Provider Manual

www.amerihealthcaritasnh.com

AmeriHealth Caritas™
New Hampshire

This Provider Manual is subject to change. Changes subject to State or federal requirements may be made at any time.

Provider Manual
New Hampshire Medicaid Care Management Program

Published September 2024
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Table of Contents

Welcome

Welcome to AmeriHealth Caritas New Hampshire – a mission-driven managed care organization located in New Hampshire and serving beneficiaries of the New Hampshire Medicaid Care Management program. By focusing on seamless care coordination and leveraging the strength and success of current New Hampshire Department of Health & Human Services' (DHHS) initiatives, we will drive quality health outcomes for the Medicaid populations.

This *Provider Manual* was created to assist you and your office staff with providing services to our members, your patients. As a condition of providing services to AmeriHealth Caritas New Hampshire members, providers agree to comply with the provisions in this manual.

This *Provider Manual* may be changed or updated periodically. AmeriHealth Caritas New Hampshire will provide you with notice of updates; providers are also responsible to check the Plan's website, www.amerihealthcaritasnh.com regularly for updates.

Thank you for your participation in the AmeriHealth Caritas New Hampshire provider network. We look forward to working with you!

Sharing Our Mission

We invite you, as a provider participating in our network, to share our mission: To help people get care, stay well, and build healthy communities.

SECTION I
GETTING STARTED

Who We Are

AmeriHealth Caritas New Hampshire, Inc. ("AmeriHealth Caritas New Hampshire" or "the Plan") is a managed care organization (MCO) and a member of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality health care to populations covered by publicly funded programs, including Medicaid, Medicare, and State Children's Health Insurance programs. We are proud to partner with the state of New Hampshire to provide health care coverage to Medicaid-eligible individuals who fall into one of the eligibility categories set forth in the table below.

Covered Populations

Eligibility Category
Aid to the Needy Blind Non-Dual
Aid to the Permanently and Totally Disabled Non-Dual
American Indians and Alaskan Natives
Auto Eligible and Assigned Newborns
Breast and Cervical Cancer Program (Age 19–64)
Children Enrolled in Special Medical Services/Partners in Health
Children with Supplemental Security Income
Foster Care/ Adoption Subsidy
Granite Advantage (Medicaid Expansion Adults, Frail/Non-Frail Program)
Home Care for Children with Severe Disabilities (Katie Beckett)
Medicaid Children Funded through the Children's Health Insurance Program (CHIP)
Medicaid for Employed Adults with Disabilities Non-Dual
Medicaid for Employed Older Adults with Disabilities
Medicare Duals with Full Medicaid Benefits
Non-Expansion Poverty-Level Adults (Including Pregnant Women) and Children Non-Dual
Old Age Assistance Non-Dual
Third Party Coverage Non-Medicare, Except Members with Veterans Affairs Benefits
Incarcerated individuals in the State's prison system eligible for participation in the Department's Community Reentry demonstration waiver

Excluded Populations

The following populations are ineligible for participation in the Medicaid Care Management (MCM) program:

Not eligible for Managed Care (covered by DHHS)
Beneficiaries eligible for Family Planning benefit only
Beneficiaries enrolled in New Hampshire's Health Insurance Premium Payment (HIPP) program

Beneficiaries of In and Out Spend-Down medical assistance
Beneficiaries enrolled in the Medicare Savings Program only (no Medicaid services)
Members with Veterans Affairs Benefits
Retroactive/Presumptive Eligibility Segments (excluding Auto Eligible Newborns)

Through our collaboration with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

About Our Program

AmeriHealth Caritas New Hampshire's Medicaid programs are administered on behalf of the New Hampshire Department of Health and Human Services (DHHS). AmeriHealth Caritas New Hampshire has been contracted by DHHS to administer the provision of covered services for enrollees of the Medicaid Care Management Services Program, which includes the Temporary Assistance for Needy Families (TANF)/Aged, Blind, and Disabled (ABD)/CHIP eligibles.

Plan and New Hampshire DHHS Contact Information

AmeriHealth Caritas New Hampshire Contact Information:

AmeriHealth Caritas New Hampshire
Mailing Address: 25 Sundial Avenue
Suite 130 West
Manchester, New Hampshire 03103
Attn: Provider Services

Phone: **1-888-599-1479**
Provider Services Fax: **1-833-609-2264**

Monday through Friday, 8 a.m. to 6 p.m., except DHHS-approved holidays.

Provider Network Management:
Please reach out to your **Account Executive** directly or call **1-855-332-0104**,
Monday through Friday, 8 a.m. to 6 p.m. or Saturday 9 a.m. to 12 p.m.

New Hampshire DHHS contact information.

Provider Services: **1-866-291-1674 or 1-603-223-4774**

For a complete listing of important contact information, refer to the *Provider Reference Guide* found in the provider section of our website at www.amerihealthcaritasnh.com.

Member Enrollment & Health Plan Selection

Members are asked to select an MCO as part of the enrollment process in the Medicaid Care

Management program. Members who do not select an MCO will be auto assigned to an MCO by the State.

New members can change health plans during the first 90 calendar days following the date of enrollment with the health plan. All members also can change health plans during an Annual Open Enrollment Period offered by the State. For complete information about the enrollment and health plan selection process, members should consult the Member Handbook on the plan website or call 24/7 Member Services at:

Phone: 1-833-704-1177 (TTY 1-855-534-6730)

Accepting AmeriHealth Caritas New Hampshire Members

AmeriHealth Caritas New Hampshire expects network providers with open panels to accept all voluntary and assigned members without restriction and in the order in which they enroll. AmeriHealth Caritas New Hampshire providers will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of health or mental health history, health or mental health status, need for health care services, amount payable to ACNH based on the basis of the eligible person's actuarial class, or pre-existing medical or health conditions, nor on the basis of race, color, creed, religion, ancestry, marital status, national origin, age, sex, sexual orientation, gender identity, or physical or mental handicap.

Primary Care Selection & Assignment

Upon their enrollment with the Plan, members will be encouraged to select a primary care practitioner (PCP) from a list of AmeriHealth Caritas New Hampshire participating practitioners. If no PCP is selected, the Plan will:

- Inform the member of their right to choose a PCP.
- Assist the member in selecting a PCP.
- Inform the member that each eligible family member has the right to choose their own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP within 14 calendar days of enrollment with the Plan.

The Plan considers the following when assigning a PCP:

- Member claims history.
- Family member's provider assignment and/or claims history.
- Geographic proximity.
- Special medical needs.

- Language/cultural preference.

Newly enrolled members receive a welcome letter from the Plan that includes information on how to find their Member Handbook or request a physical copy. They also receive an AmeriHealth Caritas New Hampshire Member Identification (ID) Card, which, in addition to other important information for members, lists the member's PCP and telephone number. Information about the opportunity and procedures to change PCPs is included in the member welcome packet.

Verifying Member Eligibility

As a participating provider, you are responsible to verify member eligibility with AmeriHealth Caritas New Hampshire before rendering services, except when a member requires emergency services.

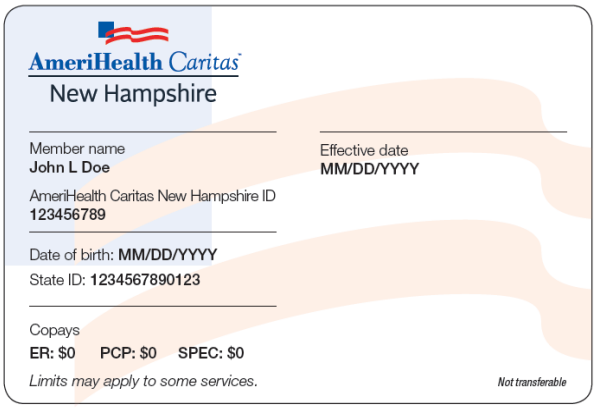
Eligibility may be verified by:

- Visiting the provider section of AmeriHealth Caritas New Hampshire's website, www.amerihealthcaritasnh.com, to access NaviNet, a web-based application for electronic transactions and information available to providers at no cost through a secure multi-payer portal.
- Calling Provider Services at **1-888-599-1479** and utilizing the automated real-time eligibility service without speaking to a representative; just follow the prompts for Member Eligibility.
- Using electronic data interchange (EDI) eligibility verification transactions available from your clearinghouse or practice management system. This service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Asking to see the member's Plan ID card. Members are instructed to keep their ID card with them at all times. The member's ID card includes:
    - The member's name, date of birth, and effective date of enrollment,
    - AmeriHealth Caritas New Hampshire ID number.
    - The Plan's name, address, and 24-hour, 7 days per week Member Services telephone number.
    - The Plan's 24-hour nurse advice/nurse triage telephone number.
    - The Pharmacy toll free call center telephone number.
    - The phone number to request non-emergency medical transportation (using the Plan's vendor)
    - How to file an appeal or grievance.
    - Procedures to be followed for emergency services.
- Visiting the New Hampshire Medicaid Management Information System (MMIS) Health Enterprise Portal.

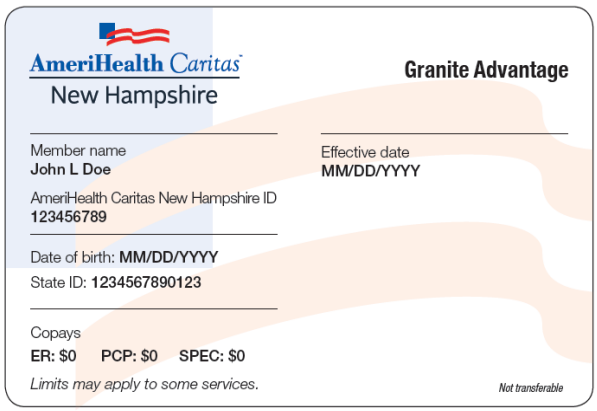
If the member eligibility verification indicates an upcoming end date for Medicaid eligibility, please let the member know, and advise them to contact NH DHHS for information about recertification. Members who need assistance completing and submitting the documents required for Medicaid recertification should be encouraged to call the AmeriHealth Caritas New Hampshire Rapid Response and Outreach Team (RROT) at **1-833-212-2264**.

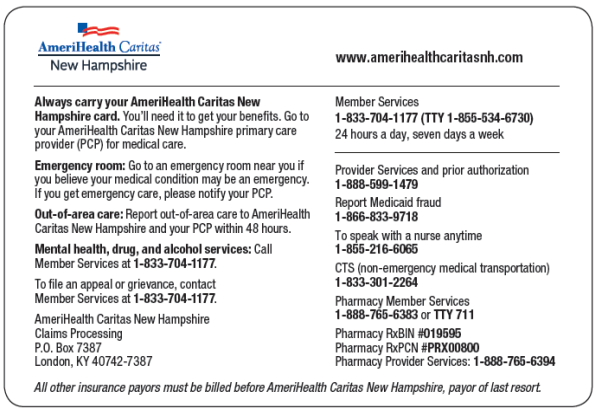
NOTE: AmeriHealth Caritas New Hampshire ID cards are not returned to the Plan when a member becomes ineligible. Presentation of an AmeriHealth Caritas New Hampshire ID card is not proof that an individual is currently a member of the Plan. In addition, you are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to our Fraud, Waste, and Abuse Hotline at **1-866-833-9718.**

AmeriHealth Caritas New Hampshire Member ID Cards



Granite Advantage Member ID Card





Member Services and Member Advocate

A dedicated, 24/7/365 Member Services unit is available to help members with any questions about their coverage and services:

Phone: 1-833-704-1177 (TTY 1-855-534-6730)

The Plan also employs a Member Advocate responsible for working with members, providers, and the member's case managers to assist in obtaining care for a member. The Member Advocate is available to assist with scheduling appointments, navigation of the grievance and appeals process, and identification of resources necessary to help members with limited English proficiency or communication barriers. Members may call Member Services to be connected to the Member Advocate.

Member Rights and Responsibilities

As a provider, it is your responsibility to recognize the following member rights and responsibilities:

Member Rights

- To be treated with dignity and respect.
- To receive information on the Medicaid Care Management program and the Plan to which the member is enrolled.
- To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting health care.
- To have their health care records remain private, according to HIPAA and applicable State rules.
- To receive free translation services as needed, including help with sign language, if hearing impaired.
- To participate in making decisions about their own health care, including the right to refuse treatment.
- To receive a full, clear, and understandable explanation of treatment/service options and the risks of each option to make an informed decision, regardless of cost or benefit coverage.
- For female members: To have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. Female members have the right to designate as their PCP a participating provider or an advanced practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).

- To request and receive a copy of his/her medical records free of charge, and to request that they be amended or corrected.
- To choose a PCP from AmeriHealth Caritas New Hampshire's list of providers.
- To change a PCP and choose another one from AmeriHealth Caritas New Hampshire's list of providers.
- To choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life-threatening health care condition.
- To file a complaint ("grievance") or appeal orally or in writing.
- To receive family planning services and supplies from the provider of choice, including non-participating providers.
- To be provided good quality care without unnecessary delay.
- To receive information on advance directives and assistance in preparing them; to choose not to have or continue any life-sustaining treatment.
- To receive a copy of the Member Handbook.
- To continue in current treatment until a new treatment plan is in place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of, request, and receive information about incentive plans for AmeriHealth Caritas New Hampshire's practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.
- To receive a copy of AmeriHealth Caritas New Hampshire's prescription drug formulary.
- To receive information about AmeriHealth Caritas New Hampshire, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To make recommendations about the members' rights and responsibilities.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- To seek a second opinion from a qualified health care professional within the network or out-of- network at no cost.
- To be informed of any cost-sharing obligations (excluding client participation) upon becoming a Plan member and at least 30 days prior to any change.
- To be informed within 10 days of any changes to client participation (patient liability) as determined by DHHS.
- To be informed about how and where to access any benefits that are available under other New Hampshire programs but are not covered by AmeriHealth Caritas New Hampshire.
- For AmeriHealth Caritas New Hampshire Medicaid members: To receive non-emergency transportation to get health care services 24 hours a day, 365 days a year.
- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).

- To not be held liable for any debts in the event of AmeriHealth Caritas New Hampshire's insolvency.
- To request information on the structure of AmeriHealth Caritas New Hampshire.
- To be treated no differently by providers or by AmeriHealth Caritas New Hampshire for exercising the rights listed here.
- To fully participate in the community and to work, live, and fully learn possible.
- To have access to a full range of primary, acute, specialty, and behavioral health services, as needed, to achieve desired outcomes.

Member Responsibilities

- To treat AmeriHealth Caritas New Hampshire employees, practitioners, and providers with respect.
- To show their Member ID card each time they visit their health care provider and make sure the office has a record that they are on Medicaid.
- To confirm that the provider is enrolled in Medicaid. Medicaid will not pay for the service or prescription if the provider is not a Medicaid provider.
- To comply with the rules of the New Hampshire Medicaid Care Management program and with the rules of AmeriHealth Caritas New Hampshire.
- To understand the member's own health condition(s), participate in developing treatment/service goals, and follow the practitioner or provider's instructions for care after deciding what treatment is needed.
- To keep doctor's appointments or call to cancel at least 24 hours in advance.
- To ask questions, discuss personal health issues, and listen to what treatment is needed.
- To know the difference between a true emergency and a condition needing urgent care.
- To seek medical services that are medically necessary.
- To know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
- To help get medical records from past providers.
- To report to AmeriHealth Caritas New Hampshire if injured in an accident or at work.
- To report to the DHHS and AmeriHealth Caritas New Hampshire if covered by other health insurance.
- To tell their medical provider, DHHS and AmeriHealth Caritas New Hampshire if anyone else is responsible for paying their medical bills.
- To report Medicaid fraud and abuse when suspected. Call the U.S. Department of Health & Human Service, Office of Inspector General at **1-800-447-8477.**

Parity

The Mental Health Parity and Addiction Equity Act of 2008, 42 CFR 438, subpart K, prohibits discrimination in the delivery of mental health and substance use disorder services. AmeriHealth Caritas New Hampshire is committed to compliance with this legislation and the final rule, to help ensure member access to person-centered care that addresses member needs with holistic solutions.

Members who believe services were not provided consistent with mental health parity laws and regulations or federal guidance may file a complaint with New Hampshire DHHS by emailing nhparity@dhhs.nh.gov.

Plan Privacy and Security Procedures

AmeriHealth Caritas New Hampshire complies with all federal and New Hampshire regulations ("Regulations") regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) and their implementing regulations, and all federal statutes and regulations governing the privacy of Substance Use Disorder patient records (42 CFR, Part 2). All member health and enrollment information is used, disseminated, and stored according to Plan policies and guidelines to ensure its security, confidentiality, and proper use. As an AmeriHealth Caritas New Hampshire provider, you are expected to be familiar with your responsibilities under the aforementioned Regulations, and to take all necessary actions to fully comply.

AmeriHealth Caritas New Hampshire Providers are required to assist with privacy and security investigations, including providing attestations of destruction for misdirected documentation containing protected health information (PHI), personally identifiable information (PII), or other sensitive or confidential information, to ensure that contractual as well as federal obligations are met in a timely manner.

SECTION II
PROVIDER AND
NETWORK INFORMATION

II. Provider and Network Information

This section provides information for maintaining network privileges and sets forth expectations and guidelines for PCPs, specialists, and facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers.

All providers are required to be re-credentialed or recertified at a minimum of every 36 months. All items collected in the credentialing process are required at the time of re-credentialing or recertification, except for work history and education for practitioners. All primary source verifications, apart from education, are also conducted at the time of re-credentialing and recertification.

Becoming a Plan Provider

AmeriHealth Caritas New Hampshire maintains and adheres to all applicable State and federal laws and regulations, New Hampshire DHHS requirements including any additional provider selections requirements, and accreditation standards governing credentialing and re-credentialing functions as defined by the National Committee on Quality Assurance (NCQA). Unless otherwise indicated, all providers participating with AmeriHealth Caritas New Hampshire must also be enrolled with New Hampshire Medicaid and have a New Hampshire Medicaid identification number and unique National Provider Identifier (NPI) for every provider type. For additional requirements for participation in the ACNH provider network, please refer to the Standards for Participation section of this manual.

AmeriHealth Caritas New Hampshire does not make credentialing/re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes, or the patients for which the practitioner provides care. In developing its network, AmeriHealth Caritas New Hampshire strives to meet the cultural and special needs of members.

Practitioner and Organizational Provider Credentialing Rights

During the review of the credentialing application, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- Review the information submitted to support their credentialing application, except for recommendations, and peer-protected information obtained by the Plan.
- Correct erroneous information. When information is obtained by the Credentialing

Department that varies substantially from the information the provider provided, the Credentialing Department will notify the health care provider to correct the discrepancy.

- Upon request, to be informed of the status of their credentialing or re-credentialing application. The Credentialing department will share all information with the provider except for references, recommendations, or peer-review protected information (e.g., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Be notified of the Credentialing Committee or Medical Director review decision, within 30 calendar days for PCPs, and within 45 calendar days for specialty providers, of receipt of a clean and complete application.
- Appeal any initial or re-credentialing denial within 30 calendar days of receiving written notification of the decision.

To request any of the above, the practitioner should contact AmeriHealth Caritas New Hampshire's Credentialing department at 1-**866-610-2770.**

Provider Credentialing and Re-Credentialing

AmeriHealth Caritas New Hampshire will rely on DHHS's NH Medicaid providers' affirmative screening in accordance with federal requirements and the current NCQA Standards and Guidelines for the credentialing and re-credentialing of licensed independent providers and provider groups. AmeriHealth Caritas New Hampshire is responsible for credentialing and re-credentialing its network of physical and behavioral health providers.

Practitioners requiring credentialing and re-credentialing include, but may not be limited to, the list below:

- Advanced Registered Nurse Practitioner (ARNP).
- Behavioral Analyst (BCBA/BCABA).
- Certified Nurse Midwife (CNM).
- Certified Registered Nurse Anesthetist (CRNA).
- Doctor of Audiology (AuD).
- Doctor of Chiropractic (DC).
- Doctor of Osteopathic Medicine (DO).
- Doctor of Podiatric Medicine (DPM).
- Doctor of Psychology (PsyD).
- Independently Practicing Licensed Behavioral Health Clinician (LPC, LMFT, LCISW, LMFT).

- Independently Practicing Licensed Physician (Psychiatrist/Addictive Medicine).
- Independently Practicing Licensed Psychologist.
- Individual and Group master's Licensed Alcohol and Drug Counselor (MLADC).
- Intensive Outpatient Substance Use Disorder (SUD) Service.
- Licensed Clinical Social Worker (LCSW).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Professional Counselor (LPC).
- Medical Doctor (MD).
- Occupational Therapist (OT).
- Optometrist who provides care under the medical benefit (OD).
- Physical Therapist (PT).
- Registered Dietician (RD).
- Speech and Language Therapist (SLT).
- Substance Use Disorder Treatment Practitioner.

Hospital-based physicians are not required to be independently credentialed if those providers serve AmeriHealth Caritas New Hampshire members only through the inpatient setting and those providers are credentialed by the hospitals. Hospital-based providers include, but are not limited to, Pathologists, Anesthesiologists, Radiologists, Emergency Medicine, Neonatologists, and Hospitalists. Hospital based physicians who furnish services to AmeriHealth Caritas New Hampshire members through a provider entity independent of the hospital, are required to be enrolled in New Hampshire Medicaid and be contracted with and appropriately screened/credentialed by AmeriHealth Caritas New Hampshire.

The criteria, verification methodology and processes used by AmeriHealth Caritas New Hampshire are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, regardless of race, ethnic/national identity, gender, age, sexual orientation, specialty, or procedures performed.

Council for Affordable Quality Healthcare (CAQH) and Online Credentialing

AmeriHealth Caritas New Hampshire works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a universal provider data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, practitioners submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. There is no charge to practitioners to participate and to submit CAQH applications. Practitioners not already enrolled are able to register for CAQH at www.caqh.org.

We strongly encourage each practitioner to participate with Council for Affordable Quality Healthcare (CAQH). Each practitioner must approve AmeriHealth Caritas New Hampshire to pull the credentialing application from CAQH. Through CAQH, each practitioner determines

what entity is eligible to receive his or her credentialing information.
Practitioners who have elected "universal" status need not do anything in order for AmeriHealth Caritas New Hampshire to receive their information. If you do not have broad

distribution permissions, please select AmeriHealth Caritas Family of Companies or AmeriHealth Caritas New Hampshire for us to receive your application.

Practitioners participating with CAQH or those who wish to participate with CAQH:

- Register for CAQH at www.caqh.org;
- Grant authorization for AmeriHealth Caritas New Hampshire to view your information via the CAQH website;
- Fax or email your CAQH ID number, on the Provider Data Intake Form, to the AmeriHealth Caritas New Hampshire Credentialing department at **866-610-2770** or amerihealthcaritasnh@amerihealthcaritas.com.

Individual Practitioner Application

For individual practitioners who choose not to enroll in CAQH, the application process requires submission of a completed application. The application must include evidence, such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc.

Individual Practitioner Credentialing and Re-Credentialing

The following criteria must be met as applicable, to evaluate a qualified health care practitioner:

- Current, active, unrestrictive medical licensure, not subject to probation, proctoring requirements, or disciplinary action to specialty. A copy of the license must be submitted along with the application.
- Current, active, unrestrictive DEA license, if applicable (DEA licenses are not transferrable by location and must contain the address where the practitioner is treating AmeriHealth Caritas New Hampshire members);
- Current, active, CDS/CSC license, if applicable.
- Evidence of professional liability insurance with limits of liability commensurate with State requirements.
- Current, active, Medicaid Enrollment.
- Individual NPI Number.
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:

  - The National Practitioner Data Bank (NPDB)
  - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  - Medicaid and Medicare Exclusions
  - Federation of Chiropractic Licensing Boards (CIN-BAD)
  - System for Award Management (SAM)/EPPLS
  - Social Security Death Master File
  - Any other relevant State sanction and licensure databases as applicable.

- Proof of the provider's medical school graduation, completion of residency and other postgraduate training.
- ECFMG Certificate for foreign medical school graduates.
- Evidence of specialty board certification, if applicable.
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Practitioner in the past five (5) years.
- Work history containing current employment over the past (5) years, as well as explanation of any gaps in work history.
- CLIA Certificate, if applicable.
- Explanation to any affirmative answers to the Disclosure Questions on the application.
- Practitioners who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with AmeriHealth Caritas New Hampshire. PCPs must have the ability to admit AmeriHealth Caritas New Hampshire members as part of their hospital privileges. As an alternative, those practitioners who do not have hospital privileges may enter into an admitting arrangement agreement with a participating practitioner who is able to admit.
- Any additional provider selection requirements established by NH DHHS.

All practitioners are re-credentialed at a minimum of every 36 months. All items noted above under Credentialing, except for education and work history, are also required at the time of re-credentialing.

All applications and attestation/release forms must be signed and dated within 305 days prior to the Credentialing Committee or Medical Director approval date. Additionally, all supporting documents must be current at the time of the decision date.

As part of the initial and re-credentialing application process for individual practitioners, AmeriHealth Caritas New Hampshire will:

- Request information on practitioner and provider sanctions prior to making a credentialing or re-credentialing decision. Information from the National Practitioner Data Bank (NPDB), HHS Office of Inspector general

(Medicaid/Medicare exclusions), system for Award management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Social Security Death Master File (SSDMF), and Excluded Parties List (EPLS) will be reviewed as applicable;

- Perform primary source verification on required items submitted with the application as required by NCQA, State, and Federal regulatory bodies;
- Performance review of complaints, quality of care issues, and utilization issues will be reviewed at the time of re-credentialing;
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing; and
- Safeguard all credentialing and re-credentialing documents by storing them in a secure location, only accessed by authorized Plan employees.
- Make outreach attempts to applicants via phone or email regarding information missing from the application packet. The credentialing process is halted until all information is received.

Presentation to the Medical Director or Credentialing Committee

During the initial and re-credentialing process for individual practitioners, upon receipt of a complete application and completion of primary source verifications, the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

Credentialing applications for PCPs will be processed, and applicants will be notified of the recommendation of the Credentialing Committee or Medical Director, within 30 calendar days of receipt of clean and complete applications. Credentialing applications for specialty providers will be processed, and applicants will be notified of the recommendation of the Credentialing Committee or Medical Director, within 45 calendar days of receipt of clean and complete applications. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Professional Provider Organization and Facility Application Process

Facility and professional provider organizations must complete a facility application. The following types of organizations are considered facilities:

- Ambulatory Surgical Center (ASC).
- Community-Based Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).
- Community Mental Health (CMH) Center/CMH Program/CMH Provider.
- Comprehensive Outpatient Rehabilitation Facility (CORF).
- Crisis Intervention/Stabilization Provider.
- Dialysis Center.
- Durable Medical Equipment (DME)/Medical Supplies.
- FQHC/RHC for behavioral health care only.
- Free Standing Radiology Center.
- Home Health Agency/Home Health Hospice.
- Home Infusion.
- Hospice.
- Hospital.
- Institute of Mental Disease (IMD).
- Medical Services Clinic and Opioid Treatment Program
- Nursing Facility – Mentally Ill.
- Nursing Home.
- Patient-centered Medical Home.
- Peer Recovery Program.
- Portable X-Ray Suppliers/Imaging Center.
- Psychiatric Hospital.
- Psychiatric Residential Treatment Facility (PRTF).
- Rehabilitative Agency.
- Residential Care Facility.
- Residential SUD Treatment Program.
- School-Based Wellness Center.
- Screening Center.
- Skilled Nursing Facility (SNF).
- Sleep Center/Sleep Lab.

Please download your application at www.amerihealthcaritasnh.com, complete, and fax it to **1-833-301-2242** or email to amerihealthcaritasnh@amerihealthcaritas.com.

Credentialing/Re-Credentialing for Facility and Professional Provider Organizations

AmeriHealth Caritas New Hampshire verifies credentialing and re-credentialing criteria for all facility and professional provider organizations. Re-credentialing occurs at least every 36 months. Facility and professional provider organization providers must meet the following criteria:

- Facility application with signature and current date from the appropriate facility officer.
- Attest to the accuracy and completeness of the information submitted to AmeriHealth Caritas New Hampshire.
- Documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance.
- Current, active, unrestrictive facility licensure not subject to probation, suspension, or other disciplinary action limits.
- AmeriHealth Caritas New Hampshire will confirm that the facility is in good standing with all State and regulatory bodies and has been reviewed by an accredited body as applicable.
- Current accreditation with an AmeriHealth Caritas New Hampshire recognized accrediting body, if applicable. If not accredited, a CMS State Survey is required. If

  the provider does not have either accreditation or a CMS State Survey, a Plan Site Visit must be conducted.
- Evidence of professional liability insurance with limits of liability commensurate with State requirements.
- Current, active, Medicaid Enrollment.
- Group NPI Number.
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
  - The National Provider Data Bank (NPDB)
  - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  - Medicaid and Medicare Exclusions
  - System for Award Management (SAM)
  - Excluded Parties List (EPLS)
  - Any other relevant State sanction and licensure databases as applicable.

Adding a New Service or Site

Facility providers who are adding a new service must complete Part II of the initial credentialing application and submit it with required attachments to the attention of their designated Account Executive. The Account Executive will notify you if a site visit is necessary. Facility providers who are adding a new site must submit an application and supporting documentation to Credential for that new site to be credentialed.

Presentation to the Medical Director or Credentialing Committee

Upon receipt of a complete application and completion of primary source verifications, the provider's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

Credentialing applications for facilities and professional provider organizations will be processed, and applicants will be notified of the recommendation of the Credentialing Committee or Medical Director, within 45 calendar days of receipt of clean and complete applications. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (except for NPDB reports and peer references).

AmeriHealth Caritas New Hampshire's Quality Assessment and Performance Improvement program (QAPI) provides oversight of the Credentialing Committee. For more information on the QAPI, please refer to the "Quality Assessment and Performance Improvement Program" section of this *Provider Manual*.

Re-credentialing involves periodic review and reverification of credentials of network providers. The credentialing database houses all provider information, and a report is run to ensure each provider organization, facility, and practitioner is re-credentialed at a minimum of every 36 months. As part of this process, AmeriHealth Caritas New Hampshire periodically reviews provider information from the following databases:

- National Provider Data Bank (NPDB).
- The Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
- Medicaid and Medicare Exclusions System for Award Management (SAM).
- Excluded Parties List (EPLS).

Providers are required to disclose, at the time of discovery, any criminal convictions of staff members related to the delivery of health care or services under the Medicare, Medicaid, or Title XX Social Service programs. Such information must also be reported at the time of application for or renewal of network participation (credentialing and re-credentialing). Providers are also obligated to provide such information to AmeriHealth Caritas New Hampshire at any time upon request.

The re-credentialing process includes an up-to-date re-examination of all materials.

Site Visits Resulting from Receipt of a Complaint and/or Ongoing Monitoring

- The Provider Network Management department may identify the need for a site visit due to receipt of a member complaint regarding the provider's office environment.
- At the discretion of AmeriHealth Caritas New Hampshire, a site visit may occur to address the specific issue(s) raised by a member. Follow-up site visits are conducted as necessary.
- For on-site reviews occurring due to a member complaint, the on-site review must demonstrate that the practitioner meets the Plan's quality, privacy and record keeping standards.
- If AmeriHealth Caritas New Hampshire standards are not met, the Account Executive, in conjunction with the office representative, develops, an individualized written corrective action plan (CAP) with the practitioner's office to ensure that the area of concern is addressed. The representative from the practitioner's office reviews and indicates acceptance by signing and dating the CAP.

Follow-Up Procedure for Initial Deficiencies

- The Provider Network Account Executive must submit the signed corrective action plan (CAP) to AmeriHealth Caritas New Hampshire within one week of the visit.
- Each follow-up contact, and visit, is documented in the provider's electronic file.
- The Provider Network Account Executive schedules a re-evaluation visit with the provider office within 30 calendar days of the initial site visit to review the site and verify that the deficiencies identified in the CAP were corrected.
- The Provider Network Account Executive reviews the results of the follow-up visit

(including a re-review of previous deficiencies) with the office contact person.

- If the site meets and/or exceeds Plan standards, a Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office. This indicates successful completion of the CAP.
- If the site does not meet Plan standards, the Provider Network Account Executive follows the procedure outlined below for Follow-Up Procedure for Continued or Secondary Deficiencies, below.

Follow-Up Procedure for Continued or Secondary Deficiencies

- The Provider Network Account Executive will re-evaluate the site monthly, up to three times (from the first site visit date).
- If, after four months, there is evidence that the deficiency is not being corrected or completed, the office will receive a failing score unless there are extenuating circumstances.
- Continued failure to correct identified deficiencies addressed in the CAP will result in appropriate disciplinary action, including and up to termination of the provider's participation in the network.

Standards for Participation

By agreeing to provide services to AmeriHealth Caritas New Hampshire members, providers must:

- Be eligible to participate in any New Hampshire or federal health care benefit program.
- Comply with all pertinent Medicaid regulations.
- Treat AmeriHealth Caritas New Hampshire members in the same manner as other patients.
- Provide covered services to all AmeriHealth Caritas New Hampshire members who select or are referred to you as a provider.
- Provide covered services and not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of health or behavioral health history or status, need for health care services, amount payable to the plan on the basis of the eligible person's actuarial class, pre-existing medical/health conditions, or race, color, creed, religion, ancestry, marital status, sexual orientation, sexual identity, national origin, age, sex, or physical or mental handicap.
- All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of Rehabilitation Act of 1974.
- Not segregate members from other patients (applies to services, supplies and

equipment).
- Not refuse to provide services to members due to a delay in eligibility updates.

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas New Hampshire may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other federal health care programs.

A sanctioned person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas New Hampshire, a provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a sanctioned person.

A provider is required to immediately notify AmeriHealth Caritas New Hampshire upon knowledge that any of its employees, directors, officers or owners has become a sanctioned person, or is under any type of investigation which may result in their becoming a sanctioned person. In the event that a provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas New Hampshire that a sanctioned person will not receive payment from the Plan under the Provider Agreement, AmeriHealth Caritas New Hampshire may immediately terminate the Provider Agreement. The Plan reserves the right to recover all amounts paid by AmeriHealth Caritas New Hampshire for items or services furnished by a sanctioned person.

Access to Care

AmeriHealth Caritas New Hampshire providers must meet access standard guidelines as outlined in this publication to help ensure that Plan members have timely access to physical and behavioral health care.

AmeriHealth Caritas New Hampshire endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. The Plan establishes mechanisms for measuring compliance with existing

standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance or comparable to the hours of operation offered to Medicaid Fee for Service patients. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to health care services and medical and behavioral health providers.
AmeriHealth Caritas New Hampshire monitors the following access standards on an annual basis per AmeriHealth Caritas New Hampshire guidelines. If a provider becomes unable to meet these standards, they must immediately advise their Provider Network Account Executive or the Provider Services department at **1-888-599-1479.**

Member Access & Availability Standards		
Visit Type	Description	Standard
Non-Symptomatic Office Visit	**Well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations**	**Within 45 calendar days**
Non-Urgent Symptomatic Office Visit	**Routine care such as that associated with the presentation of medical signs or symptoms not requiring immediate attention**	**Within 10 calendar days**
Urgent, Symptomatic Office Visit	**Care associated with the presentation of medical signs or symptoms that require immediate attention but are not life threatening and do not meet the definition of Emergency Medical Condition**	**Within 48 hours**

Member Access & Availability Standards		
Transitional Health Care	**Clinical assessment and care planning from a primary care or specialty provider**	**Within 2 business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program**
Transitional Home Care	**With a home care nurse, licensed counselor, and/or therapist (physical or occupational)**	**Within 2 calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the member's PCP or specialty care provider or as part of the discharge plan**
Behavioral Health		
Transitional Health Care	**Clinical assessment and care planning from a primary care or specialty provider**	**Within 2 business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program**
Emergency Medical and Behavioral Health Care: Non-life-threatening emergency		**Within 6 hours**
Emergency Medical and Behavioral Health Care: Urgent Care		**Within 48 hours**
Routine Office Visit		**Within 10 business days**

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for the missed appointment. The medical record should reflect any reasons for delays in providing health care,

as a result of missed appointments, and should also include any refusals by the member. Providers cannot bill for missed appointments. Providers are encouraged to advise AmeriHealth Caritas New Hampshire's Rapid Response and Outreach Team at **1-833-212-2264** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.

After-Hours Accessibility

AmeriHealth Caritas New Hampshire members have access to quality, comprehensive health care services **24 hours a day, seven days a week.** PCPs must have either an answering machine or an answering service for members during after-hours for non- emergent issues. The answering service must forward calls to the PCP or on-call provider or instruct the member that the provider will contact the member within 30 minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. AmeriHealth Caritas New Hampshire will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access

AmeriHealth Caritas New Hampshire will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews.
- Monitoring administrative complaints and grievances; and,
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care.

Non-compliant providers will be subject to corrective action and/or termination from the network.

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

Panel Capacity & Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members.

The panel remains open unless the following occurs:

- The PCP is under sanction.
- The PCP has voluntarily closed his/her AmeriHealth Caritas New Hampshire panel; or,
- The panel is closed by AmeriHealth Caritas New Hampshire due to member access issues.

AmeriHealth Caritas New Hampshire PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS and/or New Hampshire guidance on this issue. PCPs are required to provide AmeriHealth Caritas New Hampshire with a quarterly report of current caseload, including non-Plan-member patients.

In evaluating the capacity of PCPs, AmeriHealth Caritas New Hampshire shall take into consideration a PCP's existing AmeriHealth Caritas New Hampshire member load, overall member load (across all programs), and Medicaid patient load and will assess against community standards for any specialty involved.

AmeriHealth Caritas New Hampshire will also consider whether the provider is in compliance with the Access Standards set forth in this *Provider Manual*. AmeriHealth Caritas New Hampshire will not assign additional members to a single PCP if the Plan believes that PCP has reached the capacity to provide high quality services to Plan members.

Practitioner and Provider Responsibilities

Responsibilities of All Providers

AmeriHealth Caritas New Hampshire is regulated by New Hampshire and federal laws. Providers who participate in AmeriHealth Caritas New Hampshire have responsibilities, including but not limited to the following:

- Be compliant with all applicable federal and/or New Hampshire statutes and regulations.
- Treat AmeriHealth Caritas New Hampshire members in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and

programs, e.g., vaccines for children (VFC), communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.

- Comply with all disease notification laws in New Hampshire.
- Provide information to AmeriHealth Caritas New Hampshire and/or the New Hampshire DHHS as required.
- Inform members about all treatment options, regardless of cost or whether such services are covered by the Plan or other programs.
- Encourage regular review releases of information at each visit with the member and ensure that providers inquire about new or collaborating providers that members are working with to support care coordination, for either physical or behavioral health needs.
- If conducting or contributing to a Comprehensive Assessment of a member, be certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) (or an alternative evidence-based assessment tool approved by DHHS).
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, marital status, or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept AmeriHealth Caritas New Hampshire payment or third-party resource as payment-in-full for covered services.
- Comply fully with AmeriHealth Caritas New Hampshire's Quality Improvement, Utilization Management, Population Health, Credentialing, and Audit programs.
- Comply with all applicable training requirements as required by AmeriHealth Caritas New Hampshire, NH DHHS, and/or CMS.

- Promptly notify AmeriHealth Caritas New Hampshire of claims processing payment or encounter data reporting errors.
- Maintain all records as required by law and contract regarding services rendered for the applicable period, making such records and other information available to AmeriHealth Caritas New Hampshire or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.
- Immediately notify AmeriHealth Caritas New Hampshire of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify AmeriHealth Caritas New Hampshire of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas New Hampshire.
- Verify member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Inform member(s) of the availability of AmeriHealth Caritas New Hampshire's interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas New Hampshire of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by New Hampshire and federal law.
- Agree that claims data, medical records, practitioner and provider performance data, and other sources of information, may be used by the Plan to measure and improve the health care delivery services to members.
- Review Behavioral Health Took Kit, and other training resources, available on the AmeriHealth Caritas New Hampshire website that overview, resources, medication options, assessment, and screening tools.
- Agree to connect Members that are identified as having risk factors for either

physical or behavioral health with their assigned primary care or behavioral provider using resources outlined in Chapter Seven of the Behavioral Health Tool Kit.

Primary Care Provider (PCP) Responsibilities

A Primary Care Provider (PCP) serves as the member's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of AmeriHealth Caritas New Hampshire members. Advanced Nurse Practitioners, Nurse Midwives, and Licensed Physicians in the following specialties may serve as Plan PCPs:

- General Practice.
- Pediatrics.
- Internal Medicine.
- Geriatrics.
- Obstetrics/Gynecology.
- Family Practice.
- Physician Assistants (under the supervision of a physician)
- Advanced Registered Nurse Practitioners

A PCP is responsible to AmeriHealth Caritas New Hampshire and its members for diagnostic services, care planning, and treatment plan development. The PCP is expected to work with the Plan to monitor treatment planning and provision of treatment.

All new AmeriHealth Caritas New Hampshire adult and child members with a newly- assigned PCP, who has not previously cared for the member, must receive a comprehensive initial examination and a screening for mental health and substance abuse. The mental health and substance abuse screening must be completed using a validated screening tool, approved by AmeriHealth Caritas New Hampshire. This screening tool can be found under the "Forms" in the provider section of our website at www.amerihealthcaritasnh.com.

For the initial examination and assessment of a child, the PCP is required to perform the relevant screenings and services, as well as any additional assessment, using the appropriate tools to determine whether a child has special health care needs. All Medicaid-covered children under 21 years of age receive EPSDT services.

For ongoing care, the mental health and substance use disorder screening must also be administered as a routine part of every child and adult preventive health examination. Providers may encounter minors in state custody or guardianship. Providers are required to consult with the Division for Children, Youth and Families (DCYF) about any medical or behavioral health matters involving minors in state custody or guardianship.

AmeriHealth Caritas New Hampshire PCPs are also expected to assist members with accessing substance use disorder services, mental health services, and long-term services and supports as needed. The Rapid Response and Outreach Team (RROT) is available to members and providers to support care coordination and access to services. Members and providers may request RROT support by calling **1-833-212-2264.**

In addition, the PCP is responsible for:

- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the health care of a member with a participating specialist(s), care managers, caregivers, and/or behavioral health providers.
- Providing covered services to all assigned members and complying with all requirements for prior authorization.
- Providing assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance use disorder (MH/SUD), ancillary services, public health services and other community-based agency services.
- Adhering to New Hampshire's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule for members under age 21.
- Early identification of all members, including children, with special health care needs or behavioral health needs and notification to the Rapid Response and Outreach Team regarding any such identification as soon as possible.
- Collaboration with AmeriHealth Caritas New Hampshire's Population Health programs, including Local Care Managers and Local Care Management Entities to facilitate member care. Providers are strongly encouraged to utilize the "Let Us Know" program referenced in the Population Health Section of this manual.
- Notifying local care management staff, including contracted Local Care Management Networks (LCMNs), of identified member health risks, unmet needs, and/or significant changes in status.
- Ensuring that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at 9-, 18-, and 24/30-month pediatric visits; and using Bright Futures or other AAP recognized developmental and behavioral screening system. Assessments must include universal screening via the full adoption and integration of at least two specific evidence-based screening practices for depression, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.
- Incorporating the following domains into their screening and assessment

process:

- Demographic.
- Medical.
- Substance Use Disorder.
- Housing.
- Family and support services.
- Education.
- Employment and entitlement.
- Legal.
- Social Determinants of Health.
- Person-centered planning process.
- Risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning).

- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation.
- Documentation of all diagnoses and care rendered in a timely, complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas New Hampshire's medical record documentation requirements.
- Providing follow-up services for members who have been seen in the Emergency Department.
- Promptly and accurately reporting all member encounters to AmeriHealth Caritas New Hampshire.
- Releasing medical record information upon written consent or request of the member.
- Ensuring the release of medical records when a member changes PCPs. His/her medical records or copies of medical records should be forwarded to the new PCP within 10 business days from receipt of request. The State is not required to obtain written approval from a member before requesting the member's record from the PCP or any other participating provider.
- Providing preventive health care to members according to established preventive health care guidelines.
- Advising the Rapid Response and Outreach Team at 1-833-212-2264, or the member's care manager, if applicable, if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.
- Advising AmeriHealth Caritas New Hampshire 90 calendar days in advance of the effective date if they elect to decline accepting additional members.
- Advising AmeriHealth Caritas New Hampshire at least 60 calendar days in advance of any addition or change in office location.

OB/GYN Practitioner as a PCP

Participating Obstetricians are responsible for medical services during the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care.
Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma.
- Treatment of minor physical injuries.
- Preventive health screenings and maintenance.
- Routine gynecological care.

The OB/GYN is also responsible for contacting the Bright Start® Care Managers at **1-833-212-2264** for assistance with support services needed to help a member during pregnancy.

Prenatal care providers are expected to complete the Obstetrical Needs Assessment Form (ONAF) to assess risk for each expectant mother. The completed screening tool must be submitted to AmeriHealth Caritas New Hampshire as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks. Pregnancies that are considered high-risk due to physical, social, or behavioral conditions must also be reported to the Plan at the time of the first visit or at the time when the high-risk situation is identified during the pregnancy. All high- risk conditions should be reported to a Bright Start® Care Manager at by calling Member Services at **1-833-704-1177**, or the Rapid Response and Outreach Team at **1-833-212-2264.** Providers can fax reports to Bright Start® at **1-833-807-2264.**

Specialist Responsibilities

An AmeriHealth Caritas New Hampshire specialist is responsible for:

- Providing specialty care as indicated by the referring practitioner.
- Reporting clinical findings to the referring PCP.
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner.
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas New Hampshire's medical record documentation requirements.

- Refraining from referring members to other specialists without the intervention of the member's PCP.
- Verifying a member's eligibility prior to the provision of services.

Substance Use Disorder (SUD) Services Provider Responsibilities

An AmeriHealth Caritas provider contracted to provide Substance Use Disorder services is responsible for:

- Responding to inquiries for Substance Use Disorder services from members or referring agencies as soon as possible and no later than two business days following the day the call was first received.
- Conducting an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but not later than two business days following the date of first contact.
- Administering to members who have screened positive for SUD an ASAM Level of Care Assessment within two business days of the initial eligibility screening, and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than three business days after admission.
- Delivering to members identified for withdrawal management, outpatient, or intensive outpatient services, such services within seven business days of the date ASAM Level of Care Assessment was completed until such a time that the member is accepted and starts receiving services by the receiving agency.
- Delivering to members identified for partial hospitalization or rehabilitative residential services either interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven business days from the date the ASAM Level of Care Assessment was completed; and delivering identified level of care no later than 14 business days from the date the ASAM Level of Care Assessment was completed.
- Delivering, in cases when the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours, interim SUD services until such a time that the member starts receiving the identified level of care.

Compliance Responsibilities

AmeriHealth Caritas New Hampshire providers are required to comply with all applicable Plan policies and procedures, applicable federal and State regulations, and applicable contractual requirements set by New Hampshire DHHS. Although not an exhaustive list, the primary areas

of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act.
- Health Insurance Portability and Accountability Act (HIPAA).
- Program Integrity/Fraud, Waste & Abuse (FWA).
- False Claims Act.
- Fraud Enforcement and Recovery Act.
- Advance Directives.
- Marketing Activities Guidelines.
- The Nondiscrimination Rule set forth in Section 1557 of the Patient Protection and Affordable Care Act.

Americans with Disabilities Act (ADA) and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehabilitation Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require the Plan's providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas New Hampshire expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

Health Insurance Portability and Accountability Act (HIPAA)

AmeriHealth Caritas New Hampshire is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA), as well as all applicable federal and State regulations governing the privacy and security of health information. The Plan expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other identifying information on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Program Integrity

AmeriHealth Caritas New Hampshire has dedicated Program Integrity staff charged with preventing, detecting, investigating, and reporting fraud, waste, and abuse (FWA). The Program Integrity Department has cross-functional teams that support its activities to help ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with applicable federal and State regulations, contractual requirements, and

Plan requirements and guidelines. The cross-functional teams that comprise the Program Integrity Department, and are responsible for conducting specified program integrity activities, include the Special Investigations Unit, Prospective & Retrospective Client and Vendor Data Management, and Internal Claims Cost Management.

As a provider participating in AmeriHealth Caritas New Hampshire's network, you are responsible to know and abide by all applicable State and federal laws and regulations and by the fraud, waste, and abuse requirements of AmeriHealth Caritas New Hampshire's contract with the New Hampshire DHHS. Violations of these laws and regulations may be considered fraud or abuse against the Medical Assistance program. Some of the federal fraud and abuse laws physicians must be familiar with include the False Claims Act (31 U.S.C. §3729-3733), the Anti-Kickback Statute (42 U.S.C. §1320a-7b (b)), the Physician Self-Referral Law, also known as the Stark Law (42 U.S.C. §1395nn), and the federal Exclusion Statute (42 U.S.C. §1320a-7).

The Program Integrity Department utilizes internal and external resources to help ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas New Hampshire, or on behalf of AmeriHealth Caritas New Hampshire, regarding payment or recovery of potential overpayments. You may be asked to provide supporting documentation including the medical record or itemized bill to support the review of the claim. In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer's submission of similar claims; if this were to occur you would be notified and additional action might be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the communication to expedite a response to your question or concerns. Prior authorization is not a guarantee of payment for the service authorized.

AmeriHealth Caritas New Hampshire reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

False Claims Act

The Federal False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. Additionally, the FCA prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. When AmeriHealth Caritas New

Hampshire submits claims data to the government for payment (for example, submitting Medicaid claims data to the New Hampshire DHHS), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to help ensure compliance.

The FCA, through amendments made under the Fraud Enforcement and Recovery Act of 2009, also prohibits knowingly concealing or knowingly and improperly avoiding the return of identified overpayments.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a civil lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

Penalties for violating the FCA include civil monetary penalties (CMPs) ranging from $11,181 to $22,363 (as adjusted by the DOJ under the Federal Civil Penalties Inflation Adjustment Act of 1990) per false claim, and/or exclusion from federally funded programs. In addition, violators may be subject to three times the amount of damages sustained by the Federal government because of the illegal act(s) unless the violator has voluntarily disclosed the FCA violation under certain conditions.

The Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) increases the government's power to investigate and prosecute any financial fraud against the government and expands liability under the False Claims Act (FCA). FERA expanded potential liability under the FCA in several ways, most notably by:

- Expanding the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like AmeriHealth Caritas New Hampshire.
- Expanding the scope of liability for reverse false claims to include the knowing retention of overpayments.
- Expanding whistleblower ("qui tam relator") protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Program Integrity Operations Team

Program Integrity Operations is responsible for the identification, reporting, and collection of FWA recoveries. The team uses real-time data to identify overpayments, provide specific State or contractual reporting, and collect outstanding balances from providers. This team is made up of three subgroups: Claims Cost Management, Recoupment and Reporting, and Credit Balance.

The Internal **Claims Cost Management** team performs prospective (pre-payment) and retrospective (post-payment) analysis to validate the accuracy of claims payments.

- **Prospective analysis** - This analysis includes the development of front-end edits to identify inaccurate payments prior to payment of the claim. The team coordinates the correction of the claim payment with the AmeriHealth Caritas New Hampshire claims processing unit.

- **Retrospective analysis -** The team performs first-pass retrospective review of paid claims. Retrospective edits help us identify potential overpayments of professional, outpatient, and facility claims; after validation, we then submit these for recovery of the overpayment.

Recoupment and Reporting

The Recoupment and Reporting team develops and distributes both internal, Plan and State reports related to FWA services. This team acts as the gatekeeper of all FWA inventory accountable for intake, management, and monitoring of overpayment recovery projects. This team uses a claim overpayment recovery system to track and report all related activity.

The **Credit Balance** team pursues outstanding provider credit balances that exist for more than 60 calendar days. They perform provider outreach through outbound calls and letter mailings.

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified “waste” include:

- Incorrect billing from providers causing overpayment.

- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility.

The Claims Cost Containment Unit is also responsible for the manual review of provider-initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

AmeriHealth Caritas New Hampshire
Attn: Provider Appeals
PO Box 7388
London, Kentucky 40742-7377

Refunds for Claims Overpayments or Errors

AmeriHealth Caritas New Hampshire and DHHS encourage providers to conduct regular self-audits to help ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements to return the funds to AmeriHealth Caritas New Hampshire or follow DHHS protocols for returning improper payments or overpayments within 60 calendar days from the date the overpayment was identified. Overpayments not returned within 60 calendar days from the date the overpayment was identified may be a violation of State or federal law.

Contact AmeriHealth Caritas New Hampshire Provider Services at **1-888-599-1479** and follow the prompts to arrange the repayment.

There are two ways to return overpayments/improper payments to AmeriHealth Caritas New Hampshire:

1. Have AmeriHealth Caritas New Hampshire deduct the overpayment/improper payment amount from future claims payments, or Submit a check for the overpayment/improper amount directly to:

AmeriHealth Caritas New Hampshire:
Attn: Claims Processing Department PO Box 7320
London, KY 40742

Note: Please include the member's name and ID, date of service, and Claim ID.

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

The Special Investigations Unit (SIU) team is responsible for detecting fraud, waste, and abuse throughout the claim's payment processes for AmeriHealth Caritas New Hampshire. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Registered Nurses, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste, and abuse.
- Implements corrective actions for any supported allegations after thorough investigation, which may include recovery of identified overpayments, placing providers on pre-payment review of claims, and making referrals to appropriate agencies in compliance with contractual obligations.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and State law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – 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 beneficiary practices that result in unnecessary costs to the Medicaid program.

AmeriHealth Caritas New Hampshire is obligated to ensure the effective use and management of public resources in the delivery of services to its members. AmeriHealth Caritas New Hampshire does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas New Hampshire, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are

paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- Prospective (Pre-claims payment)
    - Claims editing – policy edits (based on established industry guidelines/ standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas New Hampshire medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
    - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that AmeriHealth Caritas New Hampshire is only paying claims for members where AmeriHealth Caritas New Hampshire is responsible, i.e. where there is no other health insurance coverage.

- Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

- Retrospective (Post-claims payment)
    - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas New Hampshire is the payor of last resort. The effect of this rule is if AmeriHealth Caritas New Hampshire determines a member has other health insurance coverage, payments made by AmeriHealth Caritas New Hampshire may be recovered.
    - Please also see Section XI: Claims Submission Protocols and Standards for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, AmeriHealth Caritas New Hampshire identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Records Review/Itemized Bill review – a medical record and/ or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-

admission review and pharmacy utilization review.

- Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas New Hampshire will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.

- Credit Balance Issues
  - Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
  - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas New Hampshire reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

Summary of Relevant State Laws and Examples

New Hampshire False Claims Act

The New Hampshire False Claims Act[1] authorizes whistleblowers with knowledge of fraudulent efforts by persons or businesses to obtain New Hampshire state funds or to avoid an obligation to pay New Hampshire state funds to file suit on behalf of the state of New Hampshire. The New Hampshire FCA applies only to false claims presented under the State's Medicaid program.

An action for recovery of State funds under the Act may only proceed against a defendant if the

[1] "Title XII Public Safety and Welfare Chapter 167 Public Assistance to Blind, Aged, or Disabled persons, and to Dependent Children: Medicaid Fraud and False Claims," The New Hampshire General Court, http://www.gencourt.state.nh.us/rsa/html/xii/167/167-61-b.htm.

defendant (1) has its principal place of business in NH or (2) received at least 10% of its total health insurance reimbursement from the Medicaid program in the year prior to the filing of the lawsuit.[2]

Under § 167:61-b.I of the Act, an individual or entity faces civil liability for knowingly presenting or causing to be presented a false or fraudulent claim, making or using false records or statements, or conspiracy to commit any of these acts. Aside from "knowingly" submitting false claims or causing them to be submitted, the New Hampshire False Claims Act also imposes liability on persons or entities that are beneficiaries of an inadvertent submission of a false claim to the State, who subsequently discovers the falsity of such claim, and who fails to disclose that claim to New Hampshire within a reasonable time.

If a person or business is found to have violated the New Hampshire False Claims Act, they can expect to pay civil penalties up to treble damages and a fine ranging between $5,000 and $10,000 for each specific fraudulent submission to the State. [3]Whistleblowers can initiate a claim as a result of the State FCA's qui tam provision, from which they can also receive an award of between 15% and 30%, depending on whether New Hampshire assumes control of the case.[4] In addition, the whistleblower may recover all reasonable expenses necessarily incurred in in bringing the suit, plus reasonable attorney fees and costs. Finally, whistleblowers enjoy the same level of protection against retaliation as they would under the federal False Claims Act.

Self-Referral: N.H. Rev. Stat. Ann. § 125:25-a, § 125:25-b

The New Hampshire public health general provision requires any health care practitioner who has an ownership interest in an entity that provides diagnostic or therapeutic services, or receives remuneration for referral of a patient to an entity that provides such services, to disclose this interest to any patient prior to referring the patient to such entity. Failure to provide written disclosure of an ownership interest may result in suspension of one's

[2] "Title XII Public Safety and Welfare Chapter 167 Public Assistance to Blind, Aged, or Disabled persons, and to Dependent Children: Medicaid Fraud and False Claims," The New Hampshire General Court, http://www.gencourt.state.nh.us/rsa/html/xii/167/167-61-c.htm.

[3] "Title XII Public Safety and Welfare Chapter 167 Public Assistance to Blind, Aged, or Disabled persons, and to Dependent Children: Medicaid Fraud and False Claims," The New Hampshire General Court, http://www.gencourt.state.nh.us/rsa/html/xii/167/167-61-b.htm.

[4] "Title XII Public Safety and Welfare Chapter 167 Public Assistance to Blind, Aged, or Disabled persons, and to Dependent Children: Medicaid Fraud and False Claims," The New Hampshire General Court, http://www.gencourt.state.nh.us/rsa/html/xii/167/167-61-e.htm.

health care practitioner's license or registration. This provision does not apply to in-office

diagnostic services.

Examples of Fraudulent/Abusive Activities:

- Billing for services not rendered or not medically necessary.
- Alteration or forgery of documentation
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not medically necessary.
- Misrepresenting the services rendered.
- Submitting a claim for provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failing to perform services required under a capitated contractual arrangement.
- Misrepresenting dates and times of service.
- Misusing Electronic Medical Records, such as by cloning and copying so records are identical, not unique, and/or specific as required.
- Failing to have supporting documentation for billed services.
- Duplicate payments, incorrect COB calculations, and incorrect contract reimbursement.
- Ordering excessive diagnostic tests.
- Prescribing a brand-name drug when there is a lower-cost generic option that works the same way.

Reporting and Preventing FWA

AmeriHealth Caritas New Hampshire receives State and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas New Hampshire, providers are receiving New Hampshire and federal program funds, and are therefore subject to all applicable federal and/or State laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the medical assistance program. Compliance with federal laws and regulations is a priority of AmeriHealth Caritas New Hampshire.

If you, or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas New Hampshire beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact AmeriHealth Caritas New Hampshire by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**.
- Emailing to fraudtip@amerihealthcaritas.com; or
- Mailing a written statement to:

Special Investigations Unit
AmeriHealth Caritas New Hampshire
200 Steven Drive
Philadelphia, PA, 19113

Below are examples of information that will assist the Plan with an investigation:

- Contact information (e.g., name of individual making the allegation, address, telephone number).
- Name and identification number of the suspected individual.
- Source of the complaint (including the type of item or service involved in the allegation).
- Approximate dollars involved (if known).
- Place of service.
- Description of the alleged fraudulent or abuse activities.
- Timeframe/date of the allegation(s).

Providers may also report suspected fraud, waste, and abuse directly to the New Hampshire Medicaid Fraud Control Unit:

- By calling **1-603-271-1246**.
- By faxing **1-603-271-6274**.
- By writing to:

Office of the Attorney General
Medicaid Fraud Control Unit 33
Capitol Street
Concord, NH 03301

What to Expect as a Result of SIU Activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas New Hampshire, or on behalf of AmeriHealth Caritas New Hampshire, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by investigators in regard to a complaint they are investigating.

- As a provider, you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your provider agreement, you are required to provide the records for review.

Provider agrees to cooperate with AmeriHealth Caritas New Hampshire in maintaining and providing to AmeriHealth Caritas New Hampshire or the New Hampshire DHHS, at no cost

to them: books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to the MCM Contract as well as medical information relating to the members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.

After an investigation is completed, there are several things that may occur such as a determination that the complaint was unfounded, the identified/investigated issue was found to be of an educational nature only, an overpayment was identified for recoupment, or the issue was identified as a credible allegation of fraud and is referred to the New Hampshire DHHS Program Integrity Unit.

Advance Directives

All participating Plan providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100 and to comply with all federal and State laws and regulations related to advance directives, including 42 C.F.R. 489.100 and Article 23 of Chapter 90 of the General Statutes. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when an individual is incapacitated. If a member is an adult (18 years of age or older), they have the right under federal law to decide what health care they want to receive, if in the future the member is unable to make their wishes known about medical treatment. Providers are required to document in the member's medical record and plan of care whether or not the member has executed an Advance Directive. The member has the right to choose a person to act on his or her behalf to make health care decisions for him/her, if the member cannot make the decision for him or herself.

AmeriHealth Caritas New Hampshire requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advance directives must be furnished to members by providers and/or organizations as required by federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.

- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if doing so would violate an attending physician's conscience or the conscience-based policy of the facility at which a patient is being treated. However, the physician must without delay make the necessary arrangements to affect the transfer of the patient and medical records to a facility or physician chosen by the patient, the patient's agent, or the patient's family.
- Implement an advance directive if, after reasonable inquiry, there are reasonable grounds to question the genuineness or validity of a declaration.

Provider Marketing Activities Guidelines

As a contracted provider, you are permitted to share the following with Plan members:

- General and factual information about AmeriHealth Caritas New Hampshire and your participation in the Plan's network.
- Plan-provided member education materials that have been approved by the Plan and the New Hampshire DHHS.
- Contact information for the New Hampshire DHHS' contracted Enrollment Broker.

As a contracted provider, you are prohibited from participating in the following activities:

- Conducting any marketing, including mass marketing, to individuals or the general public with the intention of inducing patients to join a particular Medicaid plan or to transfer from one plan to another. Mass marketing includes use of any mass media outlets such as radio, television, newspaper, billboards, bus posters, and social media advertisements.
- Using written or oral methods of communication with members to assert or imply that the member must enroll in a specific Medicaid health plan to obtain Medicaid benefits or in order not to lose Medicaid benefits.
- Using written or oral methods of communication with members to compare benefits or other aspects of Medicaid managed care organizations.
- Using written or oral methods of communication to share false or misleading

information regarding the Plan or the provision of services, including suggesting that any Medicaid plan is uniquely endorsed by a government entity.

- Using written or oral methods of communications with members in health care settings other than common areas. Common areas where marketing activities are permitted include hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. Marketing activities shall not be conducted in areas where patients primarily intend to receive health care services, including but not limited to emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
- Performing direct marketing activities or solicitation on behalf of the Plan, including the sale, or offering of any incentives such as private insurance, or gifts.
- Using marketing materials, strategies, or activities that discriminate against or target potential members or potential members based on health status, geographic residence, location of possible services, or income.
- Performing or permitting any marketing activities on behalf of the Plan at your office location.
- Using marketing materials that have not been approved by the Plan and the New Hampshire DHHS.
- Assisting with or making recommendations for enrollment with the Plan, except to refer prospective members to the New Hampshire DHHS contracted Medicaid Managed Care Enrollment Broker.

Provider Support and Accountability

Provider Network Management

AmeriHealth Caritas New Hampshire's Provider Network Account Executives function as a provider relations team to advise and educate AmeriHealth Caritas New Hampshire providers. Provider Network Account Executives assist providers in adopting new business policies, processes and initiatives. From time to time, providers will be contacted by Plan representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms.
- Credentialing or Re-credentialing.
- Health Management Programs.
- Orientation, Education, and Training.
- Program Updates and Changes.
- Provider Appeals.
- Provider Responsibilities.
- Quality Enhancements.
- Self-Service Tools.

New Provider Orientation

Upon completion of AmeriHealth Caritas New Hampshire's contracting processes, each provider will receive a welcome letter within 30 business days of executing the contract, which will include the contract effective date (subject to credentialing), AmeriHealth Caritas New Hampshire provider ID, and the Provider Network Account Executive's contact information. The welcome letter will refer all Plan providers to online resources, including AmeriHealth Caritas New Hampshire provider orientation and training information and more.

***Provider Manual*.**

The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies, and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this *Provider Manual* by contacting the Provider Services department at **1-888-599-1479.**

Orientation Training

AmeriHealth Caritas New Hampshire will conduct initial training within 30 days of entering a contract with a provider, or provider group. Orientation training topics will include:

- Medicaid program overview.
- Member access standards.
- Credentialing processes.
- Provider responsibilities (including Advance Directives; Fraud, Waste, & Abuse; Reporting Requirements; IDEA; HIPAA; and Privacy).
- Cultural competency.
- Plan policies and procedures.
- Utilization management, quality improvement, and population health programs.
- Medical necessity criteria, clinical practice guidelines, and screening tools.
- Medicaid compliance.
- Covered services, benefit limitations, and value-added services.
- Copays.
- Provider inquiry and appeal process.
- Member grievance and appeals and State fair hearing process.
- Billing, claims filing, and encounter data reporting.
- Electronic Funds Transfer and Electronic Remittance Advice.
- Quality enhancement programs.
- Community resources.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Provider Trainings & Meetings

At a minimum, AmeriHealth Caritas New Hampshire will provide training on the following

topics:

- Claims, billing, and required documentation, including submitting claims through the provider portal.
- Requesting prior authorization.
- Verifying eligibility and benefits.
- Provider website, provider manual, provider orientations and training.
- Supporting and assisting members in grievances and appeals.
- Opportunities for quality improvement.
- When and how to refer members for behavioral health services (for physical health providers.
- When and how to refer members for physical health services (for behavioral health providers.

Additionally, the Plan will offer training to providers on the topics below. Providers can contact Provider Services at **1-888-599-1479** or their Account Executive for more information.

- Integration of physical and behavioral health, person-centered care management, social determinants of health, and quality.
- Clinical components necessary to meet the needs of Children with Special Health Care Needs.
- Mental health first aid, recovery and resiliency principles, and trauma-informed care.
- Community Mental Health (CMH) Services and resources available within the applicable regions.
- Suicide risk assessment, suicide prevention, and post-intervention strategies (for contracted CMH providers).
- Training for primary care clinics on best practices for behavioral health screening and integrated care for depression, anxiety, and Substance Use Disorders.
- Cross training for mental health providers receive on SUD and for SUD providers on mental health.
- New models for behavioral health interventions that can be implemented in primary care settings.
- Clinical care integration models.
- Community-based resources to address social determinants of health.
- Best practices for providers serving infants with Neonatal Abstinence Syndrome (NAS).

Provider Education and Ongoing Training

AmeriHealth Caritas New Hampshire's provider training and development are fundamental components of continuous quality and superior service. The Plan offers on- going educational opportunities for providers and their staff. The Plan is committed to offering appropriate training and education to help providers achieve compliance with Plan standards, and federal and State regulations. Provider training and educational programs are based on routine assessments of provider training and educational needs. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed information is shared in advance of training opportunities and is available on the AmeriHealth Caritas New Hampshire website at www.amerihealthcaritasnh.com.

Plan-to-Provider Communications

Providers will receive or have access to regular communications from AmeriHealth Caritas New Hampshire including, but not limited to the following:

- Provider manual.
- Provider newsletters.
- Website updates and information.
- Provider notices and announcements.
- Surveys.
- Faxes.
- Emails.
- Miscellaneous other materials.

Provider Portal

Providers can access helpful information at their convenience through our web-based provider portal, NaviNet. The portal links providers to AmeriHealth Caritas New Hampshire and enables the secure sharing of administrative, financial, and clinical data.

Through the portal, you can access:

- Member eligibility verification.
- Claims submission and status.
- Claims investigation.
- Prior authorization submission.
- Care gap reports to identify needed services.
- Member Clinical Summaries.
- Medical and pharmacy claims data.
- Member panel rosters for PCPs included under your contract.

If you are not a NaviNet user, visit https://navinet.secure.force.com/ to sign up. You will

need your Federal Tax ID number. Make sure to complete all information requested. You will be able to access the AmeriHealth Caritas New Hampshire information and any specific data for your practice.

If you are already a NaviNet user for your other health plans, AmeriHealth Caritas New Hampshire will be automatically added to your account. On September 1st, you will be able to access the AmeriHealth Caritas New Hampshire information, and any specific data for your practice.

If you need more information or assistance, call NaviNet at **1-888-482-8057** or AmeriHealth Caritas New Hampshire Provider Services at **1-888-599-1479**.

Provider Appeals

AmeriHealth Caritas New Hampshire providers may file an appeal of an adverse action by AmeriHealth Caritas New Hampshire, except for member appeals or grievances, which are described in Section VI of this Provider Manual. Adverse actions include, but are not limited to:

- Actions against the provider for reasons related to program integrity.
- Termination of the provider's agreement before the agreement period has ended for reasons other than when DHHS, New Hampshire Medicaid Fraud Control Unit, or another government agency has required the Plan to terminate the agreement.
- Denial of claims for services rendered that have not been filed as a member appeal.
- Violation of the agreement between the Plan and the provider.

Provider appeals must be submitted in writing, along with supporting documentation. A telephone inquiry regarding payment or denial of a claim does not constitute an appeal of the claim. Provider appeals must be filed in writing and within 30 calendar days of:

1. The date of the Plan's notice of the adverse action to be taken, or
2. The date on which the Plan should have taken a required action but failed to do so.

Providers may submit appeals to:

AmeriHealth Caritas New Hampshire
Attn: Provider Appeals
P.O. Box 7388
London, KY 40742-7388

As part of the provider appeals process, AmeriHealth Caritas New Hampshire will take the following actions:

- Notify providers in writing of any adverse action, including a description of the basis of the adverse action and the right to appeal the adverse action.
- On request and before an appeal is filed, offer timely peer-to-peer review support to providers who receive an adverse decision. Providers may reach the Peer-to-Peer telephone line by following the prompts at **1-833-472-2264** to discuss a medical determination with a physician in the AmeriHealth Caritas New Hampshire Medical Management department. Providers must call within **five business days** of notification of the determination.
- Thoroughly investigate each provider appeal using applicable statutory, regulatory, contractual, and provider contract provisions, as well as clinical review guidelines.
- All pertinent facts will be investigated and considered. AmeriHealth Caritas New Hampshire's policies and procedures will also be considered.
- Provide written notice of resolution of the provider appeal (Resolution Notice) within 30 calendar days from the date the Plan received the appeal.
- Extend the decision deadline by 30 calendar days if the Plan determines additional evidence or supporting documentation is needed from the provider, or for other good cause as determined by the Plan.
- For appeals whose decision deadline has been extended for additional information, provide written notice of resolution within 30 calendar days of receipt of the additional information requested from the provider.
- For overturned appeals, take all steps to reverse the adverse action within 10 calendar days.

State Fair Hearings

A provider may pursue a State fair hearing after exhausting the Plan's provider appeals process or if the Plan has not adhered to notice and timing requirements. The parties to the State Fair Hearing include ACNH as well as the Provider. A State fair hearing can be requested by completing an Appeal Request form (available at https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/appeal-request.pdf) and submitting it to:

Administrative Appeals Unit
New Hampshire Department of Health and Human Services
105 Pleasant Street
Room 121C Concord, NH 03301

Upon Participating Provider's request for a State Fair Hearing, AmeriHealth Caritas New Hampshire will, within three (3) business days, provide DHHS and the participating provider all documentation related to the provider appeal, including but not limited to any transcript(s), records, or written decision(s). The MCO shall appear and defend its decision before the DHHS AAU. Nothing in this manual or provider agreement shall preclude the MCO from representation by legal counsel.

The DHHS Administrative Appeals Unit will notify the Plan of State fair hearing determinations within 60 calendar days of the date of the Plan's Notice of Resolution. AmeriHealth Caritas will be bound by State fair hearing determination and take all steps to reverse any overturned adverse action within 10 calendar days.

Provider Contract Terminations

AmeriHealth Caritas New Hampshire uses Provider Agreements that have been approved by all the appropriate local authorities. An amendment to the agreement is generated only if new services are added due to a change in the State Medicaid program.

AmeriHealth Caritas New Hampshire Provider Agreements specify termination provisions that comply with the AmeriHealth Caritas New Hampshire DHHS requirements.

Continuity of Care

Plan members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or,
- Until the member changes to a new provider.

AmeriHealth Caritas New Hampshire will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Members in an ongoing course of treatment, or who have a special condition (not included pregnancy or terminal illness), or who are Children with Special Health Care Needs, may continue seeing their participating or non-participating provider(s) for up to 90 calendar days.

Members determined to be terminally ill at the time of transition may continue seeing their participating or non-participating provider for the remainder of the member's life for care directly related to the treatment of the terminal illness or its medical manifestations.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

For continued care, AmeriHealth Caritas New Hampshire and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*. These provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas New Hampshire for cause.

SECTION III
PROVISION OF SERVICES

III. Provision of Services

This section provides a summary of the covered services offered to AmeriHealth Caritas New Hampshire members under the Medicaid Care Management program.

No content found in this publication or in the Plan's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, health care, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non- treatment and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan members.

Basic Covered Services

Basic covered services include inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; transportation; behavioral health services; and a variety of other services. Plan members may also be eligible to receive other services covered by New Hampshire's fee-for-service Medicaid program.

All services must be medically necessary, and some services may have limitations or require authorization. For information on Prior Authorization requirements, see the "Utilization Management" section of this *Provider Manual*.

For the most complete and up-to-date benefit information please contact AmeriHealth Caritas New Hampshire Provider Services at **1-888-599-1479.**

For additional information regarding the New Hampshire Medicaid program policies and benefits, please consult the DHHS NH Medicaid Providers webpage.

Covered Services
Adult Medical Day Care
Advanced Practice Registered Nurse
Ambulance Service
Ambulatory Surgical Center
Audiology Services
Behavioral Health Crisis Treatment Center
Certified Non-Nurse Midwife
Community Mental Health Services
Designated Receiving Facilities
Early and Periodic Screening, Diagnostic and Treatment Services including Applied Behavioral Analysis Coverage
Family Planning Services
Freestanding Birth Centers
Furnished Medical Supplies & Durable Medical Equipment
Home Health Services
Home Visiting Services
Hospice
Inpatient Hospital
Inpatient Psychiatric Facility Services Under Age 21 Under age 22 if individual admitted prior to age 21
Inpatient Psychiatric Treatment in an Institution for Mental Disease, Excluding New Hampshire Hospital Pursuant to 42 CFR 438.6 and 42 CFR 438.3(e)I(2)(i) through (iii)
Laboratory (Pathology)
Medical Services Clinic (e.g., Opioid Treatment Program)
Non-Emergency Medical Transportation Includes Family and Friends Mileage Reimbursement for Medically Necessary travel
Optometric Services Eyeglasses

Outpatient Hospital - Including facility and ancillary services for dental procedures
Personal Care Services
Physicians Services
Podiatrist Services
Prescribed Drugs
Private Duty Nursing
Psychology
Rehabilitative Services Post Hospital Discharge
Rural Health Clinic & Federally Qualified Health Centers
Substance Use Disorder Services (Per He-W 513) – including services provided in Institutions for Mental Diseases pursuant to an approved 1115(a) research and demonstration waiver
Transitional Housing Program Services and Community Residential Services With Wrap-Around Services and Supports
Wheelchair Van
X-Ray Services

Non-Emergency Medical Transportation (NEMT)

AmeriHealth Caritas New Hampshire contracts with Coordinated Transportation Solutions (CTS) for NEMT and mileage reimbursement. Members can access NEMT services by contacting CTS at 1-833-301-2264 or logging on to the member portal. CTS will arrange NEMT for members via the most cost-effective and least expensive mode of transportation available.

Members will be required to use the *Family and Friends Mileage Reimbursement* program if they have a car, or a friend or family member with a car to drive them to medically necessary services. It is important to remind members that, even if they are using the *Family and Friends Mileage Reimbursement* program, they must contact CTS in advance of the appointment.

In-Lieu of Services

An in lieu of service is an alternative service or setting approved by DHHS as a medically appropriate and cost-effective substitute for a service or setting covered under the Medicaid

State plan. Members are not required to use these alternate services or settings.

AmeriHealth Caritas New Hampshire will provide the following In Lieu of Services:

- Diabetes self-management.
- Tenancy supports including assistance in finding and keeping housing (not including rent).
- Medical nutrition.
- Institutions for Mental Disease (IMD) mental health inpatient (ages 22-64).

Extra Benefits

AmeriHealth Caritas New Hampshire offers members some extra benefits in addition to the covered services required by New Hampshire Medicaid. Additional details are available on our website or by calling Member Services at **1-833-704-1177 (TTY 1-855- 534-6730**).

Extra benefits include:

- **Vision** — Members get $100 per year for contact lenses.*
- **Home education visits for children** — We provide home visits to address home- based asthma triggers to qualifying members. In Manchester and Nashua, members will be referred to the local Department of Public Health for inclusion in the local program.
- **Living Beyond Pain** — Members living with chronic pain can enroll in care coordination to access alternative pain management strategies as part of a person- centered plan. Members can get referrals to and coverage for appropriate pain management alternatives such as acupuncture and chiropractic therapy, not to exceed 12 acupuncture and 12 chiropractic therapy visits per member per year. Referral and coverage of services is facilitated through a Care Coordinator as part of a member-centered plan of care statewide.

Member Rewards and Incentives

AmeriHealth Caritas New Hampshire also offers member rewards and incentives.* (*Some restrictions and limitations may apply. Earn up to $250 in cash and non-cash goods and services each state fiscal year ending June 30.)

- CARE Card* — With our CARE Card program, members can receive rewards for completing health-related activities (up to a $250 value per member per year). Visit our website to learn more about how members can earn rewards.
- Car seats and booster seats* — We provide car seats at no cost to members for children up to age 4, and booster seats for children up to age 8 (up to a $210 value).

- WW® (formerly Weight Watchers®) membership* — Up to 3 months for members with a goal to lose weight (up to a $133 value).
- Mission GED®* — AmeriHealth Caritas New Hampshire provides vouchers through our Mission GED program to adult members pursuing their high school equivalency certification (HiSet). These vouchers let members take the required tests (including practice tests and repeat tests) at no cost to them (up to a $125 value).
- Home-delivered meals after a hospital stay* — Members being discharged after a qualifying inpatient hospital stay can receive home-delivered meals (14 meals/7 days) post discharge. Qualifying stays include those for new moms in recovery from substance use disorder, members with substance use disorder who successfully complete an inpatient substance use disorder treatment program as part of the Flexible Recovery Benefit, and adult members (ages 21 to 64) with heart disease or diabetes. Meals for members with dietary restrictions are prepared according to dietary guidelines (up to a $98 value).

- Peer respite transportation — Transportation to state-covered respite services to remove access barrier for members in need of peer respite (up to a $175 value).

- Flexible recovery benefit to support recovery — Members may receive up to a
    - $500 credit to access alternative recovery support services available after completing a nonhospital substance use disorder residential treatment program. Services available are subject to a $500 lifetime limit, and some are also subject to the
    - $250 annual incentive limit. Services include chiropractic care, acupuncture, and transportation. For more information, please contact Member Services at 1-833-704- 1177 (TTY 1-855-534-6730).

Non-Covered Services

AmeriHealth Caritas New Hampshire will refer members to local resources for services that are not covered by the Plan, as appropriate. Providers may contact the Rapid Response and Outreach Team at **1-833-212-2264** for assistance with coordination of non-covered services.

Standard X -- Access A-5 ACNH ensures that providers are aware of the requirement to consult with DCYF regarding medical and psychiatric matters for members who are children in State custody/guardianship.

Services Not Included in Managed Care (DHHS Covered)

Services Not Included in Managed Care (DHHS Covered)
Acquired Brain Disorder Waiver Services
Choices for Independence Waiver Services
Child Health Support Service – Division for Children, Youth & Families, except for services eligible under EPSDT
Crisis Intervention – Division for Children, Youth & Families
Developmental Disability Waiver Services
Developmental Services Early Supports and Services
Glencliff Home
Home Based Therapy – Division for Children, Youth & Families
Home and Community-Based In Home Support Services
Inpatient Hospital Swing Beds, Intermediate Care Facility
Intensive Home and Community-Based Services– Division for Children, Youth & Families
Intermediate Care Facility Atypical Care
Intermediate Care Facility for Members with Intellectual Disabilities E.g., Cedarcrest
Intermediate Care Facility Nursing Home
Medicaid to Schools Services
Placement Services – Division for Children, Youth & Families
Private Non-Medical Institutional For Children – Division for Children, Youth & Families
Non-Swing Bed Skilled Nursing Facilities
Skilled Nursing Facilities Skilled Nursing Facilities Atypical Care

Private Pay for Non-Covered Services

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas New Hampshire, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Emergency Services

Members requiring emergency care should be advised to call **911.**

AmeriHealth Caritas New Hampshire ensures the availability of emergency services and care **24 hours a day, 7 days a week**, and is responsible for coverage and payment of emergency and post-stabilization care services regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas New Hampshire. Post- stabilization services remain covered until:

- The AmeriHealth Caritas New Hampshire physician with privileges at the treating hospital assumes responsibility for the member's care.
- The AmeriHealth Caritas New Hampshire physician assumes responsibility for the member's care through transfer.
- The AmeriHealth Caritas New Hampshire representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

AmeriHealth Caritas New Hampshire will not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

AmeriHealth Caritas New Hampshire will not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, AmeriHealth Caritas New Hampshire, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Any provider of emergency services who does not have a contract in effect with AmeriHealth Caritas New Hampshire, must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the member received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in AmeriHealth Caritas New Hampshire.

Definitions and requirements regarding urgent/emergent care are as follows:

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

Urgent Care: Office visits to the member's PCP or another provider within 48 hours for the presentation of medical signs or symptoms that require immediate attention but are not life threatening and do not meet the definition of Emergency Services.

Out-of-Network Use of Non-Emergency Services

AmeriHealth Caritas New Hampshire will provide timely approval or denial of requests for authorization of out-of- network service(s) through the assignment of a prior authorization number, which refers to and documents the determination.

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas New Hampshire, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Second Opinions

AmeriHealth Caritas New Hampshire members have the right to request a second opinion from a qualified, participating health care professional. If a participating health care professional is not available within time and travel requirements, AmeriHealth Caritas New Hampshire will arrange for the member to obtain a second opinion outside the network, at no cost to the member.

Inpatient at Time of Enrollment

The managed care plan responsible for a member's inpatient care depends upon the timing of the member's Medicaid enrollment. If a member, transferring from another Medicaid plan to AmeriHealth Caritas New Hampshire, is hospitalized at the time of

enrollment, the member's originating health plan is responsible for inpatient coverage until discharge, including for ancillary and health professional services rendered during the inpatient stay. The member's new MCO is responsible for all benefits rendered after discharge.

Likewise, if a member transfers from AmeriHealth Caritas New Hampshire to another Medicaid plan during an inpatient stay, AmeriHealth Caritas New Hampshire is responsible for inpatient facility coverage until discharge, including for ancillary and health professional services rendered during the inpatient stay.

Newborn Coverage

Newborns born to mothers who are covered by AmeriHealth Caritas New Hampshire at the time of birth will be auto enrolled for coverage with AmeriHealth Caritas New Hampshire. The Plan will provide covered services to eligible newborns retroactive to the date of birth.

AmeriHealth Caritas New Hampshire shall not limit benefits for postpartum hospital stays to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn child before that time. A participating provider is not required to obtain prior authorization for stays up to the 48 or 96 hour periods.

Sterilizations

Providers must submit the appropriate consent form with the prior authorization requests and with the claim's submission for these services. Sterilizations are not covered for members less than 21 years of age. Appropriate consent forms can be found online at www.amerihealthcaritasnh.com or on the New Hampshire DHHS website at https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms.

A member seeking sterilization must voluntarily give informed consent on the Consent form, which must accompany each claim.

The member must give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

New Hampshire's Sterilization Consent Form must accompany all prior authorization requests for sterilization services and all claims for reimbursement for sterilization services.

The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

Preventive Care/Immunizations

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the recommended childhood immunization schedule for the United States, or when medically necessary for the member's health.

- Providers are required to prepare for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit.

- Providers are required to participate in the NH Immunization Program.

AmeriHealth Caritas New Hampshire has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP)/Bright Future, and the American Academy of Family Physicians (AAFP)], and the adult immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

Immunization Schedules (Childhood, Adolescent, and Adult)

- Visit the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/vaccines/schedules/hcp/index.html for recommended vaccines and immunizations.
- Visit the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/Page/Name/tools-and-resources- for-better-preventive-care for the *Guide to Clinical Preventive Services* for recommendations made by the USPSTF for clinical preventive services.
- Review the New Hampshire Child Care Provider's Guide to Immunizations for the New Hampshire Child Care Provider's Guide to Immunizations.

Vaccines for Children (VFC) Program

AmeriHealth Caritas New Hampshire PCPs are required to enroll with the New Hampshire Immunization Program to receive vaccines for members under age 19 years through the Vaccines for Children Program (VFC). Vaccinations covered by the VFC program will not be reimbursed by AmeriHealth Caritas New Hampshire; however, the Plan reimburses providers for appropriate vaccine administration to members ages 18 years and younger. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC vaccines immunizations by:

- Billing the Plan with the appropriate procedure code(s) and modifier.
- Reporting all immunizations to the New Hampshire Immunization Program Immunization Registry.

EPSDT

Our Pediatric Preventive Health Care Program is designed to improve the health of Medicaid members from birth to under age 21 by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines through identification of growth and development needs and coordination of appropriate health care services.

All Plan PCPs are responsible to provide EPSDT services to AmeriHealth Caritas New Hampshire members from birth to under age 21 according to the AAP Bright Futures Periodicity Schedule or upon request at other times in order to determine the existence of a physical or mental condition. The most current periodicity schedules are available online https://brightfutures.aap.org/Pages/default.aspx.

For the initial examination and assessment of a child, PCPs are required to perform the relevant EPSDT screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs.

Periodic assessments must consist of the following components:

- Routine physical examinations as recommended by the AAP and “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.”
- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for Substance Use Disorders.
- Screening for developmental delay at each visit through the fifth year using a validated screening tool.
- Screening for Autism Spectrum Disorders per AAP guidelines.
- Comprehensive, unclothed physical examination.
- All appropriate immunizations in accordance with the schedule established by the

Advisory Committee on Immunization Practices.
- Vision and hearing screening.
- Dental screening and education.
- Nutrition assessment and education.
- Laboratory tests including blood lead screening.
- Health education and anticipatory guidance for both the child and caregiver.
- Referral for further diagnostic and treatment services, if needed.

EPSDT providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to AmeriHealth Caritas New Hampshire members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris (of one's own right) teenagers. This explanation of EPSDT services should occuron the member's first visit and quarterly thereafter and must include distribution of appropriate EPSDT educational tools and materials.

Screening Timeframes

EPSDT providers (PCPs) are contractually obligated to provide EPSDT screenings within 30 calendar days of the scheduled due date for children under the age of 2 years and within 60 calendar days of the scheduled due date for children ages two and older, or within no more than 2 weeks after the initial request. Inter-periodic exams must also be promptly provided, as needed.

Initial EPSDT screenings must be offered to new members within 60 calendar days of becoming an AmeriHealth Caritas New Hampshire member, or at an earlier time if needed to comply with the periodicity schedule. At the latest, the initial EPSDT screening must be completed within three months of the member's enrollment date with AmeriHealth Caritas New Hampshire. Periodic EPSDT screenings must occur within no more than two weeks of the request.

Plan PCPs are expected to assist members with accessing substance abuse and mental health services, as needed. The Plan's Rapid Response and Outreach Team is also available to members and providers to support care coordination and access to services. Members and providers may request RROT support by calling **1-833-212-2264.**

Pharmacy Services

Pharmacy services covered by AmeriHealth Caritas New Hampshire are managed by the Plan's delegated subcontractor, PerformRx. For the most current and complete information on the provision of pharmacy services, please visit: www.amerihealthcaritasnh.com > providers > pharmacy services. For questions regarding

pharmacy services, Plan members and providers may contact:

PerformRx Pharmacy Member Services
1-888-765-6383 (711 relay for TTY assistance)

PerformRx Pharmacy Provider Services 1-888-765-6394

Formulary

AmeriHealth Caritas New Hampshire utilizes the New Hampshire DHHS Medicaid preferred drug list (PDL). This drug benefit has been developed to cover medically necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, medically necessary, and are not likely to result in adverse medical outcomes.

The ACNH formulary is available at the Plan website. The PDL is available online at https://nh.magellanrxcom/documents/51139/68986/NHrx_PDL.pdf/8eb713b0-cc1d-7fd9-a0c3-12988cb1b7?t=1677610996864.

Pharmacy Prior Authorization

The Pharmacy Services Department at AmeriHealth Caritas New Hampshire issues prior authorizations for non-preferred drugs or other drugs on the PDL that require prior authorization. Contact Pharmacy Provider Services at **1-888-765-6394** between 8 am and 5 pm ET Monday through Friday. After business hours, Saturday, Sunday, and holidays, call Member Services at 1-888-765-6383.

Prior Authorization procedures are as follows:

The prescriber contacts AmeriHealth Caritas New Hampshire by:

1. Submitting a web request under Pharmacy at www.amerihealthcaritasnh.com or
2. Faxing a completed Prior Authorization form to **1-866-880-3679**.
3. Can be submitted by phone, fax or online. Please note the phone and fax number are different for CHMCs.

Pharmacy prior authorization forms can be found at **www.amerihealthcaritasnh.com.**

Emergency Supply

In the event a member needs to begin therapy with a non-preferred or other medication that requires prior authorization before such prior authorization can be obtained, pharmacies are authorized to dispense a 72-hour emergency supply to allow the prescriber time to obtain the prior authorization.

The pharmacy must enter a "3" in the Level of Service field (418-DI) to indicate that the transaction is an emergency fill. The claims will only allow a 72-hour supply. Emergency fills will be exempt from co-payments.

Over-the-Counter Medications

Certain generic over the counter (OTC) medications will be covered by AmeriHealth Caritas New Hampshire with a prescription from the prescribing physician. These include, but are not limited to, aspirin, acetaminophen, ibuprofen, tobacco cessation products, and antihistamines. Please use our searchable formulary to find covered OTCs: https://www.amerihealthcaritasnh.com/apps/formulary/formulary.aspx.

Durable Medical Equipment (DME) and Pharmacy Claims

A list of diabetic supply products able to be submitted as pharmacy claims is available at **www.amerihealthcaritasnh.com**. More products are available; use the searchable formulary: https://www.amerihealthcaritasnh.com/apps/formulary/formulary.aspx.

All other products, such as incontinence supplies, enteral feedings, etc. should be submitted to AmeriHealth Caritas New Hampshire as DME claims. DME that is available on the pharmacy formulary does process via PerformRx POS. Here are the key things pharmacies need to know when submitting DME claims:

- Pharmacies that provide DME supplies not on the pharmacy formulary must enroll as a DME provider with AmeriHealth Caritas New Hampshire and submit claims directly to AmeriHealth Caritas New Hampshire in order for claims to be processed.
- To submit a DME claim, pharmacies and/or DME suppliers can use the CMS-1500 professional claim form and submit electronically or via paper. Electronic claims can be submitted to our clearinghouse, Change Healthcare or pharmacies can use another clearinghouse.
    - AmeriHealth Caritas New Hampshire's electronic data interchange (EDI) payer ID# is **87716.**
- Paper claims can be submitted to:

AmeriHealth Caritas New Hampshire

Attn: Claims Processing Department
P.O. Box 7387
London, KY 40742-7387

A list of participating network DME suppliers can be viewed in the online provider directory at www.amerihealthcaritasnh.com.

Medicaid Managed Care Cost Sharing: Pharmacy Copays

AmeriHealth Caritas New Hampshire imposes the same cost-sharing amounts as New Hampshire DHHS and does not require members to pay for any covered services other than the copayment amounts as specified by DHHS. Except for members who are exempt from cost sharing as described in the Medicaid Cost Sharing State Plan Amendment, copayments as described below will be required for members deemed by DHHS to have annual incomes at or above 101% FPL.

Medicaid Managed Care Cost Sharing	
SERVICE	**COPAY**
Preferred/approved non-preferred prescription drugs	**$1/script or refill**
Prescription drugs not identified as preferred or non-preferred	**$1/script or refill**

Members are exempt from copayments when:

- The member falls under the designated income threshold (100% or below the FPL).
- The member is under 18 years of age.
- The member is in a nursing facility or in an ICF for members with IDs.
- The member participates in one of the HCBS waiver programs.
- The member is pregnant and receiving services related to her pregnancy or any other medical condition that might complicate the pregnancy.
- The member is receiving services for conditions related to her pregnancy and the prescription is filled or refilled within 60 calendar days after the month the pregnancy ended.
- The member is in the Breast and Cervical Cancer Treatment Program.
- The member is receiving hospice care.
- The member is an American Indian/Alaska Native.

The following services are exempt from copayments:

- Emergency services.
- Family planning services.
- Preventive services provided to children.
- Pregnancy-related services.

- Services resulting from potentially preventable events.
- Clozaril (Clozapine) prescriptions. [42 CFR 447.56(a)].

Members must show their AmeriHealth Caritas New Hampshire member ID card when they get their prescriptions. For questions, call Pharmacy Member Services at **1-888-765- 6383.**

Participating pharmacies are prohibited from refusing to fill prescriptions and to dispense as written when a member is unable to pay the applicable copayment amount at the time the prescription is filled.

Pharmacy Lock-In Program

To support the reduction of fraud, waste and abuse within the Medicaid system, and to better support our members with complicated drug regimens who see multiple physicians, AmeriHealth Caritas New Hampshire utilizes lock-in programs for pharmacy. Through data analysis and referrals by providers and the State, the Plan identifies members who may need additional support or who may have misused, abused or committed possible fraud in relation to the receipt of prescription drug services.

Under these programs, a multidisciplinary team uses established procedures to review member medical/pharmacy utilization for the purpose of identifying misuse, abuse, or potential fraud. A member may be identified for review when any of the following criteria is met:

1. All members are eligible for the Pharmacy lock-in program regardless of age.
2. Member prescription and medical service utilization data is reviewed against established conditions (set forth below) on a monthly and ad hoc basis.
3. A member is identified for review in order to determine if appropriate for pharmacy lock-in based on the criteria below. If any 2 of the following conditions are satisfied the member will receive a warning letter. If 3 or more criteria are satisfied the member will be restricted to a primary pharmacy.

The following criteria is used to determine if a member will be restricted to a primary pharmacy:

Condition 1

Member had utilized three or more pharmacies to fill narcotic prescriptions within a 90 day period.

Condition 2

Member had narcotic prescriptions from three or more different prescribers within a 90 day period.

Condition 3

Member had 2 or more Emergency Room visits with prescriptions for controlled substances within a 90 day period.

Condition 4

Member has received 100 units or more per prescription per 7-day supply.

Condition 5

Member has had three or more medications of the same drug class filled within a 90 day period.

Condition 6

Member has received the same or similar drug from different pharmacies, obtained within 2 days of each other.

Members will automatically be submitted to the pharmacy lock-in program if any of the following criteria are met:

1. Members who alter or forge prescriptions are automatically submitted to the pharmacy lock-in program.
A signed statement from the provider indicating an alteration or forgery occurred is required.

2. Referrals from the Plan's physician/pharmacy providers, the Plan's Pharmacy Services Department, Member/Provider Services, Special Investigations Unit, Special Care Unit, Quality Management, or Population Health.

3. Members who are currently known to be restricted as indicated on the Department file transfer process upon enrollment with AmeriHealth Caritas New Hampshire.

AmeriHealth Caritas New Hampshire accepts referrals of suspected fraud, misuse, or abuse from a number of sources, including physician/pharmacy providers, the Plan's Pharmacy Services, Member/Provider Services, the Special Investigations Unit, Case Management/Care Coordination, Special Care Unit, Quality Management, Medical Affairs, and the New Hampshire DHHS. If you suspect member fraud, misuse, or abuse of services, you are encouraged to make a referral to the Pharmacy Lock-In programs by calling the Fraud and Abuse Hotline at **1-866-833-9718.**

All referrals are reviewed for potential lock-in. If the results of the review indicate misuse, abuse, or fraud, AmeriHealth Caritas New Hampshire will place the member in the Pharmacy Lock-In programs, which means the member(s) can be restricted to one pharmacy.

AmeriHealth Caritas New Hampshire Prescription Drug Monitoring Program

AmeriHealth Caritas New Hampshire providers are required to follow all requirements of the New Hampshire Prescription Drug Monitoring Program including mandatory registration to access the PMP AWARxE system.

The PMP system collects information on all controlled substances (schedules II-IV) prescriptions. Prescribers registered with the PMP may obtain immediate access to an online report of their current or prospective patient's controlled substance prescription

history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the PMP system to patients.

AmeriHealth Caritas New Hampshire providers must query the PMP to view information about our member's usage before prescribing any controlled substances to them. All PMP users must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.

Vision Services

Comprehensive Eye Care Administrator
AmeriHealth Caritas New Hampshire's routine vision and eye wear benefits are covered for children ages 0–18 and adults ages 19 and older. Additionally, medical/surgical benefits are covered for all Medicaid members.

Inquiries regarding these benefits should be directed to Provider Services at 1-888-599-1479.

The plan covers the following services:

- Eye care services by an ophthalmologist, optometrist, or optician.
- One refraction eye exam to determine the need for eyeglasses no more frequently than every12 months.
- Eye exams to diagnose and monitor medical conditions of the eye.
- One pair of single vision lenses with frames, as follows:
    - For members 21 years of age and older, if the refractive error is at least plus or minus.50 diopter, according to the refractive error which may be calculated as a combined total of the spherical and cylindrical errors, **in both eyes**.
    - For members younger than 21 years of age, if the refractive error is at least plus or minus.50 diopter, according to the refractive error which may be calculated as a combined total of the spherical and cylindrical errors, **in at least one eye**.

- One pair of eyeglasses with bifocal corrective lenses (or one pair of eyeglasses with corrective lenses for close vision and one pair of eyeglasses with corrective lenses for distant vision) if there is a refractive error of at least .50 diopter for both close and distant vision.
- Transition lenses for members with ocular albinism.
- Contact lenses for ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses, or when required to correct aphakia or to treat corneal disease.
- Replacement of the component eyeglasses parts due to breakage or damage, subject to all of the following:
    - Replacements may be in the form of a single lens, both lenses, frame only, or a complete pair of corrective lenses.
    - Each component part or complete pair of corrective lenses may only be replaced one time within a 12-month period.
    - When the member has two pairs of eyeglasses in lieu of bifocals, each pair of eyeglasses is eligible for replacement.
- Only one replacement of **lost** eyeglasses per lifetime for members younger than age 21 years.

The plan covers the following services:

- Trifocal lenses if the member:
    - Is employed and the trifocal lenses are required for the work involved in the member's employment, or Vision services and eyewear
    - Is a full-time student and the trifocal lenses are required for the work involved in the member's education; or
    - Currently has trifocals.
- Replacement of nickel frames after 12 months, if the member has a documented allergy to nickel demonstrated by skin irritation and wearing down of the frame in the affected area.
- Ocular prostheses, including artificial eyes and lenses.

Prior authorization from the plan is not required for covered services provided by network providers.

Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas New Hampshire members may receive laboratory services from laboratories at our contracted hospital facilities and hospital-affiliated physician groups. The Centers for Medicare and Medicaid Services (CMS) CLIA regulations apply to laboratory testing in all settings including commercial, hospital and physician office laboratories. Claims submitted for laboratory services without the appropriate Clinical Laboratory Improvement Amendments (CLIA) Identification number will be denied.

Also, AmeriHealth Caritas New Hampshire has made an agreement with the following commercial laboratory:

Laboratory	Type	Phone	Website
Quest Diagnostics	**General lab services**	**See website for locations and contact information**	**www.questdiagnostics.com**

To quickly establish an account with one or more of these labs please visit the websites listed above. For more information about individual labs, please visit their website.

- Network Physicians are encouraged to perform venipuncture in their office whenever possible.
- Providers should contact the laboratory provider in question to arrange a pick-up service.
- AmeriHealth Caritas New Hampshire highly recommends that pre-admission laboratory testing be completed by the PCP. However, testing can be completed at the hospital where the procedure will take place and does not require a referral from AmeriHealth Caritas New Hampshire.
- **STAT labs must only be utilized for urgent problems**. The ordering physician may give the member a prescription form or AmeriHealth Caritas New Hampshire procedure confirmation form to present to the participating facility.

Hospice Services

A hospice provides palliative and supportive services to meet the physical, psychological, social, and spiritual needs of a terminally ill member, including the family or other persons caring for the member regardless of where the member resides. Below are some covered hospice services:

- Nursing Care.
- Medical Social Services.
- Physician Services.
- Counseling Services.
- Short-Term Inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards.
- Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the member's terminal illness and related conditions.
- Physical therapy, occupational therapy, and speech-language pathology.

Hospice Services in a Nursing Facility

Hospice services can occur in the home or in a nursing facility. When services occur in a nursing facility, the facility can be considered the residence of the member. When the member resides in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all the following conditions are met:

- The member is terminally ill.
- The member has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

Notification and Coverage for Hospice Benefits

AmeriHealth Caritas New Hampshire covers hospice services provided to members who are certified as terminally ill when there is no Part A, commercial, or any other coverage. The member must have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and the member must elect hospice care rather than active treatment for the illness.

When a member needs hospice services – including home hospice, inpatient hospice, continuous care, and respite – the primary care practitioner, attending physician, or hospice agency must notify the AmeriHealth Caritas New Hampshire Utilization Management department at **1-833-472-2264**. The Plan will coordinate the necessary arrangements between the primary care practitioner and the hospice provider to assure continuity and coordination of care.

It is the responsibility of hospice to obtain certification from the physician that the member is terminally ill.

Interpretation and Translation Services

Interpretation and translation services for members for whom English is not their primary language, and services for the hearing and visually impaired are provided at no cost to AmeriHealth Caritas New Hampshire members. To access any of these services, members may contact Member Services toll-free at: **1-833-704-1177**.

SECTION IV
Population Health Program

IV. Population Health Program

The following information is regarding AmeriHealth Caritas New Hampshire's Population Health program, which includes an integrated model of Care and Disease Management and Care Coordination for physical and behavioral health services provided to Plan members.

Population Health Overview

The Plan's Population Health program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution, the Plan delivers and coordinates care across all programs.

The Population Health program includes assessment, education, and other care planning, as well as service coordination. The Population Health program also incorporates health and wellness self-management education. All members in the Population Health program are screened for social determinants of health (SDoH). The program is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management. The Population Health process also includes reassessing and adjusting the person- centered care plan and its goals as needed. The Population Health program uses evidence- based practice guidelines.

AmeriHealth Caritas New Hampshire's Population Health team includes nurses, licensed clinical social workers, licensed mental health professionals, Care Connectors, clinical pharmacists, Plan medical directors, primary care providers (PCPs), specialists, as well as members and caregivers, local care management networks (LCMNs), parents, or guardians. This team works to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes. Our Population Health program applies to all AmeriHealth Caritas New Hampshire's members.

AmeriHealth Caritas New Hampshire will provide the care management services directly to our members. Members who have frequent hospital admissions, readmissions, and complex needs, including both physical and behavioral, or are difficult to contact via telephone may be engaged in high- touch, face-to-face care management services through a community-based team of registered nurses, licensed social workers, and community health workers to help them navigate and increase their access to needed medical, behavioral health, and social services. The care management team also supports the development of member self-management skills through encouragement and coaching for chronic disease management.

In addition to improving the care and health outcomes of members, this community-based team provides valuable information for, and coordination with, other health plan staff and services, as well as advancing integrated care through a person-centered approach and close collaboration with other providers, agencies, and caregivers in the community.

Population Health Components

There are seven core components of our Population Health program:

- Behavioral Health and Substance Use Disorder Care Management.
- Pediatric Preventive Health Care.
- Bright Start® (Maternity Management).
- Rapid Response and Outreach Team (RROT).
- Transitional Care Management.
- Complex Care Management (CCM).
- Social Needs Care Coordination.

Pediatric Preventive Health Care – EPSDT

This program is designed to improve the health of members under the age of 21 years by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. This is accomplished by identifying and coordinating preventive services for these members. Program approach combines scheduled member outreach and point-of- contact notification for Plan staff and providers when a member is due or overdue for an EPSDT service.

Bright Start® (Maternity Management)

This program is designed to assist expectant mothers by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG). As pregnant members are identified by new member assessments, claims data, routine member outreach, and provider reporting, Plan staff work to ensure that each pregnant member is aware of the services and support offered through the Bright Start® program.

Under this program and State guidelines, prenatal care providers are expected to complete the AmeriHealth Caritas New Hampshire Obstetrical Needs Assessment Form (ONAF) for each expectant mother and submit it to the Plan as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the

member and to develop appropriate action items in collaboration with the member to resolve the identified risks.

Rapid Response and Outreach Team (RROT)

This team is designed to address the needs of members in accessing needed health care by identifying and decreasing barriers to such care. The RROT also gives support to providers and their staff, providing assistance and follow-through for members experiencing barriers to their health care. This team performs four functions on behalf of Plan members and providers:

- Receiving inbound calls from members and providers.
- Conducting outreach activities.
- Conducting Health Risk Assessments (HRAs) and Social Determinant of Health screenings.
- Providing care coordination support to address barriers to care.
- Coordinating value added services.

Members and providers may request RROT support by calling **1-833-212-2264**.

Transitional Care Management

This program coordinates services for adult and pediatric members with transitions of care needs. Program staff includes Care Managers who are licensed registered nurses (RN), licensed clinical social workers (LICSW) or licensed mental health professionals. Program staff supports members by providing resolution for issues relating to access, care coordination, and follow up-care with the provider after hospital discharge. Program staff will monitor a member's condition(s) for a short-term period, if program staff feels the member's condition requires long term/complex care; a referral is made to program staff in Complex Care Management (CCM).

Care Management

This program serves members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of person-centered prioritized goals that are incorporated into the person-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and/or other participant of the member's choice, and the member's primary care provider (PCP) and supporting service providers when applicable and with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN), licensed clinical social workers (LICSW) or licensed mental health professionals.

Members in the Care Management program are screened for the following as part of standard protocol:

- **All AmeriHealth Caritas New Hampshire members receive a comprehensive initial assessment that meets NCQA requirements.**
- Adolescents ages 11 through 17 and adult members ages 18 years and older receive a depression screening to assess for symptoms of depression. Based on the depression score, the member is offered education and referred to the appropriate behavioral health services.
- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

Social Needs Care Coordination

Triggered through ongoing data mining combined with in-person referrals, Care Coordination programs address member's health care needs while assessing for and addressing social needs and barriers and providing hands-on coordination.

Program Participation

Participation in the Population Health program is offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified for specific Population Health needs upon joining the Plan through systematic risk stratification and Department identified priority populations. Members are also identified through material and telephonic outreach by the Plan. Members are encouraged to let the Plan know if they have a chronic health condition, special health need, or if they are receiving on-going care. A new member assessment is included in the members' welcome packet to identify current health conditions and health care services. Based upon their responses to the initial health assessment, members are identified for participation in the appropriate care management program.

Let Us Know Program

Providers are encouraged to refer members to the Population Health program as needs arise or are identified. We have many levels of support and tools available to assist in the outreach and education of our members, as well as clinical resources for providers in their care management.

We encourage you to contact the RROT at **1-833-212-2264**, or download a member intervention request form from www.amerihealthcaritasnh.com and fax to our RROT fax line, to let us know about members who are in need of:

- Assistance locating a specialty provider.
- A pharmacy consult on controlled substances.
- Education about plan benefits and resources.
- Assistance with appointment scheduling.
- Support with resources identified through Social Determinant of Health (SDoH) screening.
- SDoH resource follow-up (e.g., for transportation, food pantry, housing applications, etc.)

You may call our Care Management department at **1-833-212-2264** to refer a member who needs assistance with the following:

- Education about health conditions.
- Screening for mental health or substance use services.
- Crisis follow-up resources (e.g., recent suicide attempt or bereaved after a death by suicide).

Members are also referred to the Population Health program through internal Plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses).
- Risk score indicating over- or underutilization of care and services.
- Pediatric members requiring assistance with EPSDT.
- Pediatric members in foster care or receiving adoption assistance.
- Infants receiving care in the NICU.
- Members with dual medical and behavioral health needs.
- Members with substance use disorder-related conditions.
- Members who are developmentally or cognitively challenged.
- Members with a special health care need.
- Pharmacy consults on controlled substances.
- Pregnant members.
- Members with high trauma exposure
- Members in need of long-term services and supports to avoid hospital or institutional admission.
- Members re-entering the community from the correctional system.
- Screening for mental health or SUD services.
- Assistance with community resources.

Care Management is a voluntary program focused on prevention, education, lifestyle choices and adherence to treatment plan and is designed to support a person-centered plan of care for people such as persons living with chronic diseases including asthma, depression, diabetes, and/or coronary artery disease, those living with trauma exposure, and/or those with unmet social needs.

Care Coordination with the PCP

AmeriHealth Caritas New Hampshire recognizes that the PCP is the cornerstone of the member's care coordination and delivery system. Our care management staff contacts each PCP during a member's initial enrollment into the chronic care management program, as part of the comprehensive assessment and person-centered plan of care development process.

Program staff creates the member's person-centered plan of care, in coordination with the member's care team. Program staff complements the PCP's recommendations in the development of an enhanced and holistic plan of care specific to the member's needs. The Care Manager remains in close communication with the PCP, particularly during the implementation of the plan of care, should issues or new concerns arise.

Care Coordination with Other Providers

Program staff also contact the member's key and/or current providers of care, such as the member's behavioral health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Program staff may also engage key providers to be part of the development of the person-centered plan of care if the member agrees. As the member is reassessed, a copy of the care plan goals is supplied to both the provider and member.

Integrating Behavioral and Physical Health Care

Members with mental health and substance use disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas New Hampshire understands that coordination of care for these members is imperative. To meet their needs, AmeriHealth Caritas New Hampshire has a fully integrated Care Management department. Under this collaboration, the Plan's integrated platform will help to seamlessly coordinate member care across the physical and behavioral health and social service areas.

Plan staff will work with the involved primary care and behavioral health providers to develop an integrated plan of care for members in need of physical and behavioral health care

coordination. Care Managers will also work to assure that communication between the two disciplines, providers and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers will also work to coordinate with substance use disorder providers and community resources with the appropriate member consent as needed. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning, and provider-to- provider communication to ensure that member needs are continuously reviewed, assessed, and updated.

Person-Centered Plan of Care

Through the Population Health program, AmeriHealth Caritas New Hampshire works with practitioners, members, and their natural supports and outside agencies as appropriate to develop a person-centered plan of care for members with special or complex health care needs. Our methodology is to empower members to take the lead in identifying and prioritizing their goals and interventions. AmeriHealth Caritas New Hampshire's plan of care specifies mutually agreed-upon goals, medically necessary physical and behavioral health services, as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The person-centered plan of care also considers the cultural values, and any special communication needs of the

member, family, and/or the child. Additionally, social determinants of health as identified by the member are addressed.

AmeriHealth Caritas New Hampshire care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

AmeriHealth Caritas New Hampshire also utilizes EPSDT guidelines in the development of treatment plans for members under age 21. AmeriHealth Caritas New Hampshire works with practitioners to coordinate care with other treatment services provided by State agencies.

Through AmeriHealth Caritas New Hampshire's Population Health program, the member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to ensure that members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. To make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether AmeriHealth Caritas New Hampshire provides coverage for those treatments.

Person-centered plans of care for members with special health care needs are reviewed and updated at every contact, and at least quarterly, or as determined by the member's PCP based on the PCP's assessment of the member's health and developmental needs. The person-centered plan of care will also be updated when a member's circumstances or needs change significantly, at the member's request, when a re- assessment occurs, and upon DHHS's request. The revised plan of care is expected to be incorporated into the member's medical record following each update.

Coordinating Care through Transitions and Discharge Planning

One of the most important functions of a managed care organization is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab.
- Changes in health status due to presentation of a new chronic, sometimes life-threatening, condition.
- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition.
- Changes in a living situation to obtain more independence or because of a need for greater support; or,
- Caregiver and family changes.

During inpatient transitions, members are supported through the Population Health department. Members receive, at minimum 3 outreach calls, starting within 24-48 business hours of discharge. These calls are strategically placed to ensure the member has the appropriate resources in place and has a follow-up appointment scheduled and kept with their provider.

Priority Populations

New Hampshire DHHS considers the following as Priority Populations and most likely to have care management needs:

- Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous twelve (12) months Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS) Individuals with

behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval Individuals with high unmet resources needs (e.g., members who are homeless, experiencing domestic violence or perceived lack of personal safety, and/or demonstrate unmet resource needs.

- Other Priority Populations as determined by the Plan and/or by DHHS.

Behavioral Health Crisis Line

AmeriHealth Caritas New Hampshire supports a statewide crisis line. If you have a patient experiencing a behavioral health emergency or mental health crisis, call or text the toll-free NH Rapid Response Access Point (**1-833-710-6477**) anytime day or night. Crisis response services are available over the phone or face-to-face 365 days a year, seven days a week, 24 hours per day.

AmeriHealth Caritas New Hampshire plans to promote the use of this new system through its care management, provider, and member outreach programs. AmeriHealth Caritas New Hampshire will also utilize other methods of crisis intervention including **211, 1-800-273-TALK** and CMHC crisis programs for members in their catchment areas.

Recovery Care Team

The AmeriHealth Caritas New Hampshire Recovery Care Team (RCT) is a regional, community-based team of SUD professionals who support local care managers and LCMNs in addressing the needs of members at emerging risk for SUD, SUD relapse, or recent overdose. Overseen by an SUD Coordinator, this specialized team comprises clinical care managers, Certified Recovery Supports Workers (CRSWs), community health navigators, utilization management staff, RROT team members, and provider relations specialists. The Recovery Care Team will provide education on benefits, and assistance with addressing unmet needs that may impact recovery and ED utilization. Providers may contact the Recovery Care Team at **1-833-212-2264**.

Health & Lifestyle Education

AmeriHealth Caritas New Hampshire PCPs are expected to provide Plan members with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas New Hampshire will support Plan providers in this effort by developing and distributing State-approved health education materials for Plan members, from time to time and as needed to address specific health education needs.

Additionally, AmeriHealth Caritas New Hampshire PCPs are expected to help educate Plan members regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, mental health care, and substance use disorder services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the member's age, culture, and conditions.
- For Granite Advantage members, education about the work requirement and identifying resources, including direction to AmeriHealth Caritas New Hampshire for further education and referrals.

Health Homes

Health Homes serve as a comprehensive health management system to improve access to primary and urgent care services as well as behavioral health and supportive community services, such as housing, employment, and food access. AmeriHealth Caritas New Hampshire will partner with providers and organizations across the continuum of care to develop Health Homes

AmeriHealth Caritas New Hampshire offers individualized practice transformation support to help providers achieve, maintain, and enhance their Health Home status. This support includes:

- Initial support: collaboration on best practices, step-by-step guidance, and gap analyses.
- Ongoing growth: frequent education and training on the patient-centered medical home (PCMH) program and access to performance data.
- Provider toolbox: microsite where providers can access our online PCMH resources and tools free of charge to assist with transformation, recognition, and ongoing performance improvement.

SECTION V
UTILIZATION MANAGEMENT

V. Utilization Management

The AmeriHealth Caritas New Hampshire Utilization Management (UM) program establishes processes for an effective, efficient utilization management system. Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage. AmeriHealth Caritas New Hampshire will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member. AmeriHealth Caritas New Hampshire does not reward health care professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas New Hampshire reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued, and the service was provided.

Per the provider agreement with AmeriHealth Caritas New Hampshire, providers are required to comply fully with the Plan's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Involving the Plan's medical management nurse and/or licensed clinician in discharge planning discussions and meetings.
- Providing the Plan with copies of plan of treatment, progress notes, and other clinical documentation, as required.

Prior Authorization Policy and Procedure

1. Applies to all services and providers except pharmacy. Pharmacy providers must follow prior authorization processes with the Plan regardless of network status.

2. Prior authorizations with AmeriHealth Caritas New Hampshire are required for certain services for participating providers. Please refer to the list of services that require prior authorization in this manual. For out of network providers, prior

authorization is required for all services except emergency services. Prior authorizations must be submitted within one (1) business day.

3. AmeriHealth Caritas New Hampshire has a Prior Authorization call center available for prior authorization requests and education. Our Prior Authorization call center is open Monday – Friday, 8:00 am to 5:00 pm ET. Please call 1-833-472-2264 to reach our Utilization Management department.

4. After hours and on weekends and holidays, please call the AmeriHealth Caritas New Hampshire Member Services department at 1-833-704-1177to be connected with the on-call prior authorization nurse or licensed clinician. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.

5. For members new to AmeriHealth Caritas New Hampshire, we will cover a member's medical or behavioral health condition that is currently being treated or a prior authorization has been issued for 60 calendar days after the member's effective date or until the member's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the member's treatment plan, whichever comes first.

6. If the member is pregnant and in her first trimester at the time of enrollment we will cover her through the end of her first trimester. If a member is pregnant and in her second or third trimester at the time of enrollment we will cover her through the duration of their pregnancy and postpartum care period (60 days of postpartum care).

7. For members new to the Plan, AmeriHealth Caritas New Hampshire will receive a list of existing prior authorizations for its members and will have a record of those on file.

8. AmeriHealth Caritas New Hampshire will pay claims according to the following timeframes for both in-network and out-of-network providers:

    a. Pay or deny 95 percent of all clean claims within 30 calendar days of receipt, or receipt of additional information,
    b. Pay 99 percent of all clean claims within 90 calendar days of receipt.

9. AmeriHealth Caritas New Hampshire may conduct retrospective reviews of claims for services that did not receive prior authorization to ensure medical necessity.

10. AmeriHealth Caritas New Hampshire may recover payments from providers for reimbursed services determined not to be medically necessary.

11. AmeriHealth Caritas New Hampshire offers information on its prior authorization

policies to reduce the risk of recovery for claims paid when the service is determined to not be medically necessary. Prior Authorization requirements are listed in detail in this section of the *Provider Manual*, and in the new provider orientation program.

12. Determination of lack of medical necessity is considered an adverse determination and may be appealed through the provider appeals process. For more information on the provider appeals process, please refer to the "Provider and Network Information" section of this *Provider Manual*.

13. AmeriHealth Caritas New Hampshire will provide comprehensive, ongoing provider training and outreach to contracted providers. Training will include prior authorization and billing processes to help providers treating our members to avoid delays in payment or member service delivery.

14. AmeriHealth Caritas New Hampshire offers additional training materials on its website and these materials are accessible for both in-network and out-of-network providers.

Prior Authorization Contact Information

The most up-to-date list of services requiring prior authorization will be maintained in the provider section of our website at www.amerihealthcaritasnh.com. The Plan's UM department hours of operation are 8:00 a.m. to 5:00 p.m. ET, Monday through Friday except for State of New Hampshire holidays. The UM departments can be reached at:

- UM Telephone: **1-833-472-2264.**
- UM Prior Authorization Fax:**1-833-469-2264.**
- UM Concurrent Review Fax:**1-833-468-2264.**

For prior authorizations after hours, weekends and holidays, call Member Services at **1-833-704-1177**.

Services Requiring Prior Authorization

- In the case of a medical emergency ("medical emergency" means to encompass significant health risks namely those circumstances in which a pregnant women's life or a major bodily function is threatened). Prior authorization from the plan is not required for services provided by a network provider.
- Air ambulance services.
- All out-of-network services (with exception of services listed under Services that Do Not Require Prior Authorization).

- All unlisted miscellaneous and manually priced codes (including, but not limited to, codes ending in "99").
- Audiology
  - Hearing aid evaluation or hearing aid consultations are limited to 1 service every 2 years for age 21 and over since the last date of service and as needed for members under age 21.
  - Hearing Aids: Prior authorization is required if over $750 for members under age 21. For members over age 21, prior authorization is required regardless of cost.
- Behavioral health.
  - Mental health inpatient (IP) admissions.
  - Transcranial and vagus nerve stimulation.
  - Electroconvulsive therapy.
  - Mental health partial hospitalization program.
  - Mental health intensive outpatient program.
  - Psychological testing and neuropsychological testing. *
- Cochlear implantation.
- Contact lenses (including dispensing fees).
- Gastric bypass/vertical band gastroplasty.
- Genetic testing/Molecular Labs.
- Hyperbaric oxygen.
- Hysterectomy (Hysterectomy Consent Form required).
- Medicaid-covered abortions.
  - Abortion services:
    - ACNH covers abortion services only as follows:
      - Prior to 24 weeks of gestation:
      - If the pregnancy is the result of rape or incest; or
      - In the case of a woman who has a physical disorder, physical injury, or physical illness (including a life-endangering physical condition caused by or arising from the pregnancy itself) that would, as certified by a physician, endanger the life of the woman unless an abortion is performed. At or after 24 weeks of gestation.
- Medical Pharmacy which include Medical Oncology
- Implants (over $750), including, but not limited to, breast implants and pacemakers.
- Intensive community-based services.
- Transplants, including transplant evaluations.
- Elective procedures, including, but not limited to*, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, laparoscopic/exploratory surgeries.

Plastic surgery

Surgical services that may be considered cosmetic, including, but not limited to:

- Blepharoplasty.

- Mastectomy for gynecomastia.
- Mastopexy.
- Maxillofacial (all codes applicable).
- Panniculectomy.
- Penile prosthesis.
- Plastic surgery/cosmetic dermatology.
- Reduction mammoplasty.
- Septoplasty.
- Breast reconstruction not associated with a diagnosis of breast cancer.

Durable medical equipment (DME)

- Items with billed charges equal to or greater than $750.
- DME leases or rentals and custom equipment.
- Diapers/pull-up diapers (age 3 and older) for amounts over 300 per month.
- Select Enteral nutritional supplements.*
- Prosthetics and custom orthotics.
- All unlisted or miscellaneous items, regardless of cost.
- Negative pressure wound therapy.

Inpatient

- All inpatient hospital admissions, including medical, surgical, skilled nursing, long-term acute, and rehabilitation. Providers will be asked to notify AmeriHealth
- Caritas New Hampshire within one business day of admission.

Behavioral health.

- Inpatient psychiatric treatment at New Hampshire Hospital and other State determined IMDs for mental illness, conduct authorization for services as follows:
  i. For a Member's initial admission, an automatic five (5) business days (excluding holidays) shall be authorized for the Member's initial involuntary emergency psychiatric admission to an IMD facility.
  ii. Reauthorization of the Member's continuous admission shall be rendered promptly within 24 hours of the request for reauthorization of the initial involuntary emergency psychiatric admission.
- Obstetrical admissions: newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section.
- Medical detoxification.
- Elective transfers for inpatient and/or outpatient services between acute care facilities.

- Long-term care initial placement (while enrolled with the Plan).

Home-based services

- Therapy (physical, occupational, and speech therapy) after 20 combined visits, regardless of modality, per fiscal year.
- Skilled nursing after 18 visits, per fiscal year.
- Home infusion services and injections (required from start of service) (see pharmacy list of HCPCS codes that require prior authorization).
- Home health aide services (required from start of service).
- Private duty nursing (extended nursing services) (required from start of service),
- Personal care services (required from start of service).

Outpatient therapy (physical, occupational, or speech)

- Prior authorization is required after the 20th visit per modality, per fiscal year (7/1 to 6/30) and not per provider; benefit limit for members age 21 and older is 20 visits per modality per fiscal year. To help ensure you do not receive a denial for services because of failure to request prior authorization beginning with the 21st visit, we encourage you to notify us of the first 20 visits so we can track them in our system. You can notify us by calling **1-833-472-2264**, faxing **1-833-469-2264**, or submitting notification via the provider portal.

Pharmacy and medications

- Contact PerformRx℠ at **1-888-765-6394**.

Pain management

- External infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation, nerve blocks, and epidural steroid injections.

Select Surgical Services

- Knee joint Surgery
- Spinal Surgeries

***NOTE: Specific authorization requirements per code can be found at:https://www.amerihealthcaritasnh.com/provider/resources/prior-authorization-lookup.aspx**

Delegated Services

Advanced outpatient imaging services

- The following services, when performed as an outpatient service, require prior authorization by AmeriHealth Caritas New Hampshire's radiology benefits vendor, Evolent.
    - Nuclear cardiology.

- Computed tomography angiography (CTA).
- Coronary computed tomography angiography (CCTA).
- Computed tomography (CT).
- Magnetic resonance angiography (MRA).
- Magnetic resonance imaging (MRI).
- Myocardial perfusion imaging (MPI).
- Positron emission tomography (PET).

PerformRX: Select prescription medications Contact PerformRx℠.

- Medicaid State Plan services and/or pharmaceutical Prior Authorizations, including those for specialty drugs, in place at the time a Member transitions to an MCO shall be honored for ninety (90) calendar days or until completion of a medical necessity review, whichever comes first.

  To request prior authorization, contact AmeriHealth Caritas New Hampshire's advanced outpatient imaging services vendor Evolent via their provider web portal at www.radmd.com or by calling 1-800-424-4784 Monday through Friday 8:00 a.m. – 8:00 p.m. (EST).

  The ordering physician is responsible for obtaining a prior authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by Evolent and the ordering physician should have this information available at the time of the call.

  Weekend, Holidays and After-Hours PA Requests*
  Requests can be submitted online – The Evolent website is available 24 hours a day to providers.

  Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to Evolent and a message may be left at 1-800- 424-4784, which will be retrieved the following business day.

  Requests left on voice mail:
  Evolent will contact the requesting provider's office within one business day of retrieval of the voice mail request to obtain necessary demographic and clinical information to process the request.

  *Evolent's hours are 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday, excluding holidays

  Emergency room, observation care, and inpatient imaging procedures do not require prior authorization.

Services that Do Not Require Prior Authorization

The following services will not require prior authorization from AmeriHealth Caritas New Hampshire:

- Emergency room services (in network and out of network).
- 48-hour observations (except for maternity — notification required).
- Low-level plain films — X-rays, electrocardiograms (EKGs).
- Family planning services.
- Post-stabilization services (in network and out of network).
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
- Women's health care by in-network providers (OB/GYN services).
- Routine vision services.
- Post-operative pain management (must have a surgical procedure on the same date of service).
- Medication-assisted treatment (MAT).
- Licensed opioid treatment programs.
- Mental Health outpatient and medication management services.
- Substance Use Disorder services including Peer Support Services.
- Skilled Nursing visits: allowance for up to six (6) per benefit period.

Services that Require Notification

Providers will be asked to notify AmeriHealth Caritas New Hampshire within one business day of when the following services are delivered:

- Maternity obstetrical services (after the first visit) and outpatient care (includes48-hour observations).
- All newborn deliveries.
- Continuation of covered services for a new member transitioning to the Plan the first 90 calendar days of enrollment.

For **certain behavioral health services**, notification is required:

- Crisis Intervention: Notification required within 2 business days post service.

- American Society of Addiction Medicine (ASAM) Levels of Care: Notification is required at time of admission.
  - Level 1- Withdrawal Management: Ambulatory Withdrawal Management Without Extended On-Site Monitoring.
  - Level 2- Withdrawal Management: Ambulatory Withdrawal Management With Extended On-Site Monitoring.
  - Level 2.1- SUD Intensive Outpatient Services.
  - Level 2.5- SUD Partial Hospitalization Services.
  - Level 3.1- Clinically Managed Low-Intensity Residential Services.

- Level 3.2- WM: Clinically Managed Residential Withdrawal Management
- Level 3.3- Clinically Managed Population-Specific High-Intensity Residential Services.
- Level 3.5- Clinically Managed High-Intensity Residential Services.
- Level 3.7- Medically Monitored Intensive Inpatient Services.
- Level 4- Medically Managed Intensive Inpatient Services.
- ACNH BH UM will provide an initial two-week authorization for SUD PHP
- SUD PHP providers will need to request additional time for services beyond the initial two-week authorization.

- Court-ordered Treatment Services:
  - ACNH pays for all New Hampshire Medicaid State Plan services, delivered at an appropriate level of care, to include assessment and diagnostic evaluations for its members as ordered by any court within the State.

ACNH does not impose any prior authorization requirements for medication assisted treatment (MAT) urine drug screenings (UDS) unless a provider exceeds 30 UDS per month per treated member. ACNH will impose prior authorization requirements in the event a provider exceeds 30 UDS per month per treated member.

Providers can notify us by:

- Calling Utilization Management at **1-833-472-2264.**
- Faxing Utilization Management at **1-833-469-2264.**
- Submitting notification via the provider portal.

For hospital providers who have members in an emergency room or medical unit while awaiting admission to a Designated Receiving Facility or New Hampshire Hospital, notification of the addition to the waitlist is required immediately by calling Member Services at **1-833-704-1177**.

Submit claims and all appropriate forms to:

Claim Processing Department
AmeriHealth Caritas New Hampshire
P.O. Box 7387
London, KY 40742-7387

Benefit Determinations

A benefit determination is any determination (i.e., approval or denial) by AmeriHealth Caritas New Hampshire regarding the benefits a member is entitled to receive from the Plan. Examples include:

- Payment for emergency services, post-stabilization care, or urgently needed

services.

- Payment for any other health service furnished by a non-contracted provider and the member believes:
  - The services are covered under Medicaid program; or,
  - If not covered under the Medicaid program, should have been furnished, arranged for or reimbursed by AmeriHealth Caritas New Hampshire.
- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the member believes should be furnished, arranged for, or reimbursed by the Plan.
- Reduction or premature discontinuation of a previously authorized on-going course of treatment.
- Failure of the Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of the member.
  Service authorization decisions not reached within the timeframes specified in §438.210(d) constitute a denial and are thus an adverse benefit determination once the timeframes expire.

The procedures for appealing an organization determination are described in the "Member Grievances, Appeals, and Fair Hearings" section of this *Provider Manual*.

Standard Determination Decision Turnaround Time

AmeriHealth Caritas New Hampshire must notify the member of its determination as expeditiously as the member's health condition requires, or no later than 14 calendar days after AmeriHealth Caritas New Hampshire receives the request. For adverse standard authorization decisions, written notification will be provided within three calendar days of the decision.

The timeframe may be extended up to 14 additional calendar days if:

- The provider or the member requests an extension; and,
- The Plan justifies the need for additional information and the extension is in the member's best interest.

The member's physician may request an expedited determination, including authorizations, from AmeriHealth Caritas New Hampshire when the member or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

In situations where a provider indicates or AmeriHealth Caritas New Hampshire determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, AmeriHealth Caritas New Hampshire will make an expedited authorization decision and provide notice as expeditiously as

the member's health condition requires and no later than 72 hours after receipt of the request for service.

If the member or member's representative fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, AmeriHealth Caritas New Hampshire will, within 24 hours of the receipt of the request, advise the member or member's representative of the specific information necessary to make the determination. AmeriHealth Caritas New Hampshire will allow the member or member's representative at least 48 hours to provide the specified information, and will provide notification of the determination as soon as possible but not later than 48 hours after the receipt of the specified additional information or the end of the period afforded the member or member's representative to furnish the additional information, whichever is earlier.

Untimely service authorizations constitute an Adverse Benefit Determination, and the Health Plan treats these as appealable adverse actions. An Adverse Benefit Determination will be issued if a determination or need for an extension is not communicated to the provider within the required time frames.

For authorizations involving urgent care and relating to the extension of an ongoing course of treatment and involving a question of medical necessity, AmeriHealth Caritas New Hampshire will make a determination within 24 hours of receipt of the request as long as the request is made at least 24 hours prior to the expiration of the prescribed period of time or course of treatment.

If AmeriHealth Caritas New Hampshire requires additional information to make a determination, the member or member's representative will be given at least 45 calendar days from receipt of the notice to provide the information.

Urgent Determination and Continued/Extended Services Decision Turnaround Time

Medical Necessity of Services
For members 21 years of age and older "Medically Necessary" or "Medical Necessity" is defined as services that a licensed provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, or disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the member's illness, injury, disease, or symptoms.

- Not primarily for the convenience of the member or the member's family, caregiver, or health care provider.
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the member's illness, injury, disease, or its symptoms.
- Not experimental, investigative, cosmetic, or duplicative in nature [He-W 530.01(e)].

Per EPSDT for members under twenty-one (21) years of age, "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid state plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions. The need for the item or service must be clearly documented in the member's medical record.

AmeriHealth Caritas New Hampshire uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

- New Hampshire Department of Health and Human Services
- New Hampshire Medicaid Provider Manuals
- InterQual® Adult Criteria (Condition Specific – Responder, Partial Responder, Non-responder).
- InterQual® Pediatric Criteria (Condition Specific – Responder, Partial Responder, Non-responder).
- InterQual® Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual® Home Care Criteria.

InterQual® Procedures.

- e InterQual® DME Criteria.
- InterQual® Long-Term Acute Care (LTAC) Criteria
- InterQual® Rehabilitation (Acute Rehab) Criteria
- InterQual® Subacute/SNF Criteria
- InterQual© Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
- InterQual© Criteria for Behavioral Health Child and Adolescent Psychiatry Criteria
- InterQual© Criteria for Behavioral Health Residential and Community Based Treatment
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
- InterQual©Behavioral Health Substance Use Disorders
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
- American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines

- Corporate Clinical Policies
- Evolent Radiology Guidelines
- Other program-specific criteria as based upon program requirements.

When applying these criteria, Plan staff also consider the individual member factors and the characteristics of the local health delivery system, including:

Member Considerations

- Age, comorbidities, complications, progress of treatment, psychosocial situation, social determinants of health, home environment, and compliance with parity in mental health and Substance Use Disorder treatment.

Local Delivery System

- Availability of sub-acute care facilities or home care.
- AmeriHealth Caritas New Hampshire service area for post-discharge support.
- AmeriHealth Caritas New Hampshire benefits for sub-acute care facilities or home care where needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.
- Availability of the medically necessary behavioral health level of care.

Any request that is not addressed by or determined to not meet medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Vice President of Population Health Medical Services.

Medical Necessity decisions made by the Plan's Medical Director or designee are based on the above definition of medical necessity, in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas New Hampshire medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

Upon request by a member or practitioner/provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee.

The Utilization Management staff involved in medical necessity decisions is assessed quarterly, and physicians involved in medical necessity decisions are assessed semi- annually for consistent application of review criteria. An action plan is created and implemented for any variances among staff outside of the specified range. Both clinical and non-clinical staff members are audited for adherence to policies and procedures.

Peer-to-Peer Review Telephone Line

To discuss a medical determination with a physician in the AmeriHealth Caritas New Hampshire Medical Management department before filing an appeal, providers may reach the Peer-to-Peer telephone line by following the prompts at **1-833-472-2264**. Providers must call within five business days of notification of the determination. AmeriHealth Caritas New Hampshire will provide peer-to-peer review in a timely manner before the provider seeks recourse through the provider appeal or State fair hearing process.

Note: The purpose of the Peer-to-Peer Review process is to address ***medical determinations*** regarding health care services. This process is not intended to address denied claims or other issues. For information on appealing a claim, please refer to the "Provider and Network Information" section of this *Provider Manual.*

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call **1-833-704-1177** and follow the prompts**.**

SECTION VI
Member Grievances, Appeals, and State Fair Hearings

VI. Member Grievances, Appeals, and State Fair Hearings

Grievance Process

If a member has a concern or question regarding the health care services they have received under AmeriHealth Caritas New Hampshire, they should contact Member Services at the toll-free number on the back of the member ID card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance**.**

A *grievance* expresses dissatisfaction about any matter other than an *action* by AmeriHealth Caritas New Hampshire. (See examples of *actions* in the Appeals Process section below.) A grievance is usually submitted by a member and is not generally related to a claims payment. The member may file a grievance in writing or by telephone at the information below. It may be filed at any time either orally or in writing. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the member with the member's written consent.

A grievance may be filed about issues such as the quality of the care the member receives from AmeriHealth Caritas New Hampshire or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas New Hampshire, dispute of an extension of time AmeriHealth Caritas proposed to make an authorization decision, violation of member rights as afforded by New Hampshire law, the belief that mental health or SUD benefits are not being provided by AmeriHealth Caritas New Hampshire, or any service or item that did not meet accepted standards for health care during a course of treatment.

To file a grievance:

Member Services Hours of Operation: 24 hours per day, 7 days per week.
Telephone Member Services: 1-833-704-1177; TTY: 1-855-534-6730

Write To:

AmeriHealth Caritas New Hampshire
Attn: Complaints and Grievances
PO Box 7389
London, KY 40742-7389

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services and, if needed, interpretation services will be made available to the member free of charge. AmeriHealth Caritas New Hampshire will send the member a letter acknowledging receipt of the grievance unless

the member or authorized provider requests expedited resolution. The Plan will send a decision letter within 30 calendar days of receiving the request. If the member requests an

extension, or if the Plan shows that information is necessary and a delay would be in the member's interest, AmeriHealth Caritas New Hampshire may extend the timeframe up to 14 calendar days. If the timeframe is extended, the member will be given prompt oral notice of the delay and written notice within two calendar days.

Appeals Process

Adverse Benefit Determination

If AmeriHealth Caritas New Hampshire decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, or if the Plan fails to act in a timely manner, the member will receive a written "Adverse Benefit Determination." In most cases, the Adverse Benefit Determination will be sent within 10 calendar days of receipt of the request.

If the member does not agree with AmeriHealth Caritas New Hampshire's determination as outlined in the Adverse Benefit Determination, they may file an appeal. The member may ask an "authorized representative" (e.g., his/her physician (with the written consent of the member), a family member or friend) to file the appeal for them. The provider may also file the appeal, with the member's written consent. If the member is deceased, the legal representative of the deceased member's estate shall be a party to the Appeal.

A member may appeal any action taken by the Plan. Actions include but are not limited to the following examples:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner.
- Untimely service authorizations.
- Failure of the Plan to act within the timeframes set forth in its Agreement with NH DHHS or as required under 42 CFR 438 Subpart F.

The member, or an authorized representative with the written consent of the member, may ask for a State fair hearing after the appeals process has been exhausted. Additional information on requesting a fair hearing is available in this section of the *Provider Manual*.

Standard Appeal

A standard appeal asks AmeriHealth Caritas New Hampshire to review a decision about the member's care. The member must file an appeal within 60 calendar days from the Notice of Adverse Benefit Determination.

An Appeal Request Form will be sent to the member with the Adverse Benefit

Determination, or the member may access the form at www.amerihealthcaritasnh.com.

To file an appeal, the member or authorized representative may send a written appeal by completing the Appeal Request Form to:

AmeriHealth Caritas New Hampshire
Attn: Member Appeals Coordinator Member Appeals Department
PO Box 7389
London, KY 40742-0105

Or submit over the Telephone by calling:

AmeriHealth Caritas New Hampshire Member Services: **1-800-833-704-1177**; TTY: **1-855-534-6730** Member Services Hours of Operation: 24 hours per day, 7 days per week.

Provider appeals (on behalf of a member and with written consent): call **1-833-704-1177** and follow the prompts.

The review begins the day the Plan receives the oral or written request, whichever occurred first. The Plan will send a written acknowledgement to the member within five business days of receipt of the appeal. The Plan will provide a written notice of resolution of the appeal as expeditiously as the member's health condition requires and no later than 30 calendar days after receiving the appeal, whether oral or written, to make a decision regarding the matter. If the Plan fails to adhere to notice and timing requirements (noted above), then the member is deemed to have exhausted the Plan's appeals process and the member may initiate a State fair hearing.

Before the Plan makes a decision, the member and/or the person helping the member with the appeal may give information in writing or in person to AmeriHealth Caritas New Hampshire.

In some cases, the Plan, or the member may need additional time to obtain more information. The member may request up to 14 more days, or the Plan may have an additional 14 days if additional information is needed, and the delay is in the member's best interest. If the Plan needs more time, the Plan will:

- Make reasonable efforts to give the member prompt oral notice of the delay.
- Within two calendar days give the member written notice of the reason for the decision to extend the timeframe.
- Inform the member of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.
- Resolve the appeal as expeditiously as required by the member's health condition and no later than the date the extension expires.

The member may receive his/her file any time while AmeriHealth Caritas New Hampshire is reviewing the appeal. The member and his/her authorized representative may look at the case file. The member's estate representative may review the file after the member's death. The file may have medical records and/or other papers.

AmeriHealth Caritas New Hampshire will send the member or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas New Hampshire made its decision and the date the decision was made.

Expedited Appeal

If the time for a standard resolution could jeopardize the member's life, health or ability to attain, maintain or regain function, a member, or his/her authorized representative may request an expedited appeal orally or in writing. Note: Expedited appeals are for adverse benefit determinations pertaining to health care services only – not related to payment of claims.

To request an expedited appeal, the member or his/her authorized representative may call Member Services within 60 calendar days of the date on the notice of adverse benefit determination. The Plan will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal. AmeriHealth Caritas New Hampshire will acknowledge in writing the receipt of an expedited appeal request within 24 hours of receipt. If the request to expedite the appeal process is denied, the appeal will immediately be moved into the standard appeal timeframe of no longer than 30 calendar days and the member will be notified in writing within two business days of the denial for an expedited appeal request. The Plan will also attempt to provide prompt oral notice of the denial. The member may file a grievance if he or she does not agree with the decision to change the appeal timeframe to a standard appeal.

For expedited resolution of appeals, the Plan shall make a determination as expeditiously as the member's health condition requires but shall provide written notice, and make reasonable effort to provide oral notice, of resolution no later than 72 hours of receipt of the expedited appeal request unless the Plan determines an extension is necessary. The

Plan may extend the timeframes for expedited resolution of an appeal request by up to 14 calendar days if the member requests the extension, or the Plan determines that there is a need for additional information and the delay is in the member's interest. If the Plan needs more time, the member will be informed of the reason for the extension in writing. The Plan will also make reasonable efforts to provide oral notice.

For appeals not resolved wholly in favor of the member, the written notice shall include information about the right to request a State fair hearing, including how to do so and the right to request to receive benefits while the hearing is pending and how to make the request for benefits to continue while the hearing is pending. The written notice shall also

include notice that the member may be held liable for the cost of those benefits if the hearing upholds the Plan's action.

State Fair Hearings

The member or his/her authorized representative may seek a State fair hearing after the appeals process has been exhausted. Exhaustion of the Plan's appeals process includes circumstances in which the Plan fails to adhere to notice and timing requirements for appeals. The State fair hearing must be requested within 120 calendar days from the date of AmeriHealth Caritas New Hampshire's Appeal decision letter upholding the adverse benefit determination. A provider may also request a fair hearing on behalf of a member with the member's consent by written notice.

Members have the right to self-representation or to be represented by a family caregiver, legal counsel or other representative during a fair hearing. Parties to the fair hearing are the Plan and the member or his/her authorized representative, or the representative of a deceased member's estate.

Members can request a State fair hearing by calling the NH DHHS Administrative Appeals Unit at **1-603-271-4292** or **1-800-852-3345** extension 14292: or by sending a letter or an Appeal Request Form to:

Administrative Appeals Unit Address:

New Hampshire Department of Health and Human Services
105 Pleasant Street
Room 121C Concord, NH 03301

Continuation of Benefits

A member may continue to receive services while waiting for the AmeriHealth Caritas AmeriHealth Caritas New Hampshire appeal or the State fair hearing decision if all of the following apply:

- The appeal is filed timely as described above.
- The request for continuation of benefits is filed for within 10 calendar days of the date on AmeriHealth Caritas New Hampshire's decision, or before the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension, or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.

- The member has requested the services to continue, orally or in writing.

The member's services continue to be covered until one of the following occurs:

- The member withdraws the appeal in writing.
- The member does not request a State fair hearing within 10 calendar days of the Plan mailing an adverse decision regarding the member's appeal.
- The authorization expires or the authorization service limits are met.
- The fair hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the fair hearing is adverse to them. If the fair hearing officer agrees with the member, AmeriHealth Caritas New Hampshire will pay for the covered services that were rendered to the member while waiting for the decision. If the fair hearing officer agrees with the member and the member did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas New Hampshire will issue an authorization for the covered services to restart as soon as possible, and the Plan will pay for the covered services.

Section VII
Quality Assessment and Performance Improvement Program

VII. Quality Assessment and Performance

Improvement Program

AmeriHealth Caritas New Hampshire's Quality Assessment and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. AmeriHealth Caritas leadership provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into the Plan's operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI program is delegated by AmeriHealth Caritas leadership through the regional president to the AmeriHealth Caritas New Hampshire Market President and Quality Assessment Performance Improvement Committee (QAPIC).

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness, and safety of the care and service provided to AmeriHealth Caritas New Hampshire members by providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable State and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing, and redesigning services and programs to meet the health care needs of our diverse membership.

AmeriHealth Caritas New Hampshire develops goals and strategies considering applicable State and federal laws and regulations and other regulatory requirements, including AmeriHealth Caritas New Hampshire's Quality Management Strategy (QMS), NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. The Plan also uses performance measures such as HEDIS®, CAHPS®, consumer and provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

Every provider in the AmeriHealth Caritas New Hampshire provider network is required by contract to cooperate with and participate in AmeriHealth Caritas New Hampshire's QAPI

program. We rely on your cooperation and participation to meet our own state and federal

obligations as a Medicaid MCO.

AmeriHealth Caritas New Hampshire's access to the medical records maintained by our providers is a critical component of our data collection as we seek to ensure appropriate and continued access to care for our member population. AmeriHealth Caritas New Hampshire or its designee must receive medical records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program. AmeriHealth Caritas New Hampshire will reach out from time to time to request records for these purposes; it is essential that you provide requested records within the timeframes set forth in those notices.

As our technological capabilities continue to advance, AmeriHealth Caritas New Hampshire will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including through the use of bi-directional automated data exchange with our providers These exchange opportunities, as available, are intended to capture data related to gaps in care, and to identify social determinants of health that may also be targets for intervention. AmeriHealth Caritas New Hampshire will work with our providers to identify and implement the most appropriate format and cadence for data exchange.

AmeriHealth Caritas New Hampshire clinical reviewers fully investigate potential quality of care (QOC) concerns, in accordance with AmeriHealth Caritas New Hampshire policy.
Providers are expected to comply with QOC review processes, beginning with the timely submission of records in response to requests from AmeriHealth Caritas New Hampshire.
Your support of and participation in this critical review process helps to ensure the provision of high-quality care and service to the AmeriHealth Caritas New Hampshire member population.

Quality Assessment Performance Improvement Committee

The QAPIC oversees AmeriHealth Caritas New Hampshire's efforts to measure, manage, and improve quality of care and services delivered to Plan members, and evaluates the effectiveness of the QAPI program. The QAPIC will include several practicing, local providers and LCMNs. Additional committees and council support the QAPI program and report into the QAPIC:

Member Advisory Board – Provides a forum for member participation and input on Plan programs and policies to promote collaboration, maintain a member focus, and enhance the delivery of services to AmeriHealth Caritas New Hampshire communities.

Pharmacy and Therapeutics Committee – Monitors drug utilization patterns, formulary composition, pharmacy benefits management procedures, and quality concerns.

Quality of Service Committee – Monitors performance and quality improvement activities related to the Plan services; reviews, approves and monitors action plans created in response to identified variances; and tracks and reviews operational service performance levels for multiple departments and ensures compliance with State contractual requirements.

Credentialing Committee – Reviews practitioner and provider applications, credentials, and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas New Hampshire network.

Health Equity and Culturally and Linguistically Appropriate Service (CLAS) Committee – Provides direction to AmeriHealth Caritas New Hampshire (ACNH) HECLAS initiatives and to the activities that are relevant to the 15 National CLAS standards and to NCQA's Health Equity Accreditation standards that ensure that ACNH Members are served in a way that is responsive to their cultural and linguistic needs and focused on addressing health disparities for our racially, linguistically, and ethnically diverse members.

Provider Advisory Board – Provides accurate and timely feedback on the MCM program as reflective of member needs and includes representation from a broad spectrum of local providers, including LCMNs, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), and Integrated Delivery Networks (IDNs).

Practitioner Involvement

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at **1-888-599-1479** or their Provider Network Account Executive.

QAPIC Activities

The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. Practitioners and providers agree to allow AmeriHealth Caritas New Hampshire to use their performance data as needed for the organization’s quality improvement activities to improve the quality of care and services, and the overall member experience.

Performance Improvement Projects

The Plan develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

Ensuring Appropriate Utilization of Resources

The Plan will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates, and clinical guideline adherence.

For preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or underutilization.

Disease Management Programs
The Plan's Disease Management Programs were selected to address the expected high- incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

Measuring Member and Practitioner Satisfaction
The Plan uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. The Plan will conduct member experience of care and behavioral health member experience of care surveys annually. The Plan will conduct Practitioner Satisfaction studies quarterly. Survey results, along with analysis and trends on dissatisfaction and member opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

Member and Practitioner Dissatisfaction
Dissatisfactions or complaints/grievances from members and providers are investigated, responded to, and trended. Monthly random audits on provider appeal determinations are conducted. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Member Safety Programs
The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety, and hospital safety. Members are screened for potential safety issues during the initial assessment.

Preventive Health and Clinical Practice Guidelines
The QAPIC is responsible for approving all preventive health and clinical practice guidelines. These guidelines are developed using criteria established by nationally recognized professional organizations and conform to standards of NCQA Health Plan Accreditation. These guidelines are chosen based on evaluation of member health care needs and with input from the QAPIC. Guidelines are distributed via the Plan's website, with hard copies available upon request. As mandated by the State, participating providers will utilize clinical practice guidelines, including but not limited to those addressing:

- Adult and child preventive care, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services.
- Chronic conditions (i.e., diabetes and asthma).
- Behavioral health services.

- Children with Special Health Care Needs.
- Obstetrical care.
- AIDS/HIV.
- Palliative care.

Availability and Accessibility Audits

Compliance with the Plan's availability standards is monitored at least quarterly to help ensure sufficient numbers of network providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Quality Assessment Performance Improvement Committee (QAPIC) reviews and evaluates the report. The Plan also conducts monthly assessments of network providers' compliance with appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QAPIC for review and recommendations.

Medical Record Requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized, and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality, and organization of records at all times.

Provider agrees to retain all medical records, whether electronic or paper, for a period of no less than 10 years after the last payment was made for the services of the member.

Providers are required by contract to make medical records accessible to all appropriate government agencies, including but not limited to the New Hampshire DHHS, the United States Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designees to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's first and last name and identification number is on each page of record.
- All entries specify location, date, times of service provision and are legible.
- Identification of the type of service being provided.
- All entries are initialed or signed by the author including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations, and illnesses.

- Allergies and adverse reactions are prominently listed or noted as “none” or “NKA.”
- Information regarding personal habits such as smoking, and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient’s chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service.
- Health care education provided to patients, family members, or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan’s Preventive Health Guidelines.
- Member’s response to staff interventions.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.
- Identification of the timeframe for documentation completion.
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation.
- A provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

Medical Record Requests

AmeriHealth Caritas New Hampshire conducts medical record reviews to capture HEDIS® data not obtained through claims submission. Medical records may be audited year-round.

This effort is part of health plan operations and within Plan expectations for participating providers. A written notification request may be submitted to a provider office requesting specific medical records be sent to the Plan. At least five business days' notice will be provided for a scheduled onsite audit. If requested, a member list will be provided with Medicaid ID, date of birth, and HEDIS® measure information missing prior to the audit. The names of the reviewers performing the audits will also be provided, if requested.

AmeriHealth Caritas New Hampshire appreciates and is dedicated to working with providers to coordinate medical record data collection to make these reviews as easy as possible for all practices.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient.

Adverse Event Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas New Hampshire sends information on reportable events, (as outlined in the NPDB Reporting Manual instructions) to the respective entity and to the State Board of Medicine, as appropriate, in New Hampshire.

All review outcomes, including actionable information, are incorporated in the provider credentialing file and database.

Mandatory Reporting Requirements

AmeriHealth Caritas New Hampshire providers are required to comply with the reporting of specific conditions, diseases, and major incidents in accordance with State regulations and guidelines. Participating providers are also required to report suspected abuse, neglect and financial exploitation of adults and suspected abuse or neglect of children in accordance with State law.

Potential Quality of Care Concerns

Potential quality of care concerns are fully investigated by AmeriHealth Caritas New Hampshire. Quality of care (QOC) concerns will be thoroughly investigated by clinical reviewers in accordance with company policy. Providers are required to comply with AmeriHealth Caritas New Hampshire QOC review process to include submitting records timely in accordance with our policy and procedures. Failure to provide records timely may result in sanctions.

Summaries and situational reviews are presented to the Credentialing Committee on a monthly basis. QOC concerns may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's network, sanctions or corrective action. Referral to the QAPIC is at the discretion of the Plan Medical or QM Director.

If the QAPIC investigation involves an action reportable to a national or State entity or database, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and State regulatory agencies.

The QM Department reserves the right to impose any of the following actions, based on its discretion:

- Submission of medical records.
- Requiring the practitioner/provider to submit of a written description and explanation of the quality-of-care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. If the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan (CAP), which may include continued monitoring by AmeriHealth Caritas New Hampshire to help ensure that adverse events do not continue. The CAP will be documented in writing and may also include provisions that the practitioner/provider maintain an acceptable pass/fail score regarding a particular performance metric.

In addition, the Credentialing Committee or QAPIC may recommend the following:

- Implementing formal sanctions, including termination from the AmeriHealth Caritas New Hampshire network if the offense is deemed an immediate threat to the well-being of Plan members.

AmeriHealth Caritas New Hampshire reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the actions listed above.

At the conclusion of the investigation, the practitioner/provider will be notified by letter of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas New Hampshire to assure members receive quality health care services. In the event that medical or behavioral health services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with the Plan's quality standards, recognized treatment patterns of the organized medical community, and/or standards established by the State, the network provider may be subject to AmeriHealth Caritas New Hampshire's formal sanctioning process.

Except for any applicable State licensure board reporting requirements, all sanctioning activity is strictly confidential.

Formal Sanctioning Process

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas New Hampshire will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas New Hampshire on the proposed action.
- Reminder that the practitioner/provider has 30 calendar days following receipt of notification within which to file an appeal through the provider appeals process, described in Section II of this *Provider Manual.*

Critical Incidents and Provider Preventable Conditions

The Plan's payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider- Preventable Conditions.

Providers must comply with the reporting requirement established in the Older Adult Protective Services Act and the Adult Protective Services Act. All critical incidents require notification to the Plan immediately or as reasonably possible following the incident. A critical incident includes but is not limited to the following incidents:

- Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician.
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities.
- Suspected physical, mental, or sexual mistreatment, or abuse and/or neglect of a member.
- Suspected theft or financial exploitation of a member.
- Severe injury sustained by a member.
- Medication error involving a member; or
- Inappropriate/unprofessional conduct by a provider involving a member.
- Restraint, which includes any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.
- Service interruption, which includes any e vent that results in the participant's inability to receive services that places his or her health and or safety at risk.
- Hospitalization (other than hospital stay planned in advance).
- Member fall resulting in the need for medical treatment.
- Medical emergency involving member resulting in the need for medical treatment.
- Severe injury of member resulting in the need for medical treatment.

In addition to the list above, critical incidents include Sentinel and Serious Adverse Events as defined below:

Sentinel Event – An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. These events must be reported to the Plan within the same day of discovery. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

Examples of a sentinel event include:

- Maternal death after delivery.
- Suicide while inpatient.

- Serious Adverse Event – Reportable adverse events that are serious, largely

preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Adverse events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or the proper treatment of that illness or underlying condition.

Examples include but are not limited to:

- Surgery performed on the wrong patient.
- Surgery on the wrong body part.
- Unintended retention of a foreign object after surgery.

See www.CMS.gov for a complete list.

Health Care Acquired Conditions

The category of Health Care Acquired Conditions applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery.
- Air Embolism.
- Blood Incompatibility.
- Catheter Associated Urinary Tract Infection.
- Pressure Ulcers (Decubitus Ulcers).
- Vascular Catheter Associated Infection.
- Mediastinitis after Coronary Artery Bypass Graft (CABG).
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes).
- Manifestations of Poor Glycemic Control.
- Surgical Site Infection Following Certain Orthopedic Procedures.
- Surgical Site Infection Following Bariatric Surgery for Obesity.
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric Populations.

Under the category of Hospital-Acquired Conditions and Provider-Preventable Conditions, the Plan will not reimburse providers for a condition that meets the following criteria:

- Is identified in the Medicaid State Plan.

- Has been found by New Hampshire, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- Has a negative consequence for the member.
- Is auditable; and
- Includes, at a minimum:
    - Surgical or Other Invasive Procedure Performed on the Wrong Body Part.
    - Surgical or Other Invasive Procedure Performed on the Wrong Patient; or
    - Wrong Surgical or Other Invasive Procedure Performed on a Patient.

Reporting of critical incidents, Health Care Acquired Conditions, Hospital-Acquired Conditions, and Provider-Preventable Conditions is required.

AmeriHealth Caritas New Hampshire monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies, and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan.

AmeriHealth Caritas New Hampshire's goals are to:

- Have a positive impact on improving patient care, treatment, and services and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.

Reporting Provider Preventable Conditions or Critical Incidents

Please contact the AmeriHealth Caritas New Hampshire UM Department at **1-833-472-2264** to report a provider preventable condition or critical incident. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information regarding AmeriHealth Caritas New Hampshire's policy on provider preventable conditions and how to report such conditions via the claims process.

Section VIII
Cultural Competency Program and Requirements

VIII. Cultural Competency Program and Requirements

Embedded in all AmeriHealth Caritas New Hampshire efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural and health equity awareness both in our staff and in our provider community. We leverage demographic data, including but not limited to: race, ethnicity, language data (REL), sexual orientation, and gender identity (SOGI) data, to help ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas New Hampshire routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas New Hampshire's member population, whichever is less.

In addition, the provider newsletter includes pertinent articles on addressing equity, cultural or language information.

Our Health Equity and Culturally and Linguistically Appropriate Services (HECLAS) Program, led by the Health Equity and Quality (HEQ) Analyst, is composed of a cross-departmental workgroup, has been built upon the following 15 National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) as set forth by the U.S. Department of Health and Human Services:

Principal Standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication of Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS- related measures into assessment measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance-resolution process that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Providers may request more information on the Cultural Competency Program by contacting

Provider Services **1-888-599-1479**.

Cultural and Linguistic Requirements

In summary, Section 601 of Title VI of the Civil Rights Act of 1964 states that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Section 4302 of the Affordable Care Act supports the self-reported collection of race, ethnicity, sex, primary language, and disability status according to the Office of Management and Budget (OMB categories). This provision allows the Plan to comply with federal and national provisions established to reduce health disparities and deliver culturally competent care.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible for making arrangements for language services for members, upon request, who are either Limited English Proficient (LEP),that is they do not speak English as their primary language and have a limited ability to read, write, speak or understand English, sensory impaired or experience other interpretation needs, and facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to equal access to benefits and services for LEP, sensory impaired, or members who experience other interpretation needs is to help ensure that you, our network provider, can effectively communicate with these members**.** Plan providers are required to offer interpretation and translation services to LEP member's needs upon request and to accommodate members with other sensory impairments.

Providers are required to:

- Offer written and verbal language access at no cost to Plan members with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of qualified interpreters, as necessary.

- Offer members verbal or written notice (in their preferred language or format) about their right to receive free language services assistance.
- Post and offer easy-to-understand member signage and materials in the languages of the 15 most frequently used non-English languages spoken in the State. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- Discourage members from using family or friends as interpreters. *
- Advise members that language services are available through AmeriHealth Caritas New Hampshire, if the provider is not able to obtain necessary language services for a member.

Note: The assistance of friends, family, and bilingual staff is not considered qualified, quality interpretation. These persons should not be used for interpretation services except

where a member has been made aware of their right to receive interpretation services at no cost and specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances. These persons may also provide such services in an emergency involving an imminent threat to the safety or welfare of the member or the public where there is no qualified interpreter immediately available.

AmeriHealth Caritas New Hampshire contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating Plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at **1-888-599-1479.**

Health care providers who are unable to arrange for interpretation services for an ACNH member with LEP, low literacy proficiency (LLP), or a sensory impaired member should contact Member Services at **1-833-704-1177,** TTY: **1-855-534-6730**, and a representative will help locate a professional interpreter to communicate in the member's primary language.

When a member uses the Plan's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner to reflect the use of services.

In addition to the requirements listed above, under The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services, Plan providers are strongly encouraged to:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages,

health literacy, and other communication needs.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Additional tips to support members with LEP and other interpretation needs include:

- Establishing written policies to provide interpretive services for Plan members upon request.
- Routinely documenting preferred language or format, such as Braille, audio, or large type, in all members medical records.

Enhancing Cultural Competency in Health Care Settings

AmeriHealth Caritas New Hampshire encourages providers and their staff to report their race and ethnicity, the languages they speak, and the language services available through the practice. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

Provider and member information is analyzed to identify opportunities for improvement so the Plan can provide the best possible service to its providers and members. The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

Additional Resources
The following additional resources are available upon request:

- Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency
- The Health Literacy & Plain Language Resource Guide

Cultural Responsiveness Training

In an effort to deliver culturally and linguistically appropriate care to members who have limited English proficiency, who represent diverse multicultural and ethnic backgrounds, who have special health needs, who are impacted by social determinants of health (SDoH), or or who are from a population group that disproportionally faces systemic discrimination, AmeriHealth Caritas New Hampshire offers providers an annual cultural competency training that will address:

- Delivering services and care that honors members' beliefs and cultural practices.
- Understanding and providing services in a manner that is responsive to cultural diversity.
- Fostering attitudes and interpersonal communication styles that respect diverse cultural backgrounds.
- Addressing health disparities, the social determinants of health, and health literacy.

Cultural Competency Terms and Definitions

Providers should be aware of the following terms and their definitions:

Cultural Competence
The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.

"Culture" as defined by the CDC refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

"Competence," as defined by the U.S. Department of Health and Human Services implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities.

Cultural affiliations may include, but are not limited to race, ethnicity, preferred language, sexual orientation, gender identity, disability, age, religion, deaf and hard of hearing, citizen status, homelessness, and geographic location.

Individuals with Limited English Proficiency (LEP)
Individuals who do not speak English as their primary language and who have a limited ability

to read, write, speak, or understand the English language.

Low Literacy Proficiency

In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write, and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory Impaired

A person who is deaf or visually impaired.

Section IX
Claims Submission Protocols and Standards

IX. Claims Submission Protocols and Standards

Claims Submission

All claims for services rendered by in-network providers must be submitted to AmeriHealth Caritas New Hampshire within 120 calendar days from the date of service (or the date of discharge for inpatient admissions) unless the provider meets a good cause exception. Good cause exceptions will accommodate events such as a member providing the wrong Medicaid identification number, a natural disaster, or a failure of information technology systems.

Good cause exceptions will be considered on a case-by-case basis. To initiate a good cause exception, please contact your Provider Network Account Executive.

Claims submitted by practitioners must be billed on the CMS-1500 or UB-04 or via the electronic equivalent (EDI) of these standard forms. The following mandatory information is required on all claims:

- Member's (patient's) name.
- Member's Plan ID number.
- Member's date of birth and address.
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs).
- Information advising if member's condition is related to employment, auto accident or liability suit.
- Date(s) of service, admission, discharge.
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits.
- Name of referring physician, if appropriate.
- HCPCS procedures, services or supplies codes.
- CPT procedure codes with appropriate modifiers.
- CMS place of service code.
- Charges (per line and total).
- Days and units.
- Physician/supplier Federal Tax Identification Number or Social Security Number.
- National Practitioner Identifier (NPI) of ordering, rendering, and prescribing physician.
- NPI and Taxonomy.
- Physician/supplier billing name, address, zip code, and telephone number.
- Name and address of the facility where services were rendered.
- NDCs required for physician-administered injectables that are eligible for rebate.
- Invoice date.
- Provider signature.

Note: AmeriHealth Caritas New Hampshire also encourages providers to submit claims using the

Plan-assigned individual practitioner ID numbers.

General Procedures for Claims Submission

AmeriHealth Caritas New Hampshire is required by State and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to help ensure timely processing of claims.

When required data elements are missing or invalid, claims will be **rejected** by the Plan for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas New Hampshire members must be submitted by the provider who performed the services.

Important: ***A Clean Claim*** *is a claim for payment for a health care service, which has been received by AmeriHealth Caritas NH, that can be processed without obtaining additional information from the provider of the service or from a third party. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.*

Claims filed with AmeriHealth Caritas New Hampshire are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out- of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas New Hampshire.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the “payer of last resort” on all claims submitted to AmeriHealth Caritas New Hampshire.

AmeriHealth Caritas New Hampshire strongly encourages providers to submit claims electronically for faster turn-around. The Plan also accepts paper claims.

For more detailed billing information and line-by-line instructions, please refer to the *Claims Filing Instructions*, available in the provider area of our website at www.amerihealthcaritasnh.com.

Electronic Claims Submission (EDI)

AmeriHealth Caritas New Hampshire encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare's Provider Support Line at **1-877-363-3666** for more information.

There are many different platforms that may be used for electronic billing. As long as you have the capability to send EDI claims to Change Healthcare, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may contact the EDI Technical Support at **1-833-686-2264** to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare at **1-877-363-3666** to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas New Hampshire.
- Be prepared to inform the vendor of the Plan's electronic payer identification number. **AmeriHealth Caritas New Hampshire's EDI Payer ID# is 87716.**

Paper Claim Mailing Instructions

Please submit paper claims to the address below:

AmeriHealth Caritas New Hampshire
Attn: Claims Processing Department
P.O. Box 7387 London, KY 40742-7387

Claim Filing Deadlines

All original paper and electronic claims must be submitted to AmeriHealth Caritas New Hampshire **within 120 calendar days** from the date services were rendered (or the date of discharge for inpatient admissions), unless there is an exception as described below. This applies to capitated and fee-for-service claims.

Exceptions

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 calendar days of the date of the primary insurer's EOB.

Good cause exceptions will accommodate events such as a member providing the wrong Medicaid identification number, a natural disaster, or a failure of information technology

systems. Good cause exceptions will be considered on a case-by-case basis. To initiate a good cause exception, please contact your provider account executive.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Please allow for normal processing time (which may be approximately 30 calendar days) before re- submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. to be transmitted to the Plan the next business day.

Rejected claims are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be resubmitted as a new claim. Claims originally rejected for missing or invalid data elements must be resubmitted with all necessary and valid data within 120 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

Rejected claims

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is not an AmeriHealth Caritas New Hampshire claim number. Rebilling of a rejected claim should be done as an original claim.
- Since rejected claims are considered original claims the timely filing limits should be followed.

Denied Claims are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Corrected claim is defined as a claim that AmeriHealth Caritas New Hampshire processed based on the information submitted but the provider submits a claim correcting the original data. A corrected claim must be submitted within 365 days of the original date of service.
The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 ERA, the paper Remittance Advice

or from the claim status search in NaviNet®.

- **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number.**
- Corrected/replacement and voided claims may be sent electronically or on paper.
    - If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '7' for the Replacement (correction) of a prior claim and '8' for the void of a prior claim. The Value "6" should not be sent.
    - In addition, the submitter must also provide the original claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).
    - For those interested in electronic claim filing, please contact your EDI software vendor, **Availity Client Service at 1-800-282-4548**, or Change Healthcare's Provider Support Line at 1-877-363-3666 for more information.
    - Contact your EDI software vendor, Availity Client Service at 1-800-282-4548, or Change Healthcare at 1-877-363-3666 to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas New Hampshire.

Important Billing Reminders

CMS defines an encounter as "an interaction between an individual and the health care system." Encounters occur whenever an AmeriHealth Caritas New Hampshire member is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury. An encounter is any health care service provided to a Plan member. Encounters must result in the creation and submission of an encounter record or claim (CMS-1500 or UB-04; paper form or electronic submission) to AmeriHealth Caritas New Hampshire. The information provided on these claims represents the encounter data the Plan reports to the State, according to mandatory reporting requirements.

Completion of Encounter (Claims) Data

PCPs must complete and submit a CMS-1500 or UB-04 paper form or file an electronic claim every time an AmeriHealth Caritas New Hampshire member receives services from the provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows the Plan to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows the Plan to identify the severity of illnesses of our members.

AmeriHealth Caritas New Hampshire accepts claim submissions via paper or electronically

(EDI). For more information on electronic claim submission and how to become an electronic biller, please contact the EDI Technical Support at **1-833-686-2264** or refer to the billing information available on our Plan website at www.amerihealthcaritasnh.com.

To support timely statutory reporting requirements, PCPs must submit encounters (claims) within 120 calendar days of the visit.

AmeriHealth Caritas New Hampshire monitors claim data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Claims can be rejected or denied for inaccurate, untimely, and/or incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to the Plan. Network providers may also be subject to sanctioning by the Plan for failure to submit accurate claim data in a timely manner.

Claims Inquiry

Inquiries –Inquiries are questions from providers regarding how a claim was paid. Inquiries can be received via phone, NaviNet (the provider portal) inquiry, or written correspondence. An inquiry may or may not result in a change in the payment.

If a provider does not receive payment for a claim within 45 calendar days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the NaviNet provider website, our secure provider portal. Log on to navinet.navimedix.com for web-based solutions for electronic transactions and information.
- Opening a claims investigation via NaviNet with the claim's adjustment inquiry function.
- Calling Provider Services at **1-888-599-1479** and following the prompts.
- Calling your Account Executive for assistance.

Balance Billing Members

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas New Hampshire to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balanced billed for medically necessary covered services under any circumstances. Providers may use the appeal process to resolve any outstanding claims payment issues.

Requests for Adjustments

You may open a claims investigation in the following ways:

By NaviNet: With the claim's adjustment inquiry function.

By telephone to Provider Services:
1-888-599-1479 (Select the prompts for the correct department and then select the prompt for claim issues.)

By mail:
Please address your request to:

AmeriHealth Caritas New Hampshire
Attn: Claims Processing Department
P. O. Box P.O. Box 7388 London, KY 40742-7388

Refunds for Improper Payment or Overpayment of Claims

If a Plan provider identifies improper payment or overpayment of claims from AmeriHealth Caritas New Hampshire, the improperly paid or overpaid funds must be returned to the Plan within 60 calendar days of identification with notification of the reason for the overpayment. Providers are required to return the identified funds to the Plan by submitting a refund check directly to the claims processing team:

AmeriHealth Caritas New Hampshire
Attn: Claims Processing Department
P. O. Box 7320
London, KY 40742-7320

Note: Please include the member's name and ID, date of service and claim ID.

Third Party Liability/Subrogation and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas New Hampshire. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas New Hampshire, are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the health care provider's charges before a claim is submitted to AmeriHealth Caritas New Hampshire.

Therefore, before billing AmeriHealth Caritas New Hampshire when there is a Primary Insurer, health care providers are required to bill the Primary Insurer first and obtain an Explanation of

Benefits (EOB) statement from the Primary Insurer. Providers may then bill AmeriHealth Caritas New Hampshire for the remaining balance on a claim by submitting the claim along with a copy of the Primary Insurer's EOB.

Please note that Medicare Part C (Medicare Advantage) claims **do not** coordinate with us. For those claims, the Part C insurer is the payer of last resort.

Claims with Explanation of Benefits (EOBs)

Claims with EOBs from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB.

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas New Hampshire contract, the Plan will be entitled to recover any funds up to the amount owed by the third-party payer.

While this is a requirement in most cases, there is an exception when providers are not required to bill the third party prior to AmeriHealth Caritas New Hampshire. This exception is when the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.

Following reimbursement to the provider in these cost avoidance exception cases, AmeriHealth Caritas New Hampshire shall actively seek reimbursement from responsible third parties and will adjust claims accordingly.

Additional Information for Electronic Billing

Invalid Electronic Claim Record Rejections
All claim records sent to the Plan must first pass Change Healthcare HIPAA edits and Plan- specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and resubmitted with all necessary and valid data elements within the required filing deadline of 120 days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor to identify and re-submit these claims accurately.

Monitoring Reports for Electronic Claims
Change Healthcare will produce an Acceptance Report* and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. To verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare Acceptance Report and the R059 Plan

Claim Status Report.

*Acceptance Report verifies acceptance of each claim at Change Healthcare.

**R059 Plan Claim Status Report is a list of claims that passed Change Healthcare's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

Plan Specific Electronic Edit Requirements

AmeriHealth Caritas New Hampshire currently has two specific edits for professional and institutional claims sent electronically:

- **837P –005010X222A1–** Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- **837I – 005010X223A2 –** Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits

Please Note: statement date must not be earlier than the date of service and Plan-assigned individual practitioner ID number is strongly encouraged.

Electronic Billing Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient, and outpatient claim types.

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
Claim records for medical, administrative, or claim appeals.

Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Change Healthcare or providers sending to Vendors that are not transmitting (through Change Healthcare) NCPDP Claims.

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Change Healthcare
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.).
Claims without provider numbers.

Claims without member numbers.
Claims in which the date of birth submitted does not match the member ID.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers.
Claims received with invalid member numbers.
Claims received with invalid member date of birth.

Re-submitted Corrected Claims

Providers using electronic data interchange (EDI) can submit "institutional" and "professional" corrected claims* electronically or via paper claim to AmeriHealth Caritas New Hampshire. This *Provider Manual* offers basic instructions for the submission of corrected claims via EDI or paper; for more detailed guidance, please refer to the *Claims Filing Instructions* available online at www.amerihealthcaritasnh.com.

*A "corrected claim" is defined as a re-submission of a claim with a specific change that has been made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

Your EDI clearinghouse or vendor needs to remember the following:

- Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P and 837I). Use "8" to void a prior claim.
- Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number, no dashes or spaces.
- Do include the Plan's claim number to submit your claim with the 7 or 8.
- Corrected claims for which the original claim number cannot be validated will be rejected.
- Do use the indicator for claims that were previously processed (approved or denied).
- **Do not** use the indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- **Do not** use the indicator for claims that contained errors and were not previously processed (those that were rejected upfront).
- **Do not** submit corrected claims electronically and via paper at the same time.

For more information, please contact EDI Technical Support at 1-833-686-2264 or by email to EDI.ACNH@amerihealthcaritasnewhampshire.com.

Providers can also open a claims investigation via NaviNet with the claim's adjustment inquiry function at www.navinet.net.

Electronic Billing Inquiries
Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically…	Contact Change Healthcare: **1-877-363-3666.**
If you have general EDI questions …	Contact EDI Technical Support: **1-800-833-686-2264** EDI.ACNH@amerihealthcaritasnewhampshire.com.
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports…	Contact your EDI software vendor or call the Change Healthcare Provider Support Line: **1-877-363-3666**.
If you have questions about your R059 – Plan Claim Status (receipt or completion dates) …	Contact Provider Services: **1-888-599-1479**
If you have questions about claims that are reported on the remittance advice…	Contact Provider Services: **1-888-599-1479**
If you need to know your provider NPI number…	Contact Provider Services: **1-888-599-1479**
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… OR For questions about changing or verifying provider information…	Please Contact Provider Services: By Fax: **1-833-609-2264** By Telephone: **1-888-599-1479**
If you would like information on the 835 remittance advice…	Contact your EDI vendor or call Change Healthcare: **1-877-363-3666**.
Check the status of your claim…	Review the status of your submitted claims by logging in to NaviNet at navinet.navimedix.com.

Sign-up for the provider portal…	Go to navinet.force.com or contact NaviNet Customer Service (via Nant Health Support): **1-888-482-8057**.
Sign-up for Electronic Funds Transfer…	Contact Change Healthcare : **1-877-363-3666**.

AmeriHealth Caritas New Hampshire Provider Manual Appendix

Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

For general information about, and definitions of, PPCs, please refer to the "Quality Assessment and Performance Improvement Program" section of this *Provider Manual.*

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required because of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor)

diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and "E" diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital- acquired**.**

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member's medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300: segment NTE, data element NTE02.

Valid POA Indicators include:

- "Y" = Yes = present at the time of inpatient admission.
- "N" = No = not present at the time of inpatient admission.
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission.
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not "null" = Exempt from POA reporting.

Reimbursement Policy

Prospective Claims Editing Policy
AmeriHealth Caritas New Hampshire's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare.

Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Pre-Operative Test Requirements
It is the surgeon's responsibility to provide information to the member on the hospital's requirements for pre-operative physical examination, laboratory, and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.