# Table of Contents

- Trusted Health Plan Provider Welcome Letter ................................................................. 3  
- Quick Reference Phone Numbers .................................................................................. 4  
- Quick Reference Claims Submission/ Referral / Prior Authorization Requirements ........ 5  
- Quick Reference Covered Services .................................................................................. 6  
- Mission Statement ........................................................................................................... 13  
- Credentialing .................................................................................................................. 13  
- Provider Responsibilities ................................................................................................. 18  
- Care Plans ....................................................................................................................... 21  
- Performance Data ........................................................................................................... 22  
- Member Access Standards ............................................................................................... 23  
- Access to After-hours care / On Call requirements ....................................................... 23  
- Access to Out of Network Services ............................................................................... 25  
- THP Committees ............................................................................................................. 28  
- Pharmacy ....................................................................................................................... 29  
- Continuous Quality Improvement Program ..................................................................... 28  
- Compliance Requirements ............................................................................................. 30  
- Medical Records ............................................................................................................ 36  
- Understand your Billing Practices .................................................................................. 38  
- Reporting Unusual and/or Critical Incidents ................................................................. 40  
- Pharmacy and Patient Safety Precautions .................................................................... 41  
- Health Effectiveness Data Information Set (HEDIS) .................................................... 41  
- Medical Management ...................................................................................................... 43  
- Prior Authorization/ Pre Certification Process .............................................................. 44  
- Pre-natal/GYN Services ................................................................................................... 52  
- Clinical Practice Guidelines ............................................................................................ 54  
- Case Management/ Disease Management ..................................................................... 52
Behavioral Health and Substance Abuse Care ................................................................. 58
Ancillary Services .................................................................................................................. 58
HealthCheck/EPSDT ............................................................................................................. 59
Children with Special Health Care Needs ............................................................................. 65
Special Member Support Services .......................................................................................... 66
Services for Non-English Speaking Members ........................................................................ 67
Services for Hearing Impaired Members .............................................................................. 67
Transportation ...................................................................................................................... 67
Member Eligibility, Benefits & Rights .................................................................................. 68
Advance Directives ............................................................................................................... 71
Billing and Claims ................................................................................................................ 73
Prompt Payment Act of 2002 ............................................................................................... 68
Claims Inquiry ...................................................................................................................... 68
Claims Denial ....................................................................................................................... 68
Balance Billing Members .................................................................................................... 69
Claims Payment Review ....................................................................................................... 69
Third Party Liability/Subrogation ......................................................................................... 69
Surgical Reimbursement Policies .......................................................................................... 70
Complaints, Appeals and Grievances .................................................................................. 71
Member Complaints and Grievances ................................................................................... 71
Practitioner Complaints ....................................................................................................... 72
Appeals of Utilization Review Non-Certification of Services ............................................... 72
Appeal Process ................................................................................................................... 72
Appendices ........................................................................................................................ 74
Welcome to TRUSTED Health Plan

Dear Provider:

Welcome to TRUSTED Health Plan. As a valued participating provider, you are one of the most essential elements of our fully integrated Medicaid Health Network. We are committed to ensuring that all of our members receive optimum quality health care. We value our partnership and the relationship you have with your patients and members.

This Provider Manual is intended to complement your on-site orientation and has been prepared as a reference manual for administrative procedures and clinical issues. It provides a quick and easy resource with contact phone numbers, detailed processes and site lists for various services such as access to information about verifying member eligibility, obtaining authorization for services, reimbursement and checking claim status.

The Provider Manual also gives you general information about the various departments throughout TRUSTED Health Plan, the services that they provide, and your role and responsibilities as a participating provider.

We have made it convenient for you to access the Provider Manual at our website at www.trustedhp.com. We encourage you to visit our website often, as it is modified frequently and contains the most updated plan related information available.

We are committed to ensuring that we provide you with the most up to date information so that you can then deliver the highest level of care to our members. We welcome your feedback and if at any time, you have a question or concern about the information outlined in this manual or about TRUSTED Health Plans medical care programs; you can reach the TRUSTED Health Plans Provider Relations Department by calling (202) 821-1145 between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

Please do not hesitate to contact us to discuss your issues and suggestions. Thank you for joining the TRUSTED Health Plan network.
Quick References

Quick Reference Contact Information

TRUSTED Health Plan
1100 New Jersey Ave., SE • Suite. 840 • Washington, DC  20003

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>(202) 821-1145 (202) 905-0178 (EFax)</td>
</tr>
<tr>
<td>Member Services</td>
<td>(202) 821-1100 (855) 326-4831 (toll free)</td>
</tr>
<tr>
<td>Utilization Review/Prior Authorizations and Appeals</td>
<td>(202) 821-1132 (202) 905-0157 (EFax)</td>
</tr>
<tr>
<td>Case Management/Disease Management/Discharge Planning</td>
<td>(202) 821-1132 (202) 821-1098 (EFax)</td>
</tr>
<tr>
<td>Member Eligibility Line</td>
<td>(202) 906-8319 – DC (202) 821-1100 (855) 326-4831 (toll free)</td>
</tr>
<tr>
<td>District of Columbia Eligibility Verification System (IVR)</td>
<td></td>
</tr>
<tr>
<td>TTY Line</td>
<td>(202) 821-1152 or 711 (855) 326-4831 (toll free)</td>
</tr>
<tr>
<td>Language Line Services</td>
<td>(866) 874-3972</td>
</tr>
<tr>
<td>Beacon-Health Strategies</td>
<td>(888) 204-5581</td>
</tr>
<tr>
<td>(Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>MTM- Member Transportation Services</td>
<td>(855) 824-5693</td>
</tr>
<tr>
<td>Centene / Nurse Response Line</td>
<td>(855) 872-1852</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>(855) 418-1620</td>
</tr>
<tr>
<td>EyeQuest</td>
<td>(855) 418-1620</td>
</tr>
<tr>
<td>Meridian Pharmacy Benefit Manager Providers Only</td>
<td>(855) 323-4588 (888) 274-2031 (877) 647-4026 (855) 323-4586 fax</td>
</tr>
<tr>
<td>Meridian Pharmacy Benefit Manager Member Services</td>
<td></td>
</tr>
<tr>
<td>Lab Corp</td>
<td>(800) 859-0391</td>
</tr>
</tbody>
</table>
How do I submit a claim?

You may mail claims to:
TRUSTED Health Plans
DC Healthy Families Program (Medicaid)
P.O. Box 830786
Birmingham, AL 35283-0786
or
TRUSTED Health Plans
Alliance Program
P.O. Box 830210
Birmingham, AL 35283-0210

Electronic Claims can be submitted to Emdeon Trusted Payor ID: L0230

Do I need a referral?
All Specialty Care providers require a referral from the TRUSTED Member’s PCP. This can be done through the TRUSTED Provider Portal.

How do I request a Prior Authorization?
Prior Authorization (PA) requests can be faxed to: 202-821-1098 or 202-905-0157. Requests for services will be reviewed by experienced Nurses utilizing InterQual criteria and/or other relevant clinical practice guidelines.

- Urgent PA decisions will be made within 1 calendar day and oral notification will be made within the same day of the decision.
- Priority decisions will be made within 3 calendar days and oral notification will be made within the same day of the decision.
- Non-Urgent PA decisions will be made within 14 calendar days, and oral notification will be made within 48 hours of the decision.

Prior Authorization (PA) requests for Behavioral Health Services are handled by Beacon Health Care.
(855) 326-4831

Prior Authorization for non-emergent imaging services are handled by National Imaging Associates (NIA).
www.RadMd.com or 1-888-899-7804
### Medicaid –Only Covered Services

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DC HEALTHY FAMILIES PROGRAM</th>
<th>WHO CAN GET THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Services</td>
<td>• Preventive, acute, and chronic health care services.</td>
<td>All Members</td>
</tr>
<tr>
<td>Adult Wellness Services</td>
<td>• Health care services provided by specially trained doctors or advanced practice nurses.</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Referrals are required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not include cosmetic services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs normal body function.</td>
<td></td>
</tr>
<tr>
<td>Laboratory &amp; Radiology Services</td>
<td>• Lab tests and X-rays</td>
<td>All Members</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>• Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services)</td>
<td>Any Member with a Referral from their PCP or who has an emergency</td>
</tr>
<tr>
<td>Pharmacy Services (prescription drugs)</td>
<td>• Prescription drugs included on the Trusted drug formulary. You can find the drug formulary at: <a href="http://www.Trustedhp.com">www.Trustedhp.com</a> or by calling Member Services.</td>
<td>All Members other than dually eligible(Medicaid/Medicare) Members whose prescriptions are covered under Medicare Part D</td>
</tr>
<tr>
<td></td>
<td>• Only includes medications from network pharmacies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Includes the following non-prescription (over-the-counter) medicines:</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>• A Screening exam of your health condition and stabilization if you have an Emergency Medical Condition, regardless if the Provider is in or out of the Trusted network.</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Treatment for emergency conditions</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>• Pregnancy Testing: Counseling for the woman</td>
<td>All Members as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Routine and Emergency Contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Voluntary sterilizations for Members over 21 years of age (requires signature of an approved sterilization form by the Member 30 days prior to the procedure)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening, Counseling and Immunizations (including for HPV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening and preventive treatment for all sexually transmitted diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not include sterilization procedures for Members under age 21</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>DC HEALTHY FAMILIES PROGRAM</td>
<td>WHO CAN GET THIS BENEFIT</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Podiatry</td>
<td>• Special care for foot problems</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Regular foot care when medically needed.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>• Rehabilitation Services, including physical, speech and occupational therapy</td>
<td>All Members</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>• Replacement, corrective, or supportive devices prescribed by a licensed provider</td>
<td>All Members</td>
</tr>
<tr>
<td>Vision Care</td>
<td>• Eye exams at least once every year and as needed; and eye glasses (corrective lenses) as needed</td>
<td>Members under age 21</td>
</tr>
<tr>
<td></td>
<td>• One pair of eyeglasses every two years except when the Member has lost his or her eyeglasses or when the prescription has changed by more than 0.5 diopter</td>
<td>Members age 21 and older</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>In-home health care Services, including:</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Nursing and home health aide care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home health aide Services provided by a home health agency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical therapy, occupational therapy, speech pathology and audiology Services</td>
<td></td>
</tr>
<tr>
<td>Personal care Services</td>
<td>• Services provided to a Member by an individual qualified to provide such Services who is not a member of the individual’s family, usually in the home, and authorized by a physician as a part of the Member’s treatment plan.</td>
<td>Not available to Members in a hospital or nursing home</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>• Full-time skilled nursing care in a nursing home up to 30 consecutive days</td>
<td>All Members</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>• Support Services for people who are dying</td>
<td>All Members</td>
</tr>
<tr>
<td>Transportation Services</td>
<td>• Transportation to and from medical appointments</td>
<td>All Members</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>DC HEALTHY FAMILIES PROGRAM</td>
<td>WHO CAN GET THIS BENEFIT</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
</tbody>
</table>
| Wellness Services | • Immunizations  
• Routine Screening for Sexually Transmitted Diseases  
• HIV/AIDS Screening, testing and counseling  
• Breast cancer Screening (women only) **40 and under Prior Authorization Required**  
• Cervical cancer Screening (women only)  
• Osteoporosis Screening (post-menopausal women)  
• HPV Screening (women only)  
• Prostate cancer Screening (men only)  
• Abdominal aortic aneurysm Screening (men only)  
• Screening for obesity  
• Diabetes Screening  
• Screening for high blood pressure and cholesterol (lipid disorders)  
• Screening for depression  
• Colorectal cancer Screening (Members 50 years and older) **50 and under Prior Authorization Required**  
• Smoking cessation counseling  
• Diet and exercise counseling  
• Mental Health counseling  
• Alcohol and drug Screening | Members over age 21 as appropriate |
| Child Wellness Services | Whatever is needed to take care of sick children and to keep healthy children well, including Screening and assessments such as:  
• Health and development history and Screenings  
• Physical and mental health development and Screenings  
• Comprehensive health exam  
• Immunizations  
• Lab tests including of blood lead levels  
• Health education  
• Dental Screening Services  
• Vision Screening Services  
• Hearing Screening Services  
• Alcohol and drug Screening and counseling  
• Mental health Services | Members under age 21 |
| Dental Benefits   | • General dentistry (including regular and emergency treatment) and orthodontic care for special problems  
• Check-Ups twice a year with a dentist are covered for children ages 3 through 20.  
• A child’s PCP can perform dental Screenings for a child up to age 3  
• Does not include routine orthodontic care | Members under age 21 (Members 21 years and older can receive dental services from Medicaid. Call MCO Dental Help Line at 1-866-758-6807) |
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>DC HEALTHY FAMILIES PROGRAM</th>
<th>WHO CAN GET THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Benefits</td>
<td>Diagnosis and Treatment of conditions related to hearing, including hearing aids and hearing aid batteries</td>
<td>All Members</td>
</tr>
</tbody>
</table>
| Alcohol & Drug Abuse Treatment | • Inpatient detoxification  
• Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (APRA)  
• Help with getting care from APRA | All Members |
| | • Inpatient and outpatient substance abuse treatment  
• Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (APRA)  
• Help with getting care from APRA | Members under age 21 |
| Dialysis | • Hemodialysis  
• Peritoneal Dialysis | All Members |
| Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS) | • Durable Medical Equipment (DME)  
• Disposable medical supplies (DMS) | All Members |

**Medicaid Member - Services We Do Not Pay For**

*Services We Do Not Pay For*

Exclusions are benefits and/or services that are not paid for by Trusted or DC Medicaid. They include the following:

- Cosmetic surgery
- Experimental or investigational services, surgeries, treatments, and medications
- Services that are part of a clinical trial protocol
- Abortion, or the voluntary termination of a pregnancy, not required under Federal law
- Infertility treatment
- Sterilizations for persons under the age of 21
- Services that are not medically necessary
- Services furnished in schools

After clinical review based on scientific evidence, new technology is evaluated by Trusted for inclusion as a covered benefit. Technology assessment decisions are published in the form of medical policies and are posted to our website for your review and use. In addition, members may request a copy of a medical policy by contacting our Member Services at (202) 821-1100. All existing medical policies are reviewed at least annually and updated accordingly.
### Alliance Only Covered Benefits

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>ALLIANCE PROGRAM</th>
<th>WHO CAN GET THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Services</strong></td>
<td>- Preventive, acute, and chronic health care Services generally provided by your PCP</td>
<td>All Members</td>
</tr>
</tbody>
</table>
| **Specialist Services**  | - Health care Services provided by specially trained doctors or advanced practice nurses.  
  - Referrals are required  
  - Does not include cosmetic Services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs the normal function of your body | All Members              |
| **Laboratory & X-ray Services** | - Lab tests and X-rays                                                                                                                                                                                                                                                                                                                                  | All Members              |
| **Hospital Services**    | - Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services)  
  - Inpatient Services (hospital stay) that do not meet the criteria for an admission as the result of an emergency                                                                                                                                                                                                               | Any Member with a Referral from their PCP |
| **Pharmacy Services**    | - Prescription drugs included on the Alliance drug formulary. You can find the drug formulary at [www.trustedhp.com](http://www.trustedhp.com) or by calling Member Services.  
  - Only includes medications from Alliance network pharmacies                                                                                                                                                                                                                                                                  | All Members              |
| **Family Planning**      | - Pregnancy Testing: Counseling for the woman  
  - Routine and Emergency Contraception  
  - Voluntary sterilizations for Members over 21 years of age (requires signature of an approved sterilization form by the Member 30 days prior to the procedure)  
  - Screening, Counseling and Immunizations (including for HPV)  
  - Screening and preventive treatment for all sexually transmitted diseases  
  - Does not include sterilization procedures for Members under age 21                                                                                                                                                                                                 | All Members as appropriate |
| **Podiatry**             | - Special care for foot problems  
  - Regular foot care when medically needed.                                                                                                                                                                                                                                                                                                           | All Members              |
<p>| <strong>Rehabilitation Services</strong> | - Rehabilitation Services, including physical, speech and occupational therapy                                                                                                                                                                                                                                                                      | All Members              |</p>
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>ALLIANCE PROGRAM</th>
<th>WHO CAN GET THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic devices</td>
<td>• Replacement, corrective, or supportive devices prescribed by a licensed provider</td>
<td>All Members</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>In-home health care Services, including:</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Nursing and home health aide care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home health aide Services provided by a home health agency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical therapy, occupational therapy, speech pathology and audiology Services</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>• Full-time skilled nursing care in a nursing home up to 30 consecutive days</td>
<td>All Members</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>• Support Services for people who are dying</td>
<td>All Members</td>
</tr>
<tr>
<td>Adult Wellness Services</td>
<td>• <strong>Immunizations</strong></td>
<td>Members over age 21 as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Routine <strong>Screening</strong> for Sexually Transmitted Diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV/AIDS <strong>Screening</strong>, testing and counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breast cancer <strong>Screening</strong> (women only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cervical cancer <strong>Screening</strong> (women only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Osteoporosis <strong>Screening</strong> (post-menopausal women)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HPV <strong>Screening</strong> (women only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prostate cancer <strong>Screening</strong> (men only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Abdominal aortic aneurysm <strong>Screening</strong> (men only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Screening</strong> for obesity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diabetes <strong>Screening</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Screening</strong> for high blood pressure and cholesterol (lipid disorders)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Screening</strong> for depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Colorectal cancer <strong>Screening</strong> (Members 50 years and older)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Smoking cessation counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diet and exercise counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mental Health <strong>counseling</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Alcohol and drug <strong>Screening</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Benefits</td>
<td>• General dentistry (including regular and emergency treatment) and orthodontic care for special problems</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• <strong>Check-Ups</strong> twice a year with a dentist are covered for children ages 3 through 20.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not include routine orthodontic care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Includes X-rays, extractions and fillings</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>ALLIANCE PROGRAM</td>
<td>WHO CAN GET THIS BENEFIT</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Hearing Benefits</td>
<td>• Diagnosis and Treatment of conditions related to hearing, including hearing aids and hearing aid batteries</td>
<td>Members under age 21</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Abuse Treatment</td>
<td>• Inpatient detoxification</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (APRA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Help obtaining care from APRA</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) &amp; Disposable Medical Supplies (DMS)</td>
<td>• Durable Medical Equipment (DME)</td>
<td>All Members</td>
</tr>
<tr>
<td></td>
<td>• Disposable medical supplies (DMS)</td>
<td></td>
</tr>
</tbody>
</table>

Alliance Member - Services We Do Not Pay For

**Services We Do Not Pay For**

Exclusions are benefits and/or services that are not paid for by Trusted or DC Alliance. They include the following:

- Acupuncture
- Emergency Services
- Alcohol and other drug abuse services
- Chiropractic services
- Cosmetic surgery
- Deliveries (if you are pregnant, contact the Economic Security Administration (ESA) at 202-727-5355 to determine eligibility for Medicaid. Deliveries are covered by Medicaid)
- Experimental or investigational services, surgeries, treatments, and medications
- Hearing services for members over 21
- Services that are part of a clinical trial protocol
- Abortion, or the voluntary termination of a pregnancy, not required under Federal law
- Infertility treatment
- Open heart surgery
- Organ transplantation
- Private duty nursing
- Sclerotherapy services and items
- Services furnished in schools
- Screening and stabilization services for emergency medical conditions outside of the network including inside of the District. You will be responsible for the charges for the out of network services including emergency services
- Treatment for obesity
- Vision services for members over 21
- Any covered services when furnished by providers that are not members of the Network.
- Sterilizations for persons under the age of 21
- Services that are not medically necessary
- Non - emergency transportation services
- Out of Network /Non Par services
TRUSTED HEALTH PLANS’ MISSION

TRUSTED Health Plan is committed to provide comprehensive, state of the art tools and management to enhance the health status of every member. TRUSTED Health Plan is devoted to reducing health disparities in our community and promoting healthy lifestyles. TRUSTED is also dedicated to the provision of the highest level of care for our members.

TRUSTED HEALTH PLAN WILL OFFER TO PROVIDERS:

• Fair actuarially sound financial arrangements.
• Prompt payment through electronic claims processing.
• Utilization Management with Early Intervention.
• Consistent communication between TRUSTED Health Plans medical team and providers
• Qualified and responsive Provider Relations staff.
• Comprehensive clinical guidelines to direct our quality and health-management programs.
• Online accessibility to create and check referrals, member eligibility and claim status.
• Translation / Interpretation services for Non-English speaking members.
• An extensive network of health care facilities, specialists and primary care providers.

Credentialing

Participating Practitioner Process

COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE (CAQH)

TRUSTED participates with the Council for Affordable Quality Healthcare’s (CAQH). TRUSTED requires all practitioners seeking to participate to complete the Universal Credentialing Datasource (UCD) application, which may be downloaded from CAQH website. An application will be required for all practitioners’ seeking participation within the TRUSTED Health Plan, Inc. (THP) provider network. CAHQ is a nonprofit alliance of health plans and organization that supports the industry collaboration on initiatives that streamlines healthcare administration. At no cost to the provider, CAQH allows the practitioner to fill out one set of credentialing information for all participating health plans and healthcare organizations. This reduces the time, cost, and frustrations associated with completing multiple credentialing applications. Completing an application online with CAQH is as easy as registering at www.caqh.org. Once the practitioner completes the registration process, they will create a unique user name and password and are then ready to begin updating their information online. Information may be entered at any time and changes or updates are instantly available to the health plans and other healthcare organizations authorized by the practitioner.

CREDENTIALING PROCESS

The Credentialing process for providers and practitioners is outlined in the TRUSTED Health Plan, Inc. (TRUSTED) Credentialing Program, comprised of all credentialing policies and procedures. All practitioners participating with TRUSTED undergo a review of their qualifications, including education and training, licensure status, board
certification, hospital privileges, and malpractice history. The credentialing process begins when the practitioner submits a completed, signed and dated Uniform Credentialing Datasource (UCD) application, along with a Standard Authorization, Attestation and Release Form. Copies of the practitioner’s state licenses, DEA or CDS, malpractice face sheet, and curriculum vitae must accompany the completed application. Upon receipt of a clean and complete application package, the Credentialing department will begin the credentialing process. The Credentialing Committee is responsible for making decisions regarding practitioner credentialing. The Credentialing Committee is described in the Quality Management Program. The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee (QEC). Applicants that meet TRUSTED’s credentialing criteria will be recommended to the credentialing committee for inclusion in the provider network. The credentialing committee provides final approval for network participation decisions.

In addition, as part of provider performance monitoring procedures, the Credentialing Committee may review grievances (quality of care concerns) and adverse event data regarding individuals and facilities and may recommend to the Board of Directors that interventions be taken to ensure members’ safety and satisfaction. When presented with information on potential risks to the safety of members in the treatment community, the Credentialing Committee may; based on the information provided recommend to sanction suspend and/or terminate a provider.

**CREDENTIALING COMMITTEE**

The Credentialing Committee, chaired by the Chief Medical Officer, is the physician-based committee that monitors and evaluates the mechanism for licensure of practitioners through the use of a peer review process. It is comprised of a minimum of 3 licensed providers required for credentialing file review and meets at least quarterly. The Credentialing Committee is responsible for making recommendations on credentialing and re-credentialing of the practitioner and provider networks. It also maintains the authority for recommending sanctions against individual practitioners and providers to the Board of Directors. The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee.

**PRACTITIONER PARTICIPATION**

In order to participate with TRUSTED provider network, a practitioner must:

- Be a qualified practitioner in their respective discipline-Primary Care Practitioners (PCP’s) should be licensed and practicing Family/General Practitioner, Internist, Pediatrician, Obstetrician/Gynecologist, Nurse Practitioner, or Certified Nurse Midwife.
- Maintain active admitting privileges or demonstrate adequate admitting arrangements at one or more participating TRUSTED facilities
- Be willing to collaborate with TRUSTED in coordination and optimizing the delivery and quality of care to TRUSTED members
- Comply with Federal, State and TRUSTED's Fraud, Waste and Abuse regulations and requirements
- Have an executed contractual agreement
- Meet the credentialing requirements outlined below and are approved by the Credentialing Committee
Initial Credentialing Requirements

TRUSTED requires all practitioners to complete the Uniform Credentialing Datasource (UCD) Application which may be downloaded from CAQH. The application will require the practitioner to provide:

- Current copy of DEA Certificate and/or CDS Certificate, if applicable
- Copy of internship and residency certification (if not board certified)
- Current copy of malpractice insurance liability certificate, with minimum coverage amounts for specific discipline as required by TRUSTED
- Current copy of unrestricted license to practice
- A current curriculum vitae (CV) describing professional work history to include beginning and ending month, any year for each position held
- Copy of Educational Committee for Foreign Medical Graduates Certificate (ECFMG), if applicable
- Reasons for inability to perform the essential functions as a provider, with or without accommodation; lack of present substance abuse, including illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary activities
- Written explanation regarding any sanction activity, malpractice judgments/settlements, restrictions of privileges, gaps in work history greater than six months, etc.
- Professional peer references, concerning the individual’s professional performance, judgment, and clinical or technical skills

In addition, practitioners are required to demonstrate a degree of professional competence comparable to all practitioners in their specialty, as well as demonstrate the ability to meet the geographic, specialty and business needs of TRUSTED Health Plan. Practitioners must agree to participate in all quality management activities required by the Quality Management Department.

The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee.

Credentialing Process

The credentialing process begins when the practitioner submits a completed, signed and dated Uniform Credentialing Datasource (UCD) application, along with a Standard Authorization, Attestation and Release Form. The completed application must be accompanied by copies of the practitioner’s state licenses (DEA or CDS, malpractice face sheet, and curriculum vitae. Upon receipt of a clean and complete application package, the Credentialing department will begin the credentialing process as defined below:
Incomplete Practitioner Application

The Credentialing Department will process and complete the credentialing application within 120 days from the date of receipt of the Provider Information (PI) form and applicable documentation. The Credentialing Department will notify the applicant by fax, letter, or telephone of any missing information. When an incomplete application is received, three (3) attempts will be made over a sixty - day (60) period to obtain the requested information. Failure to submit the information after the third attempt will be considered a voluntary withdrawal of the application and will result in the practitioner not being considered for the TRUSTED provider network.

COMMUNICATION TO APPLICANT

Upon receipt of all the documentation and responses to verification request and queries, the Credentialing Department will review the file for any discrepancies between the applicants provided information and information received from other parties. Should a discrepancy between these sources be identified, the applicant shall be given a timeframe to respond to the third party information. Upon the earlier date of the receipt of the applicant’s response or the deadline for the receipt of the response, the file shall be forwarded to the Chief Medical Officer (CMO) and the Credentialing Committee for review.

Primary Source Verification

Upon receipt of a completed application, the Credentialing Department will obtain and primary source verify the following information:

- **Current Professional License**: Licensure is verified by the appropriate State Department of Regulations. A verification of the practitioner’s license status is received and placed in the practitioner’s credentialing file;

- **Current Malpractice Coverage**: Current and adequate professional liability insurance is verified via submission certificate of insurance that includes dates and amount of coverage. At a minimum, the coverage amount should be $1,000,000 per incident and an aggregate $3,000,000.

- **Malpractice Claims History**: A request for professional liability claims history or at least the past five (5) years is included in the application. Affirmative responses require additional information/investigation. Additionally, for all applicants the National Practitioner Databank (NPDB) is queried for the verification of professional liability claims history.

- **Drug Enforcement Agency (DEA) Certificate**: The Credentialing Department will obtain a current copy of the DEA certificate and/or verify certificate via the DEA verification website. Any restrictions will require further investigation by TRUSTED. Practitioners that do not dispense medication in the course of practice are exempt from verification.

- **Education and Training**: When a board certification cannot be verified, education and training is verified through either the school attended, online education verification service, American Medical Association Provider Profile (AMA) or the American Board of Medical Specialties (ABMS).

- **Board Certification**: MD and DO board certification is verified by the American Board of Medical Specialties (ABMS) Compendium; Osteopaths AOA Directory of Osteopathic Physicians; Podiatrists-Directory of American Board of Podiatric Surgery or ABPOPPM; Chiropractors-not applicable. Please note that Board Certification is not a
requirement for inclusion in the TRUSTED network.

- **Non-Board Certified Practitioners:** Completion of residency training is verified through the residency training school, or AMA Provider Profile. The Education Commission for Foreign Medical Graduates Certificate (ECFMG) serves as verification for non-board certified practitioners who are foreign educated.

- **Review of Work History:** TRUSTED will review the applicant’s work history for the previous five (5) years. The history may be part of the application, or part of the curriculum vitae. A written explanation is required for gaps in work history in excess of six (6) months. Applicants work history must reflect month and year of employment to identify any gaps in history greater than six (6) months.

**CREDENTIALING DEFINITIONS**

- **Appeal:** A formal request by a practitioner for reconsideration of a decision with the goal of finding a mutually acceptable solution.

- **Attestation:** A signed statement indicating that the practitioner personally confirmed validity, correctness and completeness of his or her credentialing application at the time of application to TRUSTED Health Plan.

- **Board Certified:** A practitioner who has satisfied the requirements and/or standards of a nationally recognized specialty board and has received certification as a specialist from the specialty board.

- **Chief Medical Officer:** A physician employed by TRUSTED, appropriately licensed and credentialed.

- **Credentials:** Documented evidence of registration, licensure, education, training, experience, or other qualifications.

- **Credentialing:** The process of obtaining, verifying, and evaluating the qualifications of licensed practitioners prior to providing health care services to members of TRUSTED Health Plan, Inc.

- **Criteria:** Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific decisions, services and outcomes against which performance can be assessed.

- **Delegation:** A formal process by which TRUSTED Health Plan, Inc. gives another entity the authority to perform certain credentialing functions on its behalf. Although TRUSTED may delegate the authority to perform the credentialing functions, it will not delegate the responsibility for ensuring that the function is performed appropriately.

- **National Practitioner Data Bank (NPDB):** A federally mandated agency that is the repository of information about settled malpractice suits and adverse actions, sanctions or restrictions against the practice privileges of a physician.

- **Peer Review:** Evaluation of one physician’s credentials and practice by another physician.

- **Practitioner:** A professional who provides health care services; e.g., a physician (MD, DO), dentist (DDS), podiatrist (DPM), nurse practitioner (NP), and/or chiropractor (DC), and/or other licensed practitioner (non-physician, mid-level practitioner)

- **Privileging:** A process whereby an individual is formally granted permission to perform specific duties and job functions as defined in clinical privileges or job descriptions based on the individual’s qualifications, experience, education, training and credentials.

- **Primary Source Verification:** The process of verifying credentialing information from the entity that originally conferred or issued the credential.

- **Provider:** An institution or organization that provides health care services to TRUSTED members; e.g. a hospital,
skilled nursing facility, or home health care agency.

- **Provisional Credentialing**: An authorization process that will permit a new practitioner to participate in the network before collection or verification of all required credentials.

- **Re-credentialing**: The process of obtaining, updating and re-verifying, the qualifications of current licensed practitioners to provide health care services to TRUSTED Health Plan, Inc. members.

**SITE VISIT/MEDICAL RECORD REVIEW**

All PCP’s, OBGYN Physicians, and High Volume Behavioral Health Specialist are required to meet TRUSTED’s minimal criteria for office settings in order to be considered for the provider network. A site and medical record review is conducted prior to inclusion in the TRUSTED provider network. The minimal performance threshold for an initial site visit is 85%. All deficient areas require a corrective action plan by the practitioner, and a re-survey is scheduled within 6 months to measure compliance. Any practitioner not meeting the minimal 85% performance standard will be reviewed by the CMO and Credentialing Committee for recommendation. New practitioners joining sites that have been surveyed successfully and have practitioner open or relocate to a new location that has not been surveyed, a site review is scheduled according to the site visit requirements for initial credentialing.

**Re-credentialing Process**

Re-credentialing is performed every three (3) years, as required by NCQA and TRUSTED Health Plan, Inc. Practitioners will be contacted approximately three months prior to the expiration of their current credentialing file and asked to update their information for the next re-credentialing review. TRUSTED re-verifies only the information that is subject to change over time. Static elements such as education are not re-verified during the re-credentialing process. The intent of the re-credentialing process is to identify any changes in the practitioner’s process. The intent of the re-credentialing process is to identify any changes in the practitioner’s licensure, certification, clinical privileges, health status, sanctions status, clinical competence or any other area that may affect the practitioner’s ability to render quality healthcare services to TRUSTED members.

In addition, the re-credentialing process incorporates an assessment of the practitioner’s prior performance with TRUSTED, including but not limited to, medical record review, member complaints, member satisfaction, and information from quality and medical management activities. To ensure quality of care between re-credentialing cycles, TRUSTED performs ongoing quality monitoring for any adverse events, sanctions, or member complaints. TRUSTED will verify Medicare/Medicaid and applicable state information regarding practitioners who have received sanctions or limitations on licensure within 30 days of its release. If a practitioner is identified on a sanction report, or there is evidence of poor quality, the practitioner’s ability to provide services will be reviewed and assessed by the CMO and Credentialing Committee.

Our Standards and Evaluation Forms are available in Appendices C and D respectively. The application, all verification and site review results are forwarded to the Credentialing Committee for a decision. The Credentialing Committee consists of participating network practitioners. All practitioners are sent written notification of initial credentialing and re-credentialing decisions.
Provider Responsibilities

RESPONSIBILITIES BY TYPE OF PROVIDER

All Providers

Practitioners and providers shall facilitate advance directives for individuals as defined in 42 C.F.R 489.100. An advance directive is a written instruction, such as a living will or durable power of attorney for health care recognized under District of Columbia law (whether statutory or as recognized by the courts of the District) relating to the provision of health care when the individual is incapacitated. Practitioners and providers can receive information about procedures for advance directives from Caring Connections, 1-800-658-889, www.caringinfo.org.

PRIMARY CARE PRACTITIONER (PCP) RESPONSIBILITIES

A PCP serves medical needs of their panel of TRUSTED members. PCPs administer primary care and guarantee that the services provided to members are necessary and appropriate. A PCP should strive to provide optimum levels of care while keeping unnecessary services to a minimum.

A Primary Care Practitioner is responsible to TRUSTED and its members for diagnostic services, care planning and treatment plan development. The PCP shall work with TRUSTED to monitor treatment planning and provision of treatment.

All new TRUSTED members with a newly assigned PCP who has not previously cared for the member shall perform a comprehensive initial examination and screenings for mental health and alcohol and drug abuse problems using a validated screening tool approved by TRUSTED prior to referrals for any additional tests or examinations needed in order to complete a comprehensive assessment of the member’s health condition. TRUSTED shall forward to the PCP any information about member’s health history or health conditions received upon enrollment from DHCF, the Enrollment Broker, members, or other sources, in a manner that protects the member’s confidentiality within thirty (30) days of receipt so that it can be considered in the member’s initial evaluation.

During the initial examination and assessment of a child, the PCP shall perform EPSDT screening and any additional assessment, using the approved tool(s) needed to determine whether a child meets the definition of as the member’s personal practitioner and is responsible for coordinating and managing the Child with special health care needs and shall report this determination to the TRUSTED Care Management Department within 72 hours (3 business days).

In addition, the PCP is responsible for:

• Generating electronic referrals for specialty and other medically necessary services.
• Managing and coordinating the medical care of a member with a participating specialist(s) and/or behavioral health provider.
• Early identification of members with special health care needs and notification to TRUSTED about any such member as soon as possible.
• Collaboration with TRUSTED about members enrolled in Disease Management, Behavioral Health Management or Care Coordination program.
• Use of a valid and standardized developmental screening tool, approved by TRUSTED, to screen for developmental delays during well-child visits, episodic visits or as a stand-alone service.
• Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation.
• Early identification of children with special health care needs and notification to TRUSTED about such member within 72 hours. Documentation of all care rendered in a complete and accurate manner including maintaining a current medical record for TRUSTED members that meets TRUSTED's medical record documentation standards. These standards are available in Appendix D.
• Providing follow-up services for members who have been seen in the Emergency Department.
• Promptly and accurately reporting all encounters to TRUSTED Health Plan.
• Working with the TRUSTED multi-disciplinary teams, which include Disease Managers, Case Managers, Social Workers, Care Coordinators, and health educators to facilitate the member’s care.
• Releasing medical record information upon written consent of the member.
• Providing preventive healthcare to members according to preventive health care guidelines.
• Advising TRUSTED's Outreach Department (202) 821-1100 when a member does not keep an appointment and/or when a member cannot be reached after an outreach effort.

**OB/GYN PRACTITIONER AS A PCP**

Participating Obstetricians are responsible for medical services during the course of the member’s pregnancy and for coordinating testing and referral services. Obstetricians may 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 and asthma.
• Treatment of minor physical injuries.
• Preventive health screenings and maintenance.
• Routine gynecological care.

**SPECIALISTS RESPONSIBILITIES**

A TRUSTED specialist is responsible for:

• Providing specialty care as indicated on the referral form.
• Reporting clinical findings to the referring PCP.
• Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the patient as requested by the referring practitioner utilizing a referral form.
• Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for TRUSTED members that meets TRUSTED’s medical record documentation standards (see Appendix D).

• Refrain from referring members to other specialists without the intervention of the referring PCP.

• Assisting patients who come for services with getting a necessary referral.

• Checking the Provider Portal for the member’s continued eligibility and a referral.

**CARE PLANS**

TRUSTED works with practitioners, members and outside agencies to develop Care Plans for members with health care needs. TRUSTED Care Plans specifies mutually agreed upon goals, medically necessary services, and mental health, alcohol and drug abuse services. If the member consents to share this information with the PCP and/or treatment team, any support Services necessary to carry out or maintain the Treatment Plan, and, for children with more complex needs, planned Care Coordination activities.

Care Plans shall take into account the cultural values and any special communication needs of the family and/or the child. TRUSTED requires that 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 as determined by the member’s practitioner and standards of practice. TRUSTED utilizes EPSDT standards in the development of Care Plans for members under age twenty-one (21).

TRUSTED works with practitioners to coordinate care with other treatment services provided by District agencies such as DMH, APRA, and DCPS. The member is assisted in accessing any support needed to maintain the Care Plan. TRUSTED and the PCP must jointly ensure that members and their families (as clinically appropriate as determined by enrollee’s provider) 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. In order to make treatment decisions and give informed consent, available treatment options shall include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether TRUSTED provides coverage for those treatments.

Care Plans for an Enrollee with special health care needs are to be reviewed and updated at least every twelve (12) months or as determined by the member’s PCP on the basis of the PCP’s assessment of the member’s health and developmental status and needs. The revised Care Plan will be incorporated into the member’s medical record following each update.

TRUSTED's Case Management provides for effective methods for referring members to non-network Medicaid services specified in the Care Plan. When a Care Plan includes multiple services inside or outside of TRUSTED network, providers must ensure that there is effective communication and collaboration between Network Providers and other Medicaid Providers inside or outside of TRUSTED's network, Contractor’s Care Coordinators, and non-Medicaid Providers.
PERFORMANCE DATA

Provider agrees that during the term of this Agreement, Trusted may collect and develop data, including, but not limited to, claims, cost, utilization, outcomes, quality, financial performance, and patient satisfaction data related to the health benefit plans offered or administered by Trusted, for quality improvement activity with the Provider and public reporting to consumers. Provider agrees to comply with all reasonable requests by Trusted in the collection of such data. Collectively, such data and reports shall be referred to as, “Performance Data.” Any Performance Data regarding services of a specific provider for a specific Member shall be referred to as “Provider Specific Performance Data.” Trusted shall be the owner of all Performance Data and Provider Specific Performance Data, and to the extent permitted by law (during the term and after the termination of this Agreement), such data may be shared with a current or prospective Member, payor Member, a current or prospective employer or payor of a group health benefit plan and their auditors or health care consultants, insofar as the information concerns covered services that are or would be considered allowable charges under a current or prospective Certificate of Coverage. Performance Data and Provider Specific Performance Data provided to Provider by Trusted shall be kept confidential by Provider and used only for the purposes of carrying out Provider’s obligations under this Agreement. Upon termination of this Agreement, Provider shall return to Trusted any Performance Data that is not Provider Specific Performance Data. Upon written request of the Provider, Trusted shall make available to Provider, a description of how Trusted intends to use Provider Specific Performance Data, the methodology used in collecting and analyzing the data, and a copy of the Provider’s data Trusted intends to disclose. To the extent that Provider can reasonably demonstrate, in writing, that any data that Trusted intends to disclose is inherently inaccurate, Provider shall notify Trusted of its specific concerns. In such a case, Trusted shall make a good-faith effort to resolve Provider’s concerns; provided, however, that Trusted shall have the sole and final discretion, responsibility, and authority over the content, dissemination, and release of such data.
Member Access Standards

GENERAL ACCESS STANDARDS

Appointment scheduling and wait times for members should comply with the access standards defined below. The first set of access standards apply to all practitioners. The second set of access standards apply specifically to behavioral health practitioners. If a practitioner or provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Services Representative or the Provider Relations Department at (202) 821-1100.

<table>
<thead>
<tr>
<th>Access to Medical Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care (life threatening)</td>
<td>Immediately at the nearest facility</td>
</tr>
<tr>
<td>Urgent Care or Sick Care appointments with PCP</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Urgent Care with a Specialist</td>
<td>Within 48 hours of referral</td>
</tr>
<tr>
<td>Routine Appointments (including Health Check and IDEA appointments)</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td>Initial Appointments for pregnant women or persons needing family planning</td>
<td>Within 10 days of request</td>
</tr>
<tr>
<td>Routine Physical Examinations</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td>Waiting Time in Practitioner’s office</td>
<td>Not to exceed 45 minutes</td>
</tr>
<tr>
<td>Use of free interpreter services either onsite by prior request or by telephone</td>
<td>As needed during all appointments</td>
</tr>
</tbody>
</table>

ACCESS TO BEHAVIORAL HEALTH CARE

After a careful analysis of its Behavioral Health Program, TRUSTED decided to contract with Beacon Health Strategies to manage the benefits and services provided to our members needing behavioral health evaluation and treatment. Please go to Beacon’s web site, www.beaconhealthstrategies.com. For more information about the company and the services provided for TRUSTED members.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Emergency care (Life threatening)</td>
<td>Immediately at the nearest facility</td>
</tr>
<tr>
<td>Behavioral Health Telephone Crisis Triage</td>
<td>Within 15 minutes over the telephone</td>
</tr>
<tr>
<td>Psychiatric Intervention or face-to-face Assessment</td>
<td>Within 90 minutes of completion of telephone assessment, when needed. Available on a 24 hour basis 7 days a week</td>
</tr>
<tr>
<td>Treatment for a non-life threatening emergency</td>
<td>Treated as emergency care</td>
</tr>
<tr>
<td>Urgent care with Outpatient Behavioral Health Program Director and Doctor</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Routine Behavioral Health Appointments</td>
<td>Within 7 days of request</td>
</tr>
<tr>
<td>Waiting Time in Practitioner’s office</td>
<td>Not to exceed 1 hour</td>
</tr>
<tr>
<td>Use of free interpreter services either onsite by prior request or by telephone</td>
<td>As needed during all appointments</td>
</tr>
</tbody>
</table>

TRUSTED Health Plan does not perform behavioral health triage or screenings. Should a member call a Behavioral Health Practitioner, the Behavioral Health practitioner shall perform telephone triage and interventions in the time frames shown above, as appropriate. Emergency care does not require preauthorization.

A Beacon Health Strategies behavioral health clinician will work with the Department of Behavioral Health (DBH) in the coordination of substance abuse services. Please call Beacon at 1-888-204-5581, and ask to speak with a behavioral health clinician.

**ACCESS TO AFTER-HOURS CARE/ON-CALL REQUIREMENTS**

If a PCP is unavailable for any reason, arrangements must be made for coverage with a back-up practitioner who is also a participating PCP with TRUSTED Health Plan. **A recorded message directing all members to the emergency room is not acceptable.** TRUSTED requires that all network practitioners have coverage for after-hours care and have the appropriate member instructions on the practitioner telephone service after hours. All practitioners’ telephone services must provide the following after hour’s instructions:
Emergency care
- Call 911 and/or go to the nearest facility immediately

Urgent non-medical emergency where care is needed before business hours
- Provide a telephone number for the covering practitioner

Urgent non-medical emergency where care is not needed until business hours
- Advise member to call during business hours

**ACCESS TO OUT OF NETWORK SERVICES**

If the network is unable to provide necessary medical services covered under the contract to a member, TRUSTED will cover these services for the member. TRUSTED will continue to cover these services until the member has access to a provider in-network. TRUSTED will coordinate services for out of network providers with respect to payment and will ensure that the cost for services provided to the member is not greater than it would be if the services were furnished within the network to the extent possible.

Approval of out of network services must be obtained in advance of the services. The exception to this is in situations in which obtaining the authorization would create a delay in care resulting in jeopardizing the medical outcome of the member. In such emergent or urgent situations, the plan should be notified as soon as possible.

**ACCESS SURVEY**

TRUSTED will conduct a regular survey using secret shoppers to verify that practitioners are in compliance with the access standards. All survey results, including any recommendations for improvement, are communicated to the practitioner in writing at the conclusion of the review.

A Corrective Action Plan (CAP) will be developed and implemented for any practitioners who fail to fully meet the access standards. Follow-up surveys and visits will be conducted in three to six months to monitor the practitioner’s progress towards compliance with the standard panel closing requirements.

When members choose a practitioner as their PCP, they are assigned to the practitioner’s panel of members. The panel remains open unless the following occurs:

- The PCP is under sanction
- The PCP has voluntarily closed his/her panel
- The panel is closed by TRUSTED due to member access issues.

A PCP must provide written notice to TRUSTED at least 30 days in advance of reaching 2000 enrollees across all Medicaid health plans. A PCP must provide written notice to TRUSTED at least 90-days in advance if the PCP should decide to close their panel. TRUSTED PCP’s are contractually obligated to be available and accessible to their panel members 24 hours a day, 7 days a week.
CULTURAL AND LINGUISTICALLY COMPETENT SERVICES PROGRAM

TRUSTED Health Plan is committed to reducing barriers to health care delivery. As a major provider of health care, TRUSTED recognizes the emerging challenges and opportunities associated with the rapidly changing population we serve. The District of Columbia is comprised of various cultures, sub-cultures, and ethnicities. The Medicaid and Alliance population includes people with varied cultural values and backgrounds.

TRUSTED requires that enrollees with limited or no English proficiency be assessed for the need for, and offered, translation services. The translation services may be provided by either telephonic or face-to-face interpretation. TRUSTED Health Plan strongly recommends that all interpreters be appropriately trained in medical terminology to assure accurate translation of information. TRUSTED provides free access to Interpretation services via, Language Line Services to facilitate practitioner-member-practitioner communication. Callers may access Interpretation services by calling member services at: 202-821-1100. If a member needs an interpreter to attend their appointment with them, TRUSTED member services must be notified two (2) days or 48 hours prior to the appointment.

Family members, especially minor children, shall not be used as interpreters in assessments, therapy or other medical situations in which impartiality and confidentiality are necessary, unless specifically requested by the member. Should the member express a preference to rely on a family member or friend, the member must be advised that there is a free interpreter available. If the member refuses professional oral interpretation services, the practitioner shall document the offer of professional interpretation services and the member’s declination in the member’s medical record. If an onsite interpreter is needed, please contact Member Services at 202-821-1100.

TRUSTED Health Plan recognizes that cultural competence is not limited to the provision of medical information in an enrollee’s preferred language. The health care practitioner’s ability to accept, value, serve, communicate and interact with individuals who are racially, ethnically, linguistically, or culturally different from that of the practitioner. TRUSTED, in collaboration with the practitioner, will provide assistance with cultural and language barriers by implementing strategies supportive of cultural competency through the organization including health education and case management.

THE AMERICANS WITH DISABILITIES ACT OF 1990 & REHABILITATION ACT OF 1973

Section 504 of the Rehabilitation Act of 1973 (“Rehab Act”) and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require TRUSTED network of practitioners and providers to make their services and facilities accessible to such individuals. TRUSTED expects all practitioners and providers in its network to comply with the requirements of these statutes. The requirements of the ADA and the Rehab Act regarding accessibility are lengthy and complex. TRUSTED policy on access summarizes the main requirements and sets forth TRUSTED minimum expectations of its practitioners and providers. The policy is provided in Appendix A. This policy is not legal advice and does not purport to cover every statutory requirement. Practitioners and providers should consult with their own legal counsel about their obligations under these statutes.
REPORTING DISCRIMINATION COMPLAINTS

TRUSTED practitioners and providers must promptly address all complaints of discrimination or lack of access by individuals with disabilities. Complaints must be reported to TRUSTED as soon as reasonably possible after the complaint is received. In no case should the report be made more than seven (7) business days after receipt. Please report complaints IN WRITING TO:

TRUSTED HEALTH PLAN, INC.
ATTENTION: GRIEVANCE COORDINATOR
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
Or Call (202) 821-1100 or (855) 326-4831

www.TRUSTEDhp.com
TRUSTED Health Plan Committees

PHYSICIAN ADVISORY COMMITTEE
The Physician Advisory Committee (PAC) provides a forum for the high-volume TRUSTED Health Plan primary care practitioners to participate with TRUSTED leadership on issues related to the clinical and operational facets of TRUSTED Health Plan. The Committee provides TRUSTED with a mechanism to involve practitioners in the development of policies and procedures affecting patient care, clinical practice trends, and evidence-based guidelines and HEDIS performance. Committee members provide support and participate on other TRUSTED Quality committees.

Responsibilities:
1. Enhance TRUSTED ability to provide quality health care and services.
2. Provide strategies to improve member retention and member satisfaction.
3. Participate as advisors in member complaint resolution.
4. Participate in a forum to discuss and resolve practitioner and provider satisfaction issues.
5. Provide input in the development of educational and training sessions for TRUSTED practitioners, providers and members.
6. Participate as advisors in the discussions about the development of policies and procedures that affect clinical care, service and HEDIS performance.

MEMBER ADVISORY COMMITTEE
The Member Advisory Committee (MAC) provides a forum for TRUSTED Health Plan members to participate with TRUSTED leadership on issues related to the administration of TRUSTED Health Plan. The Committee formalizes member advocacy and member input on health care services and administration.

Committee members discuss policies and procedures, complaints and operational issues and put forward suggestions for improvement. Committee members are invited and encouraged to participate in health education sessions and community outreach initiatives and to provide feedback to TRUSTED leadership. The Committee provides TRUSTED with a mechanism to involve members in the review process, the development of new benefits and coverages, health programs, and recruitment activities.

TRUSTED ADVISORY COMMITTEE
TRUSTED has established an advisory committee to provide feedback and suggestions for improving the service TRUSTED provides its members. The Committee scope includes all aspects of TRUSTED member services. The Committee’s purpose is to enhance collaboration between TRUSTED, District of Columbia agencies and community members in improving TRUSTED operational systems.

The Committee is composed of TRUSTED employees and includes but is not limited to: TRUSTED members; primary,
specialty and behavioral health practitioners with expertise in IDEA, EPSDT, adolescent health, HIV/AIDS, substance abuse, obstetrics and gynecology, and pediatric dentistry; community representatives of advocacy groups and trade associations; District of Columbia (DC) agencies; and, TRUSTED administrative staff.

The committee is charged with:

- Providing feedback on member services and on member, practitioner and provider communications
- Reviewing qualitative and quantitative data
- Identifying opportunities to improve member services
- Providing suggestions on actions to improve performance

Any practitioner may volunteer to participate on the Committee by calling the Director of Quality at (202) 821-1100.

**PHARMACY AND THERAPEUTICS (P&T) AND FORMULARY MANAGEMENT COMMITTEE**

The Pharmacy & Therapeutics (P&T) Committee is a subcommittee of the Quality Management Committee. The Committee serves in a decision-making capacity to TRUSTED Health Plan in matters pertaining to the use of pharmaceuticals to promote high quality, cost-effective pharmaceutical therapy to TRUSTED members. The committee develops and approves policies regarding evaluation, selection and therapeutic use of pharmaceuticals for members. The Committee provides TRUSTED with a mechanism to involve pharmacists and appropriate practitioners in the development and periodic updates of its pharmaceutical management procedures.

The Pharmacy & Therapeutics Committee is further responsible for the analysis and evaluation of new developments in technology and new applications of existing technology, procedures, pharmaceuticals and devices for medical and behavioral health care. The Committee provides TRUSTED with a mechanism to involve practitioners and pharmacists in the evaluation of published scientific evidence regarding the clinical use, safety, efficacy and outcomes of medical technology to ensure that TRUSTED members have equitable access to safe and effective care.

**PHARMACY AND PATIENT SAFETY PRECAUTIONS**

TRUSTED maintains a comprehensive pharmaceutical patient safety program. In partnership with its pharmacy benefits manager, TRUSTED requires that pharmaceutical safety information be provided to all members at the point of pharmaceutical dispensing. TRUSTED will notify practitioners when point of dispensing screening identifies specific interactions that may place a member at risk.

TRUSTED and its PBM monitor for Class I and II recalls by the Federal Drug Administration (FDA). Practitioners will be notified of these recalls as expeditiously as patient safety warrants. Class I notifications are expedited. Class II notification will occur within 30 days of FDA notification. Whenever possible, TRUSTED notification will include a listing of specific members receiving the recalled medication.

Practitioners are expected to assure the security of their prescription pads, DEA numbers and CDS numbers. It is unlawful to use an unauthorized DEA number or CDS number and/or to pass forged prescriptions. Practitioners should immediately
report any instances of the improper or the unauthorized use of prescriptions pads involving TRUSTED members. Reports may be made by contacting TRUSTED at:

**PHARMACY**

Medicaid Members can fill all prescriptions written by participating practitioners at the designated pharmacies. There is no co-payment for prescriptions. Specific over-the-counter drugs are covered for Medicaid members with a written prescription when purchased at a participating pharmacy. Alliance Members can fill all prescriptions at one of the Department of health Pharmacy Network Pharmacy locations.

If your patient requires a medication not on the formulary, practitioners may request an exception. Download the form from the TRUSTED web site [www.trustedhp.com](http://www.trustedhp.com) or call the Utilization Management Department at (202) 821-1132 or (855) 326-4831 to request that a non-formulary exception override form be faxed to you. Complete the form and return it with a copy of the prescription (This is required. Avoid delays by including the prescription with your request.)

*Note: A script for a 3-day supply of the medicine may be filled while the review is completed for prescriptions written at discharge from a Hospital or Emergency Room.*

Meridian Pharmacy Benefit Manager manages TRUSTED's pharmacy network and prescription processing. There is no co-payment for prescriptions. Prescriptions must be written by participating practitioners. Specific over-the-counter drugs are covered for Medicaid members with a written prescription when purchased at a participating pharmacy.

If a patient requires a medication not on the formulary, providers may request a non-formulary exception by faxing a request to 202-821-1127 or mailing it to: Pharmacy Director; TRUSTED Health Plan, 1100 New Jersey Avenue, SE. Suite 840, Washington DC 20003.

The prescriber may call The Pharmacy Director at 202-821-1127.

The request will be reviewed to determine if it meets the criteria for approval. Note: A three-day supply of the medication may be dispensed while the review process is being completed for prescriptions written upon discharged from a Hospital or Emergency Room.

**Continuous Quality Improvement (CQI)**

TRUSTED CQI Program is a comprehensive, integrated and widely deployed approach to planning, designing, measuring, assessing, and improving quality, patient safety, health outcomes, utilization, risk management, affiliated care, and service performance. All plans, goals, and initiatives are congruent with the District of Columbia’s Department of Health Care Finance (DHCF) strategy and the National Committee on Quality Assurance (NCQA); but aligned with, and guided by, TRUSTED mission and vision. Assessing group and member needs, responding to the voice of the customer and monitoring quality of care and service are integrated into TRUSTED CQI Program.
The TRUSTED CQI Program covers all services rendered to TRUSTED members. The CQI Program is aimed at assessing and improving care and services. TRUSTED delegate’s quality management functions to some of its external organizations including:

1. Alere (Maternal Case Management/ NICU Case Management)
2. Beacon Health (Behavioral Health)
3. DentaQuest/Eye Quest
4. MTM Transportation
5. Centene/Nurse Response Line
6. NIA Magellan (National Imaging Associates)

TRUSTED will conduct delegated audits of each vendors Quality Management program annually and ensure compliance with NCQA standards.

The TRUSTED CQI Program monitors and evaluates significant aspects of the clinical care, member services and administrative services provided to members. The program integrates cross-functional activities using interdisciplinary teams whenever possible.

The program establishes performance measures and targets, identifies variation and root causes and initiates improvements to processes. Cross-functional activities are integrated to assure continuity. Monitoring of measures is conducted and results are reported on organization-wide and individual practitioner level whenever possible.

Important aspects of care and service in monitoring and improvement activities include:

- Primary network
- Access to network (including ADA standards)
- Appointment availability
- Appeals & denials
- Appropriateness and efficiency of ancillary services
- Compliance and regulatory issues
- Continuity of care
- Focused studies
- High volume and/or high risk diagnoses and/or problem prone processes
- Internal customer needs and expectations
- Medical records documentation
- Member satisfaction
- Member concerns
• Number of practitioners by geographic location
• Over utilization, miss-utilization and under utilization
• Oversight of delegated activities
• Vendor monitoring
• Preventive care
• Quality and risk occurrences
• Quality control monitoring
• Sentinel events
• Patient safety
• Fraud, waste and abuse

TRUSTED uses a model for improvement based on W. Edwards Deming’s PDSA cycle. The PDSA cycle tests a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). The model contains three fundamental questions that form the basis of improvement:
• What are we trying to accomplish?
• How will we know that a change is an improvement?
• What changes can we make that will result in improvement?

Once the three questions have been answered, a test of change is run. The cycle then repeats. Focus on the three questions and the PDSA cycle allows the application of the model to be as simple or sophisticated as necessary.

Well-defined quantitative performance measures drive clinical and service improvement activities. Whether initiated as a key element of the organizational planning process or by an individual department, every quality improvement project begins with measurable performance indicators.

Performance targets are identified for comparison with current TRUSTED performance. Interventions are designed by teams with direct clinical and operational accountability to achieve target outcomes and systematic performance improvement. In general, the Quality Management Program targets improvement in processes and outcomes that affect high risk, high volume, and under-served populations.

Leaders establish performance measures and collect data on key processes and outcomes related to patient care and organizational functions. The approach is planned, systematic and organization wide. The activities are collaborative and interdisciplinary. TRUSTED uses health status data of its members to fulfill its responsibility for meeting members’ health needs, and develops and implements initiatives as needed to assist members and practitioners in managing chronic conditions.

TRUSTED is committed to a philosophy of continuous quality improvement. Excellence in clinical care and service is
our mission with these important themes. Member needs determine our care delivery system (member-centered care). The key relationship for our member is with his or her physician(s) in the care delivery system. The member-physician relationship, responsibility, and accountability is enhanced by effective information and multi-disciplinary problem solving that is data driven; fear-free learning that is important for continuous improvement (“information for improvement, not for judgment”) and the goal to find better ways to meet or exceed our member’s need or expectations. Physician leadership in all aspects of quality activities is vital to success. Teams function effectively with precise information, leadership development, and technical process facilitation.

The overall evaluation of the effectiveness of TRUSTED CQI Program is conducted annually. The primary objective of the formal evaluation and assessment is to assure that the Program is effective in meeting its established goals and objectives as defined in the CQI Work Plan.

The formal evaluation process of the CQI Program includes assessment of TRUSTED quality structure and processes. Goals, initiatives, structure or responsibilities are revised as needed to assure an effective program. Quality initiatives are continuously assessed throughout the year. Quality issues are tracked and improvement efforts are documented. Improvement opportunities are identified through the formal evaluation process and other assessment processes.

**QUALITY OF CARE REVIEW**

TRUSTED reviews member complaints and risk management referrals for deviations from the accepted standards of practice. When a potential quality of care issue is identified, a licensed health care practitioner reviews the case. Any practitioner involved in such a review will be notified and offered the opportunity to respond to the issue(s) raised in the investigation.

In the event that health care service rendered to TRUSTED members is outside the recognized standards of practice or the TRUSTED CQI standards, the Practitioner may be subject to sanctioning. If formal sanctioning proceedings result in negative outcomes, then TRUSTED will provide the appropriate notification to all designated authorities in accordance with the specifications of such law(s).

Such actions may include: closure of practitioner member panels, suspension of privileges, withholding of payments, deduction from future payments, and termination of agreement with TRUSTED. Information on the sanction process will be provided upon request.

The TRUSTED CQI description, including information on progress toward quality goals, is available to all practitioners, providers, members and TRUSTED employees upon request. To obtain a copy of the complete CQI Program description, Work Plan or annual evaluation, or to provide input on TRUSTED CQI Program, call *(202) 821-1100* to reach the Quality Department or visit the provider resources section on our website at www.trustedhp.com.
COMPLIANCE REQUIREMENTS

TRUSTED providers are required to comply with all TRUSTED policies and with legal or regulatory standards set by relevant outside entities. Although not an exclusive list, the primary areas of compliance with policies and regulations for TRUSTED providers are:

- Medical Records Documentation Standard - See Appendix D for details
- ADA and Office Site Standards - See Appendix A, Appendix B, & Appendix C for details
- HIPAA
- DHCF Contractual Obligations
- Waste, Fraud & Abuse

As a practitioner or provider, new and unique complexities create risks to you and your practice daily. TRUSTED is concerned about the ethics and legality of the health care provided to its members and seeks partnerships with providers to comply with uniform and safe standards.

The TRUSTED Compliance program, a DHCF mandate, is responsible for detecting and reporting suspected Fraud, Waste, and Abuse and ensuring adherence to legal, regulatory, and contractual obligations. The supervision of this program has been delegated to the Compliance Officer and the Compliance Committee. The Compliance Committee is composed of management staff-level representatives from all administrative departments.

The Compliance Committee also oversees Risk Management, reviews all reported incidents and is supervising the implementation and management of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

Medicaid Fraud is a major priority of the Department of Justice and the Inspector General of the Department of Health and Human Services. It is estimated that 2-5% of claims submitted annually can be identified as potential fraud. The most common abuses are up coding, unbundling, billing for non-performed services, and organized crime. TRUSTED employees receive training in detecting and reporting suspected fraud, waste and abuse cases, and are aware of the common illegal practices of vendors, employees, and members. Providers should be aware that as subcontractors of TRUSTED Health Plan, they are recipients of Federal funds. Therefore, fraudulent billing, as well as providing assistance to members in receiving improper benefits, are both considered Medicaid fraud and subject to prosecution by Federal authorities.

TRUSTED encourages the reporting of instances of Fraud, Waste, and Abuse, by its members, practitioners and providers, employees and other vendors. Reports and complaints can be made directly and anonymously to the Compliance Hotline at (855) 228-1700 or via email at ReportFraud@trustedhp.com, 24 hours a day, 7 days a week. Individuals making reports are not required to leave their name. TRUSTED Health Plan does not discriminate or take any adverse action against members, practitioners and providers, employees, or others who make good faith reports of Fraud, Waste and/or Abuse.

Practitioners and providers pursuant to the Deficit Reduction Act of 2005 should be aware of the provisions of the Federal False Claims Act and the District of Columbia Procurement Reform Act. The Federal False Claims Act (the “Act”)
allows for triple damages and a penalty of $5,500 to $11,000 per claim for anyone who “knowingly” submits or causes the submission of a false or fraudulent claim in the United States. The government does not need to prove specific intent to defraud to find liability; rather, liability can be proven by evidence of deliberate ignorance of the falsity of the claim or if the individual acts in “reckless disregard” of the falsity of the information. A “claim” under the Act for health care purposes generally means each claim form submitted for payment but can also result from a false certification of a government-required document (e.g., false time and effort reports).

A “false claim” under the Act can result from a number of non-compliant actions; examples of false claims include billing for services not performed, up-coding (billing at a higher level when the applicable level of service was either not performed or the documentation does not support the level of service billed), knowing misuse of provider identification numbers, routine waiver of co-payments and deductibles, billing more than once for the same service, billing for services that are known to be non-covered services, or false time and effort reports. The Act has also been used to enforce the Federal Anti-Kickback Statute and the Stark law (federal prohibition on physician self-referrals).

The Act contains very detailed provisions for the filing of and prosecution of false claims actions. Under the Act, a private person, known as a “relator,” can bring a lawsuit on behalf of the United States when this private person has information that a false claim has been filed for payment to the United States. The relator does not have to be personally harmed by the submission of the false claim to bring such a lawsuit.

When the complaint is filed, it is shared only with the government (i.e., not the defendant) and it must be filed under seal (in secrecy). After the complaint is filed under seal, the government has 60 days to decide whether or not it wants to take over the lawsuit (i.e. “intervene”). Typically, the government requests many extensions to this 60-day time period. Once the government makes the decision to intervene, the complaint is finally served on the defendant. If the government decides not to intervene, the relator is still entitled to pursue the case on his/her own behalf. If the government intervenes in the lawsuit, a settlement or trial verdict in favor of the relator is obtained, and if the relator was not involved in the wrongdoing, the relator can receive between 15 and 25 percent of the settlement or proceeds of the lawsuit. If the government does not intervene and the relator obtains a settlement or trial verdict, the relator will receive between 25 and 30 percent of the proceeds. In general, a lawsuit under the Act must be filed within 6 years of the date of the violation; in some instances it can be brought later than 6 years, but in no case more than 10 years after the violation occurred.

Relators are protected under the Act from any type of retaliation (including being discharged, demoted, suspended, threatened, harassed or discriminated against) by his or her employer as a result of providing any assistance or information relating to a lawsuit under the Act.

The Procurement Reform Amendment Act (Reform Act) is very similar to the Federal False Claims Act. The Reform Act provides for treble damages, but the penalties are $5,000 and $10,000 for each false claim. The Reform Act does require that the individual have knowledge that the claim was false. The Act also provides for reduced penalties if the person committing the violation, reports the matter within 30 days of learning of the violation, cooperates in the investigation, and no formal action has been instituted.

As in the federal statute, individuals may bring a private civil action for violations of the Reform Act. The qui tam plaintiff, as such individuals are called, must serve the Office of the Attorney General of the District of Columbia on the
same day that the civil action is filed. The Office of the Attorney General has 180 days in which to determine whether it
will proceed with the action or decline to proceed. The action is held in abeyance until this decision is made. If the
Attorney General decides to proceed, he or she will have complete control over the action, including any decision to
settle.

As in the Federal False Claims act employees who disclose, assist in the investigation, initiation, testify, or provide
assistance in the filing of a qui tam action may not be discharged, demoted, suspended, threatened, harassed, denied
promotion, or in any other manner discriminated against in the terms and conditions of their employment.

**MEDICAL RECORD KEEPING GUIDELINES**

TRUSTED is committed to partnering with our contracted practitioners and providers in providing our members with the
highest possible quality of care. Consistent, current and complete documentation is an essential component of quality
patient care. The medical record must “tell the story” of the patient as determined by the physician in the circumstances in
which he or she saw the patient. The record is not just a personal memory aid for the individual physician who creates it,
but must allow other health care practitioners and providers to read quickly and understand the patient’s past and current
health concerns. Efficient medical record keeping facilitates current and future medical treatment of individuals by
recording which treatments have and which have not been effective and the degree to which they have been effective as
well as preventing harmful interactions attributable to different medical treatments.

In recognition of the key role that medical records play in providing clinical care, and to promote best-practice medical
record keeping, we have adopted the components identified by the National Committee for Quality Assurance (NCQA) as
our standard for medical record keeping. These guidelines have been incorporated into our ongoing quality oversight of
contracted practitioners and providers and are available in *Appendix D of this manual*.

Practitioners should have a member’s medical record available and accessible at all times for patient care.

**MEDICAL RECORDS HIPAA ISSUES**

TRUSTED is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability
and Accountability Act (HIPAA) and expects that its practitioners and providers are familiar with their responsibilities
under HIPAA and take all necessary actions to fully comply. Any member record containing clinical, social, financial, or
any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration,
destruction, and unauthorized or inadvertent disclosure. Medical records of network practitioners are to be maintained in
a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review.
Practitioner offices are to have an organized medical record filing system that facilitates access and availability of records
at all times. To maintain these standards, practitioners should ensure that the following standards for availability,
confidentiality and organization of medical records are met:

1. A designated staff-person qualified by training or experience, which has oversight of and access to the medical
   records storage system (paper or electronic system).
2. The office has a policy that includes the manner, in which the medical record is organized, the content of the medical
   record and the manner in which it is filed.
3. If the practitioner has several offices, there is a system to obtain records from one office to another if a patient is seen at several office locations.

4. Records for patients who have not been seen by the practitioner for a period of time may be stored off site and are easily accessible if the patient should return.

5. The office implements and maintains procedures for maintaining and safeguarding the confidentiality of member medical records and treatment in accordance with applicable federal and state law.

**RELEASE OF MEDICAL RECORDS**

A member has the right to review a copy of his/her medical records. A written authorization from the member or responsible party is required for the release of medical records, and such request shall be at no cost to the member. The authorization should include the following:

- Name of the institution or practitioner that is to release information
- Name of the institution or practitioner that is to receive the information
- Member’s full name
- Member’s address
- Member’s date of birth
- Description of type of information to be released (including dates of services)
- Date consent is signed
- A statement with respect to the member’s rights regarding to the release of psychotherapy notes if applicable
- A statement advising the member that they can revoke their authorization at any time

Copies of medical records should be released promptly upon written request and reasonable notice from the member or their representative. After the authorized release of medical record copies, the written authorization should be retained in the member’s original medical records.

**AMBULATORY MEDICAL RECORD REVIEW**

Ambulatory medical record documentation review is conducted for primary care practitioners (PCPs) and specialists, as needed. Reviews will be conducted to determine compliance with established standards and performance goals.

Satisfactory completion of the review requires PCPs and non-behavioral health specialists to have met at least 4 of the 6 critical elements for each record reviewed. Practitioners not meeting TRUSTED medical records performance goals will be informed of areas needing improvement be required to submit a corrective action plan and be re-audited within 90 days.

At the time of the review, verbal feedback will be provided to the practitioner/office staff concerning the results of the review. Practitioners who fail to meet the required 4 of the 6 elements will be expected to document and implement a corrective action plan. A follow-up visit and ambulatory chart review will be conducted no sooner than three (3) and no
more than six (6) months after the initial review to monitor progress towards compliance.

If the practitioner’s medical records fail to meet the required standards at that time, a third and final review will be conducted within three (3) months.

Failure to meet the required standard after three reviews based on the guidelines will result in disciplinary action to include but not limited to sanctioning and/or censure.

**UNDERSTAND YOUR BILLING PRACTICES**

Practitioners should be diligent in supervising and training billing personnel. It is the responsibility of the practitioner to ensure compliance with billing guidelines and regulations. Up coding, unbundling, billing for phantom patients, and billing for services that have not been performed could be found to be fraudulent practices and may be forwarded to the appropriate legal entity for review. Underutilization of services might constitute fraud in a capitated network. Each member should be seen by his or her health care practitioner at least once a year, if only for preventative screenings.

**REPORT SUSPECTED WASTE, FRAUD AND ABUSE**

Issues involving TRUSTED members can be reported to the anonymous and confidential Compliance Hotline at 855-228-1700. Issues can also be reported via email to ReportFraud@Trustedhp.com. TRUSTED shall ensure that no individual who reports plan violations or suspected fraud and abuse is subject to retaliation.

**REPORT SUSPECTED CHILD ABUSE OR NEGLECT**

Suspected abuse and/or evidence of abuse or neglect must be reported to the Child and Family Services Agency (CFSA) and/or the Metropolitan Police department. The Child Abuse and Neglect Reporting Hotline for District referrals is (202) 671- SAFE or (202) 671-7233. CFSA takes reports of child abuse and neglect 24 hours a day, seven days a week. Appropriate referrals for other social agencies should also be initiated. TRUSTED network hospitals are required to also report child abuse to TRUSTED Compliance and Risk Management Department.

**IMPLEMENT HIPAA PRACTITIONER PROVISIONS**

TRUSTED is a HIPAA compliant company. It is essential that practitioners understand the impact of this act on his/her practice. See Appendix G for additional information about TRUSTED Privacy Practices. All practitioners and providers must report potential HIPAA violations to TRUSTED Compliance Department at (855) 228-1700.

**RISK MANAGEMENT**

Risk Management is the process of identification, analysis, intervention, and monitoring of all departments within TRUSTED Health Plan, Inc. and their actual or potential ability to cause loss within the financial, reputation, patient care and/or any other sphere of operation.

Incidents are evaluated for their level of risk of loss and interventions developed to prevent or control further occurrences. Monitoring of processes and interventions with regard to the ability to control and/or decrease losses, keeping in mind company policy and strategic goals, will determine the overall success of the Risk Management
The Risk Management Program is committed to ensuring safe and professional care for all members and to ensure the safety of TRUSTED employees and health care practitioners. The Risk Management Program will identify and evaluate risks, and take appropriate action(s), including the development of corrective action plans, to prevent and reduce loss exposure.

Patient Safety is an integral part of the overall Quality and Risk Management Program. All quality initiatives are designed with consideration given to improving safety and reducing risk for our members by assuring a safe patient-care environment in the facilities of our network providers and practitioners. Recognizing that effective medical care error reduction requires an integrated and coordinated approach, we encourage our providers and practitioners to utilize a systematic program to minimize physical injury, accidents and undue psychological stress during instances of inpatient and outpatient treatment. TRUSTED organization-wide safety program includes all activities contributing to the maintenance and improvement of patient safety.

TRUSTED leadership assumes a role in establishing a culture of safety that helps to minimize hazards and patient harm by focusing on processes of care and incident reporting. The leaders of the organization are responsible for fostering an environment through their personal example emphasizing patient safety as an organizational priority, providing education to staff regarding the commitment to the reporting of medical care errors, supporting proactive endeavors to reduce medical care errors and integrating patient safety priorities into the design of all relevant organizational processes, functions and services.

TRUSTED monitors Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation status and whether the JCAHO National Patient Safety Goals are met at the time of accreditation. Almost 50 percent of Joint Commission standards are directly related to safety, addressing such issues as medication use, infection control, surgery and anesthesia, transfusions, restraint and seclusion, staffing and staff competence, fire safety, medical equipment, emergency management, and security. Additional patient safety standards went into effect for hospitals in 2001, and similar standards went into effect for behavioral health care and long-term care organizations in 2003, and for ambulatory care and home care organizations in 2004. These standards address a number of significant patient safety issues, including the implementation of patient safety programs; the response to adverse events when they occur; the prevention of accidental harm through the prospective analysis and redesign of vulnerable patient systems (e.g. the ordering, preparation and dispensing of medications), and the organization’s responsibility to tell a patient about the outcomes of the care provided to the patient—whether good or bad.

TRUSTED strongly encourages that practitioners in all care settings implement processes to meet JCAHO’s National Patient Safety Goals. The purpose of the Joint Commission’s National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that a service delivery system design is intrinsic to the safe, high quality health care, the goals generally focus on system wide solutions, wherever possible. The following table lists a few of JCAHO’s Patient Safety Goals that can be implemented in any care setting:
<table>
<thead>
<tr>
<th>JCAHO Patient Safety Goal</th>
<th>Suggested Action to Improve Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the accuracy of patient identification</td>
<td>Use at least two patient identifiers when providing care, treatment or services</td>
</tr>
<tr>
<td>Improve the effectiveness of communication among caregivers</td>
<td>Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.</td>
</tr>
<tr>
<td>Reduce the risk of health care-associated infections</td>
<td>Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines</td>
</tr>
<tr>
<td>Encourage patients’ active involvement in their own care as a patient safety strategy</td>
<td>Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so</td>
</tr>
</tbody>
</table>

**REPORTING UNUSUAL AND/OR CRITICAL INCIDENTS**

TRUSTED 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 intent of this review is to identify those 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 TRUSTED. The phrase “or the risk thereof” includes any process variation for which an occurrence (as in “near miss”) or recurrence would carry a significant chance of a serious adverse outcome. TRUSTED's goal is to:

1. Have a positive impact on improving patient care, treatment, and services and prevent sentinel events.
2. 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.
3. Increase general knowledge about sentinel events, their causes, and strategies for prevention.

Practitioners are expected to report unusual occurrences, including near misses, to TRUSTED in real time. TRUSTED recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore allowance is made for the stabilization of the member prior to reporting. All sentinel and critical events (*see Appendix H for a full copy of TRUSTED Sentinel Event policy*) must be reported to TRUSTED within 24 hours of occurrence. Reports may be made directly to TRUSTED Risk Manager by calling (202) 821-1100.

TRUSTED will not take punitive action or retaliate against any person for reporting an unusual occurrence. Involved
practitioners will be offered the opportunity to present the factors leading to the unusual occurrence and respond to any questions arising from the review of the unusual occurrence.

PHARMACY AND PATIENT SAFETY PRECAUTIONS

TRUSTED maintains a comprehensive pharmaceutical patient safety program. In partnership with its pharmacy benefits manager, TRUSTED requires that pharmaceutical safety information be provided to all members at the point of pharmaceutical dispensing. TRUSTED will notify practitioners when point of dispensing screening identifies specific interactions that may place a member at risk.

TRUSTED and its PBM monitor for Class I and II recalls by the Federal Drug Administration (FDA). Practitioners will be notified of these recalls as expeditiously as patient safety warrants. Class I notifications are expedited. Class II notification will occur within 30 days of FDA notification. Whenever possible, TRUSTED notification will include a listing of specific members receiving the recalled medication.

Practitioners are expected to assure the security of their prescription pads, DEA numbers and CDS numbers. It is unlawful to use an unauthorized DEA number or CDS number and/or to pass forged prescriptions. Practitioners should immediately report any instances of the improper or the unauthorized use of prescriptions pads involving TRUSTED members. Reports may be made by contacting TRUSTED at:

Compliance Hotline at: (855) 228-1700
or, ReportFraud@trustedhp.com

HEALTH EFFECTIVENESS DATA INFORMATION SET (HEDIS)

In an effort to assess the quality of care and service provided by the Medicaid managed plans, the District of Columbia Office of Managed Care adopted the HEDIS set of effectiveness of care measures as a tool used to assess this quality. HEDIS is a set of measures used to assess the effectiveness of health plans in providing services to promote wellness and enhance the receipt of preventive care. These measures study the proportion of the health plan population who receive the services for which they are eligible. Eligibility for any specific measure is determined by the Committee on Performance Measures (CPM) within the National Committee for Quality Assurance (NCQA).

The HEDIS process consists of following members for a set of care processes that are determined by the CPM. The CPM also sets forth criteria to determine how these processes must be completed in order to constitute compliance that meets the intended quality measure. At the end of the calendar year unless otherwise specified by the measure, members eligible for the various measures are randomized into a sample of 411 members and are reviewed to determine if they had the particular service under study. TRUSTED can determine if the member received the service using either administrative claims data and/or chart review for certain measures determined eligible for chart review.

Administrative claims review is the preferred mechanism for determining compliance. However if practitioners do not submit claims routinely, the TRUSTED must supplement the administrative compliance with compliance found during the review of charts. Therefore to enhance the efficiency of collecting HEDIS data, which is mandated by the District of
Columbia Office of Managed Care, TRUSTED request that all practitioners submit encounter data with the appropriate CPT code to indicate the service rendered during the office visit.

Category II CPT Codes are codes developed to denote services rendered that have no composite CPT code. For example, the Controlling Blood Pressure measure (CBP), the systolic blood pressure must be below 140 and the diastolic blood pressure must be below 90 for compliance. Before the advent of category II CPT Codes, this measure required review of the medical record. However, the category CPT II codes have a code (3076F) to indicate that the systolic BP is less than 140 and the diastolic code is less than 90 (3079F). Clinicians using these codes on the encounters submitted to the health plan can request a chart review for the measures. Practitioners desiring additional information regarding HEDIS measures or processes may contact the Clinical Quality Improvement department at (202) 821-1100.

PERFORMANCE DATA

Provider agrees that during the term of this Agreement, Trusted may collect and develop data, including, but not limited to, claims, cost, utilization, outcomes, quality, financial performance, and patient satisfaction data related to the health benefit plans offered or administered by Trusted, for quality improvement activity with the Provider and public reporting to consumers. Provider agrees to comply with all reasonable request(s) by Trusted in the collection of such data. Collectively, such data and reports shall be referred to as, “Performance Data.” Any Performance Data regarding services of a specific provider for a specific Member shall be referred to as “Provider Specific Performance Data.” Trusted shall be the owner of all Performance Data and Provider Specific Performance Data, and to the extent permitted by law (during the term and after the termination of this Agreement), such data may be shared with a current or prospective Member, payor Member, a current or prospective employer or payor of a group health benefit plan and their auditors or health care consultants, insofar as the information concerns covered services that are or would be considered allowable charges under a current or prospective Certificate of Coverage. Performance Data and Provider Specific Performance Data provided to Provider by Trusted shall be kept confidential by Provider and used only for the purposes of carrying out Provider’s obligations under this Agreement. Upon termination of this Agreement, Provider shall return to Trusted any Performance Data that is not Provider Specific Performance Data. Upon written request of the Provider, Trusted shall make available to Provider, a description of how Trusted intends to use Provider Specific Performance Data, the methodology used in collecting and analyzing the data, and a copy of the Provider’s data Trusted intends to disclose. To the extent that Provider can reasonably demonstrate, in writing, that any data that Trusted intends to disclose is inherently inaccurate, Provider shall notify Trusted of its specific concerns. In such a case, Trusted shall make a good-faith effort to resolve Provider’s concerns; provided, however, that Trusted shall have the sole and final discretion, responsibility, and authority over the content, dissemination, and release of such data.
Medical Management

Utilization Management

The purpose of the Utilization Management (UM) Program is to ensure appropriate allocation of resources by providing quality care/service in the most cost effective manner to Trusted’s enrollees.

The goal of the Utilization Management (UM) Program is to assure:

- Care provided is the right care, for the right patient, at the right time.
- Care is provided in the most appropriate setting.
- Care is provided is by the most appropriate provider.

To accomplish this goal, the processes must be sound and the application of the processes must be consistent. The health plan:

- Uses Case Management and continuums of care principles.
- Uses guidelines for care.
- Tracks medical utilization data.
- Follows guidelines as established by all applicable regulatory and accrediting bodies including NCQA and CMS.
- Evaluates annually the effectiveness of the health care management programs.
- Trusted Health Plan reports outcomes and customer satisfaction using the standard measures of Medicare, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Health care Providers (CAHPS) and Systems.

Authorization for Services

Prior authorization (PA) may be required for some services, products or procedures to verify documentation of medical necessity. The ordering provider is responsible for obtaining PA; however, any provider can request PA when necessary. Prior authorization is issued to the ordering and the rendering providers. It is the responsibility of the provider to clearly document that the beneficiary has met the clinical coverage criteria for the service, product or procedure.

Prior Authorizations may be obtained by contacting the Utilization Management Department (UM) at (202) 821-1132. Prior Authorization (PA) requests can be faxed to: 202-905-0157. Requests for services will be reviewed by experienced Nurses utilizing InterQual criteria and/or other relevant clinical practice guidelines.

An Urgent PA is a request for service to be rendered within 24 hours and where the standard or priority review timeframe may seriously jeopardize the life or health of the member. Decisions will be rendered within 1 calendar days, and oral notification will be made the same day of the decision.

A Priority PA is a request for service to be rendered within 3 calendar days where the standard review timeframe may seriously jeopardize the life or health of the member. A priority prior authorization request decision will be made within 3
calendar days and oral notification will be made with 48 hours of the decision.

**Non-Urgent (Routine) PA** is a request for service that is being rendered 14 or more calendar days from the date of the request. A non-urgent/routine decisions will be made within 14 calendar days, and oral notification will be made within 48 hours of the decision.

In the event of an adverse decision, the Provider may discuss the case with the Medical Director, and the member has the right to appeal as outlined in their member handbook

Prior Authorization (PA) requests for Behavioral Health Services are handled by Beacon Health Care.

Prior Authorization for non-emergent imaging services are handled by National Imaging Associates (NIA). www.RadMd.com or 1-888-899-7804

**PRIOR AUTHORIZATION /PRE-CERTIFICATION**

*Requesting Prior authorization*

The purpose of a prior authorization is to evaluate and manage use of resource-intensive services and to ensure that the member receives services at the most medically appropriate location or level of care.

The objective of the prior authorization process is to:

- Ensure that anticipated services or treatments follow sound medical practice.
- Determine whether or not the services to be rendered can be performed safely and effectively in a less intensive setting.
- Ensure that after the PCP evaluation, the appropriate practitioner and/or facility have been selected to provide the anticipated service.

TRUSTED will accept prior authorization requests from 8:00 a.m. to 5:30 p.m., Monday - Friday.

- The following is a list of services requiring prior authorization review for medical necessity and place of service.
  - Elective/Non-Emergent Air Ambulance Transportation
  - Inpatient Services
  - All Inpatient Hospital Admissions (including medical, surgical and rehabilitation)
  - Obstetrical Admissions/Newborn Deliveries (exceeding 48 hours after vaginal delivery and 96 hours after caesarean section)
  - Inpatient Medical Detoxification
  - Elective Transfers (for inpatient and/or outpatient services between acute care facilities)
  - Long-Term Care (initial placement if still enrolled with the plan)
  - All Out-of-Network Services (except emergency services)
  - Home-Based Services
  - Home Health Care (after 12 visits for therapies and 6 visits for skilled nurse visits).
  - Extended Home Health Services (when covered)
  - Home Infusions and Injections ($250 and over) provided in an outpatient setting, (not required for outpatient hospital setting)
• Enteral Feedings (including related DME)
• Therapy and Related Services
• Speech Therapy, Occupational Therapy and Physical Therapy (after 12 visits for each modality)
• Cardiac Rehabilitation
• Transplants (including transplant evaluations)
• All DME Rentals
• DME Purchases (for billed charges $500 and over, including prosthetics and orthotics)
• Diapers/Pull-Ups (age 3 and above):
  • For quantities over 200 per month (for either or both)
  • For brand-specific diapers
• Hyperbaric Oxygen
• Implants

• Injectable Medications not listed on the Medicaid Fee Schedule are not covered by Trusted Health Plan
  • Medications: 17-P and all infusion/injectable medications listed on the District of Columbia Medicaid Professional Services Fee Schedule with billed amounts of $250 or greater

• Surgical Services that may be considered cosmetic, including:
  • Blepharoplasty
  • Mastectomy for Gynecomastia
  • Mastopexy
  • Maxillofacial
  • Panniculectomy
  • Penile Prosthesis
  • Plastic Surgery/Cosmetic Dermatology
  • Reduction Mammaplasty
  • Septoplasty

• Cochlear Implantation
• Gastric Bypass/Vertical Band Gastroplasty
• Hysterectomy
• Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radio frequency ablation and nerve blocks
• Radiology Outpatient Services (Requested thru NIA)
  • CT Scan
  • MRI
  • MRA
  • MRS
  • PET scan
  • SPECT scan
  • Nuclear Cardiac Imaging

• All miscellaneous/unlisted or not otherwise specified codes
• All services that may be considered experimental and/or investigational
Services that Do Not Require Prior Authorization

The following services do not require prior authorization from Trusted:

- Emergency Services
- Women’s Health Specialist (to provide women’s routine and preventive health care services)
- OB/GYN services for one annual visit and the medically necessary follow up care for a condition detected at that visit (the recipient must use a Plan Provider for these services)
- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments
- Podiatry, and some dermatology services (the member must see a Plan provider for these services)
- Immunizations by county health departments and participating PCPs
- Imaging procedures related to emergency room services, observation care and inpatient care

Services that Require Notification

- Maternity Obstetrical Services (after the first visit) and Outpatient Care (includes 30-hour observations). Prenatal care providers are expected to complete the D.C. Collaborative Perinatal Risk Screening Tool to assess risk for each expectant mother. The completed screening tool must be submitted to Trusted Health Plan as part of the authorization for obstetric services.
- Normal Newborn Deliveries

Facility Admission

Prior authorization is mandatory for all elective inpatient facility admissions for all TRUSTED members. The admitting physician must initiate the process by calling the Utilization Management Department at 202-821-1132 at least 5 days prior to an elective admission and within 24 hours of an emergent/urgent admission.

Outpatient Services

TRUSTED must be notified before service is rendered to determine if medical necessity criteria is met. Payment is contingent upon the member’s eligibility at the time the service is rendered. Prior authorization will be valid for ninety- (90) days. The first service should take place within thirty- (30) days. Home health, podiatry, physical therapy (PT), occupational therapy (OT), & speech therapy (ST) require an evaluation and treatment plan for authorization of additional visits. Treatment plans may be required for other services at the discretion of the Medical Director.

PRIOR AUTHORIZATION POLICY

All services requested will be verified for benefit coverage. Member eligibility and practitioner status in the network will be verified prior to evaluation for authorization.

Requests for prior authorization for selected specialty services, elective inpatient services and restricted procedures/services will be evaluated for medical necessity by nurse reviewers with the appropriate clinical background. Certain PROCEDURES MAY REQUIRE MEDICAL DIRECTOR REVIEW AND DETERMINATION, WHERE QUALITY, APPROPRIATENESS, AND EFFECTIVENESS POSE SPECIAL CONCERNS.
The Medical Management staff has the authority to approve prior authorization requests that meet medical necessity screening criteria. All requests not meeting the medical necessity screening criteria will be referred to the Medical Director. The Medical Director has sole responsibility for rendering medical necessity denials.

Requests for prior authorization will be evaluated utilizing the standard clinical decision support criteria. Criteria updates and revisions are obtained and incorporated, as available.

Requests for prior authorization will be accepted from the attending practitioner or designee according to the following guidelines:

- The Medical Management Department will accept prior authorization requests during the hours of 8:00 a.m. to 5:30 p.m., Monday - Friday.
- The Medical Management Department must be notified no later than 24 hours after an emergency admission for authorization for continued acute hospital stay.
- Requests for prior authorization of procedures normally done on an outpatient basis will not be approved for inpatient stay unless medical necessity for the inpatient stay is clearly documented and approved by the Medical Director.
- Pre-admission diagnostic work-ups, including laboratory, radiology and/or supporting specialty consultations will be performed on an outpatient basis, unless underlying or critical conditions exist that preclude outpatient studies.
- The UM staff will refer chronic disease cases or those with a potential for high risk or special needs to the Case management department.
- Practitioners or their designees requesting prior, concurrent and/or retrospective authorizations must report pertinent medical and member information. This includes:
  - Diagnosis and appropriate ICD-9/10 codes
  - Supporting clinical history and physical findings (brief summary)
  - Anticipated surgical or diagnostic procedures and appropriate CPT codes
  - Attending Practitioner
  - Anticipated consultants
  - Anticipated length-of-stay
  - The name of the facility
  - Scheduled date of admission
  - Need for an assistant surgeon
- Coordination of benefits data (may include spouse, group insurance, workman’s compensation coverage, accident insurance coverage, and other third party liability)
- All authorization requests will be evaluated for:
  - Member eligibility
  - Covered benefits
- Use of participating practitioners
- Medical necessity and appropriateness of care

• Authorization requests must be complete and legible. Incomplete or illegible authorizations will result in delay of review.

PRIOR AUTHORIZATION DISCLAIMER

The following statement is made to the Practitioner who has requested approval for services/care at the time the authorization is approved:

‘Based upon the information you have provided, we are approving your prior authorization request for medically necessary services. The amount of actual benefit coverage, if any, is subject to all plan benefit provisions including member eligibility and any contractual limitations in effect when the services are provided.’

APPLICATION OF MEDICAL NECESSITY CRITERIA

“Medically Necessary” or “Medical Necessity” is defined as services or supplies that are needed for diagnosis or treatment of the member’s medical condition according to accepted standards of medical practice. The need for the item or service must be clearly documented in the member’s medical record.

Members ages 21 and older

A service is medically necessary if a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms. A service is medically necessary if provision of the service is:

○ In accordance with generally accepted standards of medical practice;
○ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, disease, or physical or mental health condition; and
○ Not primarily for the convenience of the individual or treating physician, or other treating healthcare providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual’s illness, injury, disease or physical or mental health condition.

Members through age 20

A service is medically necessary if it promotes normal growth and development and prevents, diagnoses, detects, treats, ameliorates the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. A service is medically necessary if it meets the following provision;

○ A recommended EPSDT screening service;
○ A health care, diagnostic service, treatment, or other measure described in Section 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the District of Columbia State Medicaid plan.
A health care intervention

- That assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality.
- Is appropriate for the age and developmental status of the child.
- Is reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects.
- An immunization recommended by the Advisory Committee on Immunization Practices (ACIP)

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically or appropriately on an outpatient basis or an inpatient facility of a different type. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary or a covered service/benefit.

Trusted Health Plan uses InterQual criteria as guidelines for determinations related to medical necessity. Criteria are applied for all authorization requests that require a medical necessity determination. Reviews are performed on a prospective, concurrent or retrospective basis. The Medical Management staff determines if the diagnostic and therapeutic services are clinically indicated at the proposed level of care. Once the eligibility and benefit availability are established standard criteria are utilized to determine medical necessity. Copies of the criteria are available on request. Should the review result in an adverse determination, the member and/or their designated representative, the practitioner and/or the designated representative has the right to request a copy of the review criteria used to make the determination. Additionally, they may request to speak directly with the reviewing medical practitioner making the adverse determination by calling: (202)821-1132.

Medically necessary means services, equipment, or pharmaceutical supplies that are required or are:

- To prevent the onset of an illness, condition, or disability or sustain the member’s physical, mental, behavioral, or developmental health;
- To assist the individual to achieve, maintain, or regain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age;
- Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate, and suitable alternatives, and is no more intrusive or restrictive than necessary;
- Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law and the coverage shall be no more restrictive than that used in the District’s Medicaid program as indicated in District statutes and regulations, District Plan, and other District policy and procedures; and
- Of a quality that meets standards of medical practice and/or health care generally accepted at the time services are rendered.
The Utilization Management (UM) Department will indicate which specific criteria were used to approve or deny the service. Questions or concerns will be directed to the Medical Director.

TRUSTED members and practitioners are advised that (UM) decision-making is based only on the appropriateness of care and service and the existence of coverage. TRUSTED does not reward practitioners or other individuals for issuing denials of coverage or service care.

NON-COVERED SERVICES

The following services are not covered:

- Services and procedures provided at non-network facilities or by non-participating Practitioners except for Family Planning Services
- All services and procedures related to the treatment of the Temporo-mandibular Joint (TMJ)
- Chiropractic Services
- Cosmetic Surgery
- Experimental/investigation services, surgeries, treatments and medications
- Non-network nutrition counseling
- Organ Transplants (covered by DC Medicaid members only)
- Sclerotherapy
- Therapeutic Abortion, unless medically necessary according to Federal guidelines
- Treatment and procedures related to obesity
- Treatment for infertility
- Fertility medications
- Immunizations for overseas travel
- For the Alliance member, newborn delivery coverage for both the mother and baby.

ADVERSE DETERMINATIONS

If the review results in an adverse determination, the member, his/her designated representative, the practitioner, or his/her designated representative has the right to request a copy of the documentation and or review criteria used to make the determination. The explanation of the appeal process must be provided including the time frames. The member has the right to appeal in person in front of the health plan’s personnel. The member must also be notified of which benefits will continue pending resolution of the appeal of issuance of a District Fair Hearing Decision. The member must be notified that the assistance of an Ombudsman is available and be informed how to contact the Ombudsman. The member must also be advised of the expedited appeal process, including the circumstances in which that may occur. The member must be notified that he or she has the right to a hearing from the Office of Administrative Hearing (District Fair Hearing) at any point in the process. Additionally, a member may request to speak directly with the reviewing medical practitioner making the adverse determination.
APPEALS

TRUSTED Health Plan offers two types of Appeals: Expedited Appeal and Standard Appeal (see Appendix L for types of appeals). A member, member’s representative, attending physician/practitioner or facility, may request appeals. The appeal may be initiated by a verbal or written request; however, TRUSTED prefers that verbal requests be followed by a written request for proper documentation. Submit written appeals to:

TRUSTED HEALTH PLAN, INC.
Attn: Appeals Coordinator
1100 New Jersey Ave., SE • Ste.840
Washington, DC 20003
Fax: (202) 905-0156

MEDICAL EMERGENCY CARE

Members are not required to contact their PCP in an emergency. In a true emergency, members may go directly to the emergency room. PCPs should not refer members to an emergency room during regular office hours for non-emergent conditions that can reasonably be managed in practitioner’s office.

MEDICAL REFERRALS

It is the PCP’s responsibility to coordinate all aspects of the member’s medical care, including referrals to participating specialists and facilities. The PCP must use the TRUSTED Health Plan Provider Portal to refer to specialty providers.

Referral Guidelines

The Referral Process is outlined below:

- Referrals are required for evaluation and follow-up with specialists, diagnostic testing, and other ancillary services.
- Practitioners may not refer to a non-participating practitioner or facility without prior authorization from TRUSTED.
- Referral requests for nonparticipating practitioners are reviewed on a case-by-case basis the Utilization Management Department.
- Availability of service or specialty within the network and member’s history with a practitioner is considered when reviewing referrals to nonparticipating practitioners.
- The first service should occur within thirty- (30) days from the date of referral. Referrals expire after ninety- (90) days.
- Practitioners should indicate the number of visits on a referral, (up to three (3) or it will be valid for only one visit.
- Referrals must be generated before the service, procedure, and/or evaluation occurs.
The PCP is charged with coordinating the care of members assigned to their panel.

If the network is unable to provide necessary medical services, covered under the contract, to a particular member, TRUSTED will adequately and timely cover these services out of network for the member for as long as the MCO is unable to provide them. TRUSTED will coordinate services for out of network providers with respect to payment and will ensure that the cost for services provided to the member is not greater than it would be if the services were furnished within the network to the extent possible. Approval of out of network services must be obtained in advance of the services unless a delay in care based on the need to obtain such authorization would jeopardize the medical outcome for the member. In such emergent or urgent situations, the plan should be notified as soon as possible.

**Participating practitioners may not bill TRUSTED or the member for any covered services that have been denied by TRUSTED because the service was not medically necessary.**

**PRE-NATAL/GYN SERVICES**

Participating specialists who have been credentialed as an OB/GYN are responsible for providing obstetric and gynecological care to members. Members who are pregnant may select both a PCP and Gynecologist from the current list of participating practitioners. Members may choose a practitioner who provides well woman care as their Gynecologist or Advanced Practice Registered Nurse who specializes in OB/GYN as their PCP. **Female members may obtain Family Planning Services from any Woman’s Health Specialist in or out of the Network.**

Routine and gynecological services means the full scope of medically necessary services provided by the obstetrician or gynecologist or advance practice registered nurse in the care of, or related to, the female reproductive system and breasts and in performing annual screening and immunizations for disorders and diseases in accordance with nationally recognized medical practice.

**OB REGISTRATION FORM**

Practitioners providing obstetrical care for all members enrolled in Medicaid and Alliance are required to notify TRUSTED Health Plan of a pregnancy. Practitioners may notify TRUSTED via submission of the OB notification form by mail or fax to the address listed below. **OB Registration forms are used as notification of pregnant moms. However, payment is contingent upon receiving pre-authorization and the receipt of your claims.** When calling to report a pregnancy, the following information should be provided:

- Member’s name
- Medicaid/ID,
- DOB
- Patients’ phone
- Obstetrician/Midwife Name
- LMP
- EDC
- Gravidi /Para
- Date Prenatal care initiated
- Planned C-Section indication
• Previous pregnancy outcomes
• Current pregnancy complications
• Considered high risk pregnancy (if yes, why)
• Current weight
• Pre-pregnancy weight and DOS
• Number week’s gestation at time of first visit, delivery hospital and any high risk issues that could lead to an adverse pregnancy outcome.

This information is used to assign a pregnancy care manager who works collaboratively with the obstetrical practitioner and office to coordinate care for the member. The office will be apprised of the care manager and receive contact information so that a joint effort can be made to meet the members’ needs. For practitioners choosing to send the notification form, it can be downloaded from the website at www.TRUSTEDhp.com. The completed OB Registration Form can be faxed or mailed to:

TRUSTED HEALTH PLAN, INC.
Attn: Utilization Management Department
1100 New Jersey Ave., SE • Ste.840
Washington, DC 20003
Fax: (202) 821-1098

AN OB/GYN PRACTITIONER AS A PCP

Participating Obstetricians are responsible for following the Academy of Obstetrics and Gynecology Guidelines for the provision of obstetrical care during pregnancy. Specific information regarding the guidelines can be obtained by contacting the Clinical Quality Improvement Department (202) 821-1100. Obstetricians may provide routine primary care services and treatment to members during pregnancy. 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.

OB/GYNs are responsible for coordinating services with participating hospitals and specialists for pregnancy related care. The OB/GYN is responsible for notifying the TRUSTED Case Manager at (202) 821-1132 for assistance with support services needed to help the pregnant member during pregnancy. Any high-risk pregnancies due to physical, social or behavioral conditions must be reported to TRUSTED at the time of the first visit or at the time when the high-risk situation develops during the pregnancy. All high-risk conditions should be reported to the high-risk obstetrical case manager. The case manager can be contacted via phone (202) 821-1132. The high-risk case manager partners with the OB practitioner to provide reinforcement education for the high-risk condition and coordinate services needed. For high-risk situations that require consultation and/or management of a perinatologist, practitioners should contact the high-risk case manager at the number above. She/he will help the member to contact the perinatologist for consultation and/or transition management.
If an OB/GYN practitioner feels that a member’s medical condition is outside his or her scope of clinical competence, please refer the member to an appropriate participating specialist for evaluation and treatment of the condition.

**TREATMENT FOR ROUTINE GYNECOLOGICAL CARE**

Participating PCPs are responsible for the initial evaluation and treatment of gynecological conditions that require examination to include a pelvic examination. Any sexually transmitted disease (STD) must be reported to the Department of Health Communicable Disease Division. PCPs may refer cases that are unresponsive to treatment to Participating OB/GYNs.

Members are allowed one (1) annual well woman exam a year, (unless medically necessary to be performed more frequently). The examination allows for the following:

- Detailed gynecological history including sexual practices.
- Routine gynecological exam, including pelvic exam.
- Pap smear.
- Clinical Breast exam and Mammography for all women ages 40 or older unless the clinical history indicates that earlier screening is advisable. Prior authorization is required on all women under 40 years of age.
- Counseling regarding STD prevention, pregnancy prevention if pregnancy is not desired and routine health maintenance recommendations.

**CLINICAL PRACTICE GUIDELINES**

TRUSTED Health Plan is committed to partnering with our network practitioners and providers to provide quality medical care and customer service. Therefore, TRUSTED has developed and adopted preventive health and clinical practice guidelines relative to conditions prevalent within the membership. These guidelines represent the core level of care recommended for the various conditions. All members having conditions for which clinical practice guidelines exist should receive care consistent with the guideline recommendations.

TRUSTED Health Plan reviews and updates clinical practice guidelines every two years. The guidelines meet the following criteria:

- Evidence based, as the guidelines are adopted from recognized professional organizations or involve clinical practitioners from the appropriate specialties when guidelines are developed that are not from recognized professional sources.
- Relevant to the members of TRUSTED Health Plan.
- Adopted in consultation with network health care professionals who treat populations with illnesses or diseases covered in the guidelines.

All guidelines were reviewed and approved by the Quality Management Committee. All guidelines adopted by TRUSTED Health Plan may be viewed on the Provider Website at [www.TRUSTED.com](http://www.TRUSTED.com). The website contains abstracts of tables, treatment protocols, and algorithms taken from the full-length guidelines upon request, the complete guidelines
are available for review and use by the practitioner network. To obtain the guidelines in hard copy, contact the Sr. Director for Quality Improvement Activities at (202) 821-1100

Practitioners are responsible for reviewing and following the Clinical Practice Guidelines. A listing of the guidelines adopted by the health plan is provided below:

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Source/Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Disorder</td>
<td>American Academy of Pediatrics <a href="http://www.aap.org">www.aap.org</a></td>
</tr>
<tr>
<td>Community Acquired Pneumonia</td>
<td>Infectious Disease Society of America Practice Guidelines <a href="http://www.idsocociety.org">www.idsocociety.org</a></td>
</tr>
<tr>
<td>Chronic Renal Disease</td>
<td><a href="http://www.guidelines.gov">www.guidelines.gov</a></td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>American College of Cardiology, American Heart Association, and Physician Consortium for Performance Improvement; Heart Failure Core Physician Performance Measurement Set <a href="http://www.acc.org/qualityandscience/clinical/measures/HF/HFPerfMeasFinal2%5B1%25">www.acc.org/qualityandscience/clinical/measures/HF/HFPerfMeasFinal2%5B1%</a></td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>Adult Treatment Panel III <a href="http://www.acc.org">www.acc.org</a></td>
</tr>
<tr>
<td>Depression</td>
<td><a href="http://www.depression-primarycare.org">www.depression-primarycare.org</a></td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>American Diabetes Association, Standards of Medical Care in Diabetes <a href="http://www.guidelines.gov">www.guidelines.gov</a></td>
</tr>
<tr>
<td>HIV Disease</td>
<td><a href="http://AIDSinfo.nih.gov">http://AIDSinfo.nih.gov</a></td>
</tr>
<tr>
<td>Condition</td>
<td>Guideline Source</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>American Academy of Pediatrics <a href="http://www.aap.org">www.aap.org</a></td>
</tr>
<tr>
<td>Routine and High Risk Prenatal Care</td>
<td>American College of Obstetrics and Gynecology and the American Academy of Pediatrics</td>
</tr>
<tr>
<td>Preventive Screening</td>
<td>United States Preventative Services Task Force <a href="http://www.preventiveservices.ahrq.gov">www.preventiveservices.ahrq.gov</a></td>
</tr>
<tr>
<td>Immunization Guidelines</td>
<td><a href="http://www.cdc.gov/nip/acip">www.cdc.gov/nip/acip</a></td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>Sickle Cell Disease Consortium <a href="http://www.scinfo.org">www.scinfo.org</a></td>
</tr>
</tbody>
</table>

Summary information for select clinical guidelines is available on the website. This material is for informational purposes only. These guidelines are neither comprehensive nor are they intended to serve as a substitute for individualized clinical judgment and decision-making in the care of the members. All clinical care for TRUSTED Health Plan members and related decisions are the sole responsibility of the practitioner. This information does not dictate control of the practitioner’s clinical decision regarding appropriate care of members. TRUSTED does not commit to provide coverage for all recommendations that may appear. Please refer to the member handbook or the Medical Management Department for clarification of benefit design. These guidelines may be used for objective comparison of clinical practices among network providers and to assist in assessing appropriateness of care to our members.
**CASE MANAGEMENT**

The Case Management Program provides coordination of care for patients with complex, chronic, or critical health care needs. EPSDT services are also a focus of the Case Management program. The program assists families, patients, and doctors in planning care and services. This is part of a team plan, which looks at individual health care needs. Case Managers assist members and their families by analyzing all options/choices available to them within the health care delivery system. Case Managers contact these members to work cooperatively and effectively with patients for whom some form of behavioral change and motivational interviewing might result in better health outcomes. The intended outcome is to empower members to better manage their chronic conditions and improve their use of clinical, caregiver/family and community resources to improve their health outcome. The role of the Case Manager is intended to support the care prescribed for the member by the attending physician. Their health problems can cut them off from family, co-workers and friends. A cycle of isolation, depression, and a deterioration of their health frequently sends them into a downward trend. In a combined effort of the Case Manager, and in collaboration with the member’s PCPs, members are supported in ways that make the most difference to their health. All home services must be ordered by a physician and prior authorized before services are rendered.

**DISEASE MANAGEMENT**

TRUSTED offers Disease Management Programs designed to assist in the coordination of care for members with chronic medical conditions and mental health issues. TRUSTED programs entail coordination of practitioner-delivered care, treatment guidelines, patient counseling and empowerment, patient self-management, and education.

The goals of the Disease Management Programs are to:

- Improve the health outcomes for the individual.
- Reduce the complications associated with these particular illnesses.
- Preserve the best quality of life for the member.

Disease Management programs are designed to include and involve TRUSTED practitioners. Practitioners participate in the initial development of the programs and with any succeeding revisions. Practitioners are advised of all members who have been identified for any Disease Management Programs and reminded about any member who is not current with recommended preventive measures.

TRUSTED offers free programs to help manage a member’s medical and mental health issues. The Disease Management referral form is available on the website: [www.TRUSTEDhp.com](http://www.TRUSTEDhp.com).

Common health issues managed by our Disease and Case Management Programs are:

- Pediatric Asthma
- Children and Adults with Diabetes
- Adult with Hypertension
- Adults with Cardiovascular Condition
- Persons with HIV or AIDS
• High Risk Pregnancy
• Infants, toddlers, school-age children and adolescents with evidence of development and mental disability and delay (Children with Special Needs)
• Obesity in children and adults
• Adults with mental illness and substance abuse
• Children and adults with cancers
• Complex Conditions

To refer a member for Case / Disease Management call (202) 821-1132 or fax (202) 821-1098

**BEHAVIORAL HEALTH & SUBSTANCE ABUSE CARE**

Beacon Health Strategies provides case management services for members affected by:

• Adults with mental illness and substance abuse related conditions.
• Behavioral (Mental) Health Disorders.

Beacon’s case managers are co-located at TRUSTED to ensure seamless communication and collaboration with their colleagues in the Plan’s Medical Management department.

Our case managers are licensed health care professionals who are responsible for developing and maintaining specific disease or case management program. The Disease Management Team assists members to learn more about their illness and master self-management skills necessary to control their chronic illness and decrease the risk of complications. Each program is designed to support the practitioner’s plan of care.

Behavioral Health providers will receive a separate provider manual from Beacon Health Strategies describing all aspects of the TRUSTED Behavioral Health program. To contact Beacon, call (855) 481-7041.

**ANCILLARY SERVICES**

**Dental**

DentaQuest administers dental services. To contact DentaQuest, call 1-855-418-1620.

**Home Health /Home Infusion**

TRUSTED Health Plan administers all Home Health and Home Infusion benefits. To access assistance for Home Health and Home Infusion, practitioners and members should contact (202) 821-1132

**Laboratory**

LabCorp provides outpatient laboratory services to TRUSTED members. Participating Practitioners should contact LabCorp at (800) 859-0391 to schedule specimen pick-ups, order supplies, discuss test results or get information. To establish a LabCorp provider account call (800) 859-039.
Routine specimens are processed upon receipt at LabCorp. Written reports are sent to practitioners within twenty-four (24) hours after the specimen receipt. Reporting time may vary due to the nature of the request and the amount of time required performing the test.

STAT laboratory tests are completed within four hours of their receipt at the nearest STAT laboratory. STAT results are provided by telephone as soon as they become available.

Practitioners must use a LabCorp requisition form to request services from the LabCorp locations. If LabCorp cannot provide a service for any reason, members should not be referred to freestanding laboratory centers without prior authorization.

**Pharmacy**

Meridian Pharmacy Benefit Manager manages TRUSTED pharmacy network and prescription processing. There is no co-payment for prescriptions. Prescriptions must be written by participating practitioners. Specific over-the-counter drugs are covered for Medicaid members with a written prescription when purchased at a participating pharmacy.

If a patient requires a medication not on the formulary, providers may request a non-formulary exception by faxing a request to 202-821-1198 or mailing it to: Pharmacy Director; TRUSTED Health Plan, 1100 New Jersey Avenue, SE. Suite 840, Washington DC 20003.

The prescriber may call The Pharmacy Director at 202-821-1127.

The request will be reviewed to determine if it meets the criteria for approval. Note: A three-day supply of the medication may be dispensed while the review process is being completed.

**Radiology**

Outpatient radiology services are provided at contracted facilities. Members should not be referred to non-participating hospitals or freestanding diagnostic radiology centers. TRUSTED Health Plan (THP) has entered into an agreement with National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health Services. This program includes management of non-emergent, advanced, outpatient imaging services to include prior authorization.

**Prior authorization will be required for the following outpatient imaging procedures:**

- CT/CTA
- MRI/MRA
- PET Scan
- CCTA
- Nuclear Cardiology/Nuclear Stress/MPI
- Stress Echocardiography
- Echocardiography

The ordering physician is responsible for obtaining authorization prior to rendering the above-listed services. To obtain authorization, the provider should go to the NIA web-site [www.RadMD.com](http://www.RadMD.com) or through the NIA dedicated toll-free phone
number, 1-888-899-7804. Providers rendering the services listed above should verify that the necessary authorization has been obtained by visiting www.RadMD.com, or by calling NIA at 1-888-899-7804. Failure to do so may result in nonpayment of your claim. Emergency room, observation and inpatient imaging procedures do not require authorization.

**Vision**

Vision services are administered by EyeQuest. A member’s PCP or Optometrist can refer members to a TRUSTED participating Ophthalmologist for medical conditions of the eye. To contact EyeQuest call 1-855-418-1620.

**HEALTH CHECK/EPSDT**

The Federal Government established the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in 1967, which was renamed Health Check in the District of Columbia in 2002. The purpose of the program is to provide low-income children under the age of 21 with comprehensive preventive screening, diagnostic and treatment services. All DC Medicaid Managed Care primary care practitioners are responsible for providing Medicaid Health Check services to patients from birth to 21. Practitioners must document the refusal of services in the member’s record. Practitioners in the following specialties qualify as Health Check practitioners and are responsible for providing Health Check services:

- Pediatrics
- General Practice (including Osteopathy)
- Internal Medicine
- Obstetrics /Gynecology (if the practitioner is contracted as a primary care practitioner)
- Nurse Practitioners (practicing in the clinical areas listed above)
- Family Practice Medicine

The components of the Health Check Exam include:

- Comprehensive unclothed physical examination
- Developmental screening
- Immunizations
- Laboratory screening tests
- Behavioral health screening

All patients under 21 are expected to be current with the age-appropriate preventive health supervision visits/screening. The most current District of Columbia Health Check Periodicity Schedule can be found on the District of Columbia EPSDT website. Practitioners are obligated to follow the age-appropriate screening schedule a minimum guideline, but may expand screenings (inter-periodic screens), as necessary. Additional information is available at the Bright Futures website: http://www.brightfutures.org/. Primary Care Practitioners are required to use a valid and standardized developmental screening tool during well child visits as well as episodic visits to assess developmental delays. Any practitioner who suspects that a child has a developmental delay must contact a TRUSTED Care Coordinator for
assistance in coordinating during well child visits as well as specific visits and stand-alone services.

**SCREENING TIMEFRAMES**

PCPs are contractually obligated to provide Health Check/EPSDT screenings within 60 days of the due date. The due date is one year from the date of the previous year’s Health Check/EPSDT examination except for children under the age of two years wherein the screening must be performed within 30 days of its due date. Members newly assigned to a PCP and in need of Health Check/EPSDT services must be offered an appointment for screening within 45 days of the request. The PCP must complete the screening within three months (90 days) of the member’s initial enrollment date with TRUSTED. The enrollment date can be found on the PCP panel report. Contractually, TRUSTED is obligated to make Health Check/EPSDT appointments available to current members within 60 days of the due date.

If the child misses a regular periodic screening, that child must be screened off the regular periodicity schedule in order to bring the child up-to-date.

**INTER-PERIODIC AND PARTIAL SCREENS**

Inter-periodic screens occur more frequently than scheduled screens due to medical necessity (e.g., when a child has tested positively for a condition and the physician determines that there is a medical need to re-screen for that condition.) Partial screens are incomplete screens that occur when the practitioner (e.g., specialty Practitioners) is able to perform only part of the screens required at a particular time. For example, if hearing and vision is done at one visit, this is a partial screen because the child needs to return to get the remaining components of the Health Check exam, namely the comprehensive unclothed physical, age-appropriate laboratory testing, developmental screening and age-appropriate immunizations. It is important to note that partial screenings are not considered compliant with the Health Check requirement. Therefore, if a partial screening is performed, the practitioner office needs to remember to have the child return to have the remaining components of the Health Check as soon as possible.

**CONDUCTING THE MEDICAL WELL-CHILD SCREENING VISIT**

To meet Federal Health Check screening requirements, a Health Check exam/visit must include the following five components:

- Administration of a standardized developmental screening tool to identify potential developmental and or behavioral issues.
- A comprehensive health history and unclothed physical examination;
- Immunizations
- Appropriate laboratory tests
- Health education and anticipatory guidance

Annually, TRUSTED must demonstrate compliance with the Health Check screening process. The time-frame for this compliance review is October 1, of the current year to September 30 of the next year. The compliance to be achieved is 80% of the eligible population’s receipt of the Health Check comprehensive screening. Preferably, TRUSTED relies on
the submission of encounter data to ascertain the compliance of Health Check examinations. However, if not enough 
encounter data is submitted to reach 80%, TRUSTED Health Plan staff performs reviews of office practice medical 
records for TRUSTED members to look for additional visits that have not been submitted. Any additional Health Check 
visits found during chart review are added toward the compliance needed to achieve no less than 80%. TRUSTED 
realizes that chart review is intrusive to practitioner office operations. Therefore to avoid the need for chart review, 
encounters should be submitted to the TRUSTED Health Plan Claims Department no less than monthly. TRUSTED will 
audit member medical records to confirm that the approved screening tool(s) are used as part of the encounter associated 
with the claim submitted for reimbursement.

INFORMING MEMBERS ABOUT HEALTHCHECK

To help practitioners meet Health Check compliance, TRUSTED Health Plan employs multiple strategies, including 
written and audio-visual materials, and face-to-face encounters, to inform and educate all HealthCheck eligible members. 
The TRUSTED HealthCheck representative can assure that you have information in your offices about HealthCheck to 
give to members.

TRUSTED HealthCheck materials are available in English and Spanish and will be produced in other languages as 
needed. TRUSTED offers specialized assistance with obtaining information on HealthCheck, including TTY services for 
hearing impaired individuals and Language Line Services for individuals needing translation services. Information 
regarding use of the language line is available at (202) 821-1100.

PRACTITIONER AND MEMBER COMPLIANCE WITH HEALTHCHECK/EPSDT SERVICES

Practitioner

CODING AND SUBMITTING ENCOUNTERS FOR HEALTHCHECK SERVICES

All practitioners are asked to submit an encounter for every member for whom a HealthCheck /EPSDT service is 
rendered. The encounter can be submitted on the CMS 1450 billing form, which is used as both a billing form for fee-for-
service claims and as an encounter form for reporting non-billable services.

When coding for HealthCheck services, it is important that the practitioner or billing person use the correct procedure 
Since CPT codes can be revised from time to time, practitioners are encouraged to use the most current edition of the 
CPT. Below are the most common CPT codes related to HealthCheck services.

Preventive Medicine Codes That Are Valid HealthCheck Codes

EVALUATION AND MANAGEMENT CODES

99381........ (new patient; initial comprehensive examination) less than one year of age
99382........ (new patient; initial comprehensive examination) 1-4 years of age
99383........ (new patient; initial comprehensive examination) 5-11 years of age
99384........ (new patient; initial comprehensive examination) 12-17 years of age
99385........ (new patient; initial comprehensive examination) 18-39 years of age
99391....... (established patient, periodic comprehensive exam) less than one year of age
99392....... (established patient, periodic comprehensive exam) 1-4 years of age
99393....... (established patient, periodic comprehensive exam) 5-11 years of age
99394....... (established patient, periodic comprehensive exam) 12-17 years of age
99395....... (established patient, periodic comprehensive exam) 18-39 years of age
99431....... (Newborn care, history and examination)
99432....... (Normal newborn care)

COMBINATION CPT AND DIAGNOSTIC V CODES THAT ARE VALID FOR HEALTHCHECK
99201-99205
99211-99215 .... in conjunction with V20=V20.2 and/or V70.0 and/or V70.3-V70.9.
86580.............In conjunction with V20=V20.2 and/or V70.0 and/or V70.3-V70.9.

The following diagnostic V codes with CPT codes 99201-99205 or 99211-99215

<table>
<thead>
<tr>
<th>V03</th>
<th>V05</th>
<th>V20</th>
<th>V72</th>
<th>V82</th>
</tr>
</thead>
<tbody>
<tr>
<td>V04</td>
<td>V06</td>
<td>V70</td>
<td>V74</td>
<td></td>
</tr>
</tbody>
</table>

Vision Screening Coding
99173 In conjunction with V72.0

Hearing Screening Coding
V5008 92552 92555
92551 92553 92555 in conjunction with V72.1

Immunizations
90647....... (HIB) in conjunction with V03.81
90655....... (Influenza, split virus, preservative free for 3 years old and older)
90657....... (Influenza, split virus, 6-35 months of age)
90658....... (Influenza, split virus 3 years old and older) in conjunction with V04.8
90669....... (Pneumococcal conjugate vaccine, less than 5 years of age) in conjunction with V03.82
90700....... In conjunction with V06.1
90702....... In conjunction with V06.5
90707....... In conjunction with V06.4
90713....... In conjunction with V04.0
All practitioners are required to submit a record of the immunizations given to the Department of Health/Division of Immunizations, Vaccines for Children (VFC) program. The program houses a registry that is a repository for all immunizations given to a child. This database can be of value to practitioners as they can view the registry to see which immunizations a child has been given prior to the current visit. This is extremely helpful for new patients for whom there is no vaccine history available.

**MEMBER**

TRUSTED sends members notices reminding them of their need for HealthCheck services approximately 90 days prior to the actual HealthCheck due date (one year after the previous year’s examination except for children under two years of age for whom services are due more frequently). TRUSTED EPSDT staff also attempt to contact the member to remind them to make an appointment to have the HealthCheck examination. The staff will also assist in making the appointment for the member if the member is agreeable to accept the help. Beginning in April 2008, the department will begin sending a listing of members due for HealthCheck services to the practice sites 90 days before the due date. Practices are asked to monitor the list and record the date that the member presents for the appointment.

At the end of the 90-day period, the office staff is asked to fax the list back to the EPSDT staff at (202) 821-1099. The staff will use the list to contact noncompliant members immediately to reinforce the need for HealthCheck services and to help obtain the appointment. The goal of this intervention is to have the member have the HealthCheck appointment as soon after the compliance date as possible. Practitioner staff can contact the Prevention and Wellness staff for any help they may require to have the member receive HealthCheck services. Additionally, if the member has HealthCheck services and the screening requires a more comprehensive follow-up, the office staff can contact the Prevention and Wellness staff who will communicate the request to the appropriate TRUSTED Health Plan department as needed and will work with the parent and child to obtain the necessary additional services. When appropriate, these children will be referred to the Care Management Program for assistance with obtaining comprehensive evaluations, intervention treatment planning, and monitoring.

**HEALTHCHECK TRACKING SYSTEM**

TRUSTED maintains a comprehensive system for documenting and monitoring the provision of HealthCheck services. The CMS 1450 billing form is used as both a billing form for fee-for-service claims and as an encounter form for reporting non-billable services.
A patient-specific software tracking system includes actual CPT-4 codes for each procedure performed. The listing of CPT-4 codes is vital in the reporting of specific procedures being completed and is particularly important when tracking immunizations. The tracker also imports data from the Department of Health/Division of Immunizations Vaccines for Children (VFC) program to provide additional information on vaccines provided to HealthCheck eligible members that TRUSTED may not otherwise be aware. The tracker also maintains non-clinical information such as; membership, the status of notification letters, and outcomes from follow-up calls and home visits. In addition to information available on the tracking system, this software also indicates when a member is eligible for an immunization or well-child exam according to the periodicity schedule.

Outreach via telephone calls and home visits will follow as needed. Outreach will also be initiated upon practitioner request.

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

The Individuals with Disabilities Education Act (IDEA), a Federal law, passed in 1975 and reauthorized in 1990, mandates that all children receive a free, appropriate public education regardless of the level or severity of their disability.

IDEA provides funds to enable states to provide a public education to students with disabilities. Under IDEA, students with disabilities are able to receive public education because the law provides for individualized education programs (IEP) that meet the unique needs in the least restrictive environment for each child in the IDEA program. The law also provides guidelines for determining what related services are necessary and outlines a “due process” procedure to make sure these needs are adequately met.

Children ages 3-21 assessed to need special education services because of a disabling condition are eligible for the program. Comprehensive evaluations are performed by a multidisciplinary professional team and shared with the parent, PCP, teachers and other interested parties involved with the learning of the child. TRUSTED is involved as a participant in the coordination of wrap-around services needed to support the child’s educational process. TRUSTED Health Plan notifies the Primary Care Practitioner whenever a child receiving IDEA services is identified. However, because school health personnel do not necessarily know TRUSTED as the child’s insurance carrier, TRUSTED often is placed in a position of not being aware of these children or their needs. Therefore, TRUSTED also relies upon the practitioner to inform the health plan of children they know are receiving special education services. The Care Coordinator can then work with the practitioner to obtain any services that are needed to support the educational process and are included in the benefit coverage.

IDEA, Part B, specifically details eligibility criteria and services under the IDEA program that support an appropriate, free public education for children who meet eligibility criteria. Practitioners are advised to call TRUSTED Care Coordinator for assistance as needed in obtaining support services for children receiving IDEA educational services.

IDEA, Part C, specifically details services for children from birth to three years who either have or are “at risk” for a developmental, educational, or behavioral or physical care delay. These children are likely not receiving special education services. The District of Columbia Infant and Toddlers program monitors the progress of children who are eligible for this program simultaneously with the health plan. Practitioners are asked to report any child they perceive may be eligible for services under this program. The Care Coordinator works with practitioners to obtain evaluative services for any child
who has a screening procedure that indicates the potential need for services under this program. Practitioners can call (202) 821-1100 to contact the Care Coordinator.

IDENTIFICATION OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Primary Care Practitioners are required to use a valid and standardized developmental screening tool to screen for developmental delays during well child visits or episodic care visits (standalone visits are episodic visits). If a child is identified as having a delay that is significantly different than an expected variation; however, within the norm of age-appropriate development, the PCP is required to refer the child for a comprehensive developmental evaluation. PCPs may refer the child independently of the Care Coordinator but must make the Coordinator aware of the referral within 72 hours. If the PCP would like assistance in referring the child for further evaluation, contact the Care Coordinator at the telephone number above or complete a Care Management/Disease Management referral form to fax to 202-821-1098.

Examples of children who may require a referral include, but are not limited to, those listed below:

- Diagnosed hyperactivity, attention deficit disorders, autism, severe attachment disorders, and other pervasive developmental disorders, or other behavioral disorders. Please contact Beacon Health Strategies at 1-855-481-7041 for assistance with referrals or consultation.
- Delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability to communicate emotional needs, or ability to tolerate frustration.
- Persistent failure to initiate or respond to most social interactions.
- Fearfulness or other distress that does not respond to comforting by caregivers.
- Indiscriminate sociability, for example, excessive familiarity with relative strangers; or self-injurious or other aggressive behavior.
- Substantiated physical abuse, sexual abuse, or other environmental situations that raise significant concern regarding the children’s emotional being.

Special Member Support Services

HEALTH PROMOTION AND HEALTH EDUCATION

Wellness Services encompass a range of activities that begin and continue throughout a member’s enrollment. All aspects of TRUSTED’s health education programs and other health promotion activities focus on efforts to reinforce healthy behaviors and lifestyles.

Health Education Program Philosophy and Approach

TRUSTED is committed to providing quality health education programs and health promotion activities as a part of a continuum of member services.

TRUSTED Health Education Programs include the following components:

- The importance and availability of testing for HIV/AIDS and the services available for its treatment.
• The importance and availability of early intervention for infants, toddlers and school-age children, including children who either have been diagnosed as having, or who are suspected of having, a developmental disability or delay.
• Weight control and nutritional counseling.
• Guidelines on nutrition for pregnant women and children, the importance of prenatal and post-partum care and the how to obtain benefits from the WIC program.
• Sexuality education for teenagers: prevention of pregnancy, protection from STDs, and issues of sexual orientation and gender identification.

These activities focus on wellness and begin during the enrollment and new Member orientation process. Health education programs share the dual goals of increasing Members’ knowledge, while at the same time fostering their desire to attain and maintain healthy behaviors and skills that enhance their quality of life. TRUSTED firmly believes that promoting self-confidence in managing one’s medical condition is crucial. Educating members how to do this is an adjunct to helping members be able to manage their health conditions. In addition to evaluating each class, the Health Education staff will be incorporating an evaluation of the member’s ability to sustain the behaviors learned in the classes. Practitioners are encouraged to refer members to classes and to recommend various class topics they feel will be beneficial for their patients. The Health Education Coordinator will send a summary of your patient’s participation activity and the goals accomplished at the end of the class.

Practitioners may fax a health education referral for your member to 202-821-1098.

SERVICES FOR NON-ENGLISH SPEAKING MEMBERS

One of the tools that TRUSTED makes available to providers is Language Line translation service to allow providers to communicate with members who are not proficient in English. Language Line provides trans-labors by telephone. To access the Language Line call 202-821-1100.

SERVICES FOR HEARING IMPAIRED MEMBERS

TTY/TTD Relay Service (telephonic assistance) is available for members by calling (202) 821-1152. A TRUSTED representative will answer the TTY/TTD phone and will relay requested information. All information will be documented.

Sign language assistance is also available. Please schedule an appointment by calling the member service department at (202) 821-1100. The TTY/TTD phone number above may also be used to schedule sign language interpreters.

TRANSPORTATION

Transportation is available for all members for non-emergency scheduled medical appointments to and from participating practitioners’ offices during normal business hours. If non-emergency medical transportation services are required on Sundays or Holidays, members or practitioners may contact the twenty-four hour (24) Nurse Response Line. Members must present their TRUSTED Health Plan Membership Card to schedule transportation members or practitioners may
contact the member services line at (202) 821-1100 or (855) 326-4831, Monday- Friday 8:00-5:30.

Member Eligibility, Benefits & Rights

To check eligibility, you may call the
District’s Eligibility Verification System at (202) 906-8319

Practitioners must verify each member’s eligibility prior to providing medical services.

Member ID Cards

Member ID Card - Medicaid and Alliance

TRUSTED Cards are issued to DC Medicaid (TANF), DC Healthy Family Program (DCHF) and DC Healthcare Alliance members. The card includes the following information:

PCP Selection

TRUSTED will ensure that members are assigned to a participating Primary Care Practitioner (PCP) of choice. Upon enrollment into TRUSTED Program, members select their PCP (through the Enrollment Broker or through Customer Service). In the event that a member chooses to delay their PCP choice and no selection is made, one of two mandatory selection processes will occur:

1. If a member was previously enrolled with TRUSTED and their PCP is still participating, the member is re-assigned to their previous PCP of record.

2. The Enrollment Department assigns the member to a PCP who is located in the same zip code as the member’s residence. This is done to ensure that the member is assigned within 30 minutes travel time of their home via public transportation.

Changing of PCP

At any time, the member has the right to change the assigned or selected PCP. If a member elects to change their PCP, and the request is made prior to the 15th of the month, the change will occur within 24 hours. However, if the change is requested after the 15th of the month, the change becomes effective on the 1st of the following month.

- PCP is no longer participating.
- There is a language barrier between the member and the practitioner.
- There is an enrollment error made by TRUSTED.

Should any of these factors arise, TRUSTED will change the PCP selection effective immediately.
MEMBER SERVICES

The Member Services department can be reached at (202) 821-1100 or toll free 1-855-326-4831. Member Services is open Monday through Friday, 8:00 am-5:30 pm.
The Customer Services department is staffed to assist practitioners and members with any of the following:

• Choosing or changing a member’s PCP.
• Educating members on how to access their benefits.
• Updating a member’s demographic information.
• Issuing new and replacement identification cards.
• Providing phone numbers and addresses to participating practitioners.
• Documenting and following up on concerns or complaints with services and medical treatment.
• Arranging medical appointments.
• Verifying eligibility.
• Assisting with re-certification.
• Assisting and/or facilitating the grievance process.
• Educating members on proper emergency department usage.
• Verifying claim status.

MEMBER’S RIGHTS AND RESPONSIBILITIES

Member Rights:

TRUSTED Health Plan Members have the right to:

• Be treated with dignity and respect.
• Receive all covered services listed in the handbook.
• Receive quality care.
• Transportation to health care services 24 hours a day, 365 days a year.
• Choose a PCP from TRUSTED list of providers.
• Change a PCP and choose another one from TRUSTED list of practitioners/providers.
• Receive health care in the comfort and convenience of a practitioner or provider’s office.
• To be sure that others cannot hear or see them when they are getting medical care
• Make their doctor appointments.
• Be a part of health education programs offered by TRUSTED.
• Have their medical records remain private, according to HIPAA rules.
• Have access to medical records in accordance with applicable federal and state laws.
• Get quick and polite responses to questions and concerns.
• Be advised of any changes that have something to do with health services or how to get them.
• Receive information about TRUSTED, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
• Make recommendations about the members’ rights and responsibilities.
• Have a discussion about the health care needed, regardless of cost and regardless if TRUSTED covers it.
• Have access to case management services.
• Request information regarding advance directives and receive assistance in preparing them. (See additional information below.)
• Participate in making medical decisions, including the right to refuse treatment.
• To be told if a health care provider is a student and to be able to refuse his/her care.
• Receive authorization policies and procedures.
• Be aware of incentive plans for TRUSTED practitioners and providers.
• Receive a summary of the most recent patient satisfaction survey.
• Receive a copy of TRUSTED prescription drug formulary.
• Receive information on alternative medically necessary treatment options and alternatives, presented in a manner appropriate to their condition and easy to understand.
• (Female enrollees only) 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. Also, female enrollees have a right to designate as their PCP a participating provider or an advanced-practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
• Seek a second opinion from a qualified health care professional within the network or out-of-net-work at no cost.
• Choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life threatening medical condition.
• Receive free interpreter services as needed, including help with sign language, if hearing impaired
• File a complaint or appeal orally or in writing (see Appendix L for details).
• Have someone assist with getting information regarding the qualifications and titles of those responsible for your care.
• Refuse the care of your practitioner or provider.
• 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.
• Be given upon request the current clinical practice guidelines.

Responsibilities of a TRUSTED Health Plan Member:
• Treat TRUSTED employees, practitioners and providers with respect.
• Choose a primary care provider (PCP) from TRUSTED list of practitioners/providers.
• Get medical care through TRUSTED list of participating practitioners/providers, hospitals and clinics.
• Get approval from their PCP or TRUSTED before being seen by another practitioner or provider.
• Carry your TRUSTED membership card with you at all times.
• Give TRUSTED and their PCP accurate information needed to give them care.
• Let TRUSTED know of any changes, such as:
  • Change of address or telephone number.
  • Change of name.
  • Death of a family member.
  • New additions to the family, such as a baby.
  • Other insurance coverage.
  • A move to somewhere outside of the District of Columbia.
• Keep your doctor’s appointments or call to cancel at least 24 hours in advance
• Whenever you visit the doctor’s office, tell the doctor you are a TRUSTED member.
• Ask questions, talk with your practitioner or provider about your health and listen to what treatment is needed
• Understand your health problems and follow the practitioner or provider’s instructions for care after you both have decided what treatment is needed.
• Know the difference between a true emergency and a condition needing urgent care.
• Know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
• Report to TRUSTED at the time of enrollment if you are in the course of care or treatment.

**ADVANCE DIRECTIVES**

The Advance Directive is a written instruction recognized under District law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under Federal law to decide what medical care that he/she wants done, if in the future the member is unable to make his/her wishes known about medical treatment. The member has the right to choose a person to act on his or her behalf to make health care decisions for them, if the members cannot make the decision for themselves.

Advance Directives shall be written in one of two ways:

• Living Will - A written document that tells what medical treatment the member does or does not want if the member is unable to make his/her wishes known.

• Durable Power of Attorney for Health Care - A written document that says the member has chosen someone to make their decisions for them if they are unable to do so and names the individual in the document.
TRUSTED requires that its contracted hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care and/or personal care services, hospices and religious non-medical health care institutions maintain written policies and procedures concerning advance directives with respect to all adults receiving medical care or patient care. The information regarding advanced directives must be furnished by providers/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.
• Personal care services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information 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.

The providers/organizations:

• Are not required to provide care that conflicts with an advance directive.
• Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and District law allows any health care provider or any agent of such provider to conscientiously object.
• Prepaid or eligible organizations (as specified in sections 1833(a) (1) (A) and 1876(b) of the Act) must meet the requirements specified in § 417.436 of this chapter.

If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or to say whether or not he/she has executed an advance directive, then the provider may give advance directive information to the individual’s family or surrogate. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

Members can call TRUSTED Member Services department to get more information on how to make an Advanced Directive. Useful information about Advanced Directives is available from Caring Connections at 1-800-658-8898 or their website, www.caringinfo.org
Billing and Claims

CLAIMS SUBMISSION
All claims for services rendered must be submitted within 180 days from the date of service or discharge date for inpatient admissions. All claims submitted by practitioners must be billed on CMS-1450 forms. All claims must have the following pertinent information:

• Member/Patients name and Medicaid identification number
• Member’s date of birth and address
• Diagnosis code(s)
• CPT-4 and/or Revenue Codes
• Date(s) of service
• Place of service codes
• Charges (per line and total)
• Practitioner’s federal tax identification number
• Practitioner’s name
• Practitioner’s TIN number and group number as applicable
• National Provider Identifier (NPI)
• Vendor name and billing address
• Name and address of facility where services were rendered
• Signature

HOW DO I SUBMIT A CLAIM?
TRUSTED Health Plan will accept both paper and electronically submitted claims. TRUSTED accepts claims electronically through Emdeon, payor ID: L0230. Paper claims must be mailed to the following addresses:

MEDICAID:
TRUSTED Health Plans, Inc.
DC Healthy Families
P.O. Box 830786
Birmingham, AL 35283-0786

ALLIANCE:
TRUSTED Health Plans, Inc.
Alliance Program
P.O. Box 830210
Birmingham, AL 35283-0210

All clean claims submitted in a timely manner will be paid within 30 days in accordance with the provisions of the DC Prompt Payment Act of 2002.
CAPITATED CLAIMS

Capitated Primary Care Physicians must submit a claim for all services provided within thirty days of the Date of Service (DOS).

FEE-FOR-SERVICE CLAIMS

Fee-for-Service claims for services rendered to TRUSTED members must be submitted within (180) days of the Date of Service (DOS) or as specified on the practitioner’s contracts.

PRIMARY CARE AND DEPRESSION MANAGEMENT

TRUSTED Health Plan, Inc. (TRUSTED) requires that Primary Care Practitioners submit a claim or encounter when diagnosing and treating a TRUSTED member for depression. Capitated practitioners are required to submit an encounter and will not be reimbursed above the capitation fee. Non-capitated practitioners will be reimbursed when an appropriately coded claim is submitted.

The ICD-9-CM codes that may be used and are covered for primary care depression management services are: 296.0-296.9, 298.0, 300.4, 309.1, 309.28, and 311. The depression diagnosis does not have to be the primary diagnosis.

Primary care practitioners may submit these diagnoses codes with the standard medical evaluation and management CPT codes, or with the 90862-medication management code.

PROMPT PAYMENT ACT OF 2002

TRUSTED Health Plan shall pay all clean claims within 30 days after the receipt in accordance with the District of Columbia Prompt Payment Act of 2002. A clean claim is a claim that has no material defect or impropriety, include any lack of reasonably required substantiating documentation, which substantially prevents timely payment being made on the claim. There shall be a reputable presumption that TRUSTED has received a claim within 5 business days from the date the Practitioner or person entitled to reimbursement placed the claims in the United States mail. This presumption is 24 hours for electronic submission, if not returned by the electronic claims clearinghouse.

All claims without the necessary information required to ensure timely processing will be returned within with a letter of explanation attached indicating the reason for return.

In the event that clean claims are not paid within 30 days of receipt, and TRUSTED Health Plan does not notify the Practitioner within the said 30 days of any information missing that is required to pay the claims. TRUSTED Health Plan will implement measures to calculate and pay interest penalties in accordance with the provision of the prompt payment Act of 2002 as follows:

- One and a half percent from the 31st day through the 60th day.
- Two percent from the 61st day through the 120th day.
- Two and one half percent after the 120th day.
**CLAIMS INQUIRIES**

If a practitioner has not received payment for a claim within 45 days or has concerns regarding any claim issue, claim status can be checked by doing one of the following:

- Call the Claims resolution department at 202) 821-1100 or (855) 326-4831 (toll free), select option #4 to speak directly with a Claims Resolution representative.
- Call our Provider Services Department at (202) 821-1145 or (202) 821-1100 and ask to speak to their assigned Provider Relations Representative, or call the Representative directly.
- Log in to the TRUSTED Health plan provider portal.

When calling to check the status of a claim, the following information must be provided:

- Member name and identification number
- Date of service(s)
- Practitioner Name & Identification
- Billed amount(s)
- Approximate date of claim submission

**CLAIMS DENIAL**

When a claim is denied, Remittance Advice (RA) with reason for the denial will be sent to the practitioner. The appropriate denial code(s) detailing the denial reason(s) can include but are not limited to the following:

- The services were not covered
- The member is not eligible for that DOS
- Claim was not filed within the time limit (DOS to receipt date)

All denied claims can be resubmitted for reconsideration through the appeals process.

**BALANCE BILLING MEMBERS**

All Providers shall comply with the requirements of sections 1932(b) (6) of the Social Security Act, 42 U.S.C. 1396u 2(b) 96) that an enrolled individual or the individual’s family or care giver may not be held liable or be subject to collection efforts for debts or obligation of TRUSTED Health Plan or any provider participating in our network even if in cases of insolvency.

All payments from TRUSTED Health Plan to its providers must be accepted as payment in full for services provided. Members may not be balance billed under any circumstances.

Section 1128B (d) (1) of the Social Security Act states that whoever knowingly and willfully charges for any service provided to a patient under a State plan approved under Title XIX or under a managed care organization contract under 1903(m) of the Act, money or other consideration at a rate in excess of the rates established by the State or contract shall
be guilty of a felony and upon conviction shall be fined no more than $25,000 or imprisoned for no more than five years, or both.

All Providers are encouraged to use the appeal process to resolve any outstanding claims payment issues.

CLAIMS PAYMENT REVIEW

It is TRUSTED’s policy to review all claims for irregularities utilizing its claims audit system. If the system uncovers coding irregularities such as unbundling, utilization of obsolete CPT codes, etc., the specific claims line will be denied using the appropriate denial code. All claims denied for these reasons may be appealed and submitted in writing with additional documentation for reconsideration.

THIRD PARTY LIABILITY/SUBROGATION

In the event of an accidental injury (personal or automobile) where a third party payor is deemed to have liability and makes payment for services that have been considered and paid under the TRUSTED contract, TRUSTED will be entitled to recover any funds up to the amount of the third party payor. Forward all inquiries to the Compliance Officer at:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC  20003
(202) 821-1100

SURGICAL REIMBURSEMENT POLICIES

Preoperative Test Requirements

It is the surgeon’s responsibility to provide information to the member on the hospital’s requirements for preoperative physical examinations, laboratory and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.

Multiple Procedures

Multiple surgical or invasive procedures are paid at a reduced rate. The secondary procedure is paid at 50% of the allowable charge. Subsequent procedures will be paid at 25% of the allowable charge or per provision of individual practitioner’s contract.

Incidental Surgery

Incidental procedures are not reimbursed as separate charges when they are performed in conjunction with other surgical procedures. The following are a few examples of incidental procedures:

• Procedures to create surgical entry
• Exploratory Laparotomy
• Incidental Appendectomy

Assistant Surgeons
Assistant surgeons should be limited to minor procedures and will be reimbursed at 20% of the TRUSTED maximum fee for the procedure performed. The use of an assistant surgeon does not require preauthorization when the surgeon participates with TRUSTED Health Plan. Use of a non-participating assistant surgeon is not permitted unless prior authorization is given by the Medical Management Department.

**Global Surgical Reimbursement**

Pre and postoperative visits are considered to be part of the surgical fee. Payment for visits, which do not fall within the Medicare surgical global guidelines, will be denied.

**National Provider Identifier**

The NPI is a unique 10-digit numeric identifier assigned to:

- Healthcare providers: physicians, dentists and pharmacists.
- Organizational health care providers: hospitals, pharmacies, group medical practices laboratories, ambulatory care facilities and nursing homes; and
- Other covered entities under HIPAA, i.e. managed care organizations

TRUSTED Health Plan is required by the DC Department of Health Care Finance (DHCF) to provide a National Provider Identifier (NPI) for all of TRUSTED contracted providers. Under the Federal HIPAA legislation, as of May 23, 2008, all health plans must use the NPI number to process claim transactions.

**How to Apply for Your New NPI:**

The Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) assigns these unique identifiers. There are several ways to apply:

- Practitioners can apply electronically at [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and click on the highlighted *National Provider Identifier (NPI)* text
- A paper application can be faxed. It is available at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov)
- Practitioners can call the CMS NPPES at 1-800-465-3203 or TTY 1-800-692-2326
Complaints, Appeals and Grievances

MEMBER COMPLAINTS AND GRIEVANCES

TRUSTED maintains a defined process for members to resolve disputes regarding any aspect of service provision or administration. Members, practitioners acting on behalf of a member, or a member’s authorized representative, may contact TRUSTED telephonically, in writing, or in person to voice a complaint regarding any aspect of service provision or administration of the benefit plan, including complaints regarding TRUSTED provider network and/or quality of care concerns.

There is no time limit on filing a complaint if no Notice of Action (denial) was issued. If a Notice of Action was issued, the request to file a complaint or grievance must be received within ninety- (90) days of such notice.

The member may elect to authorize a representative to act on the member’s behalf in the complaint/grievance process. This representative may be:

1. The parent, guardian, or other legal representative of a minor child.
2. A person designated through written authorization of the member, including the member’s health care practitioner.
3. The executor of the member’s estate.
4. An attorney.
5. A non-legal advocate.

TRUSTED will in no way penalize any member, or any individual acting on behalf of the member, who files a complaint or grievance, or requests a fair hearing.

Practitioners must report any complaint they receive to TRUSTED as soon as reasonably possible after the complaint is received. In no case should the report be made more than seven (7) business days after receipt. Please report complaints to:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC  20003
(202) 821-1100

Compliance Hotline at (202) 821-1060

If the complaint includes a potential quality of care issue, the practitioner may also report the issue directly to the Senior Director of Quality and Risk Management (202) 821-1100.

If a member desires assistance in filing a complaint or grievance, the member may contact Customer Service at (202) 821-
1100. Customer Service is available to assist members in filing complaints or grievances. TRUSTED will ensure that the members and his/her representative are notified of the resolution. Complaints are resolved as expeditiously as the member’s clinical condition requires (if there is a medical service component of the complaint). In no case will resolution take longer than thirty (30) days from receipt of the complaint unless the member has agreed to an extension of the resolution due date.

**PRACTITIONER COMPLAINTS**

TRUSTED will work with practitioners and providers to resolve any dissatisfaction with TRUSTED operations and services. If you have an issue you wish to bring to TRUSTED attention, please call (202) 821-1100 and speak to a TRUSTED representative. Issues may also be directed to your Provider Relations Representative.

**APPEALS OF UTILIZATION REVIEW NON-CERTIFICATION OF SERVICES**

The Appeals process is a mechanism through which a member, member’s representative, attending physician/practitioner or facility can request a review of a TRUSTED Health Plan utilization review non-certification decision. Such a request may be made after a Non-certification Letter is sent or at the time the decision is verbally given over the telephone or in person. TRUSTED Health Plan will consider all requests for appeals, but requires that the request for an appeal be made within ninety (90) days of the decision. The Appeals process is effective for review of non-certification due to failure to demonstrate medical necessity for admission, continued lengths of stay, services, procedures, and diagnostic tests.

**APPEAL PROCESS**

When TRUSTED has made a determination to deny, reduce, terminate or delay approval of a service, a member, member’s representative, attending physician/practitioner or facility, may request an appeal of that determination. Providers must have the written consent of the Trusted Health Plan In order to file an appeal of his/her behalf. A standard appeal will be investigated and an appeal determination will be issued within fifteen (15) days of the receipt of the appeal request. During this appeal review all aspects of the initial adverse determination will be reviewed. If the initial adverse determination was based on the medical necessity of the requested service, a health care practitioner who has appropriate training and experience in the field of medicine involved will review the appeal. This will not be the same practitioner who made the initial adverse determination.

TRUSTED will expedite an appeal review if taking the time for a standard appeal review could seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function. Expedited appeals are resolved within 72 hours or three (3) days of receipt. The appeal may be initiated by a verbal or written request; however, TRUSTED prefers that verbal requests be followed by a written request for proper documentation.

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
Attn: Appeals Coordinator or fax the request to 202-905-1056

Verbal requests for appeal may be made by calling the Customer Service Department at 202-821-1100.
TRUSTED enrollees have the right to ask the District of Columbia to review an appeal request at any point in the appeal process. The enrollee may contact the District of Columbia in writing or telephonically using the information below:

DISTRICT OF COLUMBIA OFFICE OF ADMINISTRATIVE HEARINGS CLERK OF THE COURT
441 4th Street, NW, - Ste. 450 - North
Washington, DC 20001
(202) 442-9094

The enrollee may also be entitled to obtain legal services from the following non-exclusive list of free legal service providers including:

• Columbus Community Legal Services, 3600 John McCormack Road, NE, Washington, DC (202)319-6788
• Neighborhood Legal Services, 680 Rhode Island Avenue, NE, Washington, DC 20002 (202) 832-6577
• Legal Aid Society, 1331 H Street, NW, Suite 350, Washington, DC 20005 (202) 628-1161

The enrollee may also contact the Ombudsman Program for assistance and advice in receiving health care from TRUSTED Health Plan. The Ombudsman Program does not make decisions in complaints, grievances, appeals or Fair Hearings. The office of Health Care Ombudsman & Bill of Rights is located at:

441 4th Street, NW, 900 South
Washington, DC 20001
(202) 724-7491 (Office)
(202) 442-6724 (Fax)
(877) 685-6391 (Toll Free)
TTY: 711
Email: healthcareombudsman@dc.gov

If the enrollee wishes assistance with any part of the appeal, such as requesting an appeal from TRUSTED, understanding the appeal process, submitting information to support the appeal, obtaining copies of documents used to make an appeal determination or requesting an appeal through the Office of Administrative Hearings, TRUSTED will assist the enrollee. The enrollee may request this assistance by contacting TRUSTED Customer Service Department.
CLAIMS APPEALS

- If a claim or a portion of a claim is denied for any reason or underpaid, it can be resubmitted as an appeal to the Appeals Department.
- Practitioners have ninety (90) days from the date of the denial to appeal.

Time for processing an appeal is thirty (30) days from the receipt date. If medical records are required, the claim will be closed pending receipt and review of those records.
- All claim appeals must be submitted in writing, along with supporting documentation.
- A telephone inquiry regarding a claim payment or denial does not constitute an appeal. All appeals must be mailed to:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
Attn: Appeals Coordinator
APPENDIX A:

Section 504 of the Rehabilitation Act ("Rehab Act") of 1973 and Title III of the Americans with Disabilities Act (ADA) Specific Requirements of 1990

Section 504 of the Rehabilitation Act ("Rehab Act") and Title III of the Americans with Disabilities Act (ADA) prohibit discrimination against individuals with disabilities and require TRUSTED network of providers to make their services and facilities accessible to such individuals. TRUSTED expects all providers in its network to comply with the requirements of these statutes. The requirements of the ADA and the Rehab Act regarding accessibility are lengthy and complex. TRUSTED policy on access summarizes the main requirements and sets forth TRUSTED minimum expectations of its providers. Providers should consult with their own legal counsel about their obligations under these statutes.

NON-DISCRIMINATION

The ADA and Rehab Act prohibit discrimination by public accommodations and recipients of federal assistance, respectively, against individuals with disabilities. TRUSTED providers fall into both of these categories. Accordingly, they may not, on the basis of an individual’s disability or an individual’s association with someone with a disability, (1) deny that individual goods, services, facilities, privileges, advantages, or accommodations; (2) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are not equal to that afforded to other individuals; (3) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are different than or separate from that afforded to other individuals; or (4) provide goods, services, facilities, privileges, advantages, or accommodations in a segregated setting.

In addition, TRUSTED providers must not use eligibility criteria that would screen out or tend to screen out individuals with disabilities from fully and equally enjoying any of their goods, services, facilities, privileges, advantages or accommodations.
MODIFICATIONS IN POLICIES, PRACTICES AND PROCEDURES

TRUSTED providers have an affirmative obligation to make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages or accommodations to individuals with disabilities, unless they can demonstrate that making the modification would fundamentally alter the nature of the goods, services, facilities, privileges, advantages or accommodations or pose an undue burden. In other words, unless providing the modification would change the fundamental nature of a provider’s service, or pose an undue burden, the modification must be made. The undue burden analysis takes into account the resources of the provider, which means that small doctors’ offices, for example, will be more likely to be able to demonstrate an undue burden than a hospital. The nature of the reasonable modification will vary depending on the circumstances of each case. However, TRUSTED providers should always consider a request for a modification carefully. It is never appropriate to reject a request without giving meaningful consideration to the request or possible alternatives’ if the request cannot be accommodated. Requests for a reasonable modification and responses to such requests should be documented. The following are some examples of reasonable modifications in policies, practices and procedures:

• Example 1: A medical facility has a policy of not allowing animals into any part of the building. This facility is required to modify this policy to allow a person with a disability to bring a service animal into the building, unless doing so would result in a fundamental alteration or jeopardize the safe operation of the medical facility. If there are facts showing that the presence or use of a service animal would pose a significant health risk in certain designated areas of a hospital, for example, may serve as a basis for excluding service animals in those areas. The provider has no obligation to care for or supervise a service animal. In addition, if the service being provided by the service animal is not apparent, a provider may ask what the animal performs for the person with a disability.

• Example 2: A health clinic has an evacuation plan for use during a fire or other emergency under which elevators will be shut off. The clinic must modify this evacuation procedure to provide alternative means for mobility-impaired patients to be evacuated from the building.

• Example 3: A doctor’s office is located in a building that has an entrance that cannot be made accessible to a patient who uses a wheelchair. Normally, the doctor does not see patients off-site. The doctor may have to modify this policy to see this patient at an alternate location that is accessible.

AUXILIARY AIDS AND SERVICES

The ADA and Rehab Act require providers to provide auxiliary aids and services to individuals with disabilities that are necessary to ensure their equal access to the goods, services, facilities, privileges, or accommodations that they offer, unless an undue burden or a fundamental alteration would result. Providers may not charge extra for these auxiliary aids and services.

Auxiliary aids and services can take many forms, depending on the needs of the individual with a disability. A good way to approach the situation is to have a dialogue with the individual with a disability about what auxiliary aid or service he or she needs. Although the decision of what auxiliary aid or service to offer is ultimately the provider’s, a dialogue between the patient and provider is usually very productive and resolves most issues.

One of the greatest challenges that providers face is how to provide “effective communication” with patients who are
vision or hearing impaired. The ADA and Rehab Act both require that providers provide auxiliary aids and services to their vision or hearing impaired patients to ensure that there is “effective communication.” Depending on the length, importance and complexity of the communication at issue, a provider may have to provide a deaf patient with a qualified sign language interpreter, at no charge. In other cases, written materials or the exchange of written notes may suffice.

- **Example 1:** An oncologist meets with a deaf patient for an hour to discuss treatment options for her leukemia. A qualified sign language interpreter must be present to provide “effective communication.”

- **Example 2:** A deaf patient goes to his doctor for a bi-weekly check-up, during which the nurse records the patient’s blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.

If the circumstances require a qualified interpreter, a provider may not rely on the family members or friends of the individual with a disability to provide interpretation services.

To provide effective communication with vision impaired patients, a provider may have to provide a reader, brailed materials, or large print materials, depending on the circumstances.

- **Example:** A blind patient cannot read and fill out the patient intake forms that must be completed for new patients. The provider should have someone read the form to the patient and help the patient complete the form.

Providers should also be aware that they may also have to provide a means for effective communication to family members and friends with vision or hearing impairments to the extent that those persons play an important role in the care of the patient, even if the patient does not have a vision or hearing impairment.

- **Example:** A patient receiving chemotherapy in the hospital is very sick and her mother, who is deaf, is at the hospital virtually all the time to assist in her care and communicate with hospital staff about her daughter’s needs. The hospital must provide effective communication with the mother.

1. **DIRECT THREAT**

A provider may exclude an individual from participating in or benefiting from its goods, services, facilities, privileges, advantages and accommodations if the individual poses a direct threat to others that can-not be mitigated with reasonable modifications of policies, practices, or procedures, or by providing auxiliary aids or services. This determination must be based on an individualized assessment of the facts, not generalizations or stereotypes about the effects of a particular disability. Exclusions based on a “direct threat” determination should be carefully documented.

2. **ACCESSIBLE FACILITIES**

TRUSTED providers must have physical facilities that are accessible to individuals with disabilities. The level of accessibility that is required depends on when the facility was constructed. Facilities constructed for first occupancy after January 26, 1993, must meet the highest level of accessibility set forth in the ADA regulations at 28 C.F.R. part 36, Appendix A (the “ADA Standards”). Facilities constructed for first occupancy prior to January 26, 1993 (Pre-1993 Facilities) are not required to meet the ADA Standards but must still remove structural barriers to the extent the removal is “readily achievable” (i.e., can be carried out without much difficulty and expense). In addition, any alterations to a Pre-1993 facility made after January 26, 1992, must comply with the ADA Standards to the maximum extent feasible.
TRUSTED recommends that its providers conduct a self-evaluation of their facilities to determine if they are in compliance with these requirements. More information concerning the ADA Standards can be found at [www.ada.gov](http://www.ada.gov).

TRUSTED will conduct periodic reviews of its providers to ensure compliance with this and other policies. With regard to physical accessibility, TRUSTED will focus primarily on the following aspects of each facility in its reviews:

a. **Accessible parking.** If parking is provided at a provider’s facility, there must be accessible parking spaces located as close to the accessible entrance as possible marked with the international symbol of accessibility (ISA). For a lot with up to 100 spaces, one in every 25 spaces must be accessible. (A provider with more than 100 spaces should consult the ADA Standards for the required number). An accessible parking space for a car must be located on level ground and at least 8’ wide; with an adjacent access aisle that is at least 5’ wide. There must be one van accessible space for every eight accessible spaces (with a minimum of one in all parking lots). Van accessible spaces must have 8’ wide access aisles.

b. **Accessible Entrance.** There must be at least one accessible public entrance for every two at the facility. An accessible entrance must meet the following minimum requirements:

1. Have no abrupt change in level greater than 1:12” (e.g., no steps). Thresholds must be beveled with a maximum 1:2 slope and no higher than 3 inches”;
2. Provide 32” of clear width when the door is open at 90 degrees; and
3. Have door hardware that can be used with a closed fist or flail hand (e.g., lever hardware).

   *Note: If the facility has public entrances that are not accessible, there must be signage at those entrances indicating the location of the accessible entrance(s).*

c. **Accessible Route.** Individuals with mobility impairments who use wheelchairs or scooters must have accessible routes that they can use to access provider facilities.

   There must be an accessible route from the accessible parking, public sidewalk, passenger loading zone, and public transportation stop to the building entrance.

   There must be an accessible route connecting (a) the accessible entrance, (b) accessible rest-rooms, and (c) and all locations within the facility where goods and services are provided to the public (e.g. reception area, exam rooms, treatment rooms, hospital rooms).

   As a general matter, an accessible route is a clear unobstructed path that is at least 36” wide with (1) a maximum primary slope of 5%; (2) a maximum cross slope of 2%; (3) a firm, stable, and slip resistant surface; (4) no abrupt change in level more than 3 inches” (e.g. steps), although thresholds can be up to 6 inches” high if they are beveled with a 1:2 slope. An accessible route can narrow to 32” clear width at doorways. An accessible route can also include curb ramps and ramps, for which there are specific standards, set forth in the ADA Standards. One of the basic requirements for ramps is that the slope cannot exceed 8.33%.

d. **Accessible restrooms.** Every facility must have at least one accessible ladies and men’s restroom that is on an accessible route. As a general rule, an accessible restroom must have the following features:

1. A door that provides a 32” clear width when open at 90 degrees;
2. A door that can be open with less than 5 lbs. of force;
3. Entrance door hardware that can be used with a closed fist or flail hand;
4. Have maneuvering space on both sides of the door that is level (i.e., maximum 2% cross slope in both directions) and at least 24” of clear space next to the latch side of the door;

5. A 5’ x 5’ stall (“Accessible Stall”) with an out-swinging door with the following features:
   i. A toilet that has a centerline at 18” from the adjacent sidewall with a seat that is no higher than 17” to 19” from the floor to the top of the seat;
   ii. A hook in the Accessible Stall that is no higher than 48” from the floor;
   iii. A horizontal grab bar behind the toilet that is at least 36” long and mounted between 33”-36” above the floor; and
   iv. A horizontal grab bar along one side of the toilet (the side closest to the toilet) that is at least 40 inches long and mounted between 33”-36” above the floor.

6. At least one sink that has (1) a bottom edge located at between 29” and 34” above the floor; (2) insulated pipes; (3) hardware that can be operated with a closed fist or flail hand; and (4) a 30” x 48” clear floor space to allow someone to approach the sink from the front.

7. Soap and towel dispensers that are no higher than 48” from the floor.

8. Either a full-length mirror, or a mirror mounted no more than 40” above the floor.

c. Restroom signage.
   1. If there are restrooms that do not have an Accessible Stall, there must be signage at those restrooms indicating the location of the restrooms that have an Accessible Stall.
   2. Signs designating restrooms must be mounted on the wall next to the latch side of the door, 60” from the floor to the centerline of the sign with raised lettering and Braille.

Providers should be aware that this is not a complete list of requirements under the ADA Standards and is only intended to provide guidance to providers about what accessibility features will be the focus of TRUSTED reviews. TRUSTED also recognizes that some Pre-1993 Facilities may not be able to meet all of these requirements due to technical or structural issues or expense (for small providers) and will take those factors into consideration.

Appendix B. Medical Practitioner Office Site

EVALUATION STANDARDS

I. Physical Accessibility and Appearance

A. Physical Accessibility and Appearance — General Facility

1. The office should be handicapped/wheelchair accessible. The office should provide a ramp to access the front door
and should have at least one restroom that has a widened doorway to accommodate a wheelchair and safety bars and hand-rails near the toilet.

2. **The office should have visible exit signs.** Exits in the office should be clearly marked to assist patients in evacuating the office in an emergency. While the office environment is familiar to the staff that is there on a daily basis, it can be very confusing to patients who may be new to the office or visit the office on an infrequent basis. Evacuation maps should be posted at regular intervals.

3. **The office should have an adequate sprinkler system or accessible fire extinguishers available in case of a fire.** Ideally, a building should be equipped with an automated sprinkler system that would be triggered and activated in the event of a fire. Offices with sprinkler systems should have hand-held fire extinguishers available in the office. A small fire may be extinguishable by use of the hand held fire extinguisher, thus preventing the sprinkler system from being activated, which can result in water damage to office equipment and medical. If the building does not have a sprinkler system it is essential that the office have at least one fire extinguisher in the office. All staff should be familiar with the location and use of the fire extinguisher. A fire extinguisher in the hall is not considered accessible.

4. **Fire extinguishers in the office should be maintained according to the manufacturer’s specifications, and documentation of this maintenance should be current.** Fire extinguishers require periodic inspection and may require recharging/replacement after use or long periods of non-use. Manufacturer’s specifications for inspection and maintenance should be followed. Documentation ensures that the required maintenance has occurred.

5. **The office should have the TRUSTED Health Plan Member Rights and Responsibilities statement available to patients and practitioners in the office.** TRUSTED Health Plan is committed to maintaining a mutually respectful relationship with its members. The Member Rights and Responsibilities statement sets a structure for cooperation among members, practitioners and TRUSTED Health Plan. The statement should be available to members and practitioners in the office setting to ensure that those who receive care and those who provide care are aware of the associated member rights and responsibilities.

### B. Physical Accessibility and Appearance — Waiting Room

1. **The office waiting area should accommodate patients and provide adequate seating.** The waiting area should include a sufficient number of chairs for patients and others waiting during office hours.

2. **The office waiting area should have adequate lighting for reading.** Lighting should include focused lights and/or lamps adjacent to chairs so patients and others waiting can be comfortable while reading.

3. **The office waiting area should be well ventilated.** The waiting area should be comfortably ventilated for patients. Smoking should be prohibited at all times in the office.

4. **The office waiting area should be clean in appearance.** The waiting area should be clean with floors, seating areas, and tables clear of clutter, toys or trash. The area should be vacuumed and cleaned on a regular schedule. Trash cans should be available and emptied routinely.

5. **The office should have educational information easily available to patients.** Appropriate written educational material concerning health issues should be available to patients. Information should be relevant to the patient’s needs and should be written at an easily understood reading level.
C. Physical Accessibility and Appearance — Examination Room

1. **The office’s exam rooms should be clean in appearance.** Examination areas should be clean, with floors; examination tables, chairs and other furniture clear of clutter and trash. Areas should be vacuumed and cleaned on a regular schedule. Trash cans should be available and emptied routinely.

2. **Patient privacy should be maintained during exams and consultations with practitioners or staff.** Patient privacy should be a priority during all encounters with the practitioner and staff. Examinations should be privately conducted. Medical consultations should be conducted in a confidential manner. Discussions about billing or other business issues should be conducted privately between staff and patients.

3. **Female chaperone should be available, offered and present during female examinations.** During female examinations, especially OB/GYN examinations, a female should have the right to have a female chaperone present.

4. **Drape sheets and gowns should be available for patients.** If it is necessary for the patient to disrobe, adequate drape sheets and gowns should be available and offered to the patient to ensure his/her modesty during the physical examinations.

5. **Sinks and soap should be available in the examination room.** Clean running water and soap should be available in the examination rooms and office to ensure that basic hand washing techniques can be observed.

6. **A needle control and bio-hazardous waste disposal system should be in place.** Federal regulations (OSHA Exposure Control Plan) require practitioners to have a system in place to handle sharps and bio-hazardous waste disposal. The system should include needle boxes for sharps disposal and red bags for the disposal of bio-hazardous waste.

7. **The office should have gloves available in the exam/procedure rooms or in the patient care areas.** In order to allow all staff to observe universal infection control precautions, gloves should be easily available in all examination areas. There should be a written Blood Bourne Pathogen and Other Potentially Infectious Materials Standard. This plan describes the actions taken for exposures and needle sticks according to CDC protocols.

8. **Red bags should be available and visible in each examination room for the disposal of bio-hazardous waste.** Red bio-hazardous waste disposal bags should be in each examination room and clearly marked as waste.

II. Risk Management

A. Risk Management — Emergency Care

1. **The office should have basic emergency equipment available.** Basic emergency equipment should consist of a Bag-valve-mask resuscitation bag or a mask/pocket mask and airways. Offices that see adult patients should have adult airways, and if pediatric patients are seen, pediatric sized airways should also be available. OB/GYN practitioners should also have a pre-natal pack available.

2. **The office should have a procedure in place to document routine checks of emergency equipment.** Emergency equipment should be regularly inspected and checked for continued functionality. These routine checks should be documented in a consistent manner to ensure that the office is prepared for any emergency occurrence.

3. **The office should have at least one CPR-certified healthcare staff member present in the office when patients
are scheduled. At least one office staff member, in addition to the practitioner, should maintain current CPR certification to ensure an adequate response to emergency situations that may occur in the office.

4. The following emergency medications should be available in Crash Cart/Emergency boxes, as required:
   - **A & B - Nitroglycerin SL or spray and Procardia should be available if the office administers stress tests.** Offices that conduct stress testing must have appropriate medications available for patients in an emergency. Possession of an AED (Automatic External Defibrillator) is strongly encouraged.
   - **C & D - Appropriate emergency resuscitation equipment and medications should be available at offices that administer injections to patients.** Medications should be available in the dosages appropriate for the ages and types of patients seen at that office. Staff should be trained to respond quickly and appropriately to emergencies and in a coordinated fashion... Allergic responses are unpredictable and require immediate attention.

B. Risk Management — Plans, Licensure and Certification
1. **The office should have a written OSHA Exposure Control Plan in place.** Federal regulations require practitioner offices to have the OSHA Exposure Control Plan in place. This plan should address blood, body fluids, chemicals, and gases, depending on the office capacity. This plan is required to be updated annually. Offices failing to meet these Federal regulations may be liable for significant fines. If a citation was issued, a corrective action should be in place or the citation closed.
2. **The office should have a written Hazard Communication Plan.** The Employee Right to know document that includes any chemicals, reagents, or other solutions the employee may con-tact while at work must be in place. A MSDS (Material Safety Data Sheet) is required to be physically present in the office for each substance at all times.
3. **The office should have an emergency preparedness plan in place.** The office should have a plan to handle the evacuation of patients and visitors in an emergency. While office staff may be very familiar with the layout of the office, patients and visitors may become confused and become trapped if there is smoke or a loss of power in the building. Staff should discuss emergency evacuations ahead of time, so each staff person will know his/her role.
4. **The office should store all controlled drugs and substances in locked areas at all times.** By law, controlled substances are required to be secured in locked areas at all times and inventory control records to be maintained. Many offices have sample medications that are actually controlled substances in open cabinets/closets. Staff should familiarize themselves with the controlled substances packaging labels on medications and stock controlled sample medications in locked areas.
5. **The office should post current licensure, certifications or registrations to practice in a prominent place in the office.** Necessary licensure and other certification and registration documents should be available to both patients and reviewers for inspection.
6. **The office should have written policies and procedures that cover the requirements of the Health Insurance Portability and Accountability Act of 1996.** The HIPAA Security Rule requires that covered entities have in place reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information.
7. **The HIPAA “Notice of Privacy Practice” should be posted in areas that are visible to patients.** If a
practitioner maintains an office or other physical site where he/she provides health care directly to individuals, the practitioner must post the HIPAA “Notice of Privacy Practice” notice in the facility in a clear and prominent location where individuals are likely to see it, as well as make the notice available to those who ask for a copy.

8. **All members should receive written notice of their Health Insurance Portability and Accountability Act of 1996 (HIPAA) rights and responsibilities.** The HIPAA Privacy Rule requires a covered health care practitioner with direct treatment relationships with individuals to give the notice to every individual no later than the date of first service delivery to the individual and to make a good faith effort to obtain the individual’s written acknowledgment of receipt of the notice. All members should receive notice and the practitioner’s office should make a good faith effort to have a statement of receipt signed by the member. The signed statement of receipt should be maintained in the member’s medical record. This should be updated annually.

9. **All employees should be trained regarding the Fraud and Abuse regulations as they relate to the medical practice and billing.**

10. **All employees shall be trained regarding HIPAA privacy and security regulations**

11. **Annual training of staff should be conducted and documented on:**
   a. Exposure Control Plan
   b. Hazard Communication Plan
   c. Fire Safety
   d. Human Resource issues- i.e. discrimination, harassment, FMLA
   e. Clinical competencies

C. **Risk Management — Ancillary Services**

1. **CLIA Certification**
   a. **If the office requires CLIA certification, certification should be current.** CLIA certification for laboratory services must be current and available for inspection, by law.
   b. **If the office does not require CLIA certification, a waiver should be present.** When offices are exempt from CLIA certification due to the nature of testing performed, a waiver is issued by CLIA and must be available for inspection.

2. **The office should have policies and procedures in place to test laboratory equipment calibration and validation.** Laboratory equipment requires periodic calibration and validation to ensure consistent accuracy of results. Equipment should be monitored and testing performed on a scheduled basis. Maintaining documentation of this is a requirement for continued CLIA certification.

3. **The office should have policies and procedures in place to ensure ancillary equipment (e.g. audiometers, scales, and mercury blood pressure cuffs) receives calibration and test validation.** Medical office equipment requires periodic maintenance and calibration to ensure accuracy of results obtained. The office should have policies to ensure equipment is monitored and a system is in place to ensure testing and validation occurs on a scheduled basis.

4. **If present, the office should ensure that X-ray equipment is inspected and licensed annually.** X-ray equipment
requires periodic inspection, preventive maintenance and annual licensure in many states. Offices should ensure that all equipment in use is maintained and licensed according to local law. Technicians should wear personal radiation monitors.

5. **If X-ray equipment is in use, the office should provide radiation protective devices, including shields, warning signs and alerts to pregnant women.** Radiation protective devices should be available in the office to shield patients receiving x-rays. Warning signs should be prominently posted in several locations.

6. **The medical refrigeration system should maintain a temperature of 35 - 46 degrees Celsius.** A consistent refrigeration temperature important to the efficacy of medications and the composition of testing samples. Non-medical items should not be stored in the refrigerator.

### III. Availability of appointments

1. **The office should have a 24-hour answering service or an answering machine available to instruct patients on how to obtain care after hours.** Patients may need to contact the practitioner after hours during urgent and emergency situations. The office should have a system in place to provide access to care after regular office hours.

2. **The office should provide coverage 24 hours per day, 7 days per week.** Practitioners should arrange to be accessible to patients 24 hours per day, 7 days per week. Groups of practitioners may arrange to share calls or other coverage arrangements. Patients should have access to a designated in network practitioner at all times.

3. **The office hours and after hours phone numbers should be easily accessible for patients.** Office hours and after hours phone numbers may be posted on the outer door, or available on the practitioner’s business card, or listed in the practitioner’s patient handbook. Patients should be educated on when the office is open and how to access care after hours.

4. **The office should ensure that TRUSTED Health Plan’s Customer Services toll-free number is available to TRUSTED members.** Office staff should ensure that TRUSTED members can reach the Member Services toll free number.

5. **The office should have a procedure in place to remind members of their appointments.** Offices can call prior to appointments or mail out reminder cards to ensure that members will keep scheduled appointments.

6. **The office should have a no-show policy, including follow-up with members who have missed their appointments.** The office has a responsibility for and should demonstrate concern for completion of the ongoing treatment plan. A record of broken or missed appointments should be maintained in the patient’s record with documentation of follow-up efforts. Documentation in the office appointment log is not adequate.

### IV. EPSDT Availability

1. **All practitioners who perform EPSDT procedures must have the appropriate equipment and it must be maintained in working condition.** TRUSTED on-site review will include a review and visual inspection of the necessary EPSDT equipment.

### V. Medical Record keeping and Filing

1. **The Office should have a policy that covers the content of the medical record and the manner in which it is
Organization of the medical record keeping system ensures that individual records can be located in a timely manner and are available for all patient care needs. A standard organizational format within each medical record allows the practitioner maximum efficiency when reviewing each record.

2. **The office should maintain medical records in an area away from public access.** The office should protect the confidentiality and integrity of medical records by storing them away from main traffic areas in the office. Medical records should not be stored in patient exam areas. Records should be stored in a private part of the office where patients and visitors do not routinely have access. Only authorized office staff should have access to the medical records.

3. **An experienced staff person should be designated to have oversight of and access to the medical records filing system.** It is important that a staff person who is trained and experience in medical record keeping and filing be in charge of the system.

4. **The office should maintain an organized medical record keeping system to ensure new information is filed in the correct record in a timely manner.** New information should be added as soon as possible to ensure a complete medical record at every patient appointment.

5. **Medical Records should be dictated and transcribed.** Medical records must be easy to read. Handwritten notes and records may be miss-read or misinterpreted in the future.

6. **The office should require a written authorization from the patient or responsible party for the release of medical records.** Office staff should provide for the confidentiality of the patient’s record by requiring a written release before copying any part of the medical record. Only copies of medical records should be released. TRUSTED requires that its members be given a copy of their medical records upon request.

7. **The office should have a confidentiality policy for medical records.** The office should develop a confidentiality policy concerning medical records so that all staff understands how records are to be handled. Many offices now require that staff sign a confidentiality agreement outlining the medical records policy, to ensure that medical records handling is conducted to protect patient privacy.

8. **Medical Record Review Format -** Medical records should be maintained in an organized manner consistent with TRUSTED Medical Record Documentation Standards. The record should include a place for the following types of information (based on a review of sample record or blinded TRUSTED member):

   a. **Medication allergies and adverse reaction notification.** Notice of any allergies and/or adverse reactions should be prominently displayed.

   b. **Past medical history should be included.** Past medical history should be easily identified and readable.

   c. **Notation concerning use of cigarettes, alcohol and/or substances should be included in children age 12 and above and adults.** File notation regarding counseling on the use of cigarettes, alcohol and substances should be in each file.

   d. **The ordering practitioner initials consultation, laboratory and imaging reports.** All consultation, laboratory and imaging reports should be in the file and should be initialed by the ordering practitioner to indicate that they have been reviewed.
e. An immunization record (child) or appropriate history (adult) is in the medical record. On-going immunization or history should be maintained.

f. Each page contains the patient’s name.

g. Personal data, including address, employer, home and work telephone numbers and marital status is included.

h. Entries in the medical record require the author’s signature, initials or other identification.

i. Entries are dated.

j. The record is legible to the reviewer.

VI. Evaluating the On-Site Review

TRUSTED Health Plan conducts on-site office visits to primary care practitioners; obstetricians/gynecologists, specialists and behavioral health care practitioners meet our office site standards. The TRUSTED Provider Relations Representative will conduct this review and will provide the results of the review. Your office will be scored based on TRUSTED standards and thresholds for office-site criteria and medical record keeping. 75% is the acceptable minimum score.

Appendix C. Medical Practitioner Office Site

EVALUATION FORM

V. MEDICAL RECORDKEEPING AND FILING

NOTE: This Section of the Practitioner Office Evaluation Form is used to identify the presence of critical medical records file documentation and key elements of an organized medical record filing system. The practice may present a sample record or blinded record for review. Clinical adequacy of medical record keeping is evaluated in detail in a clinical ambulatory medical records review process not covered in this evaluation.
1. Does the office have a policy that includes the manner, in which the medical record is organized, the content of the medical record and the manner in which it is filed?

2. Are medical records maintained in an area away from public access?

3. Is an experienced staff person designated to have oversight of and access to the medical records storage system (both paper and electronic files)?

4. Does the office maintain a filing system to ensure new information is filed in individual records in a timely manner?

5. Are medical records dictated?

6. Is written authorization obtained for the release of medical records?

7. Is there a confidentiality policy for medical records, patient confidentiality and medical filing system?

8. Medical Record Format Review:
   (TRUSTED Medical Record Documentation Standards)
   A. Medication allergies and adverse reactions (or lack of allergic reactions) are prominently noted in or on the record.

   B. Past medical history is easily identified

   C. Patients age 12 & older - There is appropriate notation sheet to use concerning the use of cigarettes, alcohol and substances.

   D. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E.</td>
<td>An immunization record (children) or appropriate history is in the medical record (child).</td>
</tr>
<tr>
<td>F.</td>
<td>Each page in the record contains the patient’s name or ID number.</td>
</tr>
<tr>
<td>G.</td>
<td>Personal biographical data includes address, employer, home and work telephone numbers and marital status.</td>
</tr>
<tr>
<td>H.</td>
<td>Entries in the medical record require the author’s identification (signature, initials, electronic id)</td>
</tr>
<tr>
<td>I.</td>
<td>Entries are dated.</td>
</tr>
<tr>
<td>J.</td>
<td>The record is legible to the reviewer.</td>
</tr>
</tbody>
</table>

TOTAL MEDICAL RECORD SCORE ______________
TOTAL COMBINED ON-SITE SCORE _____________

75% or Better required to pass
PROVIDER OFFICE SITE EVALUATION FORM

1. List of Physicians who practice in this office:

2. I, the undersigned CHP representative, have identified the following areas needing improvement and have discussed with the provider/designee:

CORRECTIVE ACTION PLAN:

Timeframe for Resolution:

Resolution:

3. Follow-up will be monitored by:

4. A copy of the office site evaluation: has been given to the provider/designee: _____________________ and will be mailed to the office: _____________________

THP Designee signature: __________________________________________

Title: __________________________________________ Date: ___________

I, the undersigned provider or designee, have reviewed the results of the office site evaluation. I agree to correct any areas needing improvement as identified by the asterisk (*) in order to meet TRUSTED Health Plan’s credentialing and
re-credentialing criteria.

Provider/Designee Signature: ____________________________________ Date: __________________

**Appendix D. Medical Record Documentation**

**STANDARDS**

It is the responsibility of TRUSTED Health Plan to ensure that consistent, current and complete documentation is in the medical record, as it is an essential component of quality patient care. TRUSTED has adopted the following best practice standards for medical record documentation. Critical elements that must be included in the documentation for TRUSTED Health Plan members are starred.

1. Each page in the record contains the patient’s name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years old and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under- or over-utilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.
18. Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them.
to signify review. (Review and signature by professionals other than the ordering practitioner do meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).

21. There is evidence that preventive screening and services are offered in accordance with the organization’s practice guidelines.
Appendix E. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

Q. Why are you giving this notice to me?

TRUSTED Health Plan knows that information about you and your health is personal, and we are required by the federal Health Insurance Portability and Accessibility Act (HIPAA) to tell you what your responsibilities are and what rights you have under the law.

Q. What is TRUSTED Health Plan required to do under HIPAA?

TRUSTED Health Plan is required by HIPAA to:

• Make sure that your protected health information is kept private;
• Give you this notice to tell you about our legal duties and privacy practices with respect to your PHI; and
• Follow the terms of this notice.

Q. What is Protected Health Information (PHI)?

Protected Health Information (PHI) is defined as any oral, written or electronic information that:

• Identifies you or can be used to identify you.
• Either comes from you or has been created or received by a health care provider, a health plan, or a healthcare clearinghouse.
• Has to do with your physical and/or mental health or condition, providing health care to you, or paying for providing health care to you.

In this notice, “protected health information” will be written as PHI.

Q. How can you use or share my PHI?

There are laws that allow or require us to use or disclose your PHI for many reasons. This Notice tells you how we may use and disclose your PHI. While not every use or disclosure is listed, the ways we may use or share your PHI falls within one of the descriptions below.

For Treatment. We may use and share your PHI for treatment. For example, we may use or share your PHI to enroll you in a disease management program, or to share it with your case manager.

For Payment to Caregivers. We may use and share your PHI in order to pay for health care you receive. For example, a bill that we may receive from your doctor may have information on it that identifies you, the nature of your illness, the treatment or tests given to you and the supplies that might have been used.
For Health Care Operations. We may use and share your PHI to run our business. We protect your PHI by limiting access to it within our Plan. Only our employees directly involved in our business activities that require access to your PHI are authorized to see or discuss your PHI. For example, we may use your PHI to review and improve the quality of health care services you receive.

For another covered entity’s needs. We may share your PHI with another covered entity, such as a doctor or health plan, for their treatment or payment use. For example, we may share your PHI with a health plan to help them pay for your care. We may also share your PHI with them so that they can do certain business tasks if you have or have had a relationship with them.

To remind you of appointments and health-related benefits or services. We may use your PHI to send you appointment reminders. We may use PHI to tell you about other health care treatment, services, or benefits.

To comply with the law. We will share your PHI when we are required by law to do so. We will share PHI when we are required to in a court or other legal proceeding. For example, we will disclose PHI if a law says that we must report PHI about people who have been abused.

To report public health activities. We will share PHI with government officials in charge of collecting certain PHI. For example, we may share PHI about births, deaths, and some diseases.

For health oversight activities. We may share PHI if a government agency conducting activities approved or required by law, such as audits, investigations, licensure or disciplinary actions. Oversight agencies include government agencies that look after the health care system, benefit programs, including Medicaid, Alliance, SCHIP, or Healthy Kids, and government regulation programs.

For purposes of disposition of your remains. We may share your PHI with coroners, medical examiners, and funeral directors. If permitted by law, we may also share PHI with organizations that help find organs, eyes, and tissue to be donated or transplanted.

To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement or others who may be able to stop or lessen the harm.

For certain government functions. We may share PHI for national security reasons. For example, we may share PHI to protect the President of the United States.

For workers’ compensation. We may share PHI to obey workers’ compensation laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may share PHI about you in response to a court or administrative order, or other lawful process.

For Research. We may share your PHI with researchers when an institutional review board or privacy board has followed the HIPAA information requirements.

Other Uses and Sharing of Your Health Information. We will ask for your written permission, called as an
authorization, before we make any use or disclosure of your PHI not described in this notice. If you give us your written permission, you may still decide later that you no longer want us to use or disclose your PHI in that way. If you change your mind, you may tell us in writing. We will then stop using your PHI in that way.

Q. Will you give my PHI to my family, friends, or others?

We may share PHI about you with a friend or family member who is involved in your care or who helps pay for your care when you are present. For example, if one of our case managers visits you in the hospital and your mother is with you, we may discuss your PHI with you in front of her. We will not discuss your PHI with others if you tell us not to. There may be times when you are not present or are unable to make healthcare decisions. If this should happen, we may share your PHI if we think it is best for you. For example, we may share PHI with someone who is with you when you are unconscious so that you can receive care.

Q. What are my rights under federal law with respect to my PHI?

The law gives you the following rights regarding your PHI. To exercise these rights, please call Member Services at (202) 821-1100 Toll Free (855) 326-4831.

1. **You can see or get copies of some of your PHI.** Sometimes your right to see or get copies of your PHI may be limited. You must ask us in writing. We may charge a fee for copying and mailing the PHI.

2. **You may ask us to limit our uses and disclosures for purposes of treatment, payment or healthcare operations.** We are not required to agree to the request. You may also ask us to limit disclosures to someone who is involved in your care or payment for your care, like a family member or friend.

3. **You may ask us to send your PHI to another address if it is necessary to protect you from danger. You may ask us to communicate with you in a certain way if it is necessary to protect you from danger.** For example, you may ask us to send PHI to you at work instead of at home. You may ask us to send your PHI by e-mail rather than regular mail. You must tell us in writing what you want. You must tell us that you could be in danger if we do not agree to your request.

4. **You can get a list of certain disclosures we have made of your PHI.** The list will only include disclosures made after April 14, 2003. The list will not include certain types of disclosures. We will give you one list free during any 12-month period. You will need to pay for any additional lists during that time.

5. **You may ask us to correct your PHI if you think there is a mistake.** You must ask us in writing and tell us why you want us to correct the information.

6. **You may get a paper copy of this notice at any time.** To obtain a paper copy of this notice, please call Member Services at (202) 821-1100 Toll Free (855) 326-4831.

Q. May I complain about your privacy practices?

**YOU WILL NOT BE PUNISHED FOR FILING A COMPLAINT.**

If you think we violated your privacy rights you may file a complaint. You may send your written complaint to:
Q. How will I know if my rights change?

We may change this notice and our privacy policies at any time. Then the new notice will apply to your entire PHI. We will make the new notice available to you at all times. The new notice will contain the new effective date.

If you have any questions about this notice, please contact Member Services at (202) 821-1100 Toll Free (855) 326-4831.
Appendix F. Sentinel Events Policy and Procedure

SCOPE MEDICAL MANAGEMENT- TRUSTED HEALTH PLAN AND ALLIANCE

TITLE MONITORING AND REPORTING OF SENTINEL EVENTS

POLICY
TRUSTED Health Plan, Inc. (TRUSTED) will monitor 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 that we authorize. The intent of this policy is to identify those 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 reputation of TRUSTED. The phrase “or the risk thereof” includes any process variation for which an occurrence (as in “near miss”) or recurrence would carry a significant chance of a serious adverse outcome.

The goal of this policy is to:

• Have a positive impact on improving patient care, treatment, and services and prevent sentinel events.
• 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 sentinel events, their causes, and strategies for prevention.

Definitions
1. **Sentinel Event**: Real-time identification of an unexpected occurrence 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 reputation of TRUSTED. Such events are called sentinel because they signal the need for immediate investigation and response. For the purpose of this policy, TRUSTED limits identification of sentinel events to occurrences in the course of a member accessing health care services. 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.

2. **Critical Event**: Retrospective identification of an unexpected occurrence that, upon investigation, is found to have caused serious harm or injury to a TRUSTED member. Critical events differ from sentinel events only in the time frame in which they are identified.

PROCEDURE
1. A TRUSTED employee identifies, or is notified of, an event which meets criteria as a potential sentinel event.
2. The following is a listing of the indicators monitored at TRUSTED Health Plan as potential sentinel events. This list should not be considered an all-inclusive list.
a. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition
b. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
c. Unanticipated death of a full term infant
d. Abduction of any patient receiving care, treatment, and services
e. Discharge of an infant to the wrong family
f. Rape - Rape as a reviewable sentinel event is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the patient’s sex organ(s) by another individual’s hand, sex organ, or object. One or more of the following must be present to determine reviewability:
   - Any staff-witnessed sexual contact as described above
   - Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.
   - Admission by the perpetrator that sexual contact, as described above, occurred on the premises
g. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
h. Surgery on the wrong patient or wrong body part
i. Unintended retention of a foreign object in a patient after surgery or other procedure
j. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
k. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

3. The Sr. Director, Quality and Risk Management is notified of the event via incident report, telephone, E-mail, or personal visit as soon as reasonably possible after identification.

4. The Sr. Director, Quality and Risk Management will collaborate with the Chief Medical Officer and investigate as appropriate. Certain incidents may require review of medical records to assist in the investigation.

5. The Quality Management Department leads the investigation; analysis and reporting of all identified sentinel events.

6. All sentinel events require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist. At the discretion of the Sr. Director, Quality and Risk Management and the Chief Medical Officer, other incidents may be subject to root cause analysis. A multidisciplinary team led by the Chief Medical Officer will perform all root cause analyses.

8. When appropriate, systems issues are identified and corrective action plans developed to prevent recurrence of the event. The corrective action plan will identify the strategies that the organization intends to implement in order to
reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, time lines, and strategies for measuring the effectiveness of the actions.

9. All confirmed sentinel events will be reported to the DHCF and the HCSNA in compliance with section C.13.2.1 & C.13.2.2 of the TRUSTED Health Plan, Inc. Core Contract. Reporting will be completing using the prescribed District of Columbia Unusual Incident Report (Attachment 2).

10. When appropriate, other agencies (such a practitioner licensing boards) will be notified of confirmed sentinel events.

11. When appropriate, information from sentinel event investigations will be provided to the Credentialing Committee to support the re-credentialing process.

General Guidelines

1. Prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement “The Prenatal Visit” (1996).

2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged, and instruction offered as recommended in the AAP statement “Breastfeeding and the Use of Human Milk” (1997).

3. For newborns discharged in less than 48 hours after delivery refer to AAP statement “Hospital Stay for Healthy Term Newborn” (1995).

4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

6. If the patient is uncooperative, re-screen within 6 months.

7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing Loss: Detection and Intervention (1999).

8. By history and appropriate physical examinations: If suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

10. These may be modified, depending upon entry point into schedule and individual need.

11. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.

12. Every visit should be an opportunity to update and complete a child’s immunizations as per AAP (American Academy of Pediatrics) guidelines.


14. All menstruating adolescents should be screened annually.

15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure refer to the District of Columbia “Childhood Lead Poisoning Screening and Reporting Emergency Act of 2002”. After 26 months, blood lead level testing is required twice up to age 6, if not done previously. If family history cannot be ascertained and other risk factors are present, a lead blood level should be drawn.

17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of “Red Book; Report of the Committee on Infectious Diseases”. Testing should be done upon recognition of high-risk factors.

18. Cholesterol screening for high-risk patients per AAP statement “Cholesterol in Childhood” (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.

19. All sexually active patients should be screened for sexually transmitted diseases (STDs). Refer to STD practice guidelines.

20. All sexually active females should have a pelvic examination. A pelvic examination and routine Pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.

21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP Guidelines for Health Supervision III (1998).

22. From birth to age 12, refer to the AAP injury prevention program (TIPP as described in A Guide to Safety Counseling in Office Practice (1994).


24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement “Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position” (2000).

25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP Handbook of Nutrition (1998).

26. Between 12 months and 24 months, one documented dental evaluation must be performed. Referrals to the dentist must begin at 3 years of age.
Appendix G.

MEMBER APPEALS PROCESS

Definitions:

1. Administrative Denial- A decision by TRUSTED Health Plan staff that a requested service will not be approved due to one or more of the following reasons:
   a. The service requested is not a Covered Benefit as described in the Member’s Handbook.
   b. The member is not eligible for service at the time of the request or the date the service is rendered.
   c. The member has exhausted the benefits provided by the benefit plan.
   d. The member and/or practitioner/provider failed to follow the rules of the plan as outlined in the Member Handbook and/or the Provider Manual.
   e. The Practitioner fails or refuses to supply sufficient information to the plan to conduct a review of the service requested.
   f. The service is conducted out of network when Network providers or practitioners are available to render the service.

2. Medical Necessity Denial- A decision by a Medical Director, a Physician Advisor, or other appropriately licensed practitioner that the services requested do not meet accepted standards of care, or the service or location of service is not appropriate for the condition being treated. A medical necessity denial may also be referred to as an Adverse Determination.

3. Reconsideration- A request from a practitioner that a medical necessity denial decision be reconsidered based on the submission of additional information and/or physician-to-physician discussion. Reconsideration is not considered an appeal and is not a prerequisite for filing an appeal. The request for reconsideration must be received within 2 business days following verbal notification to the practitioner of the denial or services based on medical necessity.

LEVELS OF APPEALS

Immediate Reconsideration

When a denial is issued, the requesting or designee is notified that TRUSTED Health Plan’s Medical or Behavioral Health Director or designee is available to discuss the denial decision with the requesting practitioner.

1. If the discussion results in an approval, the review nurse will document the decision in MHC, including the date and time of the decision, the date and time of verbal notification to the requesting practitioner and the name and title to whom the verbal notification was given.

2. If this discussion does not result in an approval, there is a dispute about whether the member has an urgent or emergent medical condition or there is a delay in the furnishing of an emergent or urgent service, a physician not involved in the original decision shall perform a review and reconsideration of the matter and a decision shall be issued within one (1) hour.

3. Immediate reconsideration will be provided when:
a. A member submits an expedited appeal request and taking the time for a standard resolution could seriously jeopardize the member’s life or health.
b. A practitioner submits an expedited appeal request or supports a member’s request and indicates that taking the time for a standard resolution could seriously jeopardize the member’s life, health, or functioning; or,
c. A member submits an expedited appeal request while accessing services for urgent or emergent care.

**Expedited Appeal**

1. The member, the practitioner on behalf of the member, or the member’s authorized representative may request an expedited appeal if:
   
   a. The member and his/her practitioner feel that waiting for a standard appeal could seriously jeopardize the member’s life or health, or ability to attain, maintain, or regain maximum function, OR in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
   
   b. A request for urgent care has been denied;
   
   c. A person with HIV/AIDS is dissatisfied with TRUSTED decision;
   
   d. A request for acute services, or for services that may be authorized as alternative to acute inpatient services, has been denied;
   
   e. A request for a surgical procedure, including circumcision, has been denied

2. Expedited request may be received verbally or in writing.
3. A verbal request for expedited appeal does not need to be followed up in writing.
4. The date the request is made, either verbally or in writing, is considered to be the date the appeal was received by TRUSTED.
5. TRUSTED will acknowledge the receipt of the expedited request immediately, and will communicate its determination as to the granting of expedited status, within twenty-four (24) hours of receiving an expedited appeal.
6. TRUSTED will ensure that no punitive action is taken against a practitioner who requests an expedited resolution or supports a member’s appeal.
7. The member or his/her authorized representative will be advised of the time limit for the member to present evidence and allegations of fact or law, in person and in writing, prior to a final determination.
8. Expedited Appeals must be completed as expeditiously as the member’s health condition requires, not to exceed seventy-two (72) hours following receipt of the request;
   
   a. TRUSTED may extend the seventy-two (72) hour time period by up to five (5) calendar days if the Member requests an extension, or if TRUSTED justifies a need for additional time and explains how the extension is in the member’s interest.
   
   b. An Extension Letter providing the rationale for the extension and the right to file a grievance will be sent to the member.
TRUSTED will ensure that an appeal is automatically transferred to the timeframe for standard resolution should the request for expedited resolution be denied. TRUSTED will give the member or his/her authorized representative prompt verbal notice (within 24 hours) that the request for an expedited appeal has been denied. TRUSTED will also provide written notice of the denial within two (2) calendar days of the decision. TRUSTED may determine that it is appropriate to transfer the expedited Appeal to the timeframe standard resolution in accordance with 42 C.F.R. § 438.408(b) (2). The member has the right to file a complaint with TRUSTED regarding the decision not to expedite the appeal, but the decision is not subject to appeal.

**Standard Appeal**

The member, practitioner (with the written authorization of the member), or the member’s authorized representative may request a reconsideration of the adverse determination.

1. These requests may be received verbally or in writing
2. A written signed follow-up is required within ten (10) days following a verbal request.
3. The date the request is made is considered the date the appeal was received by TRUSTED
4. TRUSTED will acknowledge, in writing, the receipt of the appeal within two (2) days of receipt of the request.

A standard Appeal will be completed within fifteen (15) days. TRUSTED may extend this by an additional five (5) calendar days if the Member requests an extension, or if TRUSTED justifies a need for additional time and why the extension is in the Member’s’ interest. An Extension Letter providing the rationale for the extension and the right to file a grievance will be sent to the member.

**External Appeals**

All members have the right to request a Fair Hearing from the District of Columbia at any point during the appeal process. Trusted Health Plan's General Counsel will forward all documents regarding the Plan’s actions and the member's dispute to the Medical Assistance Administration within five business days of notification that a fair-hearing request has been filed. The disputed item or service will continue to be provided at the level and in the amount, scope and duration that the item or service was provided prior to TRUSTED adverse determination. TRUSTED will assist the member with filing a request for Fair Hearing and send a copy of the request to the member’s home address.

**Appeal Resolution**

If TRUSTED reversed or modifies an authorized decision through the appeal process or is notified of the District’s Fair Hearing decision to reverse a decision, the service shall be authorized or provided no later than two (2) business days after reversal or notification of the reversal from the District. In the case of an expedited appeal, services must begin within 24 hours of the reversal.

**Pre-Service Appeals**

Pre-Service appeals are requests to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

1. TRUSTED Health Plan's Appeals Department receives a request for reconsideration of an adverse determination from a member, a practitioner on the member’s behalf, or the member’s authorized representative. Any area within TRUSTED Health Plan, including, but not limited to, may receive appeals: Members Services, Utilization Management,
Claims, or Provider Services.

2. Upon receipt of a written appeal, the appeal is time and date stamped and forwarded immediately to the Appeals unit within the Medical Management Department.

3. The staff member receiving a verbal appeal will inform the member of the need to follow the request with a written, signed appeal. The staff member will offer the assistance of TRUSTED Health Plan Member Services to write the appeal.

4. The staff member will forward the verbal request for appeal to the Appeals Coordinator. The Appeals Coordinator will send a written acknowledgement letter to the member, along with instructions for completing the written signed appeal.

5. The Appeals Coordinator logs the appeal request into the appeals database and documents the substance of the pre-service appeal and any actions taken. The Appeals Coordinator prepares an acknowledgement response for the member and/or practitioner, and mails or faxes the acknowledgment within 2 calendar days of receipt of the request. The acknowledgment letter includes the estimate date that a decision regarding the appeal will be made. If the appeal request is for an expedited appeal, the Appeals Coordinator will verbally acknowledge the receipt of the appeal and follow with the written acknowledgement within 24 hours.

6. The Appeals Coordinator compiles all the information relevant to the appeal, including any additional information received from the member or his/her authorized representative.

   a. If the appeal concerns a medical necessity determination, the Appeals Coordinator forwards the file via overnight mail, to the appropriate contracted peer review organization.

   b. The peer review organization reviews all the information relevant to the appeal and makes recommendation regarding the appeal. The peer review organization returns the review recommendation to TRUSTED, both verbally and in writing.

7. Decisions are rendered, and notification issues to the member within the mandated time frames: 72 hours for expedited appeals, 15 calendar days for standard appeals, unless an extension has been requested by the member or TRUSTED, with justification that the extension is in the best interest of the member.

8. The appeals coordinator will ensure prompt oral notice to the enrollee of any denial and will follow-up within two (2) calendar days with a written notice.

9. The Appeals includes the following:

   a. The specific reasons for the appeal decision, in easily understandable language,

   b. A reference to the benefit provisions, guidelines, protocol, or other similar criterion on which the appeal decision was based;

   c. Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision;

   d. A list of titles and qualification, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. **NOTE:** Participant names do not need to be included in the written notification to members, but must be provided to members upon request;

   e. A description of the next level of appeal, along with any written procedures for initiating the second level appeal.

   f. Specific notification to the member of the right for a District Fair Hearing, the process for initiating a Fair Hearing and
the contact information for the District Fair Hearing office.

g. If TRUSTED completely overturns the denial, the appeal notice will state the decision and the date of the decision.

10. The Appeal Coordinator logs the pre-service appeal information into the Appeals database, including the date of the decision, date(s) of notification, the parties notified, the decision rendered and all actions taken.

**Post -Service Appeals**

Post Service appeals are requests to change and the member for care or services that has already received adverse determination.

1. TRUSTED Health Plan receives a request for reconsideration of an adverse determination from a member; a practitioner acting on the member’s behalf, or the member has received the member’s authorized representative after the care or service. Any area within TRUSTED Health Plan, including, but not limited to, may receive this appeal: Member Services, Utilization Management, Claims, or Provider Services.

2. Upon receipt of a written appeal, the appeal is time and date stamped and forwarded immediately to the Appeals unit within the Medical Management department.

3. The staff person receiving a verbal appeal will inform the member of the need to follow the request with a written, signed appeal. The staff member will offer the assistance of TRUSTED Health Plan Member Service to write the appeal.

4. The staff member will forward the verbal request for appeal to the Appeals Coordinator. The Appeals Coordinator will send a written acknowledgement letter to the member, along the instructions for completing the written, signed appeal.

5. The Appeals Coordinator logs the appeals request into the appeals database including full documentation of the post-service and actions taken. The Appeals Coordinator prepares an acknowledgment response for the member and /or practitioner, and mails the acknowledgment within 2 calendar days of receipt of the request. The acknowledgment letter includes the estimated date that a decision regarding the appeal will be made.

6. The Appeals Coordinator compiles all the information relevant to the appeal, including any aspects of clinical care involved and additional information received from the member or his/her authorized representative.

- If the appeal concerns a medical necessity determination, the Appeals Coordinator forwards the file via overnight mail, to the appropriate contracted peer review organization.

- The peer review organization reviews all the information relevant to the appeal and makes a recommendation to TRUSTED regarding the appeal decision. The peer review organization returns the results of the peer review to TRUSTED both verbally and in writing.

7. Decisions are rendered, and notification issued to the member, within 15 days, unless an extension has been requested by the member or TRUSTED, with justification that the extension is in the best interest of the member.

8. The appeals coordinator will ensure prompt oral notice to the enrollee of any denial and will follow-up within two calendar days with a written notice.

9. The Appeals coordinator prepares and issues the written appeal decision. The appeal decision letter includes the following:

- The specific reasons for the appeal decision, in easily understandable language,

- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was
c. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based;

d. A list of titles and qualifications, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. **NOTE:** Participant names do not need to be included in the written notification to members, but must be provided to members upon request;

f. Specific notification to the member of the right for a District Fair Hearing, the process for initiating a Fair Hearing and the contact information for the District Fair Hearing office.

g. If TRUSTED completely overturns the denial, the appeal notice will state the decision and the date of decision.

10. The Appeal Coordinator logs the information on the post service appeal into the Appeals database, including the date of the decision, date(s) of notification, the parties notified, the decision rendered and all actions taken.

**Effectuation of Appeals Decisions**

If TRUSTED reverses or modifies a decision through the appeals process or is notified of the District’s Fair Hearing decision to reverse a decision, the service shall be authorized or provided as promptly and as expeditiously as the member’s health conditions requires, but not later that two (2) working days after reversal or notification of reversal from the District. In the case of an expedited appeal, services must begin within 24 hours of the reversal.