or the State or Medicare program that the revocation is temporary.

    d) The Provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

    e) The requirement for termination applies in cases where Providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause.

14.4.2 Federal False Claims Act:

The False Claims Act applies to the submission of claims by health care providers for payment of Medicare, Medicaid, and other federal healthcare programs. The False Claims Act is the federal government's primary civil remedy for improper or fraudulent claims.

A. The False Claims Act prohibits:

1. Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;
2. Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government.
3. Conspiring to defraud the government by a false or fraudulent claim allowed or paid; and
4. Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

B. Enforcement:

The United States Attorney General may invoke civil actions for violations of the False Claims Act. As with most other civil actions, the government must establish its case by presenting preponderance of the evidence rather than by meeting the higher burden of proof that applies in criminal cases. The False Claims Act allows private individuals to bring "qui tam" actions for violations of the Act.

C. Protection for "Whistleblowers":

Information may be reported anonymously. In addition, federal regulation and MMM Multihealth policy prohibits any retaliation against persons who in good faith report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she and been subject to any such retribution or retaliation should also report this to Ethics Point.

D. Program Fraud Civil Remedies Act of 1986 (PFCRA):

The Program Fraud Civil Remedies Act of 1986 (PFCRA) authorizes federal agencies such as the Department of Health and Human Services (HHS) to investigate and assess penalties of the submission of false claims to the agency. The conduct prohibited by the PFCRA is like that prohibited by the False Claims Act. For example, a person may be liable under PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim that the person knows or has the reason to know:

1) Is false, fictitious, or fraudulent;
2) Includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;
3) Includes or is supported by any written statement that;
    - Omits a material fact;
    - Is false, fictitious, or fraudulent because of such omission; and
    - Is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact; or

- Is for payment for the provision of property or services which the persons have not provided as claimed.

If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further the investigation or may refer the matter to the Department of Justice for proceedings under the False Claims Act. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint (following approval from the Department of Justice) regarding the false claim. A hearing would be held, following the detailed due process procedures set forth in the regulations implementing the PFCRA.

E. Disclosure of False Claims:

Under the False Claims Act, the organization may avoid treble damages and civil penalties if it discloses to the relevant federal health care program any false or fraudulent claims, and makes appropriate restitution of any overpayments, within 30 days of discovery of the false claim.

F. Education:

MMM Multihealth provides regulatory Compliance and FWA trainings to Employees, Providers, Beneficiaries, Board of Directors, Contractors, Subcontractors including components addressing the False Claims Act, and is also provided to Providers through various types of educational activities performed by the Provider Network Department.

14.4.3 The Physician Self-Referral Law (Stark Law):

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements.

A. Designated Health Services are:

1) Clinical Laboratory Services;
2) Physical therapy, Occupational therapy, and Outpatient Speech-language Pathology services;
3) Radiology and certain other imaging services;
4) Radiation therapy services and supplies;
5) DME and supplies;
6) Parenteral and enteral nutrients, equipment, and supplies;
7) Prosthetics, orthotics, and prosthetic devices and supplies;
8) Home health services;
9) Outpatient prescription drugs; and
10) Inpatient and outpatient hospital services.

Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

14.4.4 The Anti-Kickback Statute:

Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal

healthcare program. Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration. Each party's intent is a key element of their liability under the anti-kickback statute (AKS).

A. Kickbacks in health care can lead to:

1) Overutilization;
2) Increased program costs;
3) Corruption of medical decision making;
4) Patient steering;
5) Unfair competition.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

14.4.5 Exclusion Provisions - Federal health care programs should not be billed for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. 42 U.S.C. § 1395 (e) (1) 42 C.F.R. § 1001.1901

14.4.6 Examples of FWA:

1) **Provider Fraud** - Kickbacks - Hidden financial arrangements between various healthcare Providers. There is a variety of improper arrangements where Providers will provide some material benefit in return for other Providers prescribing or using their products or services. In most instances, such arrangements are illegal. Doctors are supposed to decide on the most appropriate treatment for their patients without consideration of their own financial interests. Kickbacks often result in medically unnecessary treatment.

    a. Upcoding - A pattern of assigning a code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive.

    b. Billing for services/supplies not provided.

    c. Billing for medically unnecessary services – Billing a pattern of services that are not justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care and are used to generate higher reimbursement.

    d. Incorrect coding – Using an incorrect CPT, CDT, ICD-10, DRG, and HCPCS codes and modifiers to misrepresent the service that was provided to increase revenue.

    e. Double billing – Submitting a charge more than once, often with a slight modification, for the same service and same patient.

f. Unbundling – The practice of separating and billing for the individual components of a medical service to increase revenue, rather than correctly billing with an all-inclusive procedure code.

g. Misrepresentation of services/supplies – Providing one service but billing another to obtain reimbursement.

h. Substitution of services – Billing for one type of service or supply but performing or providing another.

i. Submission of any intentionally false documents, addresses, phone numbers, etc.

j. Overutilization of services – Over utilizing certain services resulting in medically unnecessary treatment and financial gain.

2) **Pharmacy Fraud -** Prescription drugs not dispensed as written– Dispensing other drugs than what is prescribed by the Physician (e.g., generic vs. brand name).

a. Prescription splitting – Separating prescriptions into multiple orders to seek additional reimbursement, such as dispensing fees.

b. Expired, fake, diluted or illegal drugs - Dispensing inappropriate drug types to unsuspecting individuals that could create harmful situations.

c. Non-dispensed or non-existent prescriptions – Billing for prescriptions that were not dispensed or picked up by the intended party.

d. Bait and switch – Occurs when an individual is led to believe that a drug will cost one price, but at the point of sale, the individual is charged a higher amount.

e. Multiple prescription billing – Billing multiple payers for the same prescriptions, except as required, for coordination of benefit transactions.

f. Brand name vs. generic – Billing for a more expensive brand drug when a less expensive generic prescription is dispensed.

g. Quantity shortage – Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fee.

3) **Beneficiary Fraud -** Controlled substances - Obtaining controlled substances from multiple Providers/Pharmacies for non-medically necessary reasons and/or to sell.

a. Prescription forgery – Altering and/or forging prescriptions for use or sale.

b. ID card fraud - Loaning, sharing, or selling their ID Cards.

c. Eligibility fraud – Misrepresenting their eligibility for coverage.

4) **Workforce Member Fraud**

a. Kickbacks/Stark violations – Receiving gifts or kickbacks from MMM Multihealth vendors for goods or services purchased by MMM Multihealth.

b. Fraudulent credentials – Falsify credentials submitted for employment.

c. Fraudulent enrollment and marketing practices – Federal and state health program enrollment practices are heavily controlled. An example would be enticing potential Beneficiaries to enroll by presenting incorrect benefit information.

d. Embezzlement and theft – The appropriation of company/Medicaid-/Medicare monies by a workforce member for his/her own use or benefit.

e. Underutilization of services/benefits – Denying or limiting access to Services/Benefits to which the Beneficiary is entitled.

14.4.7 Investigation and Referrals:

The detection and prevention of FWA is the responsibility of everyone. MMM Multihealth has written policies and procedures that address the prevention, detection, and investigation of suspicious noncompliance activity. MMM Multihealth has implemented mechanisms for the detection of potential FWA. The following steps are considered;

The Medicaid Compliance Specialist registers and has the responsibility to document during the investigation the case until is considered completed/closed.

b A data gathering is considered during the first twenty-four (24) hours to determine if a preliminary investigation is required. An internal checklist to cover all the required elements is used.

c Information is analyzed and compared, taking into consideration Enrollee's wellness as the priority, the applicable subject matter experts of departments/operational processes impacted, and the data stored by MMM Multihealth in its systems;

d Once all the elements of data analysis, documentation, subject matter experts (if applicable) interviews/opinions are satisfied a preliminary investigation report is developed following MMM Multihealth established protocols and ASES/Medicaid's reporting requirements.

Case is moved to the next step of reporting, considering ASES reporting requirements, Medicaid Compliance Officer and MMM Multihealth FWA Committee supporting processes.

14.4.8 Responding to Possible or Detected Violations:

MMM Multihealth is committed to investigating any incident of noncompliance or significant breach to abide by applicable federal or state laws and regulations; and other types of misconduct that threaten or call into question MMM Multihealth's standing as an honest, reliable, and trustworthy entity. Fraudulent or inappropriate incidents and events detected, but not rectified, can seriously threaten its reputation and jeopardize its legal status. In this regard, MMM Multihealth has developed internal and external audit procedures to encourage the employee to voluntary present any FWA situation. If after an investigation, it is determined that the case was unsubstantiated, it is MMM Multihealth commitment always, even during the investigation, to diligently protect the reporting party or the affected area's reputation.

14.4.9 Collaboration with Federal and State Agencies:

MMM Multihealth comply with requests for information from ASES, the Medicaid Anti-Fraud Unit (MFCUs), the Office of Inspector General (OIG), the Department of Justice (DOJ), or any other federal or state agency or program divisions in charge of preventing and prosecuting cases related to FWA of services under the Medicaid program. MMM Multihealth will cooperate fully with Federal and Puerto Rico agencies in FWA investigations and subsequent legal actions, whether administrative, civil, or criminal. Such cooperation shall include actively participating in meetings, providing requested information, access to records, and access to interviews with employees and consultants, as well as providing personnel to testify at hearings, trials, or other legal proceedings as needed.

MMM Multihealth will notify ASES of any participation in meetings with other Managed Care Organizations (MCOs) regarding the PIP and share meeting minutes with the discussion topics and information. If any investigation results of such meetings, these will be managed following the established policies and procedures for FWA investigations, unless otherwise directed by ASES, OIG-HHS or other government agency. MMM Multihealth shall maintain ASES informed of those investigations by identifying these investigations in FWA and PIP reporting requirements. If ASES requires status of any ongoing investigation resulting of such meetings, additional reports or information will be handled through the Medicaid Compliance Officer or designee. MMM Multihealth complies with the following established standards by Medicaid Fraud Control Units and /or law enforcement agencies;

a. All cases of suspected Provider fraud are referred to the antifraud / integrity organization's unit;

b. If the antifraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for;

- Access to, and free copies of, any records or information kept by the organization or its contractors;
- Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit;
- Access to any information kept by Providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients;

c. Communicate to ASES (and other appropriate Federal and State agencies, as required) preliminary findings within 2 business days of completing the investigation; and

d. On referral from the unit, coordinate with ASES and the appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a Provider.

14.4.10 Provider Credentialing, Screening and Required Disclosure Information:

Provider Credentialing is considered an essential part of the Program Integrity Plan. During the initial credentialing process, once all credentials are gathered in a file, they are evaluated or reviewed by an MMM Multihealth Credentialing Committee. The committee may recommend approval without conditions, approval with conditions, denied participation, or defer the decision for further investigation. All applicants receive written notice within ten (10) calendar days after the committee has rendered a final decision.

MMM Multihealth notify ASES of any adverse or negative action taken on a Provider application or actions to limit the ability of the Provider to participate in the program within five (5) days of the decision. Pursuant to legal and regulatory requirements, MMM Multihealth has established policies and procedures for the screening of Providers before Contracting. Screening and Enrollment procedures will be performed based on PPACA requirements applicable to program integrity provisions including:

a. Enhanced Provider Screening and Enrollment, Section 6401;
b. Termination of Provider participation, Section 6501;
c. Provider disclosure of current or previous affiliation with excluded Provider(s), Section 6401; and

d. Provider Screening and Enrollment,

MMM Multihealth has also established policies and procedures to ensure that all Providers and Fiscal Agents comply with disclosure of information requirements pursuant to the Medicaid Program Integrity Plan. For this purpose, a process is performed to update the Provider enrollment packages, including the application form and credentialing procedures. Providers are requested a Certificate of Criminal Background (Good Behavior as defined in PR) and to identify Agents or managing Employees' criminal convictions. The following disclosures are required of Providers, Agents, and Employees during the Enrollment, Contracting and/or Application process:

- **Information related to:**
    - Ownership, Control and Conflict of Interest;
    - Business transactions;
    - Persons convicted of crimes or illegal conduct.

MMM Multihealth will not approve a Provider agreement or contract with a Fiscal Agent and will terminate an existing agreement or contract if the Provider or Fiscal Agent fails to disclose the required information. If any disclosure of criminal convictions is received by MMM Multihealth from a Provider or Fiscal Agent during the credentialing process, this information will be submitted to ASES and HHS-OIG within twenty (20) business days.

14.4.11 Provider Cancellation due to Inactivity:

MMM Multihealth has established policies and procedures for Provider contract cancellations which include the element of inactivity for the past twelve (12) consecutive months. Any identified Provider who has been inactive for the established timeframe will be

terminated. A communication is sent to the Provider notifying the cancellation due to inactivity, where the Provider is granted the opportunity to demonstrate evidence of billing activity during that time.

14.4.12 Mechanisms for Reporting

MMM Multihealth has also established reporting mechanisms such as;

a) "Hotline"
- 1-844-256-3953 (providers, beneficiaries)

b) Mailboxes established in the facilities of MMM Multihealth Vital so that reports can be deposited;

c) Emails:
  - VitalSIU@mmmhc.com

d) Through the website:
- www.psg.ethicspoint.com y (beneficiaries and providers)

Employees, Directors, Providers, Subcontractors, Beneficiaries and the public. Individuals or entities may **anonymously** report fraud, waste, abuse or misconduct.

Any Employee, Director, Provider, Beneficiary, Subcontractor and Delegated entity, who in good faith believes they have knowledge of a potential violation of this program or its policies and procedures, must report their findings to MMM Multihealth. Violations to the Program or its policies and procedures or failure to report known violations of the program or its policies and procedures are a serious violation of MMM Multihealth policy's resulting in the imposition of disciplinary actions, which may include the termination of employment and/or business relation. **Nobody must be subjected to any form of retaliation based solely on the good faith or honest intention of reporting a suspected violation.**

14.4.13 Suspension of Payments in case of Potential FWA:

MMM Multihealth suspends payments to Providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency has a good cause to not suspend payments or to suspend payment only in part.

14.3 Laws and Regulations

14.3.1 Health Insurance Portability and Accountability Act (HIPAA):

A major purpose of the HIPPA Privacy Rules is to define and limit the circumstances in which an individual's protected health information (PHI) may be used or disclosed be covered entities. The privacy provisions of HIPAA apply to health information created or maintained by healthcare providers who engage in certain electronic transactions, health plans, and healthcare clearinghouses. The statute protects individually identifiable health information, that is related to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual or the past, present, or future payment for the provision of health care to an individual and identifies or could identify the individual (45 CFR §160.103). Examples of protected health information are the medical health records whether it is on paper or electronically.

A covered entity is a healthcare provider that conducts certain transactions in electronic form regulated by HIPAA (called here a "covered healthcare provider"), a healthcare clearinghouse, or a health plan.

Generally, the use and disclosure of member medical information for purposes of treatment, payment and healthcare operations that occur between a Provider and a health plan, clearinghouse, another Provider, or other insurance carrier is permitted without the necessity of seeking an authorization from the member. For example, under HIPAA, determinations of medical necessity, appropriateness of care, justification of charges and utilization reviews activities are included within the definition of payment; and conducting quality assessment and improvement activities reviewing the qualifications of healthcare Providers and conducting fraud and abuse detection and compliance programs are included within the definition of healthcare operations.

In other hand, a covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment, or healthcare operations, or otherwise permitted under HIPAA Law andmust make reasonable efforts to use, disclose or request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity may not condition treatment, payment, enrollment, or benefit eligibility on an individual granting an authorization, except for limited circumstances. The authorization must be written in plain language and specific terms as required by HIPAA. It may allow the use and disclosure of PHI by the covered entity seeking the authorization, or by a third party. Covered entities must ensure that an authorization of uses and disclosures is a valid authorization that complies with the content requirements as required by the Privacy Rule

before any use or disclosure of information is made. In addition, the HIPAA Privacy Rule provides individual's rights respect their health information such as:

- Right to inspect or request a copy of his/her protected health information,
- Right to correct or amend his/her protected health information,
- Right to request confidential communications,
- Right to request restrictions of uses and disclosures of his/her protected health information,
- Right to obtain a list or report of those his/her protected health information has been share,
- Right to receive a copy of the Notice of Privacy Practice that describes how their health information may be use or disclose, in paper or electronic format.

The US Congress established civil and criminal penalties for covered entities that misuse personal health information. In other hand, the office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) can impose civil penalties on covered entities that fails to comply with a requirement of HIPAA Act.

14.3.2 Code of Federal Regulations:

Federal regulations require that a Medicaid Provider Organization, such as MMM Multihealth, must establish procedures to abide by all Federal and States laws regarding confidentiality, enrollment and disclosure of medical records, or other health information. Organizations must safeguard the privacy of any information that identifies an enrollee.

14.3.3 State Law:

In Puerto Rico, the Patient's Bill of Rights (Article 11) establishes that a patient has the right to have full confidence that their medical and health information will be kept strictly confidential and that all Providers and health insurers will take necessary measures to protect the privacy of their patients when managing all related documents and information.

Also, the Mental Health Law of Puerto Rico (Law Num. 408 of October 2, 2000) requires Providers to maintain in strict confidentiality, the mental health information of the patients contained on the medical record and forbid the disclosure of such information to third parties without the patient authorization.

14.3.4 Contractual Arrangements:

MMM Multihealth agreements with ASES (the Puerto Rico Health Insurance Administration) request compliance with federal regulations regarding privacy, confidentiality, and HIPAA administrative simplification rules. These rules address the transmission and disclosure of patient information between covered entities. According to the rules, MMM Multihealth must safeguard protected health information to limit incidental uses or disclosures of PHI made pursuant to an otherwise permitted or required use or disclosure.

In addition, the provision of the ASES contract provides that all medical records shall be treated as confidential and shall only be disclosed to provide necessary medical care, to conduct quality assurance functions and peer review functions, or as necessary to respond to a complaint or appeal. The transmission of information with providers will only be conducted according to HIPAA Law. In addition to the provider's obligation to comply with applicable federal and state laws and regulations, a provider must abide by the contract provisions that

apply to them in the agreements and must maintain all relevant safeguards to protect the confidentiality of his/her patient's information.

14.4 Fraud, Waste & Abuse (FWA):

MMM Multihealth, comply with its responsibility to implement and manage a Medicaid Program Integrity Plan (PIP) for the Government Health Plan (GHP). MMM Multihealth has developed a Compliance and Program Integrity Plan (Fraud, Waste and Abuse (FWA) as well as policies and procedures with the purpose of establishing guidelines to reduce FWA, enhance healthcare Provider operations and improve quality of services. The Program Integrity Plan (PIP) supports MMM Holdings, LLC Compliance Program, Fraud, Waste, and Abuse Program, Code of Ethics and Corporate Conduct.

The Medicaid PIP will assist MMM Multihealth in fulfilling its legal duty to provide quality care, refrain from submitting false and inaccurate claims or cost information to the *Administración de Seguros de Salud* (ASES), the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA), Office of the Advocate for Patients' Bill of Rights of the Commonwealth of Puerto Rico, the State Insurance Commissioner's Office, among others.

14.4.1 Definitions:

31. Fraud - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

32. **Waste –** Waste occurs when someone makes careless or extravagant expenditures, incurs unnecessary expenses, or grossly mismanages resources. This activity results in unnecessary costs. It may or may not provide the person with personal gain. Waste is almost always a result of poor management decisions and practices or poor accounting controls.
33. **Agent -** means any person who has been delegated the authority to obligate or act on behalf of a Provider.
34. **Abuse -** means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
35. **Anonymous –** Given without name or other identifying information.
36. **Confidential –** Revealed in the expectation that anything done or revealed will be kept private. Reported concerns are kept private to the extent permitted by law.
37. **Medicaid Compliance Officer (CO) –** CO oversees the compliance, Program Integrity, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization.
38. **Corrective Action Plan (CAP) –** A written notification outlining the mandatory steps to be implemented to maintain compliance with state, federal, NCQA, URAC and/or MMM Multihealth designated requirements.

39. **Downstream Entity** - Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
40. **False Claims Act –** This act permits individuals to help reduce fraud against the federal government by allowing them to bring "whistleblowers" lawsuits on behalf of the government (known as "qui tam" suits) against groups or other individuals that are defrauding the government through programs, agencies, or contracts.
41. **Ethics –** The discipline of dealing with what is good and bad and with moral duty and obligation.
42. **FWA reporting mechanisms** – Ways an Employee, Provider, Enrollee/Beneficiary or other may report allegations of FWA to MMM Multihealth. Reports can be made anonymously and are kept confidential to the extent permitted by law.
43. **HIPAA** – Health Insurance Portability and Accountability Act.
44. **Integrity –** The adherence to a moral code, reflected in honesty and harmony in what one thinks, says and does.
45. **Retaliation–** A negative consequence for something done in good faith. This can include things like demotion, hostility, adverse changes in job requirements or other undesirable actions by an Employer, Supervisor or Coworker. Retaliation against an Employee for a good faith action is strictly prohibited.

46. **Unbundling –** A fraudulent practice in which Provider services are broken down to their individual components, resulting in a higher payment by the payor.
47. **Upcoding** – A practice of assigning a billing or diagnosis code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive right to access their medical records, request an amendment to their records and receive a list of individuals and/or entities to whom MMM Multihealth has disclosed their information.
48. **Whistleblower –** A person that files an action under the False Claims Act is informally called a whistleblower. A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public.
49. **Contract -** means the written agreement between ASES and MMM Multihealth for the GHP; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.
50. **Conviction or Convicted -** means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
51. **Disclosing Entity -** means a Medicaid Provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
52. **Exclusion -** means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

53. **Group of Practitioners** - means two or more health care practitioners who practice their profession at a common location (whether they share common facilities, common supporting staff, or common equipment).

54. **Immediately -** means within twenty-four (24) hours.

55. **Indirect ownership interest** - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

56. **Program Integrity Plan (PIP) -** means the program, processes and policies that each Contactor has implemented to comply with integrity requirements. The PIP shall be developed in accordance with federal regulations and these guidelines.

57. **Provider Contract -** means any written contract between MMM Multihealth and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.

58. **Stakeholder -** means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid Beneficiaries.

59. **Suspension -** means that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

60. **Termination:**

a) Medicaid or CHIP Provider, a State Medicaid program or CHIP has taken an action to revoke the Provider's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

b) Medicare Provider, supplier or eligible professional, the Medicare program has revoked the Provider or supplier's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

c) In all three programs, there is no expectation on the part of the Provider or supplier or the State or Medicare program that the revocation is temporary.

d) The Provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

e) The requirement for termination applies in cases where Providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause.

14.4.2 Federal False Claims Act:

The False Claims Act applies to the submission of claims by health care Providers for payment of Medicare, Medicaid, and other federal health care programs. The False Claims Act is the federal government’s primary civil remedy for improper or fraudulent claims.

G. The False Claims Act prohibits:

5. Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;

6. Knowingly making or using, or causing to be made or used, a false record or statement to have a false or fraudulent claim paid or approved by the government;
7. Conspiring to defraud the government by a false or fraudulent claim allowed or paid; and
8. Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government.

H. Enforcement:

The United States Attorney General may invoke civil actions for violations of the False Claims Act. As with most other civil actions, the government must establish its case by presenting preponderance of the evidence rather than by meeting the higher burden of proof that applies in criminal cases. The False Claims Act allows private individuals to bring "qui tam" actions for violations of the Act.

I. Protection for "Whistleblowers":

If any Employee has knowledge or information that any such activity may be occurring or may have taken place, the employee must notify his or her supervisor or director, the Medicaid Compliance Officer, or Ethics Point line at 1-844-256-3953 or www.psg.ethicspoint.com, or by writing to the following e-mail address: VitalSIU@mmmhc.com . Information may be reported anonymously. Employees are encouraged to contact their Supervisor or the Medicaid Compliance Officer if they have questions as to whether certain practices violate the Federal False Claims Act.

In addition, federal regulation and MMM Multihealth policy prohibits any retaliation against persons who in good faith report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she and been subject to any such retribution or retaliation should also report this to Ethics Point.

J. Program Fraud Civil Remedies Act of 1986 (PFCRA):

The Program Fraud Civil Remedies Act of 1986 (PFCRA) authorizes federal agencies such as the Department of Health and Human Services (HHS) to investigate and assess penalties of the submission of false claims to the agency. The conduct prohibited by the PFCRA is like that prohibited by the False Claims Act. For example, a person may be liable under PFCRA for making, presenting, or submitting, or causing to be made, presented, submitted, a claim that the person knows or has the reason to know:

4) Is false, fictitious, or fraudulent;
5) Includes or is supported by any written statement which asserts a material fact which is false, fictitious or fraudulent;
6) Includes or is supported by any written statement that;
    - Omits a material fact;
    - Is false, fictitious, or fraudulent because of such omission; and
    - Is a statement in which the person making, presenting or submitting such statement has a duty to include such material fact; or
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If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further the investigation or may refer the matter to the Department of Justice for proceedings under the False Claims Act. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint (following approval from the Department of Justice) regarding the false claim. A hearing would be held, following the detailed due process procedures set forth in the regulations implementing the PFCRA.

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11) Clinical Laboratory Services;

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13) Radiology and certain other imaging services;

14) Radiation therapy services and supplies;

15) DME and supplies;

16) Parenteral and enteral nutrients, equipment, and supplies;

17) Prosthetics, orthotics, and prosthetic devices and supplies;

18) Home health services;

19) Outpatient prescription drugs; and

20) Inpatient and outpatient hospital services.

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B. Kickbacks in health care can lead to:

6) Overutilization;

7) Increased program costs;

8) Corruption of medical decision making;

9) Patient steering;

10) Unfair competition.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs. Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.

14.4.5 Exclusion Provisions - Federal health care programs should not be billed for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. 42 U.S.C. § 1395 (e) (1) 42 C.F.R. § 1001.1901

14.4.6 Examples of FWA:

5) **Provider Fraud** - Kickbacks - Hidden financial arrangements between various healthcare Providers. There is a variety of improper arrangements where Providers will provide some material benefit in return for other Providers prescribing or using their products or services. In most instances, such arrangements are illegal. Doctors are supposed to decide on the most appropriate treatment for their patients without

consideration of their own financial interests. Kickbacks often result in medically unnecessary treatment.

a. Upcoding - A pattern of assigning a code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive.

b. Billing for services/supplies not provided.

c. Billing for medically unnecessary services – Billing a pattern of services that are not justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care and are used to generate higher reimbursement.

d. Incorrect coding – Using an incorrect CPT, CDT, ICD-10, DRG, and HCPCS codes and modifiers to misrepresent the service that was provided to increase revenue.

e. Double billing – Submitting a charge more than once, often with a slight modification, for the same service and same patient.

f. Unbundling – The practice of separating and billing for the individual components of a medical service to increase revenue, rather than correctly billing with an all-inclusive procedure code.

g. Misrepresentation of services/supplies – Providing one service but billing another to obtain reimbursement.

h. Substitution of services – Billing for one type of service or supply but performing or providing another.

i. Submission of any intentionally false documents, addresses, phone numbers, etc.

j. Overutilization of services – Over utilizing certain services resulting in medically unnecessary treatment and financial gain.

6) **Pharmacy Fraud -** Prescription drugs not dispensed as written– Dispensing other drugs than what is prescribed by the Physician (e.g., generic vs. brand name).

a. Prescription splitting – Separating prescriptions into multiple orders to seek additional reimbursement, such as dispensing fees.

b. Expired, fake, diluted or illegal drugs - Dispensing inappropriate drug types to unsuspecting individuals that could create harmful situations.

c. Non-dispensed or non-existent prescriptions – Billing for prescriptions that were not dispensed or picked up by the intended party.

d. Bait and switch – Occur when an individual is led to believe that a drug will cost one price, but at the point of sale, the individual is charged a higher amount.

e. Multiple prescription billing – Billing multiple payers for the same prescriptions, except as required, for coordination of benefit transactions.

f. Brand name vs. generic – Billing for a more expensive brand drug when a less expensive generic prescription is dispensed.

g. Quantity shortage – Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fee.

7) **Beneficiary Fraud -** Controlled substances - Obtaining controlled substances from multiple Providers/Pharmacies for non-medically necessary reasons and/or to sell.

   a. Prescription forgery – Altering and/or forging prescriptions for use or sale.

   b. ID card fraud - Loaning, sharing, or selling their ID Cards.

   c. Eligibility fraud – Misrepresenting their eligibility for coverage.

8) **Workforce Member Fraud**

   a. Kickbacks/Stark violations – Receiving gifts or kickbacks from MMM Multihealth vendors for goods or services purchased by MMM Multihealth.

   b. Fraudulent credentials – Falsify credentials submitted for employment.

   c. Fraudulent enrollment and marketing practices – Federal and state health program enrollment practices are heavily controlled. An example would be enticing potential Beneficiaries to enroll by presenting incorrect benefit information.

   d. Embezzlement and theft – The appropriation of company/Medicaid-/Medicare monies by a workforce member for his/her own use or benefit.

   e. Underutilization of services/benefits – Denying or limiting access to Services/Benefits to which the Beneficiary is entitled.

14.4.7 Investigation and Referrals:

The detection and prevention of FWA is the responsibility of everyone. MMM Multihealth has written policies and procedures that address the prevention, detection, and investigation of suspicious noncompliance activity. MMM Multihealth has implemented mechanisms for the detection of potential FWA. The following steps are considered;

a The Medicaid Compliance Specialist register and has the responsibility to document during the investigation the case until is considered completed/closed.

b A data gathering is considered during the first twenty-four (24) hours to determine if a preliminary investigation is required. An internal check list to cover all the required elements is used.

c Information is analyzed and compared, taking into consideration Enrollee's wellness as the priority, the applicable subject matter experts of departments/operational processes impacted, and the data stored by MMM Multihealth in its systems;

d Once all the elements of data analysis, documentation, subject matter experts (if applicable) interviews/opinions are satisfied a preliminary investigation report is develop following MMM Multihealth established protocols and ASES/Medicaid's reporting requirements.

Case is moved to the next step of reporting, considering ASES reporting requirements, Medicaid Compliance Officer and MMM Multihealth FWA Committee supporting processes.

14.4.9 Responding to Possible or Detected Violations:

MMM Multihealth is committed to investigating any incident of noncompliance or significant breach to abide by applicable federal or state law and regulations; and other types of misconduct that threatens or calls into question MMM Multihealth standing as an honest, reliable, and trustworthy entity. Fraudulent or inappropriate incidents and events detected, but not rectified, can seriously threaten its reputation and jeopardize its legal status. In this regard, MMM Multihealth has developed internal and external audit procedures to encourage the employee to voluntary present any FWA situation. If after an investigation, it is determined that the case was unsubstantiated, it is MMM Multihealth commitment always,

even during the investigation, to diligently protect the reporting party or the affected area's reputation.

14.4.9 Collaboration with Federal and State Agencies:

MMM Multihealth comply with requests for information from ASES, the Medicaid Anti-Fraud Unit (MFCUs), the Office of Inspector General (OIG), the Department of Justice (DOJ), or any other federal or state agency or program divisions in charge of preventing and prosecuting cases related to FWA of services under the Medicaid program. MMM Multihealth will cooperate fully with Federal and Puerto Rico agencies in FWA investigations and subsequent legal actions, whether administrative, civil, or criminal. Such cooperation shall include actively participating in meetings, providing requested information, access to records, and access to interviews with employees and consultants, as well as providing personnel to testify at hearings, trials, or other legal proceedings as needed.

MMM Multihealth will notify ASES of any participation in meetings with other Managed Care Organizations (MCOs) regarding the PIP and share meeting minutes with the discussion topics and information. If any investigation results of such meetings, these will be managed following the established policies and procedures for FWA investigations, unless otherwise directed by ASES, OIG-HHS or other government agency. MMM Multihealth shall maintain ASES informed of those investigations by identifying these investigations in FWA and PIP reporting requirements. If ASES requires status of any ongoing investigation resulting of such meetings, additional reports or information will be handled through the Medicaid Compliance Officer or designee. MMM Multihealth complies with the following established standards by Medicaid Fraud Control Units and /or law enforcement agencies;

a. All cases of suspected Provider fraud are referred to the antifraud / integrity organization's unit;

b.If the antifraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for;

- Access to, and free copies of, any records or information kept by the organization or its contractors;
- Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit;
- Access to any information kept by Providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients;

c. Communicate to ASES (and other appropriate Federal and State agencies, as required) preliminary findings within 2 business days of completing the investigation; and

d. On referral from the unit, coordinate with ASES and the appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a Provider.

14.4.10 Provider Credentialing, Screening and Required Disclosure Information:

Provider Credentialing is considered an essential part of the Program Integrity Plan. During the initial credentialing process, once all credentials are gathered in a file, they are evaluated or reviewed by an MMM Multihealth Credentialing Committee. The committee may recommend approval without conditions, approval with conditions, denied participation, or

defer the decision for further investigation. All applicants receive written notice within ten (10) calendar days after the committee has rendered a final decision.

MMM Multihealth notify ASES of any adverse or negative action taken on a Provider application or actions to limit the ability of the Provider to participate in the program within five (5) days of the decision. Pursuant to legal and regulatory requirements, MMM Multihealth has established policies and procedures for the screening of Providers before Contracting. Screening and Enrollment procedures will be performed based on PPACA requirements applicable to program integrity provisions including:

e. Enhanced Provider Screening and Enrollment, Section 6401;

f. Termination of Provider participation, Section 6501;

g. Provider disclosure of current or previous affiliation with excluded Provider(s), Section 6401; and

h. Provider Screening and Enrollment,

MMM Multihealth has also established policies and procedures to ensure that all Providers and Fiscal Agents comply with disclosure of information requirements pursuant to the Medicaid Program Integrity Plan. For this purpose, a process is performed to update the Provider enrollment packages, including the application form and credentialing procedures. Providers are requested a Certificate of Criminal Background (Good Behavior as defined in PR) and to identify Agents or managing Employees' criminal convictions. The following disclosures are required of Providers, Agents, and Employees during the Enrollment, Contracting and/or Application process:

- **Information related to:**

1.Ownership, Control and Conflict of Interest;

a. 2.Business transactions;

b. 3. Persons convicted of crimes or illegal conduct.

MMM Multihealth will not approve a Provider agreement or contract with a Fiscal Agent and will terminate an existing agreement or contract if the Provider or Fiscal Agent fails to disclose the required information. If any disclosure of criminal convictions is received by MMM Multihealth from a Provider or Fiscal Agent during the credentialing process, this information will be submitted to ASES and HHS-OIG within twenty (20) business days.

14.4.11 Provider Cancellation due to Inactivity:

MMM Multihealth has established policies and procedures for Provider contract cancellations which include the element of inactivity for the past twelve (12) consecutive months. Any identified Provider who has been inactive for the established timeframe will be terminated. A communication is sent to the Provider notifying the cancellation due to inactivity, where the Provider is granted the opportunity to demonstrate evidence of billing activity during that time.

14.4.12 Mechanisms for Reporting

MMM Multihealth has also established reporting mechanisms such as;

1. Ethics-Point Hotline *1-844-256-3953*);

- **2. Email address** VitalSIU@mmmhc.com for Employees, Directors, Providers, Subcontractors, Beneficiaries and public. Individuals or entities may **anonymously** report fraud, waste, abuse or misconduct.

Any Employee, Director, Provider, Beneficiary, Subcontractor and Delegated entity, who in good faith believes they have knowledge of a potential violation of this program or its policies and procedures, must report their findings to MMM Multihealth. Violations to the Program or its policies and procedures or failure to report known violations of the program or its policies and procedures are a serious violation of MMM Multihealth policy's resulting in the imposition of disciplinary actions, which may include the termination of employment and/or business relation. **Nobody must be subjected to any form of retaliation based solely on the good faith or honest intention of reporting a suspected violation.**

14.4.13 Suspension of Payments in case of Potential FWA:

MMM Multihealth suspend payments to Providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency has a good cause to not suspend payments or to suspend payment only in part.

14.5 Cultural Competency Plan

MMM Multihealth Vital has established a comprehensive Cultural Competency Plan to provide a standardized method to ensure that all services provided are culturally competent for their beneficiaries. The following information provides a clear understanding of how MMM Multihealth Vital works and describes how Employees, Directors, Providers, Contractors, Subcontractors, Delegated Entities and systems within MMM Multihealth Vital will provide services to people of all cultural and ethnic backgrounds, disabilities and regardless of gender. , sexual orientation, gender identity, communities or religion LGBTQIA2S+ (lesbian, gay, bisexual,

transgender and trans, queer and questioning, intersex, asexual or agender, and two-spirit) in a way that recognizes the values, affirms and respects the value of the people registered and protects and preserves the dignity of each person. Its main purpose is to ensure that the unique and diverse needs of all beneficiaries are met. The Cultural Competence Plan has established the following objectives and goals;

A. Objectives

1. Identify Enrollees with possible cultural or linguistic barriers for which alternative communication methods are needed;
2. Use appropriate and culturally sensitive educational materials for each type of cultural restriction, including race, religion, gender identity, gender expression, real or perceived sexual orientation (LGBTQIA2S+), ethnic origin or language;
3. Decrease the discrepancies in the medical attention received;
4. Ensure that resources are available to meet unique language barriers and communication barriers that exist with certain beneficiaries;
5. Ensure that Providers recognize cultural diversity and the needs of the population they serve, considering any protocol that must be adopted to ensure adequate quality of services;
6. Ensure that Providers recognize the diverse religious beliefs of the population they serve;
7. Ensure that Employees, Directors, Board of Directors, contracted Providers, Contractors, Subcontractors and Delegated Entities are educated to assess the

various cultural, religious and linguistic differences in the organizations and the population they serve;

8. Provide mechanisms to avoid cultural barriers;
9. Act as facilitator of the Providers, understanding and assisting the LGBTQIA2S+ (lesbian, gay, bisexual, transgender and trans, queer and questioning, intersex, asexual or agender, and two-spirit) ensuring the accessibility of the services.
10. Learn about state and federal regulations related to the Cultural Competency Plan.

B. Goals:

1. Improve communication with beneficiaries for whom cultural or linguistic barriers exist.
2. Reduce the disparities in the medical care received by the minorities to which MMM Multihealth Vital provides services.
3. Improve understanding of cultural and religious diversity within the population served.
4. More awareness about values, attitudes, beliefs, diversity and inclusion.
5. Expand communication efforts to assure Enrollees' accessibility.

14.5.1 Components of the Plan:

1. Data Analysis;

2. Language Services;

3. Religious Beliefs;

4. Non-discrimination against the LGBTQIA2S+ population;

5. Education to Providers - The Provider receives information about the Cultural Competency Program. The Provider may request, through the Internet, by telephone or in person, a printed copy of this Plan without any cost. The information is also posted on the MMM Multihealth Vital Providers website at https://www.innovamd.com/, a resource for physicians and other contracted providers. The recruitment of MMM Multihealth Vital staff and the development processes of the Provider Network are driven by the membership and the cultural and language needs of the beneficiaries. In addition, training in Cultural Competence allows the Provider to perform the training at their convenience. The training addresses the same elements described in the plan for employee training. Recognizing that Providers may require assistance to communicate with beneficiaries who speak other languages besides Spanish and English, MMM Multihealth Vital trains Providers to use MMM Multihealth Vitals' translation services through initial guidance, Provider's Guide, and the continuous visits of relations with the Provider.
6. MMM has a telephone translation service for your medical office.
7. Electronic Media - Beneficiaries have access to the TTY / TDD line 787-999-4411 for services for the hearing impaired.
8. Cultural Competency Survey

14.6 Training & Education:

MMM Multihealth Vital is committed to education efforts for the existing Provider Network. The Medicaid Compliance Department selects annually the critical regulatory issues that affect Providers and their patients. Material is selected from state and federal regulators to maintain a standardized process and to meet the educational requirements of the Centers for Medicare and Medicaid (CMS). The following topics are considered but not limited to;

1. Compliance Program and Integrity Program (Fraud, Waste and Abuse)
2. Cultural Competency Plan;
3. Grievances & Appeals System;
4. Advance Directives;
5. Vital Programs;
6. HIPAA Law (Privacy and Security), among other regulatory topics that are required to be provided.

14.7 Overpayment/Payment Retractions Efforts:

MMM Multihealth has established policies and procedures to withhold/retract payments to any identified Provider or Supplier who committed fraud or willful misrepresentation.

1) Basis for withholding/retraction. MMM Multihealth may withhold capitation or claims payments, in whole or in part, to a Provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. MMM Multihealth may

withhold payments without first notifying the Provider of its intention to withhold such payments. A Provider may request, and must be granted, administrative review where State law so requires."

2) Notice of withholding/retraction. MMM Multihealth must send notice of its withholding/retraction of program payments within five (5) days of taking such action. The notice must set forth the general allegations as to the nature of the withholding/retraction action but need not disclose any specific information concerning its ongoing investigation. The notice must:

    - State that payments are being withheld in accordance with this provision;
    - State that the withholding/retraction is for a temporary period, and cite the circumstances under which withholding/retraction will be terminated;
    - Specify, when appropriate, to which type or types of payment (capitation or claims) withholding/retraction is effective; and
    - Inform the Provider of the right to submit written evidence for consideration by the agency."

3) Duration of withholding/retraction. "All withholding/retraction of payment actions under this section will be temporary and will not continue after:

    - The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the Provider; or
    - Legal proceedings related to the Provider's alleged fraud or willful misrepresentations are completed."

- Documentation will be kept by MMM Multihealth Medicaid Compliance Department of the actions taken.

15. GRIEVANCE SYSTEM

In accordance with 42 CFR Part 438, Subpart F, MMM Multihealth (MMM) has an internal Grievance System under which Enrollees, or Providers acting on their behalf, may challenge the denial of coverage of, or payment for, covered services. MMM Grievance System includes (i) a Complaint process, (ii) Grievance process, (iii) Appeal process, and (iv) Access to the Administrative Law Hearing process. MMM designate, in writing, an officer who has primary responsibility for ensuring that Complaints, Grievances, and Appeals are resolved and for signing all Notices of Action. MMM has a written Grievance System, and policies and procedures that detail the operation of the Grievance System.

At a minimum, MMM Grievance System policies and procedures include the following:

1. Process for filing a Complaint, Grievance, or Appeal, or seeking an Administrative Law Hearing.
2. Process for receiving, recording, tracking, reviewing, reporting, and resolving Grievances and Appeals filed verbally, in writing or in-person.
3. Process for requesting an expedited review of an Appeal.
4. Process and timeframe for a Provider to file a Complaint, Grievance or Appeal on behalf of an Enrollee.
5. Process for notifying Enrollees of their right to file a Complaint, Grievance or Appeal with the Patient Advocate Office and how to contact the Patient Advocate Office.

6. Procedures for the exchange of Information with Providers, ASES, and the Enrollees regarding Complaints, Grievances and Appeals.
7. Process and timeframes for notifying Enrollees in writing regarding receipt of Complaints, Grievances, Appeals, resolution, action, delay of review, and denial of request for expedited review.
8. MMM Grievance System fully complies with the Patient's Bill of Rights Act and with Act No. 11 of April 11, 2001 (known as the Organic Law of the Office of the Patient Advocate), to the extent that such provisions do not conflict with or pose an obstacle to Federal regulations.
9. MMM processes each Complaint, Grievance, or Appeal in accordance with applicable Puerto Rico and Federal statutory and regulatory requirements.

15.1. Complaint

The Complaint process is the process for addressing Enrollee's complaints, defined as expressions of dissatisfaction about any matter other than an Action that are resolved at the point of contact rather than through filing a formal grievance. An Enrollee or Enrollee's Authorized Representative may file a complaint orally or in writing. The Enrollee or Enrollee's Authorized Representative may follow-up an oral request with a written request. However, the timeframe for resolution begins with the date MMM receives the oral request. An Enrollee or Enrollee's Authorized Representative shall file a Complaint within fifteen (15) Calendar Days after the date of occurrence that initiated the Complaint. If the Enrollee or Enrollee's Authorized Representative attempts to file a Complaint beyond the fifteen (15) Calendar Days, the Contractor shall instruct the Enrollee or Enrollee's Authorized Representative to file a Grievance. MMM will resolve each

complaint within seventy-two (72) hours of the time MMM received the initial complaint. If the complaint is not resolved within this timeframe, the complaint will be treated as a grievance. The Notice of Disposition include the results and date of the resolution of the complaint and will include notice of the right to file a grievance or appeal and information necessary to allow the Enrollee to request an Administrative Law Hearing.

15.2. Grievance Process

An Enrollee or Authorized Representative may file a Grievance with MMM or with the Office of the Patient's advocate of Puerto Rico either orally or in writing. A Provider cannot file a Grievance on behalf of an Enrollee unless the Enrollee grants consent. An Enrollee may file a Grievance at any time. MMM will acknowledge receipt of each Grievance in writing to the Enrollee (and the Provider, if the Provider filed the Grievance on the Enrollee's behalf, if the enrollee authorized the provider) within ten (10) Business Days of receipt. MMM will provide written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but in any event, within ninety (90) Calendar Days from the day MMM Multihealth receives the Grievance. The Notice of Disposition will include the following:

- The resolution of the Grievance.
- The basis for the resolution.
- The date of the resolution.

MMM may extend the timeframe to provide a written notice of disposition of a Grievance for up to fourteen (14) Calendar Days if the Enrollee requests the extension or MMM demonstrates (to the satisfaction of ASES, upon its request) that there is a need for additional information and how

the delay is in the Enrollee's interest. If MMM extends the timeframe, it must notify the beneficiary of the request in writing, stating the reason.

15.3. Appeal Process

The Enrollee, their authorized representative, or the provider authorized by the beneficiary may file an appeal either orally or in writing. Unless the Enrollee requests expedited review, the Enrollee, the Enrollee's authorized representative or the provider acting on behalf of the Enrollee with the Enrollee's written consent, must submit an oral filing with a written, signed, request for appeal. The requirements of the appeal process will be binding for all types of appeals, including expedited appeals, unless otherwise established for expedited appeals. An appeal may be filed with MMM up sixty (60) calendar days from the date on MMM notice of action. Appeals must be filed directly with MMM. The appeals process provides the Enrollee, the Enrollee's authorized representative, or the provider acting on behalf of the Enrollee with the Enrollee's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. MMM informs the Enrollee of the limited time available to provide this in case of expedited review. The appeals process provides the parties involved the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process and provide copies of documents contained therein without charge. If requested, MMM will offer copies of the documents contained therein, at no cost. For verbal appeals it is not necessary to submit to the plan written evidence of the appeal request within 10 days. MMM resolves each standard appeal and provide written notice of the disposition, as expeditiously as the Enrollee's health condition requires but no more than thirty (30) calendar days from the date MMM

receives the appeal. MMM establishes and maintains an expedited review process for appeals, subject to prior written approval by ASES, when MMM determines (based on a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. MMM resolves each expedited appeal and provides a written notice of disposition, as expeditiously as the Enrollee's health condition requires, but no longer than seventy-two (72) hours after MMM receives the appeal and make reasonable efforts to provide oral notice.

If MMM denies the request for an expedited review, it utilizes the timeframe for standard appeals specified herein and makes reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow-up within two (2) calendar days with a written notice. If the Enrollee disagrees with the decision to change the prescribed timeframe, they have the right to file a grievance and is resolved within twenty-four (24) hours. MMM also makes reasonable efforts to provide oral notice for resolution of an expedited review of an appeal. MMM may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the involved parties request the extension or MMM demonstrates (to the satisfaction of ASES, upon its request) that there is need for additional information and how the delay is in the Enrollee's interest. If MMM Multihealth extends the deadline, you will be sent a written notice of the reason for the delay. MMM informs the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe.

MMM provides written notice of disposition of an appeal to the Enrollee (and the Provider, if the Provider filed the Appeal on the Enrollee's behalf) as well as a copy to ASES within two (2) business days of the resolution. The written notice of disposition includes:

1. The results and date of the appeal resolution.
2. For decisions not wholly in the Enrollee's favor:
    a. The right to request an Administrative Hearing.
    b. How to request an Administrative Hearing.
    c. The right to continue to receive benefits pending an Administrative Hearing;
    d. Notification if MMM Multihealth action is upheld in a hearing.

15.4. Administrative Law Hearing

MMM is responsible for explaining the Enrollee's right and the procedures for an Administrative Hearing, including the beneficiary must exhaust the complaint, grievance and appeals process with MMM Multihealth before requesting an Administrative Hearing. The parties to the Administrative Law Hearing include MMM, the Enrollee, their authorized representative, or the representative of a deceased Enrollee's estate. If MMM takes an action, the Enrollee appeals the action and the resolution of the appeal is not in the Enrollee's favor, and the Enrollee requests an Administrative Law Hearing, ASES will grant the Enrollee such hearing. The right to such Administrative Law Hearing, how to obtain it, and the rules concerning who may represent the Enrollee at such hearing is explained to the Enrollee and by MMM. ASES shall permit the Enrollee to request an Administrative Law Hearing within one hundred and twenty (120) Calendar

Days of the Notice of Resolution of the Appeals. The insured or his/her authorized representative may request an appeal hearing before ASES by faxing 787-474-3346 or writing to: ASES PO BOX 195661 San Juan, PR 00919-5661. In the denial notification letter, MMM explains the detail of how, and when, you can complete this process.

16. CLAIMS

16.1 Claims Processing

MSO will receive claims from contracted providers and process them in a timely, accurate manner. MMM Multihealth shall process paper and electronic claims according to the requirements established in the Contract with the Government Health Plan. Claims payments shall also be based on the terms specified in the provider's contract. Providers shall send Electronic Encounter Data to MSO on a weekly basis.

ASES notifies the effectiveness of the adoption of 75% of the Medicare Fee Schedule for Puerto Rico, as the minimum fee for payment for services offered to Plan Vital beneficiaries. This rate is part of the initiatives to increase reimbursements to suppliers. The implementation of this tariff entails faithful compliance with the following conditions:

1. The Medicare Fee Schedule of reference is the one applicable to Puerto Rico as per ASES approval.

2. The minimum rate for *Plan Vital* providers is 75%, according to the procedure code.

3. It is applicable to all providers who are recognized for Medicare-Part B, regularly known as the professional component.

4. No provider should receive a service fee reduction if there is a current contract with the MCO greater than the minimum established.

5. The MFSPR 2023 based on your specialty is a reference one, for which the *Plan Vital* benefit coverage does not have changes.

6. This measure is applicable to providers of services to *Plan Vital* beneficiaries. It does not include services provided to beneficiaries enrolled in Medicare Advantage *Platino*.

7. It also excludes capitated services and other sustainability measures directed at short-term intensive care hospitals that qualify in the amount and frequency established by ASES.

MMM Multihealth will use this rate as a minimum for the payment of invoices for services incurred as of the date approved by the ASES.

A. Definitions:

1. **Clean Claims**: A claim received for adjudication, which can be processed without obtaining additional information from the provider of the service or from a third party. This includes claims with errors originated in the MMM Multihealth Claims System and does not include claims from a provider who is under investigation for fraud, waste, or abuse, or a claim under review to determine medical necessity.
    - ✓ 95% of clean claims will be paid in 30 days from the receipt date.
    - ✓ 100% of clean claims will be paid in 50 days from the receipt date.
2. **Unclean Claims**: A claim for which additional documentation or corrections from an outside source is required to make the claim payable. This includes claims from

providers who are under investigation for fraud, waste, or abuse, or a claim under review to determine medical necessity.

- ✓ 90% of unclean claims will be paid in 90 days from the received date.
- ✓ 9% of unclean claims will be paid in 6 months (180 days) from the receipt date.
- ✓ 1% of unclean claims will be paid one year (12 months) from the receipt date.

3. Correct Billing

It is important to follow the billing guides established by the National Correct Coding Initiative. This includes and does not limit to the correct use of modifiers, incidental codes, etc., as these edits will be taken in consideration when bill is being processed.

4. Electronic Claims

MSO of Puerto Rico, LLC, has the capability to accept electronic claims transaction through Inmediata or Assertus clearinghouses. This should be the first alternative to submit the claims. To summit Vital claims, use the following Payer ID:

- ✓ MMM Multihealth: 660653763

If not possible to submit the claims through the clearinghouses, the paper claims should be sent to:

MMM Multihealth

PO Box 71307

San Juan, PR 00936-71307

5. Adjustments

In the event a claim is denied for any reason, the provider shall re-submit such claim along with any applicable documentation to MSO consistent with the terms of the agreement, and no later than thirty (30) days*. If the provider does not re-submit the applicable documentation to MSO for services rendered within said time, the provider claim for compensation with respect to the detailed services shall be deemed waived.

The provider must include all support information that may be considered vital for the resolution of the case, including a list of the enrollees involved in the appeal case. For example: payment receipt or evidence, additional medical documentation of the patient, HCFA 1500 and/or UB04 Form, etc.

MSO has established a format to request an adjustment. This format must be included in all adjustment requests and should not be modified.

***For time frame reference, see your contract.**

16.2 Payment Schedule

MSO will run two (2) Provider Payment cycle per week. This applies for Fee for Services claims. For Capitation services, a monthly payment will be generated.

16.3 Timely Filling

The provider shall submit claims on or before ninety (90) days from the date of service with all required information to receive a correct payment and to receive it on time.

If a claim is submitted to MSO with more than ninety (90) days after the date of provider's provision of Covered Services, the claim will be denied.

As established in the Contract, the provider shall submit all claims data through electronic format. For paper claims, the provider should submit all applicable documentary support to the following address:

MMM Multihealth
PO Box 71307
San Juan PR. 00936-71307

16.4 Unclean claims process

No later than the fifth (5th) Business Day after a received claim has been determined that it does not meet Clean Claim requirements, the claim will be suspended, and a letter will be sent requesting all outstanding Information so that the claim can be deemed clean.

The provider shall submit the claim with the information requested, no more than ninety (90) Calendar days. Upon receipt of all the requested information from the Provider, MSO shall complete processing of the Claim, and finalize (to a paid or denied status) within ninety (90) Calendar Days. In denied claims, if the provider does not agree with the resolution (determination), they must follow the Adjustment process defined in the Claims Processing Section.

16.5 Dispute resolution system

MSO has established a process to resolve disputes related to billing, payments, and other administrative disputes between providers and MMM Multihealth that arise under the provider's contract. Through this process, the provider has the opportunity to submit their complaint with

all the required documentation in writing to the MSO through FAX 787-300-4885 and/or email providerdisputeresolution@mso-pr.com. MSO will issue a written decision regarding the provider's dispute within fifteen (15) calendar days of receipt of the supplier's written complaint. The written decision of MSO that is in some way adverse to the provider will include an explanation of the reasons for the decision and a notification of the rights and procedures that the provider must follow for a legal administrative hearing with ASES.

MSO has also established a process to resolve complaints related specifically to the payments received from their PMG. Through this process, the provider can submit their complaint in writing to the MSO via a centralized email (ServiceRequests@mso-pr.com). The MSO will contact the provider within thirty (30) calendar days of receipt of the written complaint. Should the involved parties not reach an agreement, the issue will be escalated to ASES for further case management.

16.6 Financial Recovery

MMM Multihealth has a process to handle audits to determine whether it has paid a Claim incorrectly. It identifies potential overpayments and requests the reimbursement from the Provider or recoupment through the payment system. The Provider will have a period of sixty (60) Calendar Days to submit the payment and/or appeal the recovery determination made by MSO.

Self-Reporting of Overpayment By A Provider:

If provider identifies an overpayment from the MSO when reviewing their Explanation of Payments, the provider should report it and return the overpayment within sixty (60) Calendar

Days after the date on which the overpayment was identified. The provider should include the Member ID, Member Name, Date of Service, Paid Date, Check Number, and the reason of the overpayment. The above information will be sent to the following address:

MSO OF PUERTO RICO
ATT: FINANCIAL RECOVERY DEPARTMENT
PO BOX 71500
SAN JUAN, PR 00936

17. ADMINISTRATION AND MANAGEMENT

17.1 Hours of Business Operations

Plan Vital will be responsible for the administration and management of all the requirements and in accordance with the rules of Medicaid managed care 42 CFR Part 438. Since registration occurs mainly in the administrative offices, *Plan Vital* will ensure that its administrative offices are physically accessible to all beneficiaries and fully equipped to perform all functions related to the implementation of this Agreement. *Plan Vital* keeps administrative offices across the island. *Plan Vital* will accommodate any request from ASES to visit the administrative offices of *Plan Vital* to ensure that the offices are compatible with the requirements of the American with Disability Act (ADA) for public buildings, and all other rules and regulations applicable federal and state. *Plan Vital* must keep one (1) administrative headquarters and additional administrative offices across the island. *Plan Vital* offices are in a central location accessible on foot and / or by vehicle.

Plan Vital can set more than one (1) administrative office but must designate one (1) office as the central administrative office. All written communications to *Plan Vital* beneficiaries must contain the address of the place identified as the legal, administrative headquarters licensed. This

administrative office must be open at least from 8:00 a.m. to 5:00 p.m. (Atlantic Time), Monday through Friday. Furthermore, in accordance with the enrollment Promotion, *Plan Vital* administrative office should have extended open hours (until 7:00 p.m. (Atlantic Time) at least one (1) day business of the week, and must be open (to the extent necessary to permit enrollment activities) one Saturday a month from 8:00 a.m. to 5:00 p.m. (Atlantic Time) *Plan Vital* will ensure that the office(s) are properly staffed throughout the term of the contract, to ensure that potential beneficiaries can visit the office to enroll at any time during the hours of operation. This provision will ensure that beneficiaries and providers receive prompt and accurate response to queries.

MMM Multi Health has a process in place to audit the payment process to determine if a claim has been paid correctly or not, identify potential overpayment and request reimbursement through the provider payment system.

The provider shall have a period of ninety (90) calendar days to appeal the determination of the recovery made by MSO.

18. DEFINITIONS

1. Subcapitation Arrangement

An arrangement where an entity paid through capitation contracts with other providers to reimburse for their services on a capitated basis, sharing a portion of the original capitated amount.

2. Teledentistry

The use of telehealth systems and methodologies to deliver dental services to patients in remote locations.

3. Telehealth

The use of electronic information and telecommunications technologies, including but not limited to telephonic communications, the internet, videoconferencing, and remote patient monitoring, to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.

4. Telemedicine

The clinical use of telehealth systems and methodologies by Providers to diagnose, evaluate and treat patients in remote locations.

19. ACRONYMS

A&G	Appeals and Grievance
AAP	Adult Access to Preventive / Ambulatory Health Services
ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ACOG	College of Obstetricians and Gynecologists
ADA	American Disabilities Act
ADAP	AIDS Drug Assistance Program
ADFAN	Families and Children Administration in Puerto Rico (*Administración de Familias y Niños en Puerto Rico)*

ADV	Annual Dentist Visit
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
AIMD	Associate Inpatient Medical Director
AMA	American Medical Association
AP	Admitting Physician
APP	Admiting Physician Program
ASES	Administración de Seguros de Salud, or Puerto Rico Health Insurance Administration.
ASSMCA	The Puerto Rico Mental Health and Against Addiction Services Administration or Administración de Servicios de Salud Mental y Contra la Adicción.
ASUME	Minor Children Support Administration
AWC	Adolescent Well-Care Visits
BC-DR	Business Continuity and Disaster Recovery
BCS	Breast Cancer Screening
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCS	Cervical Cancer Screening
CEHRT	Certified Electronic Health Record System
CEO	Chief Executive Officer

CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendment
CMP	Civil Monetary Penalties
CMS	Centers for Medicare and Medicaid Services
CO	Compliance Officer
COL	Diabetes Patients Screening
COVID- 19	Coronavirus Disease 2019
CPC	Comprehensive Primary Care Consulting
CPT	Current Procedural Terminology
CPTET	Centers for Prevention and Treatment of Infectious Diseases
CRN	Concurrent Review Nurse
CRIM	Center for the Collection of Municipal Revenues
DEA	Drug Enforcement Administration
DM	Disease Management
DME	Durable Medical Equipment
DNC	Days in Non Compliance – (not covered)
DENC	Detailed Explanation of Non Coverage

DNOD	Detailed Notice of Discharge
DOJ	The Puerto Rico Department of Justice
DPU	Discharge Planning Unit
ECHO	Experience of Care and Health Outcomes Survey
ECM	Electronic Claims Management
eCQM	Electronic Clinical Quality Measures
EDI	Electronic Data Interchange
EFT EHR	Electronic Funds Transfer Electronic Health Record
EIN	Employer Identification Number
E/M	Evaluation and Management
EMTALA	Emergency Medical Treatment and Labor Act
EPLS	Excluded Parties List System
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
FAR	Federal Acquisition Regulation
FDA	Food and Drug Administration
FFS	Fee-for-Service

FMC	Formulary of Medications Covered
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FUH	Follow-up after Hospitalization due to Mental Health Condition
FWA	Fraud, Waste & Abuse
PMG	Primary Medical Group
GP	General Physician
GSA	General Services Administration
HAC	Hospital-Acquired Condition
HCPCS	Healthcare Common Procedure Coding System
HEDIS	The Healthcare Effectiveness Data and Information Set
HHS	US Department of Health & Human Services
HHS-OIG	US Department of Health & Human Services Office of the Inspector General
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	The Health Information Technology for Economic and Clinical Health Act of 2009, 42 USC 17391 et. Seq
HMO	Health Maintenance Organization
IBNR	Incurred-But-Not-Reported

ICD-10	International Statistical Classification of Diseases and Related Health Problems (10th edition).
IMHD	Integrated Mental Health Department
IVR	Interactive Voice Response
JLDMPR	Junta de Licenciamiento y Disciplina / Licensing and Discipline Board of Puerto Rico
LEIE	List of Excluded Individuals and Entities
LGBTQ+	Lesbian, Gay, Bisexual, & Transgender
LME	List of Medication Exceptions
MAC	Maximum Allowable Cost
M-CHAT	Modified Checklist for Autism in Toddlers
MCG	Milliman Care Guidelines
MCO	Managed Care Organization
MCS	Centers for Medicare and Medicaid Services
MD	Medical Doctor
MFCU	Medicaid Anti-Fraud Unit
MHSIP	Mental Health Statistics Improvement Program
MI	Internal Medicine
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NDMC	Notice of Denial of Medical Coverage (letter on acute level discharge)

NEMT	Non-Emergency Medical Transportation
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPL	National Provider List
NPPES	National Plan and Provider Enumeration System
NQMC	National Quality Measures Clearinghouse
Ob-Gyn	Obstetritian / Ginecologist
OCR	Office of Civil Rights
OIG	Office of the Inspector General
ONCHIT	Office of the National Coordinator for Health Information Technology
OPA	Office of the Patient's Advocate
OTC	Over-the-counter
P&T	Pharmacy and Therapeutics
PBM	Pharmacy Benefit Manager
PCP	Primary Care Physician
PDL	Preferred Drug List
PFCRA	Program Fraud Civil Remedies Act of 1986
PHI	Personal Health Information
PIP	Performance Improvement Projects

PMG	Physician Medical Group
POA	(condition) Present on Admission
PPA	Pharmacy Program Administrator
PPACA	Patient Protection and Affordable Care Act
PPC	Prenatal and Post partum Care
PPN	Preferred Provider Network
PRHIEC	Puerto Rico Health Information Exchange Corporation
PSG	Government Health Plan
QAPI	Quality Assessment Performance Improvement Program
QIP	Quality Improvement Procedure
RFP	Request for Proposals
RHC	Rural Health Center/Clinic
RMD	Regional Medical Director
SAMHSA	Substance Abuse and Mental Health Services Administration
SARAFS	Secretaria Auxiliar para Reglamentación y Acreditación de Facilidades de Salud (Assistant Secretary for Regulation and Accreditation of Health Facilities)
SAS	Statement on Auditing Standards
SCR	Senior Concurrent Reviewer
SMART	Set goals and objectives that are Specific, Measurable, Achievable, Results-oriented and Time-based for implementation.

SMI/SED	Serious Mental Illness/Serious Emotional Disability
SNF	Skilled Nursing Facility
SRAE	Serious Reportable Adverse Event
SSD	Schizophrenia of Bipolar Disorder who are using Antipsychotic Medications
SSN	Social Security Number
SUDs	Substance Use Disorders
TAU	Transitional Admission Unit
TDD	Telecommunication Device for the Deaf
TPL	Third Party Liability
TU	Transportation Unit
UM	Utilization Management
US	United States of America
USC	United States Code

ANNEXED

1. Special Cover Form

2. Hepatitis C Screening Test Flowchart

3.Itinerary of Educational Events for beneficiaries on Hepatitis C

4.Inquiries and Referrals Form

5. Referral for Social Work

1. Special Cover Form

ADMINISTRACIÓN DE SEGUROS DE SALUD (ASES) DE PUERTO RICO

Vital

FORMULARIO DE REGISTRO DE CONDICIONES ESPECIALES

☐ First MEDICAL ☐ MMM ☐ PSM PLAN DE SALUD MENONITA ☐ TRIPLE-S SALUD

V_mayo.2021

SECCIÓN I INFORMACIÓN DEL BENEFICIARIO

APELLIDO PATERNO / APELLIDO MATERNO / NOMBRE / INICIAL	NUMERO DE CONTRATO	FECHA DE CUBIERTA MES / DIA / AÑO

TIENE OTRO SEGURO MED ☐ SÍ ☐ NO	NOMBRE OTRO SEGURO	NUM. CONTRATO DEL OTRO SEGURO	FECHA DE EFECTIVIDAD MES / DIA / AÑO	GRUPO MÉDICO

SEXO AL NACER ☐ F ☐ M	FECHA DE NACIMIENTO MES / DIA / AÑO	NÚMERO DE TELÉFONO O CELULAR	TELÉFONO O CEL. ALTERNO	NÚMERO DE FAX

DIRECCIÓN FÍSICA	MUNICIPIO	ZIP CODE	CORREO ELECTRÓNICO

DIRECCIÓN POSTAL	MUNICIPIO	ZIP CODE	FIRMA DEL PACIENTE

SECCIÓN II INFORMACIÓN DEL PROVEEDOR QUE SOLICITA

NOMBRE PROVEEDOR (letra de molde)	NÚMERO DE LICENCIA	NPI	ESPECIALIDAD	TELÉFONO OFICINA

FIRMA DEL PROVEEDOR	CORREO ELECTRÓNICO	FECHA DE EMISIÓN DEL REFERIDO A REGISTRO MES / DIA / AÑO	# CEL. PROVEEDOR (opcional)	FAX PROVEEDOR

ICD-10 (1)	ICD-10 (2)	ICD-10 (3)

☐ **AUTISMO:** **(a) Provisional coverage** ▫ **R63.50** Unspecified lack of expected normal psychological development in childhood ▫ **R62.0** Delayed Milestone in childhood ▫ **F88** Other disorders of psychological development ▫ **F80.2** Mixed receptive and expressive language disorders ☐ **(b) Permanent registration**	Certification of risk by the primary care physician and evidence of the screening tool utilized.The provisional coverage will last for six months. If the evaluation process is not completed, the provisional coverage may be renew for six additional month. (Mark what screening tools where used for evaluation): ▫ <16 months – Ages & Stages Questionnaires: Social Emotional-2 (ASQ-SE-2) or Communication Symbolic Behavior Scales -Developmental Profile (CSBS-DP) ▫ 16-30 months – Modified Checklist for Autism in Toddlers: Revised Follow-Up (M-CHAT R/F) ▫ 31-66 months – Ages & Stages Questionnaire-Social Emotional-2 (ASQ-SE-2) ▫ ≥48 months – Social Communication Questionnaire (SCQ mental age > 2 years) Communication & Symbolic Behavior Scales Developmental Profile (CSBS-DP) ▫ 67 months-11 years – Childhood Asperger Syndrome Test (CAST) ▫ > 11 years – Australian Scale for Asperger Syndrome (ASAS) **(See, Protocol of Autism from the Department of Health)** For permanent registration is required any of the following Diagnosis certification by: • Clinical Psychologist, • School Psychologist, • Counselor Psychologist, • Neurologist, • Psychiatrist, • Pediatrician development specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR. After 21 years, to continue in the special coverage, a certification by a neurologist or psychiatrist establishing the need for the condition management and treatment as an adult is required.
☐ **CÁNCER:** - *Incluyendo cuidado paliativo-* **Certificación diagnóstica (con estadio) por Hematólogo/ Oncólogo, o por especialista médico a cargo del manejo de la condición.**	**Certificación debe incluir plan de tratamiento con fechas de inicio y terminación estimadas.** (La aseguradora proveerá un documento específico para que el especialista documente la certificación de diagnóstico específico y solicitud de Registro de Cáncer.) - Evidencia de resultado de biopsia. - En casos donde no pueda confirmarse el diagnóstico por patología (biopsia), se considerará la evidencia de estudios diagnósticos como CT, MRI, PET Scan, Sonografía, que justifiquen diagnóstico/ estadio.
☐ **CÁNCER DE PIEL / CARCINOMA IN SITU:**	Certificación diagnóstica con resultado positivo en Biopsia

SECCIÓN III CONDICIÓN ESPECIAL SOLICITADA Y DOCUMENTOS REQUERIDOS PARA SU VALIDACIÓN	
☐ **ANEMIA APLÁSICA:** **Certificación de diagnóstico definitivo por Hematólogo/ Oncólogo.**	**Evaluación Hematológica:** Contaje absoluto de Neutrófilos<500/mm3 Plaquetas <20,000/mm Reticulocitos <1% Resultados de la aspiración y/o biopsia de Médula Ósea
☐ **ARTRITIS REUMATOIDE:** **Certificación de diagnóstico por Reumatólogo.**	**Evidencia de al menos 4 de 7 criterios establecidos por Colegio Americano de Reumatología:** -Rigidez matutina de las articulaciones (al menos durante una hora) durante más de seis semanas. -Inflamación articular (artritis) con hinchazón palpable en tres o más regiones articulares durante más de seis semanas. - Artritis en articulaciones de la mano o de los dedos durante más de seis semanas. - Artritis simétrica (al mismo tiempo en ambos lados de la misma región articular) durante más de seis semanas. - Nódulos reumatoides. - Prueba positiva de Factor reumatoide. - Pruebas de laboratorios: ESR, ANA Test, CRP, RA Factor, Radiografías. - Evidencia de tratamiento con un medicamento DMARD

☐ **AUTISMO:** **(a) Provisional coverage** ▫ **R63.50** Unspecified lack of expected normal psychological development in childhood ▫ **R62.0** Delayed Milestone in childhood ▫ **F88** Other disorders of psychological development ▫ **F80.2** Mixed receptive and expressive language disorders ☐ **(b) Permanent registration**	Certification of risk by the primary care physician and evidence of the screening tool utilized.The provisional coverage will last for six months. If the evaluation process is not completed, the provisional coverage may be renew for six additional month. (Mark what screening tools where used for evaluation): ▫ <16 months – Ages & Stages Questionnaires: Social Emotional-2 (ASQ-SE-2) or Communication Symbolic Behavior Scales -Developmental Profile (CSBS-DP) ▫ 16-30 months – Modified Checklist for Autism in Toddlers: Revised Follow-Up (M-CHAT R/F) ▫ 31-66 months – Ages & Stages Questionnaire-Social Emotional-2 (ASQ-SE-2) ▫ ≥48 months – Social Communication Questionnaire (SCQ mental age > 2 years) Communication & Symbolic Behavior Scales Developmental Profile (CSBS-DP) ▫ 67 months-11 years – Childhood Asperger Syndrome Test (CAST) ▫ > 11 years – Australian Scale for Asperger Syndrome (ASAS) **(See, Protocol of Autism from the Department of Health)** For permanent registration is required any of the following Diagnosis certification by: • Clinical Psychologist, • School Psychologist, • Counselor Psychologist, • Neurologist, • Psychiatrist, • Pediatrician development specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR. After 21 years, to continue in the special coverage, a certification by a neurologist or psychiatrist establishing the need for the condition management and treatment as an adult is required.
☐ **CÁNCER:** - ***Incluyendo cuidado paliativo-*** **Certificación diagnóstica (con estadio) por Hematólogo/ Oncólogo, o por especialista médico a cargo del manejo de la condición.**	**Certificación debe incluir plan de tratamiento con fechas de inicio y terminación estimadas.** (La aseguradora proveerá un documento específico para que el especialista documente la certificación de diagnóstico específico y solicitud de Registro de Cáncer.) - Evidencia de resultado de biopsia. - En casos donde no pueda confirmarse el diagnóstico por patología (biopsia), se considerará la evidencia de estudios diagnósticos como CT, MRI, PET Scan, Sonografía, que justifiquen diagnóstico/ estadio.
☐ **CÁNCER DE PIEL / CARCINOMA IN SITU:**	Certificación diagnóstica con resultado positivo en Biopsia

☐ **CÁNCER DE PIEL: MELANOMA:** **Certificación de registro por dermatólogo u Oncólogo/Hematólogo**	Patología o Biopsia positiva Estudios especiales CT Scan, MRI, Sonograma
☐ **CERNIMIENTO AUDITIVO NEONATAL: Cubierta TEMPORERA hasta los seis (6) meses de edad o diagnóstico definitivo, lo que ocurra primero.** Los proveedores que pueden solicitar el registro provisional o temporero: médicos primarios, incluyendo pediatras.	El neonato con problema inicial de audición, según refleja el resultado de la prueba de cernimiento neonatal, se debe registrar obligatoriamente en Cubierta Especial bajo un Registro Provisional Temporero. Para ello se requiere el informe inicial de hallazgos auditivos que es parte del cernimiento neonatal. Es la única documentación que se requiere a esta etapa del proceso. *(Para más detalles, referirse al Protocolo de pruebas de audición y su seguimiento en neonatos (ASES-OPCAC-2019/P004-1).*

☐ **EMBARAZO:** **Certificación de embarazo por ginecólogo obstetra**	Hoja de registro Obstétrico. Una vez se registra el caso, se enviará a la asegurada por correo una certificación de la cubierta especial.
☐ **ENFERMEDAD RENAL CRONICA:** **Se utiliza la razón de filtrado glomerular calculado, (GFR por sus siglas en inglés).**	Se requiere evidencia de resultados reciente de creatinina en sangre, edad, sexo y raza del asegurado. **Nivel 3:** GFR mayor de 30-59, N18.3 **Nivel 4:** GFR mayor de 15-29, N18.4 **Nivel 5:** GFR menor de 15, N18.5 **ESRD:** N18.6
☐ **ESCLERODERMA:** **Certificación de diagnóstico por reumatólogo**	Certificación de diagnóstico por reumatólogo con evidencia de los siguientes laboratorios; - ANA Test, DS-DNA - Anti Sm - Anti Fosfolípidos - Biopsia de piel.
☐ **ESCLEROSIS MULTIPLE** ☐ **ESCLEROSIS LATERAL AMIOTROFICA:** **Certificación del diagnóstico por neurólogo.**	CRITERIOS Dos (2) episodios distintos de síntomas neurológicos causando síntomas o hallazgos de laboratorio. Resultado de MRI de cerebro. Resultado de punción lumbar. Síntomas que indican daño en más de una región del Sistema Nervioso Central. -Validar que otra enfermedad no es causante de los síntomas presentes.

☐ **FALLO CARDIACO CLASE III y CLASE IV NYHA: Cubierta especial TEMPORERA con duración <u>máxima</u> de cuatro (4) meses, NO PRORROGABLES..**	CRITERIOS - El cardiólogo del beneficiario tendrá que someter una certificación, donde indique el diagnóstico de fallo cardíaco con fracción de eyección disminuida (HFrEF), con un EF igual o menor de 30%, y sustentar con pruebas objetivas los hallazgos y el tratamiento ofrecido hasta la fecha del referido. **Tiene que informar que, el beneficiario es un candidato real para ser recipiente de un trasplante de corazón y documentar al menos una (1) de los siguientes:** - Fracción de eyección ventricular izquierda o LVEF <30% - Hospitalizaciones recurrentes por la condición de fallo cardíaco. - Fallo sintomático a pesar de haberse optimizado las terapias y el uso de dispositivos de ayuda. - Incremento continuo de requerimientos de medicamentos diuréticos. - Dependencia progresiva de agentes inotrópicos positivos. **<u>Y:</u> Ausencia de disfunción ventricular derecha severa e insuficiencia de la válvula tricúspidea** *(Absence of severe right ventricular dysfunction and tricuspid regurgitation)*
☐ **FENILCETONURIA (PKU) EN ADULTOS**	Si antes de alcanzar la edad adulta (21 años), el beneficiario estaba registrado bajo la cubierta de Niños con Condiciones Especiales por diagnóstico de PKU, esto se considera suficiente evidencia para una continuación de cubierta. No se requiere evidencia clínica adicional.
☐ **FIBROSIS QUISTICA:** **Certificación del diagnóstico por neumólogo confirmando condición.**	Prueba de sudor. Evidencia de tratamientos.
☐ **HEMOFILIA:** **Certificación por hematólogo de diagnóstico de Hemofilia:**	**Severa**: Niveles de Factor VIII <1% **Moderada**: Nivel de Factor VIII<1-5% **Leve**: Nivel de Factor VIII 5-25% con sangrado severo. •Resultados de Niveles de Factores de Coagulación Pacientes con Hemofilia A y B severas. Pacientes con Hemofilia A y B severas, con presencia de inhibidores. Pacientes con Hemofilia A y B moderadas, con presencia de inhibidores.

☐ **HEPATITIS C CRONICA (HCV):** **Certificación por: Gastroenterólogos, Infectólogos, o Hematólogos, Primarios capacitados, HIV Treaters**	**Se requiere la evidencia de:** • Examen positivo de anticuerpos HCV • Examen cuantitativo RNA Puede ser sometido por el MCO / PCP o Especialista. La cubierta durará desde el momento en que el paciente sea registrado hasta 6 meses luego de completado el tratamiento con el medicamento Antiviral de Acción Directa (DDA con evidencia de respuesta virológica sostenida no detectada. El paciente tendrá acceso directo sin referido del PCP: • A especialista o subespecialista para el manejo de su condición. • Al medicamento Antiviral de Acción Directa (DDA) establecido bajo la Cubierta de Medicamentos de ASES. • A laboratorios médicamente necesarios, así como Imágenes, Sonografía, MRI, CT o alguna otra imagen radiológica sin referido del PCP.
☐ **HIPERTENSIÓN PULMONAR:** **Certificación de diagnóstico y plan de tratamiento por el neumólogo o cardiólogo.**	Evidencia de Estudio que certifique condición.
☐ **LEPRA:** **Certificación del diagnóstico por infectólogo o dermatólogo confirmando condición.**	-Evidencia de resultado de biopsia de piel -Resultado positivo en cultivo de infección
☐ **LUPUS ERITEMATOSO SISTÉMICO:** **Certificación de diagnóstico por reumatólogo.**	Evidencia de los siguientes laboratorios: -ANA Test, DS-DNA -Anti Sm -Anti Phospholipids.
☐ **NIÑOS CON CONDICIONES ESPECIALES: Certificación del pediatra o especialista en la condición afectada.** **Laboratorio o estudio que determinó Dx:** _____	Laboratorios pertinentes que sustente el diagnóstico.

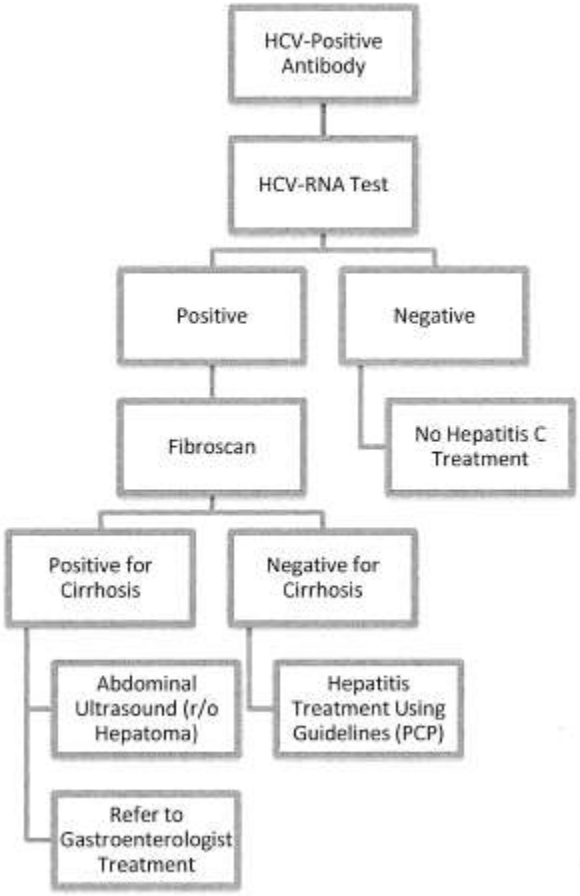
☐ **POST-TRASPLANTADOS: Excepto los trasplantes de córnea, hueso o piel a los que no les aplica la clasificación como condición especial .** **Certificación del especialista en trasplante o el especialista en la condición del órgano afectado (neumólogo; nefrólogo; hepatólogo/gastroenterólogo; cardiólogo; cirujano de trasplantes)**	Fecha del trasplante Tratamiento actual y medicamentos.

☐ **TUBERCULOSIS:** **Certificación del Neumólogo con plan de tratamiento**	**Evidencia de:** - Resultado de Prueba de la tuberculina - Resultado de prueba IGRA - Radiografía de tórax (pecho). - Muestras de esputos (secreción, flema) para AFB Y cultivo para M. tuberculosis o Lavado Bronquial cuando no pueden expectorar. - Biopsias del lugar afectado, si aplica. - Resultado de Prueba de VIH
☐ **VIH SIDA:** **Certificación de registro por medico primario o médico de clínica de HIV**	**Evidencia de:** o Resultado positivo en Western Blot (IFA) Inmunofluorescent Assay o Prueba de CD 4 o Evidencia de Enfermedades Oportunistas: - *Candidiásis* - *Cáncer del cuello uterino (invasor)* - *Coccidioidomicosis, criptococosis, criptosporidiosis* - *Enfermedad por Citomegalovirus* - *Encefalopatía (relacionada con el VIH)* - *Herpes simple (infección grave)* - *Histoplasmosis* - *Isosporiasis* - *Sarcoma de Kaposi* - *Linfoma (ciertos tipos)* - *Complejo mycobacterium* - *Neumonía (por pneumocystis)* - *Neumonía (recurrente)* - *Leucoencefalopatía multifocal progresiva (PML)* - *Septicemia por salmonela (recurrente)* - *Toxoplasmosis del cerebro* - *Tuberculosis* - *Síndrome de Emaciación*

COMENTARIOS

2. Hepatitis C Screening Test Flowchart

Flowchart for Diagnosis and Treatment Initiation for Patients with Positive Antibody for Hepatitis C Viral Infection



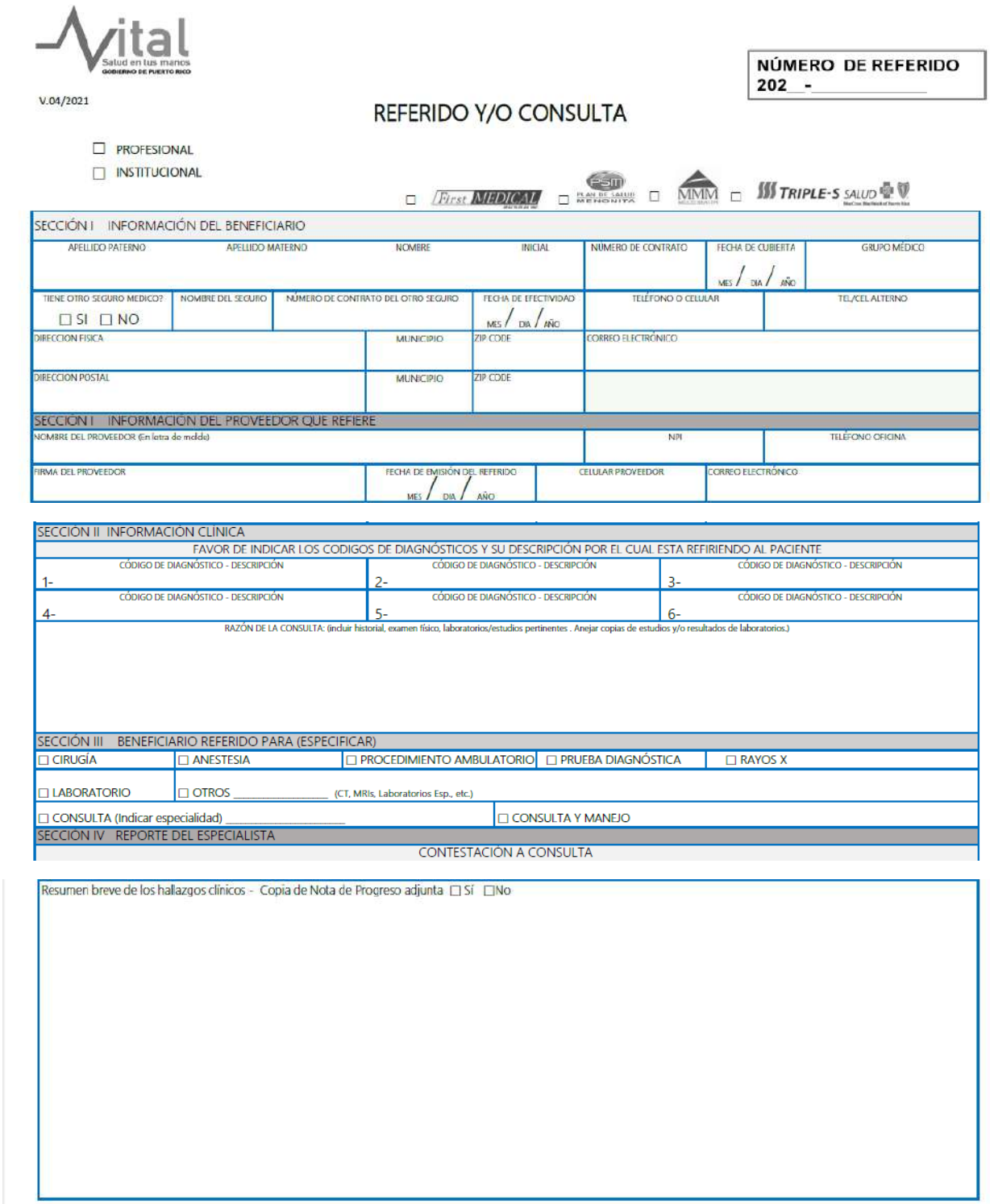
3. Itinerary of Educational Events for beneficiaries on Hepatitis C

Table. Schedule of Events for Patients who will be receiving direct acting agents (Anti-Viral Therapy).

	Pre-Treatment	Week 2 of Anti-viral Treatment	Week 8 End of Anti-viral Treatment	12 weeks ***AFTER*** finishing Anti-viral therapy
Clinic Visit	X		X	X
HCV RNA	X		X	X
HCV Genotype*	X			
CBC	X		X	X
Liver Panel	X	X	X	X
Creatinine /INR	X		X	X

**For stratification of response to therapy, cirrhosis and clinical outcomes.*

4. Inquiries and Referrals Form



Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

V.04/2021

NÚMERO DE REFERIDO
202__-_____

REFERIDO Y/O CONSULTA

☐ PROFESIONAL
☐ INSTITUCIONAL

☐ First MEDICAL ☐ PLAN DE SALUD MENONITA ☐ MMM ☐ TRIPLE-S SALUD

SECCIÓN I INFORMACIÓN DEL BENEFICIARIO						
APELLIDO PATERNO	APELLIDO MATERNO	NOMBRE	INICIAL	NÚMERO DE CONTRATO	FECHA DE CUBIERTA MES / DIA / AÑO	GRUPO MÉDICO

TIENE OTRO SEGURO MEDICO? ☐ SI ☐ NO	NOMBRE DEL SEGURO	NÚMERO DE CONTRATO DEL OTRO SEGURO	FECHA DE EFECTIVIDAD MES / DIA / AÑO	TELÉFONO O CELULAR	TEL/CEL ALTERNO

DIRECCION FISICA	MUNICIPIO	ZIP CODE	CORREO ELECTRÓNICO
DIRECCION POSTAL	MUNICIPIO	ZIP CODE	

SECCION I INFORMACION DEL PROVEEDOR QUE REFIERE		
NOMBRE DEL PROVEEDOR (En letra de molde)	NPI	TELÉFONO OFICINA

FIRMA DEL PROVEEDOR	FECHA DE EMISIÓN DEL REFERIDO MES / DIA / AÑO	CELULAR PROVEEDOR	CORREO ELECTRÓNICO

SECCIÓN II INFORMACIÓN CLÍNICA		
FAVOR DE INDICAR LOS CODIGOS DE DIAGNÓSTICOS Y SU DESCRIPCIÓN POR EL CUAL ESTA REFIRIENDO AL PACIENTE		
CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 1-	CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 2-	CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 3-
CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 4-	CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 5-	CÓDIGO DE DIAGNÓSTICO - DESCRIPCIÓN 6-
RAZÓN DE LA CONSULTA: (incluir historial, examen físico, laboratorios/estudios pertinentes . Anejar copias de estudios y/o resultados de laboratorios.)		

SECCIÓN III BENEFICIARIO REFERIDO PARA (ESPECIFICAR)				
☐ CIRUGÍA	☐ ANESTESIA	☐ PROCEDIMIENTO AMBULATORIO	☐ PRUEBA DIAGNÓSTICA	☐ RAYOS X
☐ LABORATORIO	☐ OTROS _____ (CT, MRIs, Laboratorios Esp., etc.)			
☐ CONSULTA (Indicar especialidad) _____		☐ CONSULTA Y MANEJO		

SECCIÓN IV REPORTE DEL ESPECIALISTA
CONTESTACIÓN A CONSULTA
Resumen breve de los hallazgos clínicos - Copia de Nota de Progreso adjunta ☐ Sí ☐No

Estudios realizados y resultados

Diagnósticos

Plan de tratamiento

INFORMACIÓN DEL ESPECIALISTA				
NOMBRE DEL PROVEEDOR (En letra de molde)	NPI	TEL OFICINA	CELULAR (OPCIONAL)	CORREO ELECTRÓNICO
FIRMA DEL PROVEEDOR			FECHA DE SERVICIO DESDE MES / DIA / AÑO	FECHA DE SERVICIO HASTA MES / DIA / AÑO

*** Este documento es válido por 90 días a partir de la fecha de emisión del proveedor que refiere.

Programa de Trabajo Social Hoja de Referido

El Programa de Trabajo Social de MSO of Puerto Rico, LLC, procura mejorar la calidad de vida y bienestar de los participantes adscritos a las cubiertas de Medicaid. Luego de evaluar los criterios y prioridad de la situación referida, un trabajador social puede realizar una evaluación biopsicosocial si la persona referida acepta participar. Es importante que este formulario se complete y se envíe por correo electrónico a **GHP-SW-Referrals@mmmhc.com** **o** vía fax al **787-999-1761** para ser evaluado. Incluya toda la información relevante, para facilitar el proceso de evaluación.

INFORMACIÓN GENERAL	
Número de identificación:	Fecha de referido:
Nombre del participante:	Teléfono #1:
Persona contacto:	Teléfono #2:
Persona que refiere:	**Teléfono:**
Según su mejor entendimiento, ¿el/la participante y/o su comunidad podría(n) representar un riesgo de seguridad para el/la Trabajador(a) Social?	☐ No ☐ Sí, especifique: _____

CRITERIOS DEL REFERIDO

FACTORES SOCIALES (Debe cumplir uno o más criterios)

- ☐ No tiene hogar (deambula)
- ☐ Inhabilidad para autocuidado y:
  - ☐ no cuenta con un cuidador
  - ☐ no cuenta con apoyo de familiares o personas cercanas
- ☐ Problemas relacionados a inhabilidad para comprar o preparar alimentos
- ☐ Vive en condiciones infrahumanas (extremadamente inadecuadas para un ser humano)
- ☐ Negligente con su cuidado debido a:
  - o no acude a seguimiento médico
  - o no cumple con recomendaciones clínicas (dieta, instrucciones, tratamiento o medicación)
- ☐ Problemas de transportación para cuidado médico o para cubrir necesidades básicas
- ☐ Infraestructura del hogar insegura debido a que:
  - o requiere relocalizar mobiliarios, espacios no apropiados
  - o tiene problemas eléctricos
  - o el nivel de salubridad en la comunidad o alrededores puede amenazar su seguridad física

FACTORES CLÍNICOS
(Debe cumplir al menos con un criterio social)

- ☐ Amerita coordinación de servicios clínicos
- ☐ Múltiples admisiones
- ☐ Múltiples visitas a sala de emergencias por cuidado inapropiado o falta de recursos (económicos o humanos)
- ☐ Múltiples readmisiones
- ☐ Manejo inadecuado de úlceras o heridas
- ☐ Pérdida de memoria, Demencia o Alzheimer
- ☐ No adherente a medicamentos
- ☐ No adherente a tratamiento

☐ Problemas financieros dificultan seguimiento clínico	

Incluya información adicional relevante: