Provider Manual

Michigan
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CONTACTS AT A GLANCE

- **Customer Service**
  Phone: 1-877-372-8085

- **Care Coordination**
  *InPatient / OutPatient Authorization,*
  *Scheduling and Notification*
  Phone: 1-877-372-6121
  Fax: 1-866-596-1054

- **Pharmacy Customer Service**
  Phone: 1-800-922-1557

- **Pharmacy Prior Authorization**
  Phone: 1-800-935-6103

- **Provider Services**
  Phone: 1-877-372-8085
  Fax: 1-866-852-3141
  Email: provider.contracting@fidelissc.com

- **Mail Claims To:**
  Fidelis SecureCare, Inc.
  P.O. Box 3597
  Scranton, PA 18505

- **Electronic Claim Processing Contact**
  Emdeon
  Fidelis Payor ID # 77054
  1-877-819-3267

- **Appeals**
  Fidelis SecureCare, Inc.
  Attention: Appeals Dept.
  2030 Main Street, Suite 600
  Irvine, CA 92614
  Phone: 1-847-592-9483
UTILIZATION MANAGEMENT AFFIRMATIVE STATEMENT REGARDING INCENTIVES

This statement is intended to comply with the Code of Federal Regulations 42 (CFR) 422.208 regarding Utilization Management Affirmative Statement Regarding Incentives.

In accordance with the regulations above, Fidelis requires that all utilization-related decisions regarding member coverage and/or services must be based on appropriateness of care and service. Financial rewards or incentives must not influence any utilization decision. To assure that the risks of underutilization are considered, no rewards or incentives can be issued by Fidelis that will discourage appropriate care and services to members.

Fidelis does not reward providers, employees, or other individuals for issuing denials of coverage, service, or care. Denials for medical service requests are reviewed by medical directors and are based strictly upon review of the available clinical information, clinical judgment and plan benefits.
INTRODUCTION TO FIDELIS

Fidelis SecureCare was founded in 2005, and began as a Medicare Advantage Special Needs Plan for eligible individuals residing in nursing facilities. Since then we have expanded our plans to cover Medicare and dual-eligible enrollees who reside in their own homes, as well as those in Group Homes and Adult Foster Care Homes.

Beginning in 2015, Fidelis will offer a Medicare-Medicaid Plan in accordance with the Michigan Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid, known as MI Health Link. Fidelis’ service area for MI Health Link includes Wayne and Macomb counties.

Fidelis plans are available for individuals who desire a more focused coordination of care than traditional Medicare can provide. Our employed and contracted providers and care managers provide a high quality of care while effectively managing the medical and psychosocial needs of these enrollees.

At Fidelis, we firmly believe that the quality of life of our enrollees can be significantly improved—and their rate of decline measurably reduced—through clinically focused and consistently attentive care. In concert with nursing staff, our provider partners and our network of expert healthcare professionals, we strive daily to achieve improved health outcomes for every enrollee we serve.

Our Vision
Fidelis is committed to achieving the highest level of care for our population, one that is compassionate, person-centered, self-directed and focused on the needs of the whole person.

Our Mission
Fidelis plans to fundamentally improve the way healthcare is delivered to our most vulnerable populations. It will do so by partnering with providers to provide care in the most effective and efficient clinical setting; by creating a person-centered model that coordinates services and enables communication with all domains of the delivery system; by eliminating barriers to and encouraging the use of home and community based services; and by providing high quality, compassionate service focusing on enrollee satisfaction.

Our Model of Care
The Fidelis Model of Care includes comprehensive evaluations and care planning; small panel sizes to enable our employed providers to facilitate direct access on a 24/7 basis, including home visits when needed; comprehensive care coordination across the care continuum; frequent enrollee touches with extended appointment times; meaningful engagement of all enrollees of the enrollees care team, including personal care assistants and family enrollees, if desired by the enrollee.

Customer Service
Should you have any questions or need assistance, please contact Fidelis SecureCare Customer Service at 1-877-372-8085 (TTY users should call 711). We are open Monday through Friday from 8:00 AM to 8:00 PM. EST. Outside of these time frames, please leave a detailed voice message.
FRAUD, WASTE AND ABUSE

Providers and Fidelis have an obligation to comply with all federal and state laws and Medicare requirements related to fraud, waste, and abuse.

Provider Responsibilities:

By December 31, 2009, and annually thereafter, affected providers and entities should:

- Complete training as defined in 42 CFR 422.503 and 42 CFR 423.504
- Submit an attestation to Fidelis verifying completion of training

The topics that providers must be trained on:

- Laws and regulations related to Medicare Advantage and Part D fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
- Ensure downstream contractors and related entities have appropriate policies and procedures in place to address fraud, waste, and abuse
- Reporting process in place for suspected fraud, waste and abuse in first tier, downstream, and related entities to Fidelis along with protections for employees of downstream contractors and related entities who report suspected fraud, waste and abuse
- An understanding of the types of fraud, waste and abuse that can occur with downstream contractors and related entities

Provider is also responsible for cooperating with Fidelis during any investigation of suspected fraud, waste or abuse on the part of the provider or any of its downstream contractors.

Fidelis Responsibility:

Fidelis is responsible for monitoring the activities of its providers, vendors, and other downstream contractors to ensure that claim submission / billing practices, utilization practices, and business practices meet federal, state and Medicare requirements. Fidelis will notify any provider or vendor that it suspects is not complying with these requirements and request a review of its records and/or activities. In certain cases, this could include suspension of payment until corrective action plans are in place.

Effective January 1, 2009, The Centers for Medicare and Medicaid Services (CMS) is requiring that all Medicare Advantage Organizations and Prescription Drug Plan Sponsors must apply Fraud, Waste and Abuse (FWA) training to all entities that they are partnering with to provide benefits or services in the Part C or the Part D programs

Fidelis is offering this service in accordance with the requirement of the “Revisions to the Medicare Advantage and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes; Final Rule” published by CMS which includes a requirement that Medicare Advantage Plan Sponsors provide Fraud Waste and Abuse training annually to all contracted providers participating in a Medicare Advantage network.

To access this training go to the Fidelis website at http://www.fidelissc.com and a link to FWA training can be found under the PROVIDERS tab on the right hand column of our webpage.
REGULATIONS AND RESPONSIBILITIES

Compliance with the Contract, Regulations, and this Manual

Fidelis is subject to certain requirements as set forth by the Centers for Medicare and Medicaid Services (CMS) for this health plan and will disclose to CMS all information necessary to administer and evaluate the program, and establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. The Fidelis provider contract requires compliance with the contract and with federal regulations governing Medicare Advantage health plans and the plan’s policies and procedures. Those requirements are set forth in the Fidelis provider contract, this manual and from time to time in provider newsletters and other communications and notices sent by Fidelis.

General Federal and Medicare Regulations

- A Fidelis provider is required not to contract with or employ individuals who have been excluded from participation in the Medicare Program.

- If a Fidelis provider files an affidavit with CMS stating that they will furnish Medicare-covered services to Medicare beneficiaries only through private (direct) contracts with the beneficiaries under Section 1802(b) of the Social Security Act (i.e. they will not accept payment from Medicare), then their contract with Fidelis will terminate concurrently. A Fidelis provider must provide notice to Fidelis within five (5) days of providing any notice with CMS.

- Fidelis providers must provide covered services to all members, including those with ethnic backgrounds, physical or mental disabilities, and limited English proficiency, in a culturally competent manner.

- Fidelis providers must provide disabled covered persons with the assistance necessary to effectively communicate with the participating provider and their staffs, as required by the Americans with Disabilities Act.

- Fidelis monitors and reports on quality and performance including but not limited to: member satisfaction, disenrollment, and health outcomes.

- Provider will comply with the requirements of 42 CFR 422.504(g)(l)(iii) and agrees that dual eligible enrollees will not be responsible for any plan cost sharing for Medicare A and B services when the state is responsible for paying those amounts. Provider shall either (1) accept amounts received from Fidelis as payment in full, or (2) bill the state Medicaid program for applicable co-payments, deductibles, and co-insurance for dual eligible members.

Synopsis of Important Contract Requirements

The Agreement with Fidelis contains numerous important provisions that are summarized below. In some situations, a Fidelis contracted provider may subcontract with another provider to provide services to a Fidelis Member. In all cases, any such subcontracts must include the following provisions:

- Providers understand that Fidelis is responsible for overall administration of the health plan including all final coverage determinations and monitoring of its contracted provider’s compliance with state and federal regulations.
Fidelis is responsible for all marketing of the health plan and providers are not authorized to act as agents of Fidelis in marketing. Only Fidelis approved marketing materials may be provided to beneficiaries to explain the Fidelis program.

Providers will comply with Fidelis Utilization/Medical Management Policies and Procedures.

Providers will comply with Fidelis Quality Management Programs. Fidelis requires that all providers participate in periodic audits and/or site surveys for evaluating compliance with Fidelis Quality Management standards and regulatory requirements.

Medical Records - Fidelis Providers must safeguard the privacy of any information that identifies a particular Member and must maintain Member records in an accurate and timely manner.

Contracted providers must provide a Fidelis Medical Director or designee access to all Fidelis Members' charts and medical records for the purpose of determining or resolving eligibility, liability or appropriate care issues. Provider, as prescribed by State and federal law under HIPAA regulations, will maintain confidentiality of this information.

Fidelis is concerned with protecting Member privacy and is committed to complying with the HIPAA privacy regulations. Generally, covered health plans and covered providers are not required to obtain individual Member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact your Provider Relations Representative.

No Balance Billing of Members with the exception of applicable co-payments or coinsurances.

A Fidelis contracted provider agrees not to impose any charges on any Fidelis Member for Covered Benefits beyond those shown in the Evidence of Coverage. Further, contracted providers agree to accept the Fidelis payment as payment in full and agree not to seek compensation from a Fidelis Member for services provided to that Member, even in the event of non-payment by Fidelis. Provider further agrees that it will not attempt to collect co-payments or coinsurances from members who have Medicaid as a secondary insurance, or for members who have lost their Medicaid coverage while they are eligible to remain in the plan.

Contracted providers agree to retain financial and medical records relating to Fidelis members for a period of ten (10) years from the termination of the contract or such time as may be required by applicable state or federal law, regulation or customary practice.

Fidelis providers must give the U.S. Department of Health and Human Services, the U.S. Government Accounting Office and their designees the right to audit, evaluate, and inspect their books, contracts, medical records, member documentation and other relevant records. These rights will extend for ten (10) years beyond termination of the Fidelis agreement and until the conclusion of any governmental audit that may be initiated that pertain to such records.

Fidelis providers must not discriminate against members based on their health status. Further, providers must ensure that members are not unlawfully discriminated against based on race, color, creed, national origin, ancestry, religion, sex, marital status, age, physical or mental handicap, or in any other manner prohibited by state or federal law.

Fidelis providers must provide all covered benefits in a manner consistent with professionally recognized standards of health care.
• Fidelis providers must cooperate with the plan’s grievance and appeals procedures that protect beneficiary and member rights.

• Fidelis providers have specific continuity of care obligations in the event that the Fidelis agreement terminates for any reason, including a provider’s de-participation or if Fidelis becomes insolvent. In the event of insolvency, Fidelis providers must continue to provide care to members through the period in which their CMS payments have been made to Fidelis. Additionally, if the member is hospitalized, services must be provided until termination of CMS’ agreement with Fidelis or, in the event of Fidelis’ insolvency, through the date of the member’s discharge.

• Fidelis providers may not encourage members to dis-enroll.

Review the Fidelis contract for any additional sections or provisions not discussed in this section. In addition, the description of the contract provisions listed in this section does not constitute the complete disclosure of all requirements placed on providers contracted with Fidelis. Contracted providers should refer to their Fidelis contract for further information.

Member Relationship and Communications

Participating providers are responsible to maintain the provider-member relationship with each member. Nothing contained in the Fidelis agreement or this manual is intended to interfere with such provider-member relationship, nor should any provision be interpreted to discourage or to prohibit a participating physician or other provider from discussing treatment options or providing other medical advice or treatment deemed appropriate by the participating physician. The participating physician shall have the sole responsibility for the medical care and treatment of members.

In the event that a Fidelis provider terminates their participation or relationship with the plan, Fidelis has the exclusive right and responsibility to communicate with its members regarding those changes; participating providers should not send independent notices to Fidelis members.

The Health Insurance Portability & Accountability Act Of 1996

Fidelis is concerned with protecting member privacy and is committed to complying with the HIPAA privacy regulations. Generally, covered health plans and covered providers are not required to obtain individual member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities that fall into this category include care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement. If you have further concerns, please contact your Fidelis Provider Relations Representative.

All medical records must be maintained for up to ten (10) years.

Providing Access to Medical Records

Members may access their medical records at any time by contacting their provider directly. Members shall be given the opportunity to review their medical records in a timely fashion.
PHYSICIAN RESPONSIBILITIES

Primary Care Physicians and Medical Team Members

Primary Care Physician (PCP’s) and medical team members are defined as Family Providers, General Practice Physicians, Geriatricians, Internal Medicine Physicians and their associated nurse providers and physician assistants.

Fidelis PCP responsibilities include:

- Provide access to medical services 7 days a week/24 hours a day either directly or through call coverage.
- The management of medical care provided to members who have chosen or been assigned to the physician and team as their PCP. A PCP is expected to provide all necessary care required by a member that is within the scope of his or her practice and expertise. The PCP should refer a member to a specialist or other provider only when he or she is not able to provide the specialty care.
- Coordinate the services a member may need that can be effectively provided within the nursing facility.
- Coordinate and obtain a referral or prior authorization from Fidelis’ Medical Management team prior to directing a member to receive care from another Fidelis provider inside or outside the nursing facility.
- Coordinate a member’s care needed from specialty physicians or other healthcare providers by referring to providers in the Fidelis network of providers. Except in emergency and urgent situations and for renal dialysis services for those members temporarily out of the service area, if services are not available within the Fidelis network of providers, then the PCP must contact Fidelis’ Medical Management team to obtain prior authorization to refer a member to a non-participating provider prior to the care being rendered.
- Provide direction and follow-up care for those members who have received emergency services.
- PCP’s and their care team are responsible for all members who select them, including members whom the PCP has not yet seen.

Panel Closure

Occasionally PCPs will request closure of their panel to new Fidelis members. Fidelis requires a 90-day written notice to the Provider Relations department prior to the proposed effective date of such closure. This panel closure must be in writing.

During the 90-day period between notification of closure and revision of the provider directories to reflect such closure, PCPs must continue to accept members who select them. Fidelis will continue to list closed PCPs in Fidelis’ provider directories with a notation designating them as “Not accepting new members.”
Reopening of Panel

The Fidelis Provider Relations department will continuously monitor the membership of all PCPs who have “closed” their panel to new members. When a PCP requests to re-open their panel to new members, the PCP will send a written notice to the Provider Relations department requesting re-opening of their panel and the effective date of the re-opening.

Specialist Physicians

The role of a Fidelis participating specialist is to provide consulting expertise, as well as specialty diagnostic, surgical and other medical care for Fidelis members. Fidelis expects a participating specialist to support the role of a PCP in coordinating and managing a member’s health care by providing only those specific services for which a referral has been issued and promptly returning the member to the PCP as soon as medically appropriate. (See section on referrals and authorizations for details.) Open, prompt communication with the PCP concerning follow-up instructions, circumstances of further visit requirements, medications, lab work, x-rays, etc. are essential to the coordination of care.

The Fidelis Specialist’s responsibilities include:

• Specialists must provide access to medical services 7 days a week/24 hours a day either directly or through call coverage.

• Specialists should order all laboratory testing, radiology studies or other diagnostic testing through a contracted, in-plan facility unless an emergency situation clearly indicates emergency lab or radiology services are indicated. Fidelis has specific, contracted laboratory and radiology service providers in all regions. There are specific Fidelis policies within each region that outline which of these services may be rendered in an office setting. If you have any questions, please contact your regional Provider Relations department.

• Specialists are encouraged to “Fast Track” the member through his/her office on the day of their scheduled appointment. “Fast Track” is defined as such: when the member gets to the office, the member will be escorted immediately back to an exam room and be seen by the specialist. The transportation attendant will also wait for the member during this “fast tracking” so the member will not have to wait in the waiting area after the appointment and the office staff will not have to call for the transportation company to return to pick-up the member.

Access to Care

Fidelis has adopted the following standards for access:

Prompt access to providers is vital for care to members. The Fidelis policy on Provider/Plan Access Standards was developed with this core value in mind. The standards listed in this policy support the value of service as it seeks to anticipate, understand and respond to individuals, organizations, nursing facility and community needs as member’s access healthcare services.

Fidelis believes that our members are entitled to care that is delivered in the appropriate setting, appropriate timeframe and appropriate manner.
Fidelis requires health care providers to provide access to health care services without excessive scheduling delays. Providers will have policies and procedures in place to properly identify emergency conditions and appropriately triage such cases. Triage involves identifying which cases can be managed in the office/nursing facility or making alternative arrangements, e.g. immediate care service or emergency room for cases which cannot be safely managed in the office/or nursing facility setting.

The maximum time period between a request for an appointment/or visit to the nursing facility and the date offered will be:

**Medical Appointments**

- **Life Threatening, Emergent problem:** Immediate access
- **Urgent Care:** Same day

    *Defined as services provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion and breathing difficulties, other than those of sudden onset and persistent severity.*

- **Preventive Care:** 30 days

    *Defined as a preventive health evaluation without medical symptoms for existing member (i.e. routine exam, annual physical).*

- **Routine Care:** 7-14 days or earlier based on the population

    *Defined as non-urgent symptomatic condition that is medically stable. Special attention will need to be given based on the geriatric population and how symptoms are presented.*

- If a provider’s schedule cannot accommodate the member requesting an Urgent Care or Routine Care appointment within these time intervals, an appointment will be offered with an alternative provider, nurse provider, physician assistant or certified nurse midwife at the same location, or if none are available, at another location. Immediate care service may also be offered as an alternative to an Urgent Care appointment or a Routine Care appointment request, which cannot be scheduled within the appropriate timeframe. The member may choose to decline alternatives and accept a delayed appointment with the provider.

**Behavioral Health Appointments**

The maximum time period between a request for an appointment and the date offered will be:

- **Emergent, Life Threatening:** Immediate access
- **Emergent, Non-Life Threatening:** 6 hours
- **Urgent Care:** 48 hours
- **Routine Care:** 10 working days
- If a provider’s schedule cannot accommodate the member requesting an appointment within these time intervals, an appointment will be offered with an alternative provider
at the same location, or if none available, at another location. The member may choose to decline alternatives and accept a delayed appointment with the provider.

**Office Hours/Office Wait Time**

- Fidelis requires health care providers to have established hours that accommodate the needs of Fidelis members. These hours should be clearly posted and communicated to members, authorized representatives and nursing staff at each facility. Wait time standards require members to be seen within 30 minutes of the scheduled appointment.

**Care Management**

The Centers for Medicare and Medicaid Services are contracted with Fidelis SecureCare to provide comprehensive, cost-effective managed care health services to enrolled members.

Care Management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Care management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

The Care Management team is comprised of specially qualified nurses who assess the member’s risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.

Care Managers work collaboratively with Primary Care Physicians (PCPs) who serve as the principal care manager and works to coordinate care for the member and expedite access to care and needed services. Fidelis SecureCare’s Care Management team also serves in a support capacity to the PCP and assists in coordinating care actively linking member to providers, medical services, residential, social and other support services, as needed. Fidelis SecureCare’s Care Management team adheres to the Case Management Society of America (CMSA) standards of practice.

The Fidelis SecureCare Care Management process illustrates the formation of one seamless Care Management Program and begins with Member enrollment. All Fidelis SecureCare Members are assigned a Case Manager at the time of enrollment.

The Fidelis SecureCare Care Management process includes the following:

- Member Enrollment
- Member Evaluation/Assessment
- Member Stratification
- Member Planning
- Member Referral/Service Facilitation
- Member Advocacy

Members have access to Care Management at any time. The Member can contact their assigned Care Manager for additional support or assistance.

The Fidelis SecureCare Care Management program is an “opt out” program. The Care Management Program proactively identifies members and provides education for these members and/or their caregivers to empower them to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. In addition, the program educates members and their caregivers regarding the standards of care for
these disease states, triggers to avoid and to ensure they are receiving the appropriate medications for the specific conditions.

The program also focuses on educating the provider with regards to the standards of care and current treatment recommendations for the individual disease management conditions. Intervention and education will improve the quality of life of members, improve health outcomes and decrease medical costs.

Use of Evidence Based Clinical Practice Guidelines (CPGs)

- Fidelis encourages the use of CPGs for prevention, diagnosis and management of medical and behavioral health conditions.
- These CPGs correspond to nationally recognized standards of care and clinical treatments for specific conditions.
- The Goal is to support quality of care and consistency in healthcare delivery to FSC members.

Fidelis Clinical Practice Guidelines

Adult Preventive Care

- **Immunizations**
  - Centers for Disease Control and Prevention Adult Immunization Schedule (over 18 years old)
  - Website: [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html)

- **American Cancer Society Guidelines for the Early Detection of Cancer**
  - Breast cancer
  - Colorectal cancer and polyps
  - Cervical cancer
  - Endometrial (uterine) cancer
  - Prostate cancer

- **Asthma**
  - National Asthma Education and Prevention Program Expert Panel Report 3

Behavioral Health

- **Depression**

- **Substance Abuse**
• Psychotropic Medication Management
  o U.S. Department of Health & Human Services – Agency for Healthcare Research and Quality
  o The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations: [http://www.ahrq.gov/clinic/schzrec1.htm](http://www.ahrq.gov/clinic/schzrec1.htm)

• Chronic Kidney Disease (CKD)

• Chronic Obstructive Pulmonary Disease (COPD)
  o Global Initiative For Chronic Obstructive Lung Disease: [http://www.goldcopd.org](http://www.goldcopd.org)

• Congestive Heart Failure (CHF)
  o American College of Cardiology Foundation

• American Heart Association
  o Task Force on Practice Guidelines: [http://circ.ahajournals.org/content/119/14/1977.full.pdf](http://circ.ahajournals.org/content/119/14/1977.full.pdf)

• Coronary Artery Disease (CAD)

• Diabetes
  o Executive Summary: Standards of Medical Care in Diabetes—2012: [http://care.diabetesjournals.org/content/35/Supplement_1/S4.full?sid=51c7eb39-6e1b-4f3a-8557-419246b5ed07](http://care.diabetesjournals.org/content/35/Supplement_1/S4.full?sid=51c7eb39-6e1b-4f3a-8557-419246b5ed07)

• Hypercholesterolemia

• Hypertension

• Medical Necessity Criteria
  o Criteria required by applicable state or federal regulatory agency
  o Milliman Care Guidelines as the primary decision support for most medical diagnoses and conditions.
CREDENTIALING

Credentialing Program

Fidelis has a comprehensive written credentialing program that has been established in accordance with the standards of the National Committee for Quality Assurance (NCQA) and applicable state and federal regulatory requirements. The program is reviewed and revised at least annually.

All providers who fall under the scope of Fidelis Credentialing Program must meet the minimum credentials, qualifications and criteria established by the Plan. The Fidelis Credentialing Committee makes all decisions regarding provider participation in the Fidelis Network in accordance with Fidelis credentialing criteria.

Getting Credentialled with Fidelis SecureCare

Once you have completed the Fidelis Provider Application and executed the Provider Agreement, you may become credentialled with Fidelis in one of two ways:

1. CAQH

   o Fidelis is a registered organization of CAQH, a national credentialing clearinghouse. Once you have provided your credentials to CAQH, they will assign you a CAQH Provider ID and also facilitate the credentialing process with all of the payors / networks with which you wish to become affiliated. Simply provide us your CAQH Provider ID number and we will access your application and begin our credentialing process.

2. Complete a Michigan Standard Practitioner Application

   o If you prefer not to sign up with CAQH, then you must complete and submit a credentialing application to Fidelis at the address/email address below. Documentation must be received within 60 days of contract execution.

   Provider Relations  
   Fidelis SecureCare  
   3031 W. Grand Boulevard, Suite 460  
   Detroit, MI 48202  
   provider.contracting@fidelissc.com

Who needs to be credentialled?

Credentialing is **required** for:
  - All physicians who provide services to Fidelis SecureCare members, including members of physician groups; and
  - All other types of health care professionals who provide services to Fidelis SecureCare members, and who are permitted to practice independently under state law.

Credentialing is **not** required for:
Health care professionals who are permitted to furnish services only under the direct supervision of another provider;

Hospital-based health care professionals who provide services to members incident to hospital services, unless those health care professionals are separately identified in enrollee literature as available to members; or

Students or fellows

Physicians who provide services to members and practice independently under state law are defined as below:

- Doctor of Medicine (M.D.); Doctor of Osteopathic Medicine (D.O.); Doctor of Dental Science (D.D.S.) who provide care under the medical benefit program; Doctor of Podiatric Medicine (D.P.M.); Doctor of Chiropractic (D.C.); and Doctor of Optometry (O.D.).

- Behavioral Health Care Providers to include Psychiatrists and Physicians who are certified in Addiction Medicine; doctoral and/or master’s level Psychologists (PhD, PsyD) who are state certified or state licensed; master’s level Clinical Social Workers who are state certified or state licensed; master’s level Clinical Nurse Specialists or Psychiatric Nurse Providers who are nationally or state certified or state licensed; and other Behavioral Health Care Specialists who are licensed, certified, or registered by the state to practice independently.

- Nurse Providers, Nurse Midwives, and Physician Assistants who work in primary care and obstetrics/gynecology settings and who provide direct patient care, make referrals to specialists or have prescriptive duties. (Note: please see rule above regarding mid-level providers under supervision of physician)

- Urgent care physicians and anesthesiologists who work outside the hospital setting.

- Hospitalists who exclusively provide care for hospitalized members.

Providers who practice exclusively within the inpatient hospital setting, Pathologists, Radiologists, Anesthesiologists, Emergency Room Physicians, physicians practicing in free-standing facilities (i.e. surgical centers) and physicians who provide care for Fidelis SecureCare members only as a result of members being directed to the hospital/facility do not need to be credentialed by Fidelis SecureCare unless otherwise noted.

Health delivery organizations are required to be credentialed prior to seeing members to ensure organizational providers are meeting minimally acceptable standards of patient care. They must be reviewed and approved by an appropriate accrediting body, or meets the standards established by the health plan. Accrediting bodies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Community Health Accreditation Program (CHAP), and the Continuing Care Accreditation Commission.

Health delivery organizations are defined as:
- Hospitals (either JCAHO accreditation or Medicare certification). Note that Medicare also certifies organ procurement organizations (OPOs) and that organ transplants must generally be performed in certified organ transplants centers;
- Home Health Agencies (HHAs);
- Hospices;
- Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA);
- Skilled Nursing Facilities (SNFs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy and Speech Pathology Providers;
- Ambulatory Surgery Centers (ASCs);
- Providers of end-stage renal disease services;
- Providers of outpatient diabetes self-management training;
- Portable x-ray suppliers

**Credentialing Criteria**

Fidelis has adopted the following Credentialing Criteria and requirements for Participating Providers:

- Submission of a signed completed application, including the consent and other necessary releases. Submission of inaccurate or misleading information on the application, or failure to disclose relevant information will be grounds for termination from or denial into the network.
- Possess a current, valid license to practice in the state(s) in which he/she provides professional services as a contracted provider with Fidelis and certify that his/her license to practice has never been revoked, suspended, or placed on probation by any state licensing board.
- Medical staff appointment or a clinical privileges have not been denied, revoked, terminated, and has not voluntarily terminated privileges in lieu of disciplinary action by any health care facility or professional related organization.
- Agrees to notify Fidelis regarding any current or past limitations imposed upon clinical privileges, or any change in appointment or clinical privileges during the course of contract with Fidelis.
- Has never been excluded or precluded from participation in Medicare or Medicaid or has been convicted of Medicare, Medicaid, or governmental or private third party payer fraud or program abuse or has been required to pay civil penalties for the same.
- Possess and maintain certification by a medical specialty board recognized by the American Board of Medical Specialties or AOA; or, have completed a residency-training program approved by the ACGME or AOA in the contracted specialty.
- Possess malpractice history acceptable to Fidelis.
- Possess professional liability insurance coverage in such minimum amounts required by Fidelis.
- Has no criminal felony convictions, criminal misdemeanor related to the practice of their profession, other health care related matters, third party reimbursement, controlled
substances violations, child/adult abuse charges, or any other matter that in the opinion of Fidelis would adversely affect the ability of the provider to contract with Fidelis.

- Has no chemical dependency/substance abuse history; or, for those providers who have such history, must provide evidence that the provider has completed a prescribed monitored treatment program and that no current chemical dependency or substance abuse exists.
- Has no current physical or mental health condition that would impair or would be likely to impair provider’s ability to adequately perform the professional duties for which provider is contracted and that could not be accommodated without undue hardship.
- Has no history of quality issues as identified by Fidelis internal processes on review, National Providers Data Bank / Health Integrity Protection Data Bank, or from any other source.
- Possess verified, current state drug license and federal Drug Enforcement Agency certificates (DEA numbers), dependent on state requirements.
- Agree to actively participate in utilization review and quality improvement activities of Fidelis and permit access by Fidelis representatives to his/her office location for the purpose of gathering information relevant to those activities.
- Have no significant utilization issues and Member services issues or complaints identified and documented by Fidelis during participation period.

Provider Rights

As a network provider, you have the right to:

- Review information submitted to your credentialing application.
- Correct erroneous information collected during the credentialing process.
- Be informed of the status of your credentialing or re-credentialing application.
- Be notified of these rights.

Requests for Additional Information

If Fidelis receives information from an outside source that differs substantially from information you have provided us, we will contact you directly as soon as the discrepancy is noted and request your clarification in writing within 10 business days.

Appeals Process for Providers Terminated or Rejected from the Fidelis Provider Network

A provider has the right to appeal a Quality and Peer Review Committee decision that has negatively impacted the provider. Fidelis complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the Fidelis Provider Network. Fidelis notifies the provider in writing of the reason for the denial, suspension and termination. Terminated or rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by Fidelis. In addition, the request for appeal must be received by Fidelis within ten (10) days of the date of the rejection/termination letter. Upon receipt of the letter by Fidelis, the appeal is forwarded to the Fidelis Appeals Committee for review and further processing Fidelis will ensure that the majority of the hearing panel members are peers of the affected physician.
Fidelis Agreement with the National Practitioner Data Bank (NPDB) and other Authorities for Providers Terminated from the Fidelis Provider Network

As a requirement of the participation agreement between Fidelis and the National Practitioner Data Bank (NPDB) pursuant to the Health Care Quality Improvement Act of 1986, as amended and other authorities per state and federal regulations, Fidelis is obligated to report the termination of a Provider if the termination resulted from a quality of care issue resulting in harm to a member’s health and/or welfare. Any provider subject to this reporting requirement is notified via a letter of termination from Fidelis.

Confidentiality

Fidelis maintains the confidentiality of all information obtained about providers in the credentialing and re-credentialing process as required by law. Providers will have access to such information. Fidelis will not disclose confidential provider credentialing and re-credentialing information to any person or entity except with the written permission of the provider or as otherwise permitted or required by law.

Non-Discrimination

Fidelis will not discriminate against providers based on race, age, religion, creed, color, national origin, ancestry, sex, sexual orientation, gender identity, physical or mental handicap or serious medical condition, spousal affiliation, the types of procedures performed, or the members in which the provider specializes in determining a provider’s qualifications to provide health care services to Fidelis members. Selection of participating providers will be primarily based on, but not limited to, cost and availability of covered services and the quality of services performed by the providers.

Site Visits and Medical Record Audit Reviews

Office site visits and medical/treatment record keeping reviews may be conducted on all high-volume Primary Care Providers (PCPs) (physicians practicing as Family Medicine, General Practice and Internal Medicine), Specialists and high-volume behavioral healthcare providers and those providers on whom grievances have been filed. High-volume is defined as seeing/treating 20 or more Fidelis members per year as indicated by claims data.

Site visits will not be conducted for Primary Care Providers (PCPs) who’s practice are based at a participating nursing facility.

Medical/treatment record keeping reviews may be conducted on all Primary Care Providers (PCPs) (physicians, certified nurse practitioners, and certified physician assistants who practice in Family Practice, General Practice, Geriatrics and Internal Medicine) with more than 20 members within the first 12 months of seeing/treating members and then no less than every three (3) years after that for all Primary Care Providers.

Clinical documentation audits will include assessments of chart organization, appropriateness of clinical care and preventive health care, coordination of care and completeness and comprehensiveness of documentation.
All site visits must meet the threshold requirements for Fidelis.

- If the threshold score is not met at the time of the visit, a Corrective Action Plan will be initiated, and a re-audit will be conducted with six (6) months of the visit.
- If the re-audit does not produce a passing score, the provider will be presented to the Quality and Peer Review Committees with a recommendation from Credentialing to terminate.

A provider who relocates or opens an additional office site after being initially credentialed must notify Fidelis 60 days prior to the move.

**Delegated Credentialing**

Fidelis offers a delegated credentialing option for large groups of health care providers. Fidelis delegates the credentialing function to groups that meet Fidelis and National Committee for Quality Assurance (NCQA) standards and state and federal law. The decision by Fidelis to delegate the credentialing function results from a review of the group’s credentialing policies and procedures and an on-site audit of the group’s credentialing files. The Fidelis Credentialing Committee reviews the resulting delegation report and makes a determination to approve, defer or grant provisional delegated status for the group. If provisional status is granted, this is followed by a reassessment within a specified period of time and a final decision to approve or defer. Groups granted delegated status are required to sign a delegated credentialing agreement with Fidelis.

**Re-credentialing**

- Providers: Fidelis re-credentials providers on a set schedule in accordance with state and federal law and national accreditation standards. At a minimum of every 36 months, a re-credentialing application will be sent to the provider. Fidelis will identify and evaluate any changes in the provider’s licensure, clinical privileges, training, experience, current competence, or health status that may affect the provider’s ability to perform the services they are providing to Fidelis Members. Re-credentialing activities may also be triggered as a result of quality investigations or information received from state and/or federal agencies.
- Delegated Re-credentialing: On an annual basis, Fidelis conducts group audits and may delegate the re-credentialing function to delegated groups using the same process used to initially delegate the credentialing function.

All Primary Care Providers, OB/GYN providers and identified high-volume specialists and high-volume behavioral health care providers are required to have performance monitors considered by the Quality and Peer Review Committees at the time of Re-credentialing. Provider specific information considered at Re-credentialing will be:

- Quality activities
- Member complaints
- Utilization patterns
- Quality of Care issues
- Fraud and Abuse
- Pharmacy and Therapeutics patterns
- Member satisfaction survey results (optional)
- Agrees to follow Fidelis policies and procedures
ELIGIBILITY

You may verify the eligibility of a Fidelis member in one of the following ways:

The Fidelis Identification Card

Each Fidelis member is issued a member identification card within 7 days of enrollment. Members are instructed to present the Fidelis ID card as verification of insurance when seeking health care services. The member will also receive a letter that will have the member’s name, their member identification number or “ID number”, and any applicable cost sharing information. This card identifies the member as a Fidelis SecureCare member. (Sample below)

Members may select from any of a number of health plans that Fidelis offers, and benefits vary by plan.

The I.D. card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified at each visit. Failure to verify eligibility may result in non-payment of claims.

FRONT

BACK

To determine eligibility when the member does not have an identification card, you may call customer service for verification. Members may have a copy of their enrollment form as interim proof of membership until a card is issued and mailed.

You will need the following information to verify member enrollment:
- Full name
- Date of birth
- HICN (Medicare ID)

Online

Eligibility may also be verified by referencing a Medicare eligibility system or by using the Fidelis provider portal at: www.fidelissc.com.

The Fidelis provider portal now allows you to access member eligibility and claims information online, 24 hours a day, seven days a week.
Logging-In


Once you reach the provider portal, you will see the log-in screen:

![Provider Portal log-in screen](image)

You can receive your username and password with the help of the Fidelis staff, or by clicking the link under the “Not registered for the provider portal” section.

Options

Once logged in, you may select from the menu of options at the top of the screen.
Member Eligibility Look-Up

You can access member eligibility by entering the subscriber ID or the member’s first name, last name and date of birth.

When the member is retrieved, you will see all of the information required to determine eligibility.

You may also select the option to view any claims related to the member.
QUALITY PROGRAM

Purpose

The purpose of the Quality Improvement (QI) Program is to promote and continuously improve the quality of clinical care (medical and behavioral health) and service that is provided by facilities, physicians, and other providers to our members. Integral to the QI program is a commitment to provide appropriate care and resources to our members in the most appropriate setting with minimal disruption to their routines and that of their families and other caregivers.

Goals

- Evaluates the effectiveness of the model of care.
- Promotes consistent member care delivery.
- Enables early detection and resolution of issues that affect FSC members, their families, practitioners and providers.
- Collects, analyzes and reports beneficiary complaints and grievances.
- Conducts performance assessments and medical record reviews, which enable the corporate QM Director to identify and implement performance management programs.
- Produces outcome reports that demonstrate the value of complex medical management and care coordination of frail elderly.
- Collects, analyzes and reports data to comply with CMS-required quality and outcome measures that enable members to compare health coverage options, i.e., Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Health Outcomes Survey (HOS) questionnaire, HEDIS measures, and Structure and Process standards.
- Surveys beneficiaries, plan personnel, caregivers, and network providers.
- Assists practitioners and providers in improving the safety of their practices.

Targeted Quality Programs

Fidelis is committed to ensuring the highest level of clinical care for our members. We understand that, because frail, vulnerable residents often have a higher number of co-morbidities than any other group, our approach to their care must address all of the disease states and conditions present in each individual.

To meet the challenge, our comprehensive medical panel of family practice, geriatric and internal medicine physicians; pharmacists; nurses; psychologists; psychiatrists and social workers has developed clinical programs that incorporate the latest research data and best medical practices.

A description of Fidelis’ targeted quality programs follows:

- Medication Therapy Management
- Provider and/or Member Appeals
Medication Therapy Management Program

- Frail and vulnerable members utilize more medications for more disease states and conditions than any other group. Our Medication Therapy Management (MTM) program was developed to maximize the clinical benefits of drug treatment. The program is designed to monitor for various drug interactions, disease interactions, and age interactions, contraindications, prescribed drug toxicities, overdosing and appropriateness of drugs in a continuous effort to improve the member’s outcome. Members are enrolled in the MTM program as their disease states/conditions make them eligible.

- This clinical program offers a multidimensional approach to medication management that incorporates medical and lab value data to improve the member’s health. Our care management team plays a vital role in administering the program, constantly providing important clinical input into the medication management process to maximize outcomes.

- Our focused approach has made this clinical program key in improving the overall care of the member.

- Members become eligible for the Fidelis Medication Therapy Management Program as their medical conditions and prescription histories warrant. Enrollment is automatic. Members may elect to opt-out of the program if they do not wish to participate.

Provider and/or Member Appeals

- Appeals are handled in Fidelis’ Corporate office. There is a formal mechanism for receiving, processing, reviewing and determining the outcome of all issues under appeal, both verbal and in writing. These issues may address initial determinations for inpatient or observation care, Part A skilled nursing facility care or outpatient procedures. This function allows both providers and members to communicate their dissatisfaction, concern or submit further information to have a determination reconsidered. Fidelis is sensitive to the needs of its customers and provides an unbiased review of any concern.
REFERRAL AND PRIOR AUTHORIZATION PROCEDURES

Prior Authorizations

Prior authorization is designed to promote the utilization of medically necessary services, to prevent unanticipated denials of coverage, to ensure that participating providers are utilized, and that all services are provided at the appropriate level of care for the member’s needs.

Please refer to the end of the chapter for a summary of services that require referral and prior authorization. Criteria for authorizing skilled nursing intervention are also included.

Member benefit plans change annually, so we advise that providers review benefit and authorization requirements or call local Fidelis resources prior to providing services. Fidelis benefit information can be found at http://www.fidelissc.com.

How to Obtain Prior Authorization

Fidelis providers can call or fax all prior authorization requests into the Utilization Management (UM) Department Care Coordinator 24 hours per day, 7 days per week utilizing the Service Request form.

The following information will be required for prior authorization processing:

- Member name
- Date of birth and/or social security number
- Facility name
- Requesting provider
- Referral provider
- Diagnosis
- Requested service with CPT code(s) and ICD-9 code(s)
- Clinical information for medical necessity including patient progress notes, labs and imaging as appropriate

Retroactive Authorizations Policy

Fidelis SeniorCare requires that providers request authorization for services prior to services being rendered.

Retroactive Authorizations

Fidelis SeniorCare may accept a request for retroactive authorization if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Fidelis SeniorCare) and is within fourteen days of the service OR
- One of the extenuating circumstances applies (Unable to Know or Not Enough Time)
Extenuating Circumstances

If your request for retroactive authorization qualifies under the guidelines above, you may submit your request to Fidelis SeniorCare Utilization Management via fax. If your request is more than fourteen days after the date of service, please indicate which of the below extenuating circumstances apply.

Extenuating Circumstances fall into two categories:

- Unable to Know Situation-The patient is not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services.
- Not Enough Time Situations-The patient requires immediate medical services and pre-authorization work cannot be completed prior to service delivery.

In each case, the provider is unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement. Fidelis SeniorCare will accept the request for authorization more than fourteen calendar days after services are delivered as long as the provider made the request prior to submitting the claim for payment and extenuating circumstances have been established.

Allow up to 30 calendar days for processing of retroactive authorization reviews.

Referrals for Specialty Care

The primary care physician (PCP) initiates and coordinates the referral management process to ensure that appropriate care is provided when medically necessary.

The UM Care Coordinator will schedule the appointment, arrange the transportation, if needed, and provide a telephonic authorization if required followed by a faxed authorization.

Continued Coverage of Care with Terminated Providers

- Continuation of care with terminated providers is covered if a member is undergoing an active course of treatment for an acute or serious chronic condition.
- If a member is receiving specialized services or an active course of treatment that should not be interrupted, the Medical Director will authorize care and services:
  - Through the lesser of the current period of treatment or for up to 90 calendar days for ongoing active treatment of a chronic or acute medical condition as long as the practitioner or provider agrees to provide on-going care (i.e. chemotherapy or facility specializing in vent dependent member) and the termination of the contract was not related to a professional review action. These time periods may be extended if Fidelis, in conjunction with the terminated provider, determines that safe transfer is not appropriate.
  - The Care Coordinator will conduct ongoing referral management throughout the course of treatment to prevent unauthorized services that would result in denial of claims payment.
If the need to alter the transition plan is identified and the provider is unwilling to transition the member back into the network, the Care Coordinator will forward the case to the Medical Director or designee who will make the final determination.

If the termination of the provider is a result of a professional review action, the Care Coordinator will work with the member or member’s representative to identify a new Care Team, specialist or provider, and facilitate and coordinate the transitioning of the member’s care immediately.

**Referrals to Non-Participating Providers or Non-Contracted Facilities In-Area**

Except in true emergencies, Fidelis provides coverage for only those services rendered by contracted providers and facilities. The exceptions are:

- Fidelis is notified and approves and authorizes the referral in advance. In these instances, the UM Department will issue an authorization for the services to be provided. Prior approval must be obtained by the PCP/provider recommending an out-of-plan referral before arrangements have been made for those services.
- The member’s medical needs require specialized or unique services available only through a non-contracted provider or facility. In this case, Fidelis will assist the referring provider in identifying specialists or facilities with the needed capabilities. Fidelis must authorize any such referral.

**Out-of-Area Outpatient Authorization**

Members are sometimes directed from an out-of-area physician to return to the out-of-area physician for a non-urgent, non-emergent follow-up visit. Members must be educated that such follow-up care is not covered unless authorized. Refer members to their Fidelis Evidence of Coverage (EOC). In these specific situations, the Fidelis Medical Director will be contacted to intervene and make applicable evaluations.

**Out-of-Area Inpatient Authorization**

Fidelis provides coverage to members if they require emergency or urgently needed services, as well as any services needed subsequently to ensure that they remain stabilized from the time a non-contracted medical provider or facility requests authorization from Fidelis until one of the following occurs:

- The member is discharged.
- The contracting medical provider arrives and assumes responsibility for the member’s care.
- The non-contracting medical provider and Fidelis agree to other arrangements.

In some cases, members may be directed from an out-of-area physician to return to the out-of-area physician for a follow-up visit if prior approval is obtained by the Fidelis UM Department.

**Denials and Letter Issuance**

Denials related to medical necessity are made by the Medical Director. The Medical Director or licensed physician designee will review and sign the denial based on medical necessity. Providers
will have the opportunity to discuss UM denial decisions with the Fidelis medical director, physician or behavioral health provider.

Notification letters may include:

- The specific reason for the denial
- The alternative plan of treatment and provider (if applicable)
- A reference to benefit provision (EOC language) or criterion on which the decision was based
- Citation of the Medicare coverage rule, as determined locally by the carrier or nationally or the accepted clinical standards used
- A description of appeal rights and the appeal process
- The telephone number for contacting Fidelis with questions and the plan member services phone number and address.
- Language that informs the provider that a physician or reviewing provider is available to discuss the denial and the telephone number of the reviewer making the denial decisions
Observation and Assessment are skilled services when the likelihood of a change in a patient’s condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient’s need for possible modification of treatment or initiation of additional medical procedures, until the patient’s treatment regimen is essentially stabilized. (Excerpt from the Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, 30.2.3.2 - Observation and Assessment of Patient’s Condition).

To meet criteria for Observation and Assessment, one or more of the following tasks must be needed and performed by licensed nursing personnel, (as appropriate to the illness and as discussed with the care team).

☐ 1. Patient Assessments and/or Monitoring (completed a minimum of one time per shift)
   - Vital Signs q shift
     ¼ Blood Pressure
     ¼ Respiratory Rate
     ¼ Pulse
     ¼ Temperature
   - Cognitive Status
   - Neurological Checks
   - Behavior Changes
   - Lung Sounds
     ¼ Check for decreased breath sounds
     ¼ Rales, rhonchi
   - Cardiovascular Assessment
     ¼ Check heart sounds for murmurs, palpitations, etc.
     ¼ Check for edema (lower legs, ankles)
   - Bowel Sounds
     ¼ Check for active vs. non-active
   - Intensive management of intake and output (i.e., I&O q 8 hours, forcing fluids, straight catheterization)
   - Skin Assessment
     ¼ Check for skin breakdown, tears, red areas
   - Pain Status

☐ 2. Monitoring response and/or titrating dose of medication over 24-48 hour period.

☐ 3. Diagnostic testing ordered and reported to the PCT, which will determine appropriate interventions. Adjustments to the plan of care anticipated.
Fidelis SecureCare
Criteria for Authorizing Part B Therapy Interventions

1. **Prior Authorization** is required for all therapy services.
2. Decisions based on **medical necessity**.
3. **Documentation** describing identified need for therapy services present in medical record.
4. Therapy services required on an **intermittent basis** (i.e. 3x/week for 2 weeks, 5x/week for 2 weeks).
5. Therapy services necessitate skills of a **trained and licensed therapist**.
6. Location of care based on **safety and availability of required resources** to administer services.
7. Therapy services **must be ordered by the physician**.
8. Members must make **continuous improvement** towards their prior level of functioning or maximum potential for coverage to continue beyond initial authorization period. Coverage determinations beyond the initial authorization period must be reviewed/approved by the health plan utilization department.

Y4 Members receiving skilled therapy interventions evaluated at least **weekly** by FSC CM with input from the primary care and therapy providers.

<table>
<thead>
<tr>
<th>Specific Criteria</th>
<th>Initial Authorization Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For this to be approved…</strong></td>
<td><strong>the following requirements and/or restrictions apply; exceptions must be approved by utilization management department.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part B Therapy Services</th>
<th>PT</th>
<th>OT</th>
<th>ST</th>
</tr>
</thead>
<tbody>
<tr>
<td>f</td>
<td>Documentation of an acute change in condition that causes deterioration in prior functional status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Shows an ability to tolerate and meaningfully participate in therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Documented progress toward goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Member <strong>must not</strong> have reached therapy cap for the year*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y4</td>
<td>$1840 for PT/ST per member per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y4</td>
<td>$1840 for OT per member per year</td>
<td></td>
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</tr>
</tbody>
</table>

*If cap reached, member must meet criteria for therapy exceptions per CMS.

Initial Evaluation; Plan of Treatment requires prior authorization prior to initiation.
### Specific Criteria

1. **Prior Authorization required** for all Part A Skilled Nursing and Therapy Services.
2. Decisions based on **medical necessity**.
3. **Documentation** describing identified skilled needs and services present in medical record.
4. Services required on a **daily basis**.
5. Services necessitate skills of a **trained and licensed professional**.
6. Location of care based on **safety and availability of required resources** to administer services.
7. Services **ordered by the physician**.
8. Initial Authorization Period **begins** the day services start.
9. Members must make **continuous improvement** towards their prior level of functioning or maximum potential for coverage to continue beyond initial authorization period. Coverage determinations beyond the initial authorization period must be reviewed/approved by the health plan utilization department.

### Specific Criteria

<table>
<thead>
<tr>
<th>Observation and Assessment (Attachment A)</th>
<th>For this to be skilled...</th>
<th>...the following requirements and/or restrictions apply; exceptions must be approved by utilization management department.</th>
<th>Initial Authorization Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without Antecedent Hospitalization</td>
<td>f Documented evidence of a significant acute change in baseline condition that requires one or more of the following interventions: Y4 Assessment/Monitoring a minimum of 1X/shift. Y4 Monitoring response/titrating dose of medication over 24-48 hours. Y4 Diagnostic testing ordered and reported to the PCP; appropriate follow-up interventions and adjustments to the plan of care made in response.</td>
<td>Up to 3 days</td>
<td></td>
</tr>
<tr>
<td>(3 day qualifying hospital stay not required)</td>
<td>f Following Hospital Stay</td>
<td>Limit to post inpatient admissions and condition must require the interventions outlined on Attachment A and as noted immediately above.</td>
<td>Up to 5 days</td>
</tr>
<tr>
<td>Colostomy/ileostomy Care</td>
<td>f Limited to new stomas; focus on teaching care management procedures to staff, as needed</td>
<td>Up to 5 days</td>
<td></td>
</tr>
<tr>
<td>IM Injections</td>
<td>f Must be given more than 1 time per day</td>
<td>Therapy duration</td>
<td></td>
</tr>
<tr>
<td>IV Administration</td>
<td>f Medication therapy, e.g., antibiotics</td>
<td>Therapy duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f Hydration therapy</td>
<td>Therapy duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f TPN therapy; focus on teaching care management procedures to staff, as needed</td>
<td>Up to 10 days</td>
<td></td>
</tr>
<tr>
<td>PEG Tube Care</td>
<td>f Limited to new PEG Tube feedings requiring stabilization: Y4 Caloric count, formula and rate of administration have not stabilized or; Y4 Enteral feeding has been initiated within the past 1-4 days</td>
<td>Up to 7 days</td>
<td></td>
</tr>
<tr>
<td>Suprapubic Catheter Care</td>
<td>f Limited to sterile irrigation, if daily</td>
<td>Therapy duration</td>
<td></td>
</tr>
<tr>
<td>Tracheotomy Care/ Naso-pharyngeal Aspiration</td>
<td>f Limited to newly inserted tracheostomies</td>
<td>Up to 7 days</td>
<td></td>
</tr>
<tr>
<td>Ventilator Dependency</td>
<td>f Limited to new ventilator dependency</td>
<td>Up to 7 days</td>
<td></td>
</tr>
<tr>
<td>Wound Care</td>
<td>f Stage 3 and 4 pressure ulcers; are not chronic and require: Y4 Debridement at least daily Y4 Sterile dressing changes at least daily Y4 Application of dressings involving prescription medications and aseptic technique at least daily</td>
<td>Therapy duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f Complicated post-surgical or vascular lesions requiring a minimum of daily dressing changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Therapy Services</td>
<td>PT OT ST f One or more therapy modalities required for a minimum of at least 1 hour per day (combined), 5 days per week plus one skilled nursing modality f Documentation of an acute change in condition that causes deterioration in prior functional status f Shows an ability to tolerate and meaningfully participate in therapy f Documented progress toward goals</td>
<td>Up to 7 days</td>
<td></td>
</tr>
</tbody>
</table>
Fidelis SecureCare
2015 Authorization Requirements for Covered Services

All services require a written order by the PCP/NP/PA and must be performed by a contracted/In-Network FSC provider, with the exception of Urgent/Emergent services. FSC will contract with an out-of-network provider if the service/specialty is not currently available in our network.

Covered Services **Not** Requiring Prior Authorization

- In-network Specialist visits do not require prior authorization
- Benefits not traditionally covered by Medicare - including those covered in the basket of benefits and OTC Services (Dental, Hearing, Vision)
- Diagnostic Tests (i.e., EEG, EKG, ultra sound)
- Emergency Ambulance Services* dispatched through 911 or its local equivalent
- Emergency Room Services* (Notification Required within ONE Business Day)
- Influenza (yearly), Pneumococcal and Hepatitis B vaccines
- Routine, yearly OB/GYN care, including mammogram screening, pap, pelvic, breast exams
- Routine yearly physicals
- Routine yearly retinal eye exams for members with diabetes
- Renal Dialysis Services
- Screening tests (Prostate, Colorectal, AAA, Bone Mass Measurement, Cardiovascular Disease, Diabetes, Glaucoma)
- Services performed on-site at the Nursing Facility, as follows (written PCP/NP/PA order as required by state licensing requirements):
  - Labs (i.e. WBC, CBC, urine/blood cultures)
  - Basic X-rays (i.e., Skeletal/chest x-rays, Doppler studies done on site)
  - Transportation, except 911
  - Elective (non-emergent) transportation (to and from a covered medical appointment)
- All air ambulance transfers
- Urgently Needed Services

Covered Services **Requiring** Prior Authorization

Specialist/Facility Service requests should be faxed prior to rendering services. The health plan will then evaluate for benefit coverage and will determine clinical/medical necessity.

- Inpatient Admissions and Continuing Stays
- Emergent Hospitalizations (Notification Required at the time of registration)
- Elective Hospitalizations
- Skilled Nursing Facility
- Hospital Observation Stays
- Partial Hospitalization Program
- Outpatient Surgery/Outpatient Procedures
- Outpatient Mental Health Services (not delivered on-site at Nursing Facility)
- Outpatient Specialist Visits (Non Contracted)
- Services provided by non-contracted provider
- Major Diagnostic Tests (i.e. MRI, CT, Endoscopies, Angiography)

*Emergency Services* are services provided after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that, in the absence of immediate medical attention, could reasonably be expected to result in: a) placing the patient’s health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.
**AUTHORIZATION/PRE-CERTIFICATION FORM**

**IMPORTANT**

* FAX completed AUTHORIZATION/PRE-CERTIFICATION FORM to (866) 596-1054.
* Phone number: (877) 372-6121
* Please submit supporting clinical documentation such as progress notes/labs/radiology.

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<th>PLEASE SELECT STATUS:</th>
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<td>☐ EXPEDITED REQUEST</td>
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**MEMBER INFORMATION**

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**REQUESTING PROVIDER INFORMATION**

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**SERVICING PROVIDER INFORMATION**

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**REQUESTED SERVICE INFORMATION**

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<th>DIAGNOSIS</th>
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**REASON FOR REFERRAL** (ATTACH CLINICAL HISTORY/PREVIOUS TREATMENT/PLAN OF TREATMENT, SUPPORTING LAB/X-REY REPORTS, ETC.)

Payment for services is dependent upon the Patient’s eligibility at the time services are rendered. Copays, co-insurance and/or deductibles may apply. To verify member eligibility and/or benefits please call 1-877-372-8085. Pre-Certification valid for the date range approved by Fidelis SecureCare.

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.
BILLING AND PAYMENT

CLAIMS

To submit a paper claim
Send claims to Fidelis at the following address:

Fidelis SecureCare
P.O. Box 3597
Scranton, PA 18505

To submit an electronic claim
If you presently submit your claims through an electronic clearinghouse, you may continue to do so. Fidelis uses Emdeon as its clearinghouse for electronic claims. To set up electronic claim submission with Fidelis please contact Emdeon at the number below:

Emdeon
Fidelis Payor ID is #77054
1-877-819-3267

Fidelis Claim Payment Guidelines

- Fidelis will pay “Clean” Claims for health services provided to a member in accordance with the contractual agreement. Clean claims are defined by the Medicare Claim Processing Manual (IOM) Chapter 1.
- Fidelis will pay clean claims within a maximum of 30 days of when they are received. Providers should allow for an additional 3-5 days for processing and mailing of checks.
- Fidelis will automatically deny “Unclean” claims submitted by contracted providers.
- Except as noted in the member’s annual benefit plan, Fidelis will follow Medicare guidelines for claim adjudication and payment.
- Providers should submit claims electronically and include all required information including provider’s Medicaid ID and member’s Medicaid ID to facilitate Fidelis’ ability to perform cross over billing to state Medicaid programs.

Remittance Advice (RA)

- Payments received from Fidelis will include multiple claims for multiple members who received services from the physician/provider. Each check will be accompanied by an RA. The RA may include any of the following:
  - Members / claims to which the RA applies
  - Submitted charges
  - Contractual allowances
  - Co-pays and deductibles
  - Amount paid
  - Denials and reason for denial
  - Explanation of claim handling
Provider Billing and Collecting Requirements

- Unless otherwise specified in the Fidelis contract, Fidelis providers must file claims with the plan within forty five (45) days of the date of service or from the date of notice of benefit determination rendered by a third party. Fidelis will not be required to pay claims submitted after 365 days.
- Physicians and other health care providers should submit claims for health services to Fidelis using the appropriate claim form (CMS 1500 Claim Form for outpatient services; UB04 Claim Form for in-patient services, or their electronic equivalent).
- The physicians / other health care providers cannot bill the member for covered health services provided if the physician / other health care provider failed to submit a claim.
- The member cannot be balance billed for services covered under the contractual agreement at a predetermined contracted rate.
- If there are any co-payments identified, the co-payment should be either billed to the member’s secondary insurance or collected directly from the member if the member does not have any secondary insurance.
- If a claim is filed within the time period allowed and the service is a Fidelis liability, the claim must be paid by Fidelis even if the contract between the provider and Fidelis is no longer in effect; or if the member has terminated his/her Fidelis membership, provided that the member's eligibility was effective at the time that the service(s) were rendered and that the service was a covered benefit through Fidelis.

Appealing a Claims Payment or Denial

Note: This process should not be used for appealing services that were denied) Providers needing adjustments on claims that were previously paid or denied in error may contact the Fidelis Customer Service Department at 1-877-372-8085 or; submit a copy of the claim along with a written request containing the following:

- Provider name, provider ID number and provider billing address
- Claim number of original claim (from provider remittance advice).
- Member name
- Member ID number
- Date(s) of service
- Indicate telephone number and name of contact person in your office if we have questions or need additional information

Claims Information Online

- The Fidelis provider portal now allows you to access member eligibility and claims information online, 24 hours a day, seven days a week.

Logging-In

Claims Look-up

- Once logged in, you may select “Claims Look-up” from the menu of options at the top of the screen. Upon selecting “Claim Look-up” you can research claims status and history by member information or claims information as follows:

  - **Subscriber ID or First Name, Last Name and D.O.B:** OR
  - **Claim ID or Status and Date Range**

  ![Claims Look-up](image)

- You may also go directly to claims history from the member eligibility screen. Please see the Eligibility section.

Once you have entered your search criteria, the list of possible matches will appear. Double click on the claim in question to review claims details.

**Claims Examples**

![Claims Example 1](image)

![Claims Example 2](image)
CLAIMS DISPUTES AND APPEALS

Appealing an Organization Determination

The appeal process for contracted practitioners or providers applies to UM denial determinations that are adverse for the practitioner or provider, but not adverse to the member. The UM team assumes that the practitioner or provider is acting strictly on his/her own behalf when requesting the appeal when the member has no financial risk for the service denied.

Examples of UM denial determinations included in the scope of this policy include:

- Contracted provider appeal of denied standard pre-service request, member has not received the requested service, therefore has incurred no financial risk
- Contracted provider appeal of denied post service request, member is not financially at risk, i.e. denied inpatient admission at a contracted facility

The contracted provider must submit the appeal request in writing to the following:

Phone: 1- 847- 592-9483

Email: appeals@fidelissc.com

Mail: Fidelis SecureCare
Appeals Dept.
2030 Main Street, Suite 600
Irvine, CA 92614

The written request must include supporting medical documentation. This documentation will be reviewed by the Medical Director and a written determination will be mailed within 30 days of the receipt of the appeal. This determination will be final.

Claim Disputes

Providers have the right to dispute the manner in which the claim was processed or paid.

Provider Dispute

There are two levels to the provider dispute process:

1) The provider can contact the claim inquiry call center at 1- 877-372-8085. The claims team will review the provider dispute and either re-process the claim or uphold the claims processing determination. The provider will be notified of the determination via returned call or updated remittance advice report.

2) The contracted provider must submit the appeal request via email or in writing by mail as indicated above.
FREQUENTLY ASKED QUESTIONS

1. **How does Fidelis reimburse for Part A skilled nursing services?**
   The facility may submit either charges or contracted rates to Fidelis, but claims will be adjusted based on the contract between Fidelis and the facility.

2. **Can the nursing facility or other providers bill Fidelis for DME?**
   Fidelis follows Medicare guidelines for determining if DME benefits will be covered. Currently, DME is covered to the extent that it is provided in the patient’s *home*. Nursing facilities are generally excluded from Medicare’s definition of *home*. In addition, DME provided during the same Part A “spell of illness” as skilled services is included in the PPS rate and cannot be billed separately to Fidelis.
   
   Prosthetics and orthotics may be reimbursable when billed by the original provider (i.e. not the nursing facility).

3. **Do I need to place my Authorization Number on the claim form?**
   Yes, authorization numbers should be included on each claim form. They should be added to Box 63 on the UB04 and Box 23 on the CMS 1500 or the electronic equivalents.

4. **How to bill Non-Emergent Transportation Services?**
   Non-emergency, routine wheelchair transportation services should be billed using HCPCS code A0130 for each round trip. When wait times are included in contracts, they should be billed using HCPCS code A0170. HCPCS codes should be placed in Field 24d on the CMS 1500 form.
   
   Use the standard Medicare ambulance transportation modifiers attached to the A0130 to indicate the “To/From” information.

5. **Does Fidelis enroll hospice patients?**
   Yes, Fidelis SecureCare can enroll a prospective member even if they are a Hospice patient. However, when a prospective member enrolls in a Medicare-certified hospice program, the hospice services and Part A and Part B services related to the enrollee’s terminal condition are paid for and managed by original Medicare, not Fidelis SecureCare.
   
   An enrollee must get care from a Medicare-certified hospice. It should be clear to the enrollee that most of Fidelis clinical benefits such as extra physician visits could be contrary to the hospice plan of care.

6. **Can SNFs bill Traditional Medicare for a Part A skilled stay for a member who was enrolled with Fidelis, then dis-enrolled, even though there was no 3-day qualifying hospital stay?**
   SNFs should bill claims to their Fiscal Intermediary using Condition Code 58 if they are seeking Part A reimbursement for a former MA member, who dis-enrolled, when there was no 3-day qualifying hospital stay.
7. **Does Fidelis cover routine Blood Glucose Testing?**

   Fidelis follows Medicare guidelines. Medicare does not pay for blood glucose tests unless the physician is actively involved in analyzing the result of each test.

8. **How is a benefit period calculated?**

   A benefit period begins on the first day a member goes to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when the member has not been an inpatient at any hospital or SNF for 60 days in a row. If the member goes to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a member can have. The type of care members actually get during the stay determines whether they are considered an inpatient for SNF stays, but not for hospital stays.