

GuildNet Provider Manual

**15 West 65th Street
New York, New York 10023
212-769-7855**

Table of Contents

HOURS OF OPERATION	4
GUILDNET CONTACT NUMBERS	5
EMPLOYMENT STANDARDS FOR GUILDNET PARTICIPATING PROVIDERS ...	6
GUILDNET OVERVIEW	7
ENROLLMENT ELIGIBILITY CRITERIA	8
SERVICE AREA	8
GUILDNET MLTCP COVERED SERVICES/BENEFITS	9
GUILDNET MLTCP NON-COVERED SERVICES	10
GUILDNET GOLD COVERED SERVICES/BENEFITS.....	11
GUILDNET GOLD NON-COVERED SERVICES	11
GUILDNET HEALTH ADVANTAGE COVERED SERVICES/BENEFITS.....	12
GUILDNET HEALTH ADVANTAGE NON-COVERED SERVICES	12
THE ROLE OF GUILDNET CASE MANAGEMENT	14
COORDINATION OF CARE/PROVIDER RESPONSIBILITIES	15
AUTHORIZATION REQUIREMENTS.....	20
AUTHORIZATION PROCESS	25
SERVICE STANDARDS FOR PROVIDERS	28
CLAIMS SUBMISSION AND INQUIRY.....	29
FRAUD AND ABUSE	30
GUILDNET MEDICARE CLAIM SUBMISSION AND INQUIRY.....	32
CLAIM INQUIRY:.....	33
APPEALS OF DENIED CLAIMS	35
ADVERSE REIMBURSEMENT CHANGE	36
FALSE CLAIMS ACT	37
MEDICAID SPEND-DOWN AND THIRD PARTY INSURANCE	39
GUIDELINES FOR MARKETING GUILDNET SERVICES	40
MEMBER CONFIDENTIALITY	41
MEMBER RIGHTS.....	42
MEMBER RESPONSIBILITIES	43
MEMBER GRIEVANCES	44
MEMBER APPEALS OF GRIEVANCES	46
CHOOSING AMONG PROVIDERS.....	47

DISPUTE RESOLUTION	48
PROVIDER CREDENTIALING	49
MONITORING OF PROVIDERS	50
PROVIDER AUDITS	51
PROVIDER TERMINATION.....	52
UPDATING POLICIES AND PROCEDURES	54

HOURS OF OPERATION

Monday through Friday, 8:00AM to 5:00 PM:

Contact Numbers

Case Management and Member Services:

212-769-7855 - Telephone

646-619-6093 - Electronic Fax Number

Provider Relations:

917-386-9208 - telephone

212-712-2427 – fax

gnprovrel@jgb.org

Outside of Normal Business Hours, Weekends & Holidays:

[1-800-932-4703](tel:1-800-932-4703)

GuildNet Contact Numbers

Wanda Figueroa-Kilroy, Executive Vice President	212-769-7851
Case Management Department	212-769-7855
Eileen Hanley, Senior Vice President, GuildNet	212-769-6301
Anne Becker, Assistant Vice President of Case Management	212-769-7803
Sharese Brundage, Assistant Vice President of Case Management	917-386-9701
Social Work:	
Portia McCormack, Director, Clinical Support Services	917-386-9844
Isabel Gill, Supervisor	212-712-9908
Ellen Gordon, Supervisor	917-386-9356
Quality Assurance & Performance Improvement	
Laura Brannigan, Senior Vice President	212-769-7852
Michelle Sulfaro, Director of QA	212-712-9940
Intake:	
Ruth Fowler, Senior Vice President	212-712-9939
Matilda Simpson, Senior Medicaid Eligibility Specialist	212-769-7866
Marketing	
Joselyn Salazar, Director	212-769-7854
Provider Relations:	917-386-9208
Judith Shargel, Senior Vice President	212-769-7857
Ada Bekker, Provider Relations Manager	212-769-7856
Nancy Martinez, Senior Authorization Specialist	212-769-6238
Lok Wong, Senior Authorization Specialist	212-712-9952
Kelly Lewis, Provider Services Analyst	212-712-9906
Monica Miller, Authorization Specialist	212-712-9938
Margarita Morales, Authorization Specialist	212-712-9998
Medicare Services	
Sandra Birnbaum, Assistant Vice President	212-712-9918

Employment Standards for GuildNet Participating Providers

GuildNet is committed to providing the highest quality of health care to its members.

To provide the best possible care, it is essential that GuildNet Participating Providers attract and retain the highest quality of staff to perform these services. While mindful that providing services must be accomplished within available funding levels, we believe that morally and ethically, we have an obligation to encourage our business partners to treat their employees fairly.

The five items below enumerate the terms and conditions of employment that we consider to be minimum standards for all GuildNet Participating Providers. Providers that meet or exceed these minimum standards will be considered “preferred” in consideration of future business:

1. Provide the highest level of care
2. Provide safe and healthy working conditions
3. Treat employees with dignity and respect
4. Maintain full compliance with the New York State Home Care Worker Wage Parity Law Provide fair and reasonable wages;
5. Provide fringe benefits including, but not limited to, adequate health care, retirement and paid leave.

GUILDNET OVERVIEW

GuildNet Inc., a subsidiary of The Jewish Guild for the Blind, offers a Managed Long Term Care Program (MLTCP) established to coordinate healthcare services for chronically ill adults wishing to remain in their own home and communities as long as possible. Member's healthcare needs, both covered and non-covered, are coordinated by an assigned Case Manager in collaboration with Member's primary care physician and GuildNet Participating Providers. Collaboration by a physician means that the physician is willing to write orders for covered services and non-covered services, to refer to GuildNet's Network Providers, and to work with the GuildNet Care Management Team to coordinate all care. The benefits provided to individuals enrolled in GuildNet MLTCP are considered to be Medicaid benefits.

GuildNet, Inc. also offers two Medicare Advantage Special Needs Plans (SNPs): GuildNet Gold HMO-POS SNP, a Medicaid Advantage Plus plan, and GuildNet Health Advantage HMO-POS SNP, a Medicaid Advantage plan. GuildNet Gold is available to individuals who are eligible for both Medicare and Medicaid, and meet most of the Managed Medicaid Long Term Care Program (MLTCP) enrollment criteria. GuildNet Gold has an integrated benefit package that includes both Medicare and Medicaid benefits. GuildNet Health Advantage is available to individuals who are also eligible for both Medicare and Medicaid; however, its benefits package does not include long term care services.

Enrollment Eligibility Criteria

To be enrolled in GuildNet members must meet the following eligibility criteria:

- Age 18 or older;
- Reside within GuildNet's service area;
- Have Medicaid;
- Be eligible for nursing home level of care at the time of enrollment as determined by the New York State patient assessment instrument;
- Capable, at the time of enrollment, of returning to or remaining at home and community without jeopardy to their health and safety;
- Expected to need care management and long-term care services for at least 120 days.

In addition to criteria above, GuildNet **Gold** members must also:

- Have Medicaid AND Medicare Part A & B;
- Be enrolled in GuildNet's Medicaid Advantage Plus.

GuildNet **Health Advantage** members must:

- Be age 18 or older;
- Reside within GuildNet's service area;
- Have Medicaid;
- Be enrolled in GuildNet's Medicaid Advantage.
- No requirement to be eligible for nursing home level of care.

Service Area

GuildNet MLTCP is available in the Bronx, Brooklyn, Manhattan, Queens, Staten Island, Westchester, Nassau and Suffolk Counties.

Gold and Health Advantage plans are available in the Bronx, Brooklyn, Manhattan, Queens, Nassau and Suffolk Counties.

GUILDNET MLTCP Covered Services/Benefits

GuildNet Medicaid Benefits are community based services that would otherwise be covered in whole or part by Medicaid. These services are listed below.

Adult Day Health Care
Adult Social Day Care
Audiology
Certified Home Health Care Services
Dentistry
Durable Medical Equipment
Medical and Surgical Supplies
Licensed Home Care
Meals (Home/Congregate)
Non-Emergency Transportation
Skilled Nursing Facility
Nutritional Counseling
Optometry
Outpatient and in-home physical, occupational, speech therapy
Podiatry
Personal Emergency Response System (PERS)
Private Duty Nursing
Prosthetics/Orthotics
Respiratory Therapy
Social and Environmental Supports
Social Work Services

There are no cost-sharing expenses for GuildNet members, including deductibles or co-payments. For more information, please call GuildNet Provider Relations at 1-917-386-9208 Monday through Friday, between 8:30 a.m. to 5:00 p.m.

GuildNet is always secondary payer to Medicare and other third party payers.

GUILDNET MLTCP Non-Covered Services

Services that a GuildNet MLTCP Member may require that are not covered by GuildNet but are billed directly by the Provider to Medicaid, Medicare, or other third party payer may be included in the Member's GuildNet Service Plan of Care and coordinated by the Case Manager in collaboration with the PCP and Providers involved in the Member's care. These non covered services include:

Physician Services

Inpatient Hospital Stay

Laboratory Services

Radiology and Radioisotope Services

EMERGENCY Transportation

Chronic Renal Dialysis

Hospice Services

Alcohol and Substance Abuse Services

Family Planning Services

Prescription & Non Prescription Medications

Mental health services listed below

- Methadone maintenance treatment
- Intensive psychiatric rehabilitation treatment programs
- Day treatment
- Continuing day treatment
- Case management for seriously and persistently mentally ill
- Partial hospitalizations
- Assertive Community Treatment (ACT)
- Personalized recovery oriented services (PROS)

Rehabilitation services provided to residents of OMH Licensed Community Residences and Family Based Treatment Programs

Office of Mental Retardation and Developmental Disabilities (OMRDD) Services

AIDS Adult Day Health Care

GUILDNET GOLD Covered Services/Benefits

GuildNet Gold covered benefits include all services otherwise covered by fee for Service Medicaid, Original Medicare under Part A and Part B, and prescription medications covered under Part D, excluding those listed under “GuildNet Gold Non-Covered Services”. There are no cost-sharing expenses for GuildNet Gold members, including deductibles or co-payments, except small co-payments for some Part D Prescription medications.

For more information, please call GuildNet at 1-917-386-9208 Monday through Friday, from 8:30 a.m. to 5:00 p.m.

GUILDNET GOLD Non-Covered Services

Services that a Member may require that are not covered by GuildNet Gold may be included in the Member’s Plan of Care and coordinated by the Case Manager in collaboration with the PCP and Providers involved in the Member’s care. These non-covered services include:

Services Covered by Direct Reimbursement from Original Medicare:

- Hospice services

Services Covered by Medicaid Fee-for-Service:

- Family planning, (covered by Medicaid fee for service)
- Mental health services listed below
 - Methadone maintenance treatment
 - Intensive psychiatric rehabilitation treatment programs
 - Day treatment
 - Continuing day treatment
 - Case management for seriously and persistently mentally ill
 - Partial hospitalizations
 - Assertive Community Treatment (ACT)
 - Personalized recovery oriented services (PROS)
- Rehabilitation services provided to residents of OMH Licensed Community Residences and Family Based Treatment Programs
- Office of Mental Retardation and Developmental Disabilities (OMRDD) Services
- AIDS Adult Day Health Care

GUILDNET Health Advantage Covered Services/Benefits

GuildNet Health Advantage covered benefits include all services otherwise covered by Original Medicare Part A and Part B, prescription drugs covered under Part D, and some services covered by Medicaid only, excluding those listed under “GuildNet Health Advantage Non-Covered Services”. There are no cost-sharing expenses for GuildNet Health Advantage members, including deductibles or co-payments for covered medical services, except small co-payments for Part D Prescription drugs.

For more information, please call GuildNet at 1-917-386-9208 Monday through Friday, from 8:30 a.m. to 5:00 p.m.

GUILDNET Health Advantage Non-Covered Services

Services that a Member may require that are **not covered** by GuildNet Health Advantage may be included in the Member’s Plan of Care and coordinated by the Case Manager in collaboration with the PCP and Providers involved in the Member’s care. These non-covered services include:

Services Covered by Direct Reimbursement from Original Medicare:

- Hospice services

Services Covered by Medicaid Fee-for-Service:

- Non-Medicare covered skilled nursing facility care
- Adult Day Health Care
- Adult Social Day Care
- Dentistry (Nassau and Suffolk only)
- Medicaid-only Medical and Surgical Supplies
- Licensed Home Care
- Non-Emergency Transportation (Nassau and Suffolk only)
- Nutritional Counseling
- Personal Emergency Response System (PERS)
- Social Work Services
- Family planning
- Mental health services listed below
 - Methadone maintenance treatment
 - Intensive psychiatric rehabilitation treatment programs
 - Day treatment
 - Continuing day treatment
 - Case management for seriously and persistently mentally ill

- Partial hospitalizations
- Assertive Community Treatment (ACT)
- Personalized recovery oriented services (PROS)
- Rehabilitation services provided to residents of OMH Licensed Community Residences and Family Based Treatment Programs
- Office of Mental Retardation and Developmental Disabilities (OMRDD) Services
- AIDS Adult Day Health Care

The Role of GuildNet Case Management

Case Manager/Interdisciplinary Team

Each Member is assigned to a Case Manager/care coordinator/Interdisciplinary Care Team that will include health care professionals (nurses, social workers, psychologists or therapists, as appropriate) who have ongoing responsibility for coordinating, managing and authorizing all aspects of the delivery of care and services to members.

As the primary coordinator of care, the Case Manager's responsibilities include:

- Authorization and implementation of covered services outlined in the Member's service plan,
- Monitoring of all services for quality and effectiveness,
- Integration of feedback, observations, and recommendations of other professionals involved in managing the care to the Member, including network Providers, PCP's, Specialists, and Providers of uncovered services,
- Coordination of discharge planning from hospital or nursing home stays.

Member Service Representative/Member Service Assistant

Member service staff serves as liaison between the Member and Case Manager and assist the care management team by providing information about GuildNet policies, available services, and network Providers to Members; making and confirming service arrangements; issuing authorizations as directed by the Case Manager; and answering questions and resolving problems presented by Members and Providers, as appropriate.

Coordination of Care/Provider Responsibilities

GuildNet's New York State Managed Long Term Care program is responsible for providing long-term care and health services to its members. Because intensive care coordination and management is critical to the health and well-being of its membership, GuildNet participating providers agree, through the GuildNet Participating Provider Agreement, to fully cooperate with GuildNet case management, even if the episode of care does not result in any payment by GuildNet to the participating provider because the provider's fee is covered entirely by a primary payer, such as Medicare. Specifically, it is not unusual for a GuildNet member to also be Medicare-eligible. In these cases, because Medicaid is always the payer of last resort and Medicare is the primary payer, under the GuildNet coordination of benefits procedure GuildNet may owe no secondary payments to the participating provider. This payment circumstance does not alter the responsibility of participating providers to cooperate with GuildNet care management.

Providers are responsible for effectively communicating with the Case Manager/ Interdisciplinary Team, along with the Member Services staff **regardless of primary payer**, in order to promote optimal scheduling of services, prevent duplication of services, remove barriers to care, access appropriate reimbursement sources for services, increase continuity of care, and progress toward goal achievement.

As part of its role in managing a Member's care, GuildNet authorizes services and provides the following information:

- Member Demographics
- Physician Information
- Description of Requested Service
- Clinical Status as appropriate

Podiatry, Optometry, and Audiology screening services provided by network Providers do not require authorization; however, the above information is available upon request.

A Member may refuse care that has been specified in the Member's service plan. GuildNet will not place, or will terminate, services that the Member refuses after the Member, their family, or representative has been fully informed of the health risks and consequences involved in such refusal, and the Member, upon being fully informed, continues to refuse care. **Providers must notify GuildNet immediately if an authorized or requested service is refused.**

All Providers are required to

- Comply with all regulatory and professional standards of practice and are responsible to **acquire physician orders whenever required** by regulation or local, state or federal law as well as for determination of medical necessity **and/or 3rd party reimbursement**. The Case Manager/Interdisciplinary Team may assist in obtaining orders if the Provider has been unsuccessful.
- Notify GuildNet immediately whenever there is identification of a clinical issue of serious concern, change in Member status, refusal of service, inability to access Member's home, or inability to provide service for any reason.
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member and the Member's progress and status.
- Cooperate with GuildNet on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to GuildNet within 10 working days of request.
- Communicate to GuildNet any complaint made by or on behalf of the Member.
- Cooperate with GuildNet's quality assurance and improvement programs (QAPI) as needed.
- Assure that all Provider's employees and agents involved in direct contact with Members carry proper Agency identification.
- Notify GuildNet of the provision of any unauthorized urgent services within 48 hours.
- Prior to the addition of any new Provider owner, director, employee, agent, contractor or referral source, and on a monthly basis thereafter, Provider shall confirm that such individuals and entities are not Excluded by checking the excluded parties lists maintained by the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services Office of Inspector General, and the United States General Services Administration;

In addition:

Home Care Providers are responsible for

- Obtaining physician orders;
- Developing the aide care plan for requested services;
- Ensuring that Family members of GuildNet enrollees who are HHA/PCA are NOT assigned to handle the care of their family member;
- Notifying Member in advance of name of assigned staff;
- **Notifying GuildNet and Members in advance of need for replacements and name of replacement staff;**
- Submitting evaluation and progress notes following first assessment visit by any/all disciplines and every two weeks thereafter unless specified otherwise;
- Cooperating fully with GuildNet case management; communicate verbally or in writing regarding the member's progress even if the episode of care does not result in any payment by GuildNet to the participating provider;
- **Confirming aide daily attendance: Effective January 1, 2012** all Licensed Home Care Providers (LHCSAs) must implement an electronic call in/call out attendance program in addition to other manual random verification. Agency protocols on Aide attendance verification must be available to GuildNet Provider

Relations upon request. If a member does not allow the aide to call in or call out from their telephone, the Case Manager must be informed and the information documented;

- Submitting Attendance Activity reports as requested. Reports should indicate:
 1. date and time of electronic call in/out;
 2. date and time of manual modifications/entries; and
 3. name of user modifying/entering time in/out.
- Maintain full compliance with the New York State Home Care Worker Wage Parity Law (New York State Public Health Law Section 3614-c, as amended, and all New York State Health Department regulations and guidance with respect thereto) (the "**Wage Parity Law**"); and shall provide GuildNet with all information to verify such compliance

Residential Health Care Providers are responsible for:

For Short Term Stay (up to 6 months):

- Determining the type of health insurance coverage the prospective resident has and whether or not the RHCF is authorized to serve the member (MAP Procedure 03-01 <R1>);
- Submitting progress notes to GuildNet Case Manager Bi-Weekly;
- Obtaining authorization for any covered service outside of daily rate; and
- Assisting in the Medicaid recertification process.

For Long Term Care:

- Determining eligibility for Institutional Medicaid and other Third Party Health Insurance and whether or not the RHCF is authorized to serve the member;
- Submitting Conversion applications for members placed for long term care; identifying the admission as a Managed Long Term Care admission;
- Collecting the NAMI (NAMI will be deducted from payments);
- Submitting Resident Monthly Summaries to the GuildNet Case Manager;
- Including GuildNet Case Manager in case conferences;
- Obtaining authorization for any covered service outside of daily rate; and
- Assisting in the Medicaid recertification process.

Note: GuildNet members must be eligible for Institutional Medicaid to remain in a RHFC for long term care.

DME and Medical Supply Providers are responsible for:

- Verifying primary payor coverage and eligibility prior to delivery;
- Acquiring physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3rd party reimbursement;
- Exhausting all other payment sources prior to billing GuildNet; and
- Timely Delivery of requested products.

Note: It is the responsibility of the provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the provider does not know if the service or item is covered, the provider must first submit a claim to Medicare, as GuildNet is always the payer of last resort.

If the item is normally covered by Medicare but the Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the GuildNet Case Manager prior to delivery.

Transportation Providers are responsible for:

- **Arriving within 30 minutes of scheduled pick up time and within 1 hour of will call time;**
- Providing all requested in and out of borough transportation requests, including special needs transports;
- Assuring that all transportation is to Medical Appointments unless specifically noted in the authorization;
- Notifying GuildNet when a requested trip is to a non-medical destination not noted in the authorization;
- Notifying GuildNet when a member cancels or does not show for a pick up;
- Notifying GuildNet when it is determined, upon arrival, that the driver is unable to transport a member safely; and
- Obtaining documentation for each trip provided, including the following:
 - Member's name and ID number
 - Date of Transport
 - Pick up address and time of pick up
 - Drop off address and time of drop off
 - Vehicle License Plate number
 - The full printed name of Driver

GuildNet requires that all Ambulette and Car Service participating providers follow the safety criteria in accordance with the TLC & Safety Emissions of New York when transporting members, including the following securement systems:

- Tie Down Straps: 4 Tie Down Straps for each Wheelchair Position.
- Seat Belts: A passenger seat belt and shoulder harness shall also be provided for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device, which secures the mobility aid itself.

ADDITIONAL TRANSPORTATION REQUIREMENTS:

Each vehicle must be equipped (installed) as follows:

- Body Fluid/Spill Kit
- Reflector Triangle Kit (3 Triangles)
- First Aid Kit
- Fire Extinguisher

AUTHORIZATION REQUIREMENTS

MLTCP Authorization Requirements

GuildNet MLTCP requires prior written authorization, except for *in network* Optometry, Podiatry, Dentistry, Nutritional Counseling and Audiology Screening. Those services may be self-selected and self-scheduled by the Member from the Provider Network for routine visits. Limitations of services are in accordance with MMIS guidelines.

GuildNet Gold and Health Advantage Authorization Requirements

GuildNet Gold and Health Advantage members do not require a referral, but some GuildNet Gold and Health Advantage services require prior authorization. Please see the table on the following pages for authorization requirements.

GuildNet **Gold and Health Advantage** are point of service plans for most Medicare services. Out of network providers must accept Medicare assignment and can submit claims for services not requiring authorization to:

GuildNet c/o EmblemHealth, PO Box 2830, New York, NY 10116-2830

Out of Network provider forms can be obtained on line at:

<http://www.emblemhealth.com/pdf/hcfa1500-emb.pdf>

The table on the following pages outlines the authorization requirements for GuildNet MLTCP, GuildNet Gold and GuildNet Health Advantage. Services not requiring prior approval are allowed according to Medicare/Medicaid quantities and limitations, including appropriate diagnosis. It is best to check prior approval requirements with EmblemHealth/GHI by calling:

1-866-557-7300 or fax to: 1-866-725-6603.

For GuildNet MLTCP, authorizations and prior approvals are obtained from the GuildNet Case Manager (1-212-769-7855)

For GuildNet Gold and Health Advantage, authorizations and prior approvals for covered services are obtained from the GuildNet Case Manager (1-212-769-7855) or EmblemHealth Utilization Management (1-866-557-7300 Fax: 1 866-725-6603) as follows:

Covered Service	Authorization/Prior Approval Requirement		
	GuildNet MLTCP	GuildNet Gold	GuildNet Health Advantage
Adult Day Care	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Ambulance - Emergency	Not Covered	None	None
Ambulance - Non-emergent	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Yes GuildNet Case Manager. Not covered in Nassau and Suffolk
Diabetes Monitoring - Diabetes self-monitoring, management training and supplies, including glucose monitors, test strips and lancets.	Yes GuildNet Case Manager	Sometimes Claim submitted to EmblemHealth. Authorization from EmblemHealth needed for non-Abbott items.	Sometimes Claim submitted to EmblemHealth. Authorization from EmblemHealth needed for non-Abbott items.
Durable Medical Equipment (DME)	Yes GuildNet Case Manager	Yes* > \$500 * EmblemHealth < \$500 none	Yes* > \$500 * EmblemHealth < \$500 none
Medical and Surgical Supplies - Medicaid-covered	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Medical and Surgical Supplies - Part B	Yes GuildNet Case Manager	Yes > \$500 * EmblemHealth UM; < \$500 none	Yes > \$500 * EmblemHealth UM; < \$500 none
Parenteral/ enteral feeds	Yes GuildNet Case Manager	Yes EmblemHealth UM	Yes EmblemHealth UM if Medicare-covered

	Authorization/Prior Approval Requirement		
Covered Service	GuildNet MLTCP	GuildNet Gold	GuildNet Health Advantage
Hearing Exams/ Hearing Aids	None	None	None
Home Health Care (CHHA)	Yes GuildNet Case Manager	Yes EmblemHealth UM for skilled services; GuildNet Case Manager for long term chronic care.	Yes EmblemHealth UM for skilled services.
Home Health Care (Licensed)	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Hospice Care: Fee for service Medicare/Medicaid	Not Covered	Not Covered	Not Covered
Meals on Wheels	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Nutrition Therapy	No for in-network providers	No	Not Covered
Occupational Therapy Services	Yes GuildNet Case Manager	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.
Optometry - Eye Exams, Eye Glasses, Contact Lenses; Low Vision Services	No	No Davis Vision Network for vision services, exams, glasses, contacts Phone: 800-999-5431 Eligibility: 800-783-6872* PO Box 1525, Latham, NY 12110 www.davisvision.com	
Orthotics/Prosthetics Orthopedic Footwear	Yes GuildNet Case Manager	Yes >\$500 EmblemHealth UM	Yes >\$500 EmblemHealth UM

	Authorization/Prior Approval Requirement		
Covered Service	GuildNet MLTCP	GuildNet Gold	GuildNet Health Advantage
Ostomy Supplies	Yes GuildNet Case Manager	None	None
Oxygen Therapy	Yes GuildNet Case Manager	Yes EmblemHealth UM	Yes EmblemHealth UM
PERS	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Physical Therapy/ Occupational Therapy/ Speech-Language Pathology (PT/OT/ST)	Yes GuildNet Case Manager	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.
Podiatry/Foot Care	No* Routine foot care 4 times per year and for medically-necessary treatment of injuries or diseases of the foot. *GuildNet Case Manager for routine foot care beyond 4 visits per year.	None	None
Private Duty Nursing	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Yes GuildNet Case Manager
Prosthetics and Orthotics	Yes GuildNet Case Manager	Yes > \$500 * EmblemHealth UM; < \$500 none	Yes > \$500 * EmblemHealth UM; < \$500 none

	Authorization/Prior Approval Requirement		
Covered Service	GuildNet MLTCP	GuildNet Gold	GuildNet Health Advantage
Respite Care	Yes GuildNet Case Manager	Yes* EmblemHealth UM for first 8 Respite days in calendar year (in home or SNF) GuildNet Case Manager for remaining days after the 8 th day.	Not Covered
Skilled Nursing Facility (SNF) Care	Yes GuildNet Case Manager	Yes EmblemHealth UM for skilled services GuildNet Case Manager for long term chronic care	Yes EmblemHealth UM for Medicare-covered care. Non-Medicare services are not covered.
Social and Environmental Modifications	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Social Day Care	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Not Covered
Social Work Services	Yes GuildNet Case Manager	No	Not Covered
Speech-Language Pathology	Yes GuildNet Case Manager	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.	Yes EmblemHealth UM for Medicare-covered. GuildNet Case Manager for chronic care.
Transportation – Non Emergent	Yes GuildNet Case Manager	Yes GuildNet Case Manager	Yes GuildNet Case Manager for NYC. Not covered in Nassau and Suffolk.

Authorization Process

For Services Authorized by the GuildNet Case Manager:

Authorization for services, revised authorizations, and authorization terminations are faxed to the Provider. Each authorization has the following information:

- Heading indicating the Plan name (GuildNet MLTCP, GuildNet Gold or GuildNet Health Advantage)
- Authorization or Request Number
- Authorization effective and expiration date;
- Name, Address, and GuildNet Identification Number of Member;
- Diagnosis;
- Physician Name, Address, and Telephone Number;
- Service code and description of service;
- Amount, frequency and duration of service;
- Name and Address of the Provider;
- The name of the Member service staff person entering authorization;
- The name of the member's Case Manager;
- Additional information is documented in the "Notes" section of the authorization. This information would include relevant clinical information and reason for referral.

In addition, if the request is unusual, time-sensitive, especially complicated or requires a particular customization, additional written or verbal communication with the Provider will take place. This information will be provided consistent with the Confidentiality Policy referenced in the Quality Assurance Plan.

The Provider should review the authorization to confirm the vendor name, dates of service, service code, and number of units authorized. If any of these fields do not match the service/item requested, call the GuildNet representative issuing the authorization immediately and request a corrected authorization.

Authorization is not required for payment of Medicare or other Primary Payor Co-Insurance, with the exception of Skilled Nursing Facilities.

See sample authorization on next page.

**GuildNet Managed Long Term Care
SERVICE AUTHORIZATION**

Request #: 3/21/2012-00002-0001 Initial Request Date: 3/21/2012
Effective Period: 4/1/2012 - 4/30/2012 Last Date Modified: 3/21/2012

MEMBER DEMOGRAPHIC INFORMATION

Member Name: John S. Doe Patient Address: 1122 Testing 1122 Testing
Member ID #: GNT040440-00 New York, NY 12333
Diagnosis Code: 428.0 Patient Phone #: (333) 666-9999
Date of Birth: 10/10/1957 Cell Phone #: (914) 319-6998
Priority: 3

Providers are responsible for verifying primary payer coverage

Medicaid #: FF54654F

ADDITIONAL INSURANCE:

Medicare Policy #: 654894984FF

PHYSICIAN INFORMATION

Physician: VALDO, PETER
Telephone Number: (484) 835-4693

GuildNet Case Manager:

NOTES

03/21/2012 11:01:01 AM Test 1
Authorizing HHA service 4 hours x 5 days (Mon - Fri). Aide must be Spanish speaking.
Member should be taken for a short walk each day; aide must be experienced with hoysa lift.

SERVICE INFORMATION

Vendor: ABC HOME CARE

Contact:

Fax:

SERVICE CODE:

S5125 HHA per 15 minutes

SUN	MON	TUE	WED	THU	FRI	SAT
0.00	16.00	16.00	16.00	16.00	16.00	16.00

Day Adjustments:

To ensure prompt payment for this service, please submit claims to the following address:

GuildNet C/O RelayHealth
1564 Northeast Expressway Mail Stop HQ-2361
Atlanta, GA 30329-2010
Phone: (877) 875-4138 Fax: (404) 728-2405

Services fully or partially covered by Medicare or other primary insurance:

Verifying primary payor coverage and eligibility, acquiring any needed physician orders and exhausting all other payment sources prior to billing GuildNet remains the responsibility of the Provider.

In the event that a provider has knowledge that a Medicare covered item has already been obtained through Medicare, or other payor, and the allowable time period for replacement has not expired, the provider must contact the GuildNet Case Manager prior to delivery.

Where required by individual regulatory requirements, or third party reimbursement, Providers are responsible for obtaining their own physician orders and medical necessity. The Case Manager/Interdisciplinary Care Team can assist the Provider in obtaining the orders if the Provider's attempts have been unsuccessful.

Providers must advise GuildNet immediately if services cannot be provided.

For GuildNet Gold or Health Advantage Services requiring Prior Approval from EmblemHealth Utilization Management (UM) please call:

EmblemHealth: 1-866-557-7300 Fax: 1-866-725-6603

Service Standards for Providers

Providers participating in the GuildNet Provider Network shall provide service to Members in accordance with the standards set by GuildNet except when a longer time-frame is required by the Member. These standards are outlined below:

<u>Service:</u>	<u>Standard</u> (relative to requested start date):
Adult Day Health Care	Placement must occur within 14 days
Audiology	Standard: within 7 days Emergency: within 48 business hours
Dentistry	Standard: within 28 days Emergency: within 24 business hours
DME/Supplies	Delivery must occur within 72 hours, unless custom order or otherwise noted.
Home Health Care	Initial visit must occur within 24 hours
Meals (Home/Congregate)	Date and time specified by GuildNet
Skilled Nursing Facility	Placement must occur within 7 days or as otherwise noted
Nutritional Counseling	Service must be provided within 14 days
Optometry	Standard: within 7 days Emergency: within 24 business hours
Personal Care	Initial visit must occur on the date and time specified by GuildNet
Physical, Occupational & Speech Therapy (not in home)	Initial visit within 7 days
Physical, Occupational & Speech Therapy (in home)	Initial visit must occur within 72 hours
Podiatry	Standard: within 7 days Emergency: within 24 business hours
Private Duty Nursing	Date and time specified by GuildNet
Prosthetics/Orthotics	Measurement within 14 days
Respiratory Therapy	Initial visit must occur within 24 hours
Social Day Care	Placement must occur within 14 days
Social and Environmental Supports	Delivery within 14 days unless custom ordered
Social Work Services	Service must be provided within 14 days
Transportation	Pick up within 30 minutes of scheduled time

Clinical notes should be submitted within 48 hours of assessment visit. Progress notes/summaries should be submitted every two weeks thereafter unless otherwise requested or there is a decrease in member health status.

Claims Submission and Inquiry

Providers must inform GuildNet Provider Relations of any changes in Tax ID, Corporate Name and/or addresses as soon as they are known. Allow 30 days for record updates.

CLAIM SUBMISSION

Claims for authorized services must be submitted to GuildNet within 120 days of the date of service. GuildNet may pay claims denied for untimely filing where the provider can demonstrate that a claim submitted after 120 days of the date of service resulted from an unusual occurrence *and* the provider has a pattern of timely claims submissions.

Claims submitted beyond 120 days will be paid at a discount up to 25%. Claims for dates of service beyond 365 days will not be considered for payment. All claims should be submitted to:

GuildNet c/o Relay Health
1564 Northeast Expressway
Mail Stop HQ-2361
Atlanta, GA 30329
1-866-775-8860
Fax 1-770-237-1535

Claims for services **partially covered by Medicare or another primary payor** must be accompanied by a Medicare or other primary payor EOB.

Electronic Submission:

Participating Providers submitting claims for 10 or more GuildNet members per month **must submit electronic claims in HIPAA 5010 format. Information regarding submission of electronic claims can be obtained by sending an email to:**
guildnetit@jgb.org.

All Claims must include:

1. **Member name and GuildNet Member ID number**
2. **Provider Name, Tax ID Number and NPI number**
3. **Valid ICD-9/Diagnosis Code**
4. A **Date of Service** that falls within the effective and expiration date printed on the authorization
5. The **Service Code**
6. **The number of Units** (cannot exceed the total units or units per day on the authorization)
7. Copy of the primary insurer EOB for co insurance claims

Prompt Payment:

Electronic Claims will be paid within 30 days of receipt.
Paper claims will be paid within 45 days of receipt.

PAPER CLAIMS MUST BE SUBMITTED IN THE FOLLOWING FORMAT:

- CMS HCFA 1500 :
Individual Practitioners
DME & Medical Supplies
Transportation Providers
Rehab Therapy - Pvt. Practice (home or office setting)

All fields must be completed including Place of Service and Valid Diagnosis Code

- UB-04
Home Care
Nursing Home
Day Care
PERS
Rehab Therapy Clinic Setting

All fields must be completed including Bill Type and Valid Diagnosis Code

Company invoices and spread sheets will not be accepted.

Electronic Claims are submitted in 837I or 837P format.

FRAUD AND ABUSE

Do not submit claims based on authorizations without proper documentation. Billing for services not rendered or different than the service actually provided is considered to be Fraud and Abuse.

All Providers are expected to be familiar with and compliant with GuildNet's Fraud, Waste and Abuse Policies and Procedures. Fraud, Waste and Abuse Training for Providers is located on GuildNet's website at <http://www.jgb.org/pdf/shared/FraudWasteandAbuse.pdf>.

How to Obtain a GuildNet 835

- Provider must obtain access to an FTP product or program
- Provider must supply IP address of machine(s) that will send and receive files
- Provider must supply Public Key and obtain GuildNet's Public Key

Once all requirements above are met, a testing phase must take place in order to ensure accuracy.

To begin, please email GuildNet IT at guildnetit@jgb.org.

GUILDNET MEDICARE CLAIM SUBMISSION AND

INQUIRY

GuildNet Gold and Health Advantage Claims for services accessed through EmblemHealth (see GuildNet Gold and GuildNet Health Advantage Covered Services) should be submitted to EmblemHealth. Please see contact numbers and addresses below.

GuildNet Gold and Health Advantage are Point of Service plans for most services. If you are not an EmblemHealth/ GHI Medicare Choice Participating Provider, you may obtain a non-participating claim form at: <http://www.emblemhealth.com/pdf/hcfa1500-emb.pdf>.

Claims for all other GuildNet services (those authorized by the GuildNet Case Manager) should be submitted to GuildNet in the same manner as claims for the MLTCP.

EmblemHealth Contact Numbers for GuildNet Providers of <u>Medicare</u> Services	
Member Eligibility and Benefits	1-866-557-7300 (toll free)
Claims Status Inquiries	1-866-557-7300 (toll free)
Claims Submission Address	EmblemHealth/ GuildNet P.O. Box 2830 New York, NY 10116-2830
Provider Correspondence All facilities and practitioners	EmblemHealth/ GuildNet P.O. Box 4296 Kingston, NY 12402-4296
Pre-Certification Inquiries	1-866-557-7300 (toll free)
Electronic Claims Inquiries Payer ID Number 13551	1-212-615-4362

CLAIM INQUIRY:

All Claim inquiries/appeals must be submitted within 45 days of receipt of claim determination.

To inquire about the status of a claim for which no payment or denial has been received within 45 days

Or

If a line/claim that was submitted in a batch with other claims that were paid on an EOP is missing from that EOP, contact:

GuildNet CLAIMS PROCESSING at 1-866-775-8860.

For all other inquiries:

Compare the claim to the authorization. Only authorized services are paid. If the service is provided on an emergency basis or requested outside of business hours, an authorization should be requested on the next business day.

- If you are denied for a claim and subsequently find that there is an error on the authorization, call Provider Relations at 917-386-9208.
- If you provided a service different from the service requested (changed hours or days, completed visit after expiration date, etc) contact the Member's case manager or staff person who issued the authorization to discuss the situation. (Note: Case Management is not *required* to change an authorization if a different service was provided).
- If your claim is incorrect, resubmit the claim with the corrections clearly noting "CORRECTED CLAIM".

Changes or Retroactive authorizations will only be considered if there is documentation that GuildNet intended to authorize the service provided.

Paper Claims: If your claim matches the authorization, compare all fields of the claim line printed on the EOP with your claim. If any of the fields (date of service, code, amount charged, etc) are not the same as what you submitted on your claim, call Claims Processing at 866-775-8860. Provide the claim number and the information that was entered incorrectly

Denials or partial payments due to authorization issues, member status or fee schedule, contact Provider Relations at: 917-386-9208.

COMMON REASONS FOR DENIAL:

Denied for “NO AUTH” or “SERVICE NOT AUTHORIZED”:

This means that there is no authorization found for date of service or that there is an authorization but not for the service (code) billed. Check your authorization dates and codes.

Denied for Duplicate or Paid Authorized Units:

This means that a payment for that code and that day of service was previously paid in full.

Denied for Diagnosis Code (DX Code):

This means that the Diagnosis code on your claim is either missing or inactive.

Denied for Incorrect Bill Type:

This means that you may have used the wrong Claim Form or your Bill Type is inconsistent with service.

UNA - “Units Not Authorized” means that the number of units charged is in excess to the amount authorized or the date of service falls within the authorization effective date range but no units are authorized for that particular day (i.e. authorized MWF; billed Tues).

FNF - “Service Not in Fee Schedule”:

The Code billed is not among the list of codes attached to your contract with GuildNet. For paper claims, check to see if the service code on the EOP is the same as the service code on your Claim.

ALL - “Reimbursement limited to Prevailing Medicaid or Contractual Amount:”

Contact Provider Relations for Unit Rate inquiry.

PAU - Claim units are in excess of units billed for date of service:

The claim paid the authorized number of units for that day or authorization.

NOTE: A corrected authorization does not automatically reprocess denied claims. You must submit a corrected claim.

GUILDNET GOLD/ GUILDNET HEALTH ADVANTAGE CLAIM INQUIRIES

GuildNet Medicare claim inquiries regarding claims submitted to EmblemHealth/GHI must be addressed with EmblemHealth at: 1-866-557-7300.

Appeals of Denied Claims

All Claim inquiries and Appeals must be submitted within 45 days of receipt of claim determination and include the following information:

After comparing your claim to the EOP and the authorization, appeals must include:

- Claim Number
- Authorization Number
- Member Name
- GuildNet ID Number
- Date of Service (do not include range)
- Service Code Billed
- Units Billed
- Amount Billed
- **Reason for Inquiry or Appeal**

Claim Inquiry Contacts:

Claims Processing: 866-775-8860

Provider Relations: 917-386-9208

Member Services: 212-769-7855

Written Appeals should be sent to:

Senior Vice President, GuildNet Provider Relations

15 West 65th Street

New York, NY 10023

gnprovrel@jgb.org

Adverse Reimbursement Change

Notice of adverse reimbursement change will be provided **at least 90 days prior to an adverse reimbursement change** to the Health Care Professional's (HCP) contract. If the health care professional objects to the change that is the subject of the notice by the MCO, the health care professional may, within thirty days of the date of the notice, give written notice to the GuildNet to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional." **A health care professional under this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.**

Exceptions:

- 1) The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association's Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and
- 2) The change is provided for in the contract between the MCO and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a health care professional relative to this provision.

False Claims Act

Scope of the False Claims Act

The False Claims Act (the “FCA”) is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term “knowingly” means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include “treble damages” (damages equal to three times the amount of the false claims) and civil penalties of up to \$11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

Potential FCA Violations

Knowingly submitting claims to (GuildNet) for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Submitting a claim for DME or Supplies when delivery was refused by the member;
- Submitting a claim for 2-man transportation, as authorized, but providing 1 man; and
- Submitting a claim for a service not provided.

The FCA’s Qui Tam Provisions

The FCA contains a *qui tam*, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

The FCA’s Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a *qui tam* lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. GuildNet’s False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws punishing the submission of false claims and

the making of false statements:

- Article 175 of the Penal Law makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime it is punishable as a felony.
- Article 175 of the Penal Law also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.
- Article 176 of the Penal Law makes it a misdemeanor to commit a “fraudulent insurance act,” which is defined, among other things, as knowingly and with the intent to defraud, presenting or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds \$1,000, the crime is punishable as a felony.
- Article 177 of the Penal Law makes it a misdemeanor to engage in “health care fraud,” which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds \$3,000, the crime is punishable as a felony.

Medicaid Spend-down And Third Party Insurance

GuildNet assumes responsibility for billing Medicaid Spend-down amounts for community-based GuildNet Members who have been determined by Medicaid to have monthly surplus amounts and/or excess resources. Providers shall not bill or collect such amounts from the Member.

For long term/permanent nursing home placement, the Residential Health Care Facility is responsible to collect the NAMI for Members designated long term. A stay is considered short term for a maximum of six (6) months.

Providers are required to bill Medicare or any other third party insurance that is Primary to Medicaid.

Medicare and Other Primary Payor Services

MLTCP members continue to access their services fully or partially covered by Medicare through Original Medicare or another Medicare plan that the MLTCP member may be enrolled in. Participating Providers may bill GuildNet for any required secondary payments not covered by other insurance as stipulated in the Provider Agreement.

GuildNet members are not responsible for any deductibles or co-payments for covered services.

GuildNet Gold and GuildNet Health Advantage members access their services fully or partially covered by Medicare through the Emblem Health/ GHI Medicare Choice PPO Network under an arrangement between GuildNet and EmblemHealth. Under this plan, providers do not have to bill separately for Medicare covered services that are traditionally paid for in part by fee for service Medicaid. Providers are paid in full by GuildNet Gold through EmblemHealth. No secondary billing is needed. **GuildNet Gold and GuildNet Health Advantage members are not responsible for any deductibles or co-payments for covered medical services.**

Referrals for services fully or partially covered by Medicare:

GuildNet is payor of last resort. It is the provider's responsibility to determine primary coverage and eligibility. Co-insurance claims do not require authorization, except Skilled Nursing Facilities. A copy of the primary and secondary insurer's EOP must accompany all co-insurance claims.

Guidelines for Marketing GuildNet Services

Providers may market GuildNet services under the following parameters:

- Providers may distribute brochures provided by GuildNet.
- GuildNet may conduct marketing activities at the Provider's site with the permission of the Provider.
- "Cold Call" telephoning and door-to-door distribution of material and solicitation is not permitted.
- There is no offer of monetary incentives to Medicaid Recipients to join the plan.
- There is no offer of monetary incentives to Providers to market GuildNet services or refer prospective Members to GuildNet.

Member Confidentiality

Providers shall ensure the confidentiality of all Member related information by maintaining all Member specific information and Member records in accordance with New York State Public Health Law and the New York State Social Services Law and HIPAA (Health Insurance Portability Accountability Act). Member information shall be used or disclosed by a Provider only with the Member's consent unless otherwise required by law and only for purposes directly connected with Provider's performance and obligations under GuildNet's Provider Agreement.

Provider will inform and train its employees and personnel to comply with the confidentiality and disclosure requirements of New York State statutes and HIPAA (Health Insurance Portability Accountability Act).

Member authorization is not required for access by:

- Medicare or CMS
- The New York State Department of Health
- Accreditation surveyors
- Federal, State and Local government agencies authorized to conduct investigations of Medicaid Managed Long Term Care Programs

Member Rights

Providers will uphold the Member's rights and responsibilities as outlined below.

As a Member of GuildNet, the Member has the right to:

- Receive medically necessary care;
- Privacy about the Member's medical record and treatment;
- Timely access to care and services;
- Receive information on available treatment options and alternatives presented in a manner and language understood by Member;
- Receive information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Receive a copy of their medical records and ask that the records be amended or corrected;
- Take part in decisions about their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to receive the services they need from GuildNet, including how they can receive covered benefits from out-of-network Providers if they are not available in the plan network;
- Complain to GuildNet, the New York State Department of Health or the New York City Human Resources Administration, the Nassau County Department of Social Services, the Suffolk County Department of Social Services, including the right to use the New York State Fair Hearing System or in some instances request a NYS External Appeal;
- Appoint someone to speak for them about their care and treatment; and
- Make advance directives and plans about their care.

Member Responsibilities

As a GuildNet Member, the Member is responsible to:

- Use Network Providers who work with GuildNet for Covered Services*
- Receive approval from their physician, Case Manager or care management team before receiving a covered service requiring such approval;
- Tell GuildNet about their care needs and concerns and work with their Case Manager in addressing them;
- Notify GuildNet when they go away or are out of town;
- Make all required payments to GuildNet; and
- Cooperate with any requests for documentation related to maintaining Medicaid eligibility.

*GuildNet Gold and GuildNet Health Advantage are point of service plans; members of these plans may go out of network for services normally covered through Original Medicare.

Member Grievances

A grievance is any communication by a Member to GuildNet about dissatisfaction with the care and treatment received from GuildNet staff or Providers of covered services, which does not amount to a change in scope, amount, and duration of service or other actionable reason.

A Member or a Provider on the Member's behalf may make a grievance **verbally or in writing**. Members are advised of their right to file a grievance at the time of enrollment (and are advised of their rights and responsibilities annually). Members are advised as to how to file a grievance, and of their ability to receive assistance from GuildNet staff, if necessary. All grievances will be resolved without disruption to the Member's plan of care. Members will be free from coercion, discrimination or reprisal in response to a grievance.

All grievances (both same day and non-same day resolution) are logged, tracked and reported. GuildNet will designate appropriate personnel who were not involved in the previous level of decision-making to review grievances in supervisory capacity and on grievance appeal. If the grievance relates to clinical matters, the personnel assigned will include duly registered health professionals to process both grievances and grievance appeals.

Grievances (Non –same day resolution) are of two types: standard and expedited. **Standard** grievances, including both those reported verbally or written, are acknowledged **in writing** within 15 business days of receipt of grievance or less by the Quality Assurance Performance Improvement Department (QAPI) or Care Management Department. Grievances are addressed as quickly as required by the Member's condition. A standard determination is to be made within 45 calendar days of the receipt of all necessary information and no more than 60 calendar days from receipt of grievance. The standard grievance decision will be communicated by telephone and in writing within 3 business days of the decision. The review period for GuildNet's grievance determination can be increased by an additional 14 calendar days if it is in the Member's best interest. The Member, the Provider on the Member's behalf, or GuildNet may request the extension. The reason for the extension must be documented. When the extension is initiated by GuildNet, a notice will be sent to the Member or the Provider advising of the extension, the reason for the extension and specify how it is in the best interest of the Member. If a decision on the grievance is reached before the written acknowledgement was sent, GuildNet will send the written acknowledgement with the grievance determination. A GuildNet decision to initiate an extension is made by senior staff, i.e., supervisors or directors, when it is established that inadequate information is available to make an informed decision.

If the standard response time to the grievance would seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, GuildNet will **expedite** the grievance. The Member or the Provider may request that a grievance be

expedited. **If GuildNet agrees to expedite the grievance**, the expedited grievance determination will be made within 48 hours of receipt of all necessary information and no more than 7 calendar days from receipt of the grievance. The expedited grievance decision will be communicated by telephone and in writing within 3 business days of the decision.

If the expedited grievance decision is made before the written acknowledgement is sent, both the acknowledgement and expedited grievance decision will be combined. If the Member or the Provider on the Member's behalf, requests that the grievance be expedited and GuildNet does not agree, GuildNet will notify the Member or the Provider verbally within 2 days and in writing within 15 days that the grievance decision was not expedited and the grievance will be handled within the standard grievance decision timeframes.

Grievance data and its analysis are to be used to identify opportunities for program improvement. GuildNet senior staff will review the grievance data from several perspectives, including Provider type, specific Providers, and GuildNet staff identified as responsible parties in the grievance.

The QAPI Director is responsible for all internal management and external reports such as those to: the Case Management Supervisors and Directors, the Administrative Senior Staff, the QA Advisory Committee, the GuildNet Board of Directors and the New York State Department of Health.

Member Appeals of Grievances

A grievance appeal is a written communication from the Member that the Member disagrees with the decision of GuildNet in response to the grievance filed. Once a Member files a grievance appeal, GuildNet must look again at the determination to decide if the decision was the correct one.

Members are instructed during enrollment of their right to appeal a grievance determination if the Member is dissatisfied with the determination of a grievance. Members are advised how to file a grievance appeal and if needed, told how to obtain assistance from GuildNet staff. GuildNet staff will review the grievance appeal with no disruption in the Member's care, and Members will be free from coercion, discrimination or reprisal by the program.

The Member has the right to present their reasons for the grievance appeal both in person and in writing during the grievance appeal process. The Member has the right to examine all records that are part of the grievance appeal process. The Member has the right to have a designated representative.

There are two (2) types of grievance appeal processes. They are:

- a. Standard grievance appeal decisions, which are made within 30 business days of the date of receipt of necessary information.
- b. Expedited grievance appeal decisions (if the Member, Provider on behalf of Member or GuildNet feel that the time interval for a standard grievance appeals process could result in serious jeopardy to the Member's health, life or ability to attain, maintain or regain maximum function), which are made within 2 business days of receipt of all necessary information.

For both the standard and expedited process, the Member must submit a written grievance appeal form request within 60 business days from the receipt of the initial grievance decision. The appeal request form is sent with all notices of action, denial of service requests or grievance determinations not made in the Members favor. Members may request an appeal verbally and GuildNet staff will complete the appeal request form on the Member's behalf and file with QAPI.

Choosing Among Providers

Providers are selected based on the following criteria:

- Member request for a specific Network Provider
- Member has a special need (such as language),
- Geographic Area
- Provider Performance, including but not limited to:
 - Level of Complaints & Incidents
 - Level of past assistance in providing services
- Providers that meet or exceed minimum employment standards described in this manual.

Dispute Resolution

Service Issues:

If there are service issues that are not resolved between the Provider and Case Management Team, the Provider can contact:

- Case Manager Supervisor, then
- Director of Case Management, then
- Assistant Vice President of Case Management
-

An internal appeal of a Plan Action may be initiated when a member or provider, on the member's behalf disagrees with GuildNet's decision to deny a request for additional services or payment or to terminate, reduce or suspend a service. The member or provider may make the request for an appeal verbally or in writing within 45 days of receipt of the notice of GuildNet's action to the Director of Quality Assurance (QAPI). If the request is made after the 45-day requirement the appeal will not be processed. If the member is requesting aid continuing as a result of a GuildNet decision to terminate, reduce or suspend services, the appeal must be filed within 10 days of notice or by the intended date of the action.

Provider complaints regarding GuildNet staff should be forwarded to Provider Relations.

Claim Issues:

Discrepancies between the claim and GuildNet's approval of services will be processed as follows:

- If the Claim Processing Provider denies a claim due to a discrepancy between GuildNet's approval record and the claim, or any other problem with the claim or authorization, the Provider may submit a corrected claim within 45 days of the denial or follow the claim inquiry procedures outlined in the Provider Manual.
- If the designated claim inquiry staff decides against the Provider, the Provider can appeal to the Senior Vice President of Provider Relations.
- The Provider will be notified in writing of the decision.
- If the Provider wishes to pursue the discrepancy further, the discrepancy becomes a dispute, and is adjudicated through the dispute resolution process.

If a dispute arises out of, or relates to, the Provider's (Provider's) contract with GuildNet, and the dispute can not be resolved by the parties within a reasonable time of either parties notice to the other party of the dispute, the dispute shall be resolved by arbitration, unless otherwise stipulated. Arbitration shall be conducted pursuant to the contract between GuildNet and the Provider. Arbitration decisions shall be final and binding.

Provider Credentialing

GuildNet Provider Relations maintains credentialing files for each Provider and ensures timely re-credentialing. Providers must submit information and documentation required by GuildNet to validate Provider's qualifications to provide contracted services to GuildNet Members.

Required documents include:

Completed and signed participating Provider application

All regulatory licenses and certifications

Evidence of Insurances:

(GuildNet, Jewish Guild for the Blind and its subsidiaries must be included as certificate holder and additional insured for General Liability)

- General Liability
- Professional Liability
- Worker's Compensation
- Automobile Insurance (as applicable)

NPI (National Provider Identification Number)

Medicaid and Medicare Provider numbers for all Medicaid/Medicare Providers

Provider information is forwarded to a credentialing organization for credential verification and to check for any existing Medicaid or Medicare sanctions.

Renewed licenses and insurances must be submitted to GuildNet Provider Relations within 7 business days of receipt.

GuildNet will inform Provider of any deficiencies or missing documents. If the Provider cannot correct deficiencies or provide timely submission of documents, termination procedures will be initiated.

GuildNet may conduct a site survey of the Provider's premises when services are to be rendered on-site at the Provider's facility at the discretion of the Senior Vice President of Provider Relations. GuildNet will consider the results of the site survey in determining whether to contract with a Provider, and in determining whether to renew a contract with a Provider. Re-credentialing will be conducted every two years.

Monitoring of Providers

GuildNet monitors provider performance on an ongoing basis as follows:

- Quality Assurance (QAPI) reviews Member satisfaction surveys and Member complaint logs.
- QAPI and Provider Relations meet monthly to review Member complaints.
- Repeated complaints regarding a particular Provider are followed up by Provider Relations.
- Provider Relations contacts the Provider to discuss complaints and request a plan of action.
- If repeated issues cannot be remedied, Provider Relations will commence contract termination procedures.

Provider Audits

GuildNet will annually review a sampling of Provider records documenting evidence of service delivery to determine accuracy and any patterns of error.

Documents collected and reviewed will include but not be limited to:

- Medical Record Notes
- Attendance records
- Activity Records and/or clinical notes
- Time Slips
- Sign in logs/attendance sheets
- DME delivery tickets
- Trip Verification
- Monitoring Reports from Network Providers

Audits will be based upon a sampling of paid claims for a specific time frame. Provider selection will be rotated based on utilization. No less than 150 claims will be reviewed.

Method:

- 1) Upon 30 days notice to Provider, GuildNet will give the Provider a list of invoice numbers, Member Names and service dates.
- 2) Provider will make available service rendered documents for GuildNet to review against the paid claims.
- 3) GuildNet will compile data into a report indicating number of Providers audited, number of claims, and number of errors, if any, found.
- 4) Providers showing a pattern of errors (excess of 5%) will be notified, and corrective action requested. Re-audits of these Providers will be conducted quarterly.
- 5) If no corrective action is taken, Provider Relations will be notified and contract termination procedures will be initiated.

Provider Termination

GuildNet may terminate its contract with a Provider/Provider pursuant to the provisions of the GuildNet Provider Agreement.

GuildNet shall not terminate a contract with an individual health care Provider except in compliance with the requirements of Section 4406-d of the New York Public Health Law. Under this policy, the term “health care professional” shall be defined in accordance with Section 4406-d of Public Health Law, as a health care professional licensed, registered or certified pursuant to Title Eight of the New York Education Law.

In accordance with the requirements of Section 4406-d, termination by GuildNet of a contract with a health care professional shall comply with the following:

- a. GuildNet shall not terminate a contract with a health care professional unless GuildNet provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This provision shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional’s ability to practice.
- b. The notice of the proposed contract termination provided by GuildNet to the health care professional shall include: (i) the reasons for the proposed action; (ii) notice that the health care professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by GuildNet; (iii) a time limit of not less than thirty (30) days within which a health care professional may request a hearing; and (iv) a time limit for a hearing date which must be held within thirty (30) days after the receipt of a request for a hearing.
- c. The hearing panel shall be comprised of three persons appointed by GuildNet. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three person, provided however that the number of clinical peers on the panel shall constitute one-third or more of the total Membership of the panel.
- d. The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by GuildNet, provisional reinstatement subject to conditions set forth by GuildNet, or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

- e. A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty (30) days after the receipt by the health care professional of the hearing panel's decision; provided, however, that Section 4403(6)(e) of the New York Public Health Law, concerning Members' rights to continue an ongoing course of care, shall apply to such termination.
- f. In no event shall termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

UPDATING POLICIES AND PROCEDURES

Updates and changes in policies and procedures related to Provider services will be reviewed and distributed to Providers at least thirty (30) days in advance of implementation.

Providers will be required to attend in-service and orientation programs as requested.