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SWH
SENIOR WHOLE HEALTH
Simple. Secure. Independent.

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Section 1	Introduction

1.1 PURPOSE

Welcome to Senior Whole Health (SWH)!
The purpose of this Provider Manual is to give to our providers and their administrative and billing staff ready access to the information they need to efficiently and effectively care for our members and to conduct business with SWH.

1.2 OVERVIEW OF SENIOR WHOLE HEALTH

Senior Whole Health is a Medicare Advantage Special Needs Plan (MA-SNP) specifically designed to meet the needs of the poor elderly who qualify for Medicare and MassHealth. SWH coordinates all the Member's Medicare, MassHealth, and Medicare Part D Prescription Drug benefits as a single integrated benefit.

Senior Whole Health assigns a Nurse Care Manager to each PCP and Members to manage all of benefits including medical, behavioral, prescription drug, vision, and dental. Additionally, SWH coordinates a wide range of social and non-medical community-based services in order to enhance a Member's health and ability to live independently.

The SWH program in Massachusetts serves Members who reside in the following counties: Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

1.3 SWH MISSION STATEMENT

Our Mission is to maximize the quality of life, health, security and independence of our Members.

1.4 WHEN THIS MANUAL AND YOUR CONTRACT DIFFER

The Provider Manual is a supplemental document to your contract with Senior Whole Health. It provides detailed information to answer many of the day-to-day operational questions about SWH, our product, our members and your relationship with us. In cases where your contract and this document differ, the contract takes precedence.

1.5 ORGANIZATION OF THIS MANUAL

Each section is organized to answer the most commonly asked questions first. All forms and work aides can be found in the Appendices. Within each section, hyperlinks are provided to the referenced forms and aides.

The manual is organized for ease of use. We recommend that the reader take a few minutes to familiarize him/herself with the table of contents. Having done so will help tremendously when a quick answer is needed.

Each section of the manual, and each form and aid, is updated independently. The date of update, if any, is noted. Each section and each form and aid is reviewed at least annually. For the most current version of any section, web access is recommended.

Section 2 Compliance

2.1 OUR COMMITTMENT

Senior Whole Health (SWH) is committed to compliance with regard to member protections as well as regulatory and contractual relationships. The structure of the Compliance Plan at Senior Whole Health remains steadfast; however the Plan itself is constantly evolving. In addition to standard compliance oversight, we continually make it more robust by incorporating activities into our daily work that include: communication to enhance awareness, trainings and spot audits. These activities provide two important results. Primarily, it drives the culture at SWH by establishing the expectation of compliance in our daily work and thus drives how we do business. Second, it allows us to assess our work and determine how we can consistently improve our processes.

2.2 REGULATION FOR FRAUD WASTE AND ABUSE TRAINING

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage-Prescription Drug (MA-PD) health plans like SWH to ensure their participating providers complete Fraud, Waste, and Abuse training no later than December 31, 2009 and annually thereafter.

Effective June 7, 2010, providers who have met the fraud, waste and abuse certification requirements through enrollment in the Medicare program are deemed to have met the training and educational requirements for fraud, waste and abuse.

Providers who need to fulfill the training requirements should go to http://www.hcasma.org and click on Medicare Training. HealthCare Administrative Solutions (HCAS) has created this website, which includes an online training program to be completed by providers.

- **Senior Whole Health Fraud Waste an Abuse Hotline**

SWH has implemented the following Compliance Hotline where our employees and contracted providers can report suspected fraud, waste and abuse anonymously.

SWH Compliance Hotline: 866-260-2456

- **Agreement to abide by CMS Guidelines**

Contracted providers agree to comply with all Medicare and/or MassHealth guidelines as outlined in the provider contract.

2.3 REGULATORY COMPLIANCE INFORMATION FOR ALL CONTRACT PROVIDERS

Because Senior Whole Health is a Medicare Advantage Special Needs Plan (MA-SNP), SWH contracted providers ("Contract Provider") are required to adhere to the following federal, State and Medicare Advantage provisions which are incorporated into SWH's and Contracted Provider's ("Parties") Agreement:

- **ANTI-DISCRIMINATION FEDERAL FUNDS**

  - Contracted Provider agrees not to discriminate against a Member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

  - SWH hereby notifies Contracted Provider that payments received under the Agreement are from federal funds. Contracted Provider is obligated to comply with all laws applicable to individuals and entities receiving federal funds, including without limitation (I) the Civil Rights Act of 1964, (ii) the Age Discrimination Act of 1975 and (iii) the Americans with Disabilities Act.

➢ HIPAA

- Each Party agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and the implementing regulations under HIPAA and HITECH, as modified from time to time. Furthermore, SWH reserves the right to audit, no less than once every three (3) years, Contracted Provider's written information security program to determine such program meets the requirements of the security regulations issued under HIPAA and/or HITECH.

➢ CERTIFICATION REGARDING LOBBYING

- Contracted Provider agrees that no federally appropriated funds have been paid or will be paid to any person by or on behalf of Contracted Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. Contracted Provider agrees to complete and submit, if required, a "Certification Regarding Lobbying" if payments to Contracted Provider by SWH under this Agreement exceed $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement, and payments to the contractor by SWH under this Agreement exceed $100,000, Contracted Provider shall complete and submit, if required, Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

- Contracted Provider shall include in its subcontracts that exceed $100,000 a provision substantially similar to this Section, including the requirement that a subcontractor shall certify and disclose as required.

FRAUD AND ABUSE PREVENTION; WHISTLEBLOWER PROTECTION

- In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), Contracted Provider shall comply with SWH's Fraud and Abuse Prevention Policy, as revised from time to time by SWH. Contracted Provider shall make available to all employees and agents, and, to the extent required by DRA, his or her contractors a copy of the SWH Fraud and Abuse Prevention Policy, including specific discussion of the provisions of the SWH Fraud and Abuse Prevention Policy, in an employee handbook, if such agent or contractor has an employee handbook.

NON-DISCRIMINATION

- Contracted Provider shall provide services to Members on the same basis as it provides services for all other patients and Contracted Provider may only deny, limit or condition the provision of services to a Member on the same grounds as it denies, limits or conditions the provision of such services to others, subject to any applicable SWH policies or terms of Agreement. Contracted Provider shall provide Covered Services to Members in a culturally competent manner, including Members with limited English proficiency; limited reading skills and Members with diverse cultural and ethnic backgrounds.

MEDICARE ADVANTAGE PROVISIONS

- Contracted provider agrees to comply with the provisions of Attachment "A", which is expressly incorporated into the Agreement and is binding upon the Parties to the Agreement.

➢ COPAYMENTS, COINSURANCE AND DEDUCTIBLES

- In accordance with 42 CFR §422.504(g)(1)(iii), effective January 1, 2010 should SWH be required to impose copayments, coinsurance or deductibles (collectively "Member Expenses") for Covered Services for Medicare Part A and B services Members eligible for both Medicare and MassHealth ("dual eligible Members"), the amount collected for Member Expenses may not exceed the amount that could be collected had Member otherwise been enrolled in original Medicare and MassHealth. Dual eligible Members will not be responsible or billed for any Member Expenses for Medicare Part A and B services when the MassHealth program or SWH is responsible for paying Member Expenses. If the State is responsible for paying those amounts, Contracted Provider may accept SWH payment as payment in full or bill MassHealth.

➢ INTERPRETATION

- In the event of any inconsistency between the Provider Manual Section 2.3 and the Agreement, the Parties agree that the terms of Provider Manual Section 2.3 shall control.

- Except as modified by the terms of Provider Manual Section 2.3, all terms, conditions, and provisions of the Agreement shall remain in full force and effect.

Section 3 Quick References

The SWH Quick Reference Guide is available in job-aid format to answer most commonly asked questions. It lists key telephone numbers, FAX numbers, and Web contact information for most commonly needed resources.

Additional information on the Quick Reference topics is provided in the appropriate sections of this manual. The Quick Reference Guide is found in the Appendix.

3.1 HOW TO CONTACT SWH

The Provider Relations Department is the provider's contact for most communications with SWH. If a representative cannot help you directly, he/she will connect you with the department best able to handle your question or concern.

Contact	Info
Provider Call Line	617-494-5353 Ask for Provider Relations Staffed Monday through Friday 8:00 AM - 5:00 PM (checked hourly for messages; calls returned within one business day
Provider Relations email	providerrelations@seniorwholehealth.com
Member Care Coordination	Contact the Member Services at 888-794-7268.
Clinical Services	Clinical team may be reached at 888-794-7268.
Secure email	If you wish to email PHI (Protected Health Information) and do not have a secure email service, call Provider Relations and ask that a secure email be sent to you to establish a link.
FAX	617-494-5599 Attn: Provider Relations
US Mail	Senior Whole Health 58 Charles Street Cambridge, MA 02141 Attn: Provider Relations
Member Services Line	888-794-7268 After hours, Member-specific urgent matters.

3.2 HOW TO CONTACT SWH SUB-CONTRACTED VENDORS

SWH uses several vendors to administer certain benefits:

- **Behavioral Health** – Value Options: 866-300-0217
- **Dental** – DentaQuest: 800-341-8478
- **Vision** – Vision Service Plan (VSP): 800-615-1883

Section 4	Referrals & Authorizations.

4.1 REFERRALS & AUTHORIZATIONS

Senior Whole Health does **not** require referrals for network specialists. Please refer to the SWH Provider Directory. **Authorizations are required for non-participating specialty physicians and for some service types**. Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization.

4.2 NON-PARTICIPATING PHYSICIANS AUTHORIZATIONS

Referrals to non-participating physicians require an authorization. The Senior Whole Health participating physician directory is available on our website.

To request services by a non-participating physician, complete and fax the SWH authorization form to the confidential Clinical fax at 617-494-5554. A copy of the form can be found in the Appendix. The completed authorization form will be returned via FAX within two (2) business days.

4.3 DURABLE MEDICAL EQUIPMENT (DME) AUTHORIZATIONS

All DME, with the exception of disposable medical and surgical supplies (such as latex gloves) and support stockings, requires authorization. DME services must be authorized verbally by the Nurse Care Manager responsible for the member's care management.

To request DME authorization, call the Provider Relations Department at 617-494-5353. A representative will forward your call to the appropriate Nurse Care Manager. Nurse Care Managers return authorization calls within two (2) business days. The Nurse Care Manager enters the authorization number into SWH's centralized enrollee record. Providers need not submit the authorization number when billing SWH.

If a DME item or service is urgently needed, please inform the Provider Relations Representative; he/she will direct the call to a Nurse Care Manager supervisor for an expedited authorization.

4.4 HOME HEALTH AUTHORIZATIONS

All home health services require an authorization.

To request authorization for home health services, complete and fax the Universal Home Health Authorization form to the confidential Clinical fax at 617-494-5554. A copy of the form can be found in the Appendix. The completed authorization form will be returned via FAX within two (2) business days.

4.5 OTHER SERVICES REQUIRING AUTHORIZATION

Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization.

To request authorization for any other service type for which authorization is required, complete and FAX the SWH authorization form to the confidential Clinical fax at 617-494-5554. A copy of the form can be found in the Appendix. The completed authorization form will be returned via FAX within two (2) business days.

4.6 RETROACTIVE AUTHORIZATIONS

To request a retroactive authorization for any service for which authorization is required, complete and FAX the SWH authorization form to the confidential Clinical fax at 617-494-5554 and provide a detailed explanation regarding why the authorization is needed on a retroactive basis. For services provided more than fourteen days prior to the request, the claim may be submitted, denied by SWH, and then appealed.

4.7 INPATIENT (ACUTE HOSPITAL) AUTHORIZATION

Authorizations for elective inpatient stays should be obtained prior to the admission. For non elective stays, the authorization should be obtained the next business day after the admission.

Inpatient authorizations must be called in to: 617-252-6357. Information may be left as a recorded message. Include: caller name and phone number, member name and member SWH ID, date of admission. A SWH discharge planner will return the call within one (1) business day.

4.8 PHARMACY AUTHORIZATIONS

A small number of drugs require a prior authorization. Other exceptions to the standard formulary require specific documentation. Refer to Section 8. Pharmacy: Requesting an Exception for instructions specific to the situation.

Section 5 Claims

5.1 HOW TO SUBMIT A CLAIM

Claims should be submitted following CMS claims submission policy and guidelines unless your contract specifies otherwise. For MassHealth services, follow MassHealth claims submission policies and guidelines.

Additional service specific claims submission guidelines may be found in Section 6 - Payment Policies.

Senior Whole Health accepts claims in paper or electronic format.

EDI is the preferred claims format for faster turnaround time and efficient payment. SWH accepts EDI claims through EMDEON in the standard 837 format. Providers should work directly with their clearinghouse or billing service to ensure successful claims transmission to EMDEON.

Type	Format	Submit to:
EDI – Institutional claims	HIPAA Compliant *837-i* format	EDI Payer ID 83035
EDI – Professional Claims	HIPAA Compliant *837-p* format	EDI Payer ID 83035
Paper	CMS -1500 or UB - 04	Senior Whole Health Claims Department P.O. Box 425027 Cambridge, MA 02142
Paper – Claims requiring additional documentation	CMS -1500 or UB – 04 and any additional documentation	Senior Whole Health Claims Department P.O. Box 425027 Cambridge, MA 02142
SWH EDI Help Desk 617-551-4155		

The claims department accepts claims inquiry calls between the hours of 9 AM – 5 PM at 866-233-4773

5.2 TIMELY FILING

A Clean Claim must be submitted within 90 days of the date of service or discharge.

5.3 INTERIM BILLING

When a Member's care is ongoing a claim must be submitted within 90 days after the last day of the month. SWH requests that the provider bill every 30 days. The final bill must be received within 90 days of the last date of service. Interim billing may be used for inpatient hospital admissions, skilled nursing facility admissions, hospice admissions and other types of ongoing care.

5.4 CLAIMS SUBMITTED TO AN INCORRECT CARRIER

In the case that a claim is submitted to, and denied by, an incorrect carrier, a claim should be submitted to SWH within 90 days after the denial by the incorrect carrier. A copy of the incorrect carrier's Explanation of Payment, showing the denial, must be submitted with the claim. SWH requires that the claim and supporting documentation be submitted together in paper format with a Provider Payment Dispute and Adjustment Request Form.

5.5 CLEAN CLAIMS

SWH defines a Clean Claim as: a claim that has no defect, impropriety, lack of substantiating documentation, and which complies with standard CMS coding guidelines, and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely.

To be considered a clean claim by SWH, all claims must be submitted on the appropriate claim form, either a CMS-1500 or UB-04, or alternative electronic format and have the required fields completed. Electronically submitted claims must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions.

The following information is required for all claims:

Member Information:

- Member's name
- Member's date of birth
- Member's Senior Whole Health Member Identification Number

Provider Information:

- Servicing provider name
- Servicing provider address
- Servicing provider's NPI Number
- Billing provider's group name and address (if applicable)
- Billing provider's NPI number
- Billing provider's federal tax identification number (TIN)
- The TIN and NPI number combination must match the W-9 information on file with SWH.

Service Level Information:

For each procedure, the claim must have:

- Date of service
- Complete diagnosis codes (ICD-9 CM)
- Place of service/Bill type
- Procedure code (CPT-4, HCPCS, or successors) and/or Revenue code
- Units
- Charge
- Modifiers as required

5.6 NON-CLEAN CLAIMS

A non-clean claim is a claim that requires corrected data, additional information or investigation in order for it to be processed. The following are considered non clean claims:

- Claims to be investigated for coordination of benefits, subrogation or worker's compensation.
- Claims that require medical records for processing.
- Claims that include billing for non Covered Services.
- Claims that include billing for unlisted procedures.
- Claims lacking any of the required elements of a Clean Claim.

5.7 CLAIMS SUBMISSION REQUIREMENTS

To be accepted by SWH's clearinghouse, EMDEON, a claim must include all required elements and coding must meet HIPAA standards. Paper claims that do not meet these same standards will be returned to the provider

5.8 CORRECT CODING INITIATIVE (CCI)

Claims should be billed in accordance with CMS's Correct Coding Initiative (CCI) guidelines. Senior Whole Health processes claims utilizing CCI-based claims edit software and may deny services that do not conform to CCI guidelines. Because SWH coverage includes MassHealth as well as Medicare services, overrides allow some services typically denied by Medicare to be paid by SWH.

Refer to Section 6 Payment Policies for coding instructions for specific types of services.

5.9 CLAIM PAYMENT

SWH processes, and pays or denies, all claims for Medicare services within 60 days of receipt of a Clean Claim. SWH processes, and pays or denies, all claims for MassHealth services within 45 days of receipt of a Clean Claim.

5.10 REMITTANCE ADVICE

A remittance advice is sent with all claim payments. The remittance advice addresses paid and denied, but not pended claims. See the Appendix for an annotated remittance advice.

5.11 CLAIMS STATUS INQUIRIES

Providers may inquire on the status of a claim by calling the Claims Department**. It is requested that providers allow at least 30 days from the date the claim was sent to SWH before making a claims status inquiry telephone call.**

5.12 CLAIMS ADJUSTMENT REQUESTS

Requests for claims adjustments do not require an appeal. Valid claims adjustments include:

- Claims denied for lack of prior authorization when the provider has evidence of prior authorization, telephone adjustment requests are accepted.
- SWH paid the claim incorrectly, for example: a claim was submitted for purchase of a wheelchair and SWH paid for a rental.
- Claim was billed incorrectly. Corrected claims are subject to the timely filing limits of the original claim received.
- Claim was denied for timely filing, and the provider has evidence of timely filing.

To make a claims adjustment request, use the Provider Payment Dispute and Adjustment Request Form.

5.13 CLAIMS APPEALS

A claim appeal is a provider's written notice to SWH challenging, contesting, appealing, or requesting reconsideration of a claim or a bundled group of substantially similar multiple claims that are individually numbered that have been denied, or adjusted.

Claims appeals include:

- Seeking resolution of billing determination (adjusted, denied, paid incorrectly or overpaid).
- Disputing a request for recovery of overpayments.

Claims appeals do not include:

- Seeking resolution of a contractual issue.
  Payment disputes wherein the provider believes that SWH is paying an amount different than was contractually agreed should be directed to the Provider Relations Department at 617-494-5353.

- An appeal made by a provider on behalf of a specific Member.
  These are considered Member appeals. Appeals on behalf of a specific Member should be directed to the Quality Department at 617-494-5353. See Section 7: Membership and Eligibility for more information on filing of Member appeals.

- Incomplete or incorrect claims.
  If a claim is found to be incomplete or incorrect, the claim will be denied and an appropriate reason code will appear on the remittance advice. For example, an NPI number and provider name may not match, or a quantity may not have been specified when one was required. The claim may be resubmitted with the requested information.

Senior Whole Health does not discriminate or retaliate against a provider because the provider has filed an appeal.

5.13.1 HOW TO SUBMIT CLAIMS APPEALS AND ADJUSTMENT REQUESTS

Claims appeals must be submitted in writing to the SWH claims department. Appeals can be made on SWH's claims appeal form.

- **Via US mail:** **Claims Operations Department**
PO Box 425027
Cambridge, MA 02142
- **Physical Delivery:** **58 Charles Street**
Cambridge, MA 02141
- **Secure Email:** **claimsdept@seniorwholehealth.com**

All provider appeals must include:

- Provider's tax identification number.
- Provider's contact information (an individual person's name and phone number).
- A clear identification of the appeals item.
- The remittance advice (or the member name, date of service, CPT or HCPC codes, original claim number).
- Authorization number (if authorization was required).
- A clear explanation of basis upon which the provider believes the payment amount (denial or adjustment) the request for additional information, the request for reimbursement for the underpayment of the claim, or other SWH action is incorrect.

When submitting multiple batches of claims appeals:

- Sort appeals by similar issue or by individual member name.
- Provide cover sheet for each batch.
- Number each cover sheet.
- Provide a cover letter that gives a summary description of all the batches.

5.13.2 INCOMPLETE PROVIDER APPEALS

Provider appeals that do not include all required information as listed above will be returned to the submitter for completion. Appeals will be closed if complete information, as requested, is not received within 30 days of the request for additional information.

5.13.3 TIMELY SUBMISSION OF APPEALS

Provider appeals must be received by SWH within 45 days from the date of the Remittance Advice. Provider appeals regarding SWH notice of overpayment must be submitted within 45 days of receipt of the notice of overpayment of a claim.

5.13.4 RESOLUTION OF APPEALS

SWH will resolve each provider appeal within 45 days of receipt of a complete appeal. SWH will reply to the provider via Remit (if claim is going to be paid), or by letter that the Appeal for the denied claim is not being considered for an adjustment.

5.14 COORDINATION OF BENEFITS AND SUBROGATION

Coordination of Benefits:

- If claims are subject to recovery through coordination of benefits or subrogation activity, claims must be submitted to Senior Whole Health within eighteen (18) months of date of service. A copy of the Explanation of Payment from the primary carrier must be included with the claim. It is the provider's responsibility to ask Members if they have additional coverage and to report this information to Senior Whole Health on the claim forms. Providers must follow standard procedures for pre-authorization regardless of secondary responsibility.

- Submit COB claims to:

  Senior Whole Health
  Claims Department
  P.O. Box 425027
  Cambridge, MA 02142

- Senior Whole Health coordinates benefits and third party liability for its Members as a contractor with Medicare and MassHealth. As such, SWH is the payer of last resort. Worker's Compensation, automobile liability insurance and other health and long-term care insurance are primary to Senior Whole Health.

Subrogation:

- If a Member has a fall, physical injury due to an automobile accident, non-automotive accident or injury due to product liability, or other such conditions, Senior Whole Health has the right to recover the costs for which a third party is responsible. Senior Whole Health works directly with the Member or the Member's attorney in these cases.

- Bill Senior Whole Health directly for medical services. SWH will coordinate directly with the Member and the Member's attorney.

5.15 AUDIT, ADJUSTMENTS AND RIGHT TO RECOVERY OF OVERPAYMENTS

SWH conducts periodic audits of claims. Audits may encompass any claims with dates of payment within two years prior to the date the audit was commenced. In cases of suspected fraud, waste or abuse, audits may encompass a longer time frame. Providers must provide any additional information requested by SWH within fifteen (15) days of such a request.

SWH will give written notice to providers of any recoveries fourteen (14) days before such recoveries.

Recoveries may include offsets of future payments.

Providers may appeal the results of any audit findings within 45 days of receipt of notice of overpayment.

Section 6	Payment Policies & Service Requirements

6.1 INTRODUCTION

As a general rule, SWH requests that its participating providers follow the Medicare or MassHealth guidelines that govern the services rendered. In other words, if the services provided are Medicare services, they should be billed following Medicare guidelines; if the services provided are covered by MassHealth, the service requirements as prescribed by MassHealth should be adhered to, etc.

This section includes the payment policies and service requirements for which SWH requests its providers follow that either differ from, or are in addition, to Medicare or MassHealth guidelines.

6.2 AMBULANCE REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to eligible provider or supplier of ambulance services to SWH members. SWH benefits coverage and billing guidelines are based on Medicare and/or MassHealth benefit coverage and billing guidelines.

Benefit Overview:

SWH covers medically necessary and reasonable ambulance services in accordance with Medicare benefit coverage. In addition, SWH covers wheelchair van transport and mileage in accordance with MassHealth benefit coverage.

Definitions:

- *Ambulance Vehicle*: Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in non-emergency situations, be capable of transporting SWH Members with acute medical conditions. The ambulance must have customary patient care equipment and first aid supplies, including reusable devices and equipment such as backboards, neck boards, and inflatable leg and arm splints. These are all considered part of the general ambulance service and payment for them is included in the payment rate for the transport.
- *Reasonableness of the Ambulance Trip*: Payment shall be made in accordance with the level of medically necessary services furnished, not based on the vehicle used, including if a local government requires an ALS response for all calls.

Billing Requirements:

Medically necessary ambulance services must be billed with the appropriate HCPCS code to reflect level of service. In addition, applicable ambulance origin and destination modifiers must be used with the procedure codes listed in the contract's Ambulance Reimbursement Rates and Terms.

Prerequisites:

Prior authorization is required for wheelchair van transport (A0130.)

Payment Guidelines:

The information provided in no way represents a guarantee of payment.

Reimbursement is limited to the services listed in the contracted Ambulance Reimbursement Rates and Terms.
No additional services will be reimbursed other than those services contracted.

6.3 CHIROPRACTIC REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to eligible providers of chiropractic services to SWH Members. SWH benefits coverage and billing guidelines are based on Medicare and/or MassHealth benefit coverage and billing guidelines.

Benefit Overview:

SWH covers medically necessary manual manipulation of the spine to correct subluxation in accordance with Medicare benefit coverage. An additional twenty (20) medically necessary routine visits per calendar year in accordance with MassHealth's chiropractic coverage and service limitations.

Definitions:

- *Chiropractor*: One who is licensed to practice chiropractic manipulation to correct interference with spinal nerves by adjusting the spinal column.
- *Routine Visit*: Office visit or an office contact during which a chiropractor provides a session of chiropractic manipulative treatment.

Billing Requirements:

Medically necessary manual manipulation of the spine to correct subluxation must be billed with CPT codes 98940, 98941, or 98942 in conjunction with modifier AT and appropriate diagnosis codes.

Medically necessary routine visits must be billed with the appropriate CPT codes to reflect the Evaluation and Management Services, Chiropractic Manipulative Treatment and/or Diagnostic Imaging Services listed in the contract's Chiropractic Services Reimbursement Rates and Terms.

Payment Guidelines:

The information provided in no way represents a guarantee of payment.

Reimbursement is limited to the services listed in the contract's Chiropractic Services Reimbursement Rates and Terms.
No additional services will be reimbursed when a CPT code is billed in conjunction with the AT modifier.
Evaluation and management service provided on the same day as a chiropractic manipulative treatment are not reimbursed.

Services provided by chiropractic assistants (CAs), massage therapists, or other unlicensed providers, even when performed under the direct supervision of a licensed chiropractor are not eligible for reimbursement.

Diagnostic imaging services are limited to plain film x-ray and must be related to the purpose of the diagnostic visit to confirm a neuromusculoskeletal condition for treatment. The imaging service must be performed and developed in the chiropractor's office and read by the servicing chiropractor.

6.4 PODIATRY REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to eligible providers of podiatry services to SWH Members. SWH benefits coverage and billing guidelines are based on Medicare and/or MassHealth benefit coverage and billing guidelines.

Benefit Overview:

SWH provides coverage for foot care services that are necessary for the diagnosis and treatment of a foot condition, illness, injury or to improve the functioning of the foot; or a service performed in the absence of localized illness, injury, or symptoms involving the foot.

SWH also provides coverage for medically necessary foot care services rendered in a SWH Member's private home. Providers are required to bill the appropriate CPT code for these services: (99341-99345 or 99347-99350).

In addition to Medicare and/or MassHealth benefit coverage, SWH covers the following routine foot care for up to six (6) visits per calendar year, in the absence of underlying conditions (sometimes referred to as "hygienic foot care"):

•Cutting or removing of corns and calluses

•Trimming, cutting, clipping or debriding nails including mycotic nails

•Cleaning and soaking feet

•Applying creams or topical medications

Prerequisites: N/A

Definitions:

Podiatrist: A podiatrist is a doctor of podiatric medicine (DPM), also known as a podiatric physician or surgeon, qualified by their education and training to diagnose and treat conditions affecting the foot, ankle and related structures of the leg.

Routine Foot Care: An office visit or an office contact during which a podiatrist provides routine foot care in the absence of underlying conditions.

Billing Requirements:

Routine foot care in the absence of underlying conditions must be billed with CPT code 99429.

All other medically necessary services must be billed with the appropriate CPT codes to reflect the Qualified Routine Foot Care, Foot Care Related Services, and Nursing Facility Assessments listed in the contract's Podiatry Services Reimbursement Rates and Terms.

Payment Guidelines:

The information provided in no way represents a guarantee of payment.

Reimbursement is limited to the services listed in the contract's Podiatry Services Reimbursement Rates and Terms.

6.5 DME SERVICE REQUIREMENTS

Response Times and Coverage:

- Maintain 24 hours-a-day, 7-days-a-week availability to provide DME, respiratory, and oxygen services and supplies. Be available to SWH on call coverage at all times.

- Provide all emergently needed supplies, services and/or equipment within two (2) hours of receipt of request from SWH. Emergently needed services or equipment shall be defined as those items whose malfunction or absence present an immediate life threatening situation to the SWH Member, as defined by the SWH Nurse Care Manager.

- Provide all non-emergently needed supplies, services and/or equipment within twenty-four (24) hours of receipt of request from SWH.

- Notify SWH, at the time of request, of any anticipated delay or back order in the provision of supplies, services, and/or equipment.

- Make every effort to fill order as same-day order if requested by SWH.

- Remove rental items within 48 hours of SWH request.

- Respond within twenty (20) minutes of receipt of telephone call during normal business hours (9 am to 5 pm, Monday through Friday).

- Train all staff in SWH protocols.

Provision and Maintenance of Equipment:

- Fit all equipment properly to SWH Member's specifications at the time of delivery.

- Instruct SWH Member or caregiver on the safe and proper use of equipment.
- Retain all warranties, serial numbers and/or model numbers of purchased equipment, including but not limited to: wheelchairs, batteries, beds, lifts.
- Notify SWH immediately if a repair is required for urgently needed, owned equipment. Notify SWH within twenty-four (24) hours if a repair is required for non-emergently needed owned equipment.
- Notify SWH, and request Authorization, if rebuilt parts are to be used in repair of owned equipment.
- Respond within 2 business days to members' complaints regarding their DME.

6.6 DME REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to Suppliers of Durable Medical Equipment, Prosthetics/Orthotics, Enterals and Supplies to SWH Members. SWH benefits coverage and billing guidelines are based on Medicare and/or Medicaid benefit coverage and billing guidelines.

Benefit Overview:

SWH's review process is a systematic evaluation of the coverage, necessity and appropriateness of the use of durable medical equipment, prosthetics, orthotics, enteral formulae and medical/surgical supplies, assuring that members receive the highest quality, cost effective care as provided in the member contract.

The following items and service are not covered benefits:

- Any item or service that is considered experimental or investigational.
- Any accessory of supply that is being dispensed for the purpose of supporting a non-covered item.
- Shipping, handling, sales tax and any insurance costs.
- Maintenance and repair for any item that is being rented.
- Services and items for members in an institutional setting for temporary acute treatment purposes. Items provided to Members within a facility setting are not payable unless such items are for home use and are supported by documentation in the Member's discharge records, or the institutions serves as the Member's residence.

Definitions:

Durable Medical Equipment/Prosthetics/Orthotics: Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specified medical conditions and which have all the following

characteristics: can withstand repeated use; are primarily and customarily used for medical purposes; are generally not useful in the absence of an illness or injury; are reasonable and necessary to sustain a minimum threshold of independent daily living; appropriate for use in the home (private residence, Member's dwelling, home for the aged, or institution which is considered to be the Member's primary residence); and where equipment is intended for use by only the one individual it may be either custom-made or customized.

Orthotic Appliances and Devices: Appliances and devices used to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body.

Prosthetic Appliance and Devices: Appliances and devices (other than artificial eyes and dentures); which replace any missing part of the body.

Enteral/Parenteral Nutrition Products (PEN): Enteral products are liquid nutritional formulas to be administered via a feeding tube into the gastrointestinal tract or consumed by mouth.

Medical/Surgical Supplies: Items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose, and generally have no salvage value. Examples include: diabetic supplies, enteral formulas, incontinence products, ostomy and urological supplies and wound dressings.

Prerequisites:

Applicable SWH referral, notification and authorization policies and procedures apply. Any item that requires authorization may not be dispensed or billed without authorization by the SWH Nurse Case Manager.

Billing Requirements:

Medically necessary DMEPOS and PEN must be billed with HCPCS Codes and applicable modifier.

Miscellaneous code E1399 may only be billed when there is no more appropriate HCPCS code; Supplier is required to obtain an authorization prior to dispensing such item or service. SWH shall reimburse according to the price paid by the provider to a manufacturer, as evidenced by an invoice, adjusted to reflect a standard mark-up of 20%.

Invoice/Quote Requirements:

Any invoice/quote submitted to SWH must be issued by the manufacturer, wholesaler, or distributor, and must include their logo and company name.

DME Rental and Purchase Options:

SWH utilizes the Medicare standard for classifying DME items into payment categories. These categories are identified below and must be followed for correct payment. When an option to rent or purchase is available, the decision will be made by the SWH Nurse Case Manager at the time of authorization. For items that do not require an authorization, the decision to purchase or rent is based on the prescribing provider's order.

Applicable to DME Rentals

SWH will administer the DME rental benefit according to Medicare guidelines unless otherwise stated below.

For capped rental items and rent-to-purchase items not otherwise designated with a defined rental period, SWH shall pay the SWH rental fee corresponding to the RR modifier on a monthly basis until the sum of rental payments is equivalent to the SWH purchase price, after which the product shall be deemed as purchased (typically 10 months).

In accordance with SWH protocols, SWH may purchase certain low-cost items in lieu of following Medicare's rental guidelines.

For new SWH enrollees who are receiving rental-to-purchase or capped rental equipment from Supplier, SWH requires that new equipment be dispensed in order for Supplier to qualify for reimbursement under the terms of this Agreement.

SWH requires that CPAP (E0601) and similar devices (BiPAP, auto-titrating CPAP) be rented for up to four (4) months in order to demonstrate patient compliance and treatment effectiveness prior to SWH's purchase in the fifth month at the purchase price less rental payments. Supplier must bill with appropriate CMS modifiers indicating documentation of member compliance. Such documentation may be audited to ensure compliance; if such compliance cannot be demonstrated, SWH shall recover its payment.

Items included in the Purchase Price of a DME:

Reimbursement for the following items and services are included in the fees paid by SWH to a DME Supplier for purchased equipment unless otherwise specified in this policy:

- All accessories required to complete initial set-up.
- Delivery of the equipment to the member's home.
- Installation and/or set-up of the equipment.
- Instruction of the member in the use of equipment.
- Removal of equipment, if applicable.
- Necessary adjustments to the equipment for six months after the initial set-up.
- Any specific component of an item that would ordinarily be included if purchased new.
- All repairs covered under the manufacturer's warranty.

Items included in DME Rental:

Reimbursement for the following is included in the fees paid for a DME rental, unless otherwise specified in this policy:

- Maintenance, service and repair of the equipment as needed, including replacement of defective parts.
- All accessory equipment and disposable items necessary for the proper function and use of the equipment during the rental period.

- Delivery of equipment to the Member's home.
- Installation and/or set-up of the equipment.
- Instruction of the member in use of the equipment.

DME Warranties:

- Repairs to DME that are covered by a manufacturer's warranty will not be reimbursed. Coverage of a repair is contingent on the timeframe specified in the manufacturer's warranty for the item.

- Replacement equipment that is provided due to defective parts or failure must be replaced by equipment that is functionally equivalent to the original item. No additional payment is made for any equipment that is replaced under warranty.

- If damaged or defective equipment is no longer covered by warranty, and repairs are more costly than a replacement, SWH will allow for replacement but will not reimburse providers more than the cost to rent the original piece of equipment. Rental payments will be made for the remaining period of the time authorized.

Payment Guidelines:

Supplier shall only provide the following if a physiatry or physical therapy review/evaluation has been performed **and** prior authorization has been obtained:

- Customized wheel chairs
- Scooters
- Lift chairs
- Any DME item with a contracted rate > $500
- Certain prosthetics and orthotics as deemed necessary by SWH nurse care manager

Supplier shall bill with modifier “SC” for medically necessary items ordered by physician or otherwise authorized by a SWH nurse care manager whose HCPCS code billed without a modifier is inappropriate due to the enhanced nature or special features of the item; SWH shall reimburse AAC+20% for such items upon submission of an invoice at time of billing.

The information provided herein in no way represents a guarantee of payment. Reimbursement is limited to the services listed in the contract’s Durable Medical Equipment Prosthetic, Orthotics and Supplies Reimbursement Rates and Terms.

Supplier Requirement List:
Applicable only to DME, Medical Supply, Respiratory and Oxygen Supplies, Diabetic Supplies, Orthotics and Prosthetics and not to Hearing Aids.
Supplier’s contracted status is conditional upon adherence to the following requirements; as applicable, Supplier will:

- Meet or exceed the Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (“DMEPOS”) quality standards established by CMS in accordance with Section 302 (b)(1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- Be accredited by a CMS-approved Deemed Accreditation Organization.
- Comply with Medicare reporting guidelines.
- Submit to audit and be accountable for findings in accordance with Medicare guidelines.
- Follow PLAN authorization policy in accordance with the Agreement and Protocols.
- Bill in accordance with Medicare guidelines including, but not limited to:
    - Coding
    - Modifiers
    - Bundling
    - Providing/maintaining appropriate documentation

- Submit quality program description, annual work plan and annual self-assessment upon initial contracting and, thereafter, upon request.
- Demonstrate customer satisfaction with Supplier products and services.
- Respond within two business days to Members' complaints regarding their DME.
- Must have an order from the treating SWH Participating Provider or authorization from a nurse care manager prior to dispensing any DMEPOS item; physician order must be signed and dated by the SWH Participating Provider; Supplier must keep such order on file, which is subject to audit.

6.7 HOME HEALTH SERVICE REQUIREMENTS

Vendor shall maintain 24 hours-a-day, 7-days-a-week availability of Skilled Nursing Services and be available to SWH via on-call phone coverage at all times.

Home Health Aide, Personal Care, Homemaker, and Certified Nursing Assistant services shall be available 24 hours per day on a pre-planned basis. Physical Therapy, Occupational Therapy, Speech Therapy and Nutrition Counseling services shall be available at least eight hours per day at least five (5) days per week on a preplanned basis.

Vendor shall make best effort to arrange for all non-urgently needed supplies, equipment or services within 24 hours of receiving a request from SWH. Vendor shall make every possible effort to provide services on the same day order if requested by SWH.

Vendor shall notify SWH at the time of request of any anticipated delay or back order expected to last more than 24 hours in the provision of supplies, services, and/or equipment.

6.8 HOME HEALTH REIMBURSEMENT POLICY

Purpose:

This SWH Reimbursement Policy governs payments made to providers for Home Health Services provided to SWH Members.

Benefit Overview:

SWH Home Health Care coverage requires that the service must be both a covered benefit as listed in the SWH Evidence of Coverage and medically necessary for the treatment of the member's conditions.

Eligibility of Home Health Services:

In order to be eligible for home health services, a Member must be in need of preventive, supportive or restorative nursing regimens or require an approved standard or prescribed medical regimen. The Member's assessed health care needs must be best met in the Member's own home or home substitute (any place of residence, either permanent or temporary, other than a hospital, skilled nursing home, or health related facility) in the judgment of a SWH Nurse Case Manager or the responsible Primary Care Provider (PCP), or pursuant to a discharge plan (e.g. from a skilled nursing facility or hospital.)

The SWH Nurse Case Manager uses written criteria based on sound clinical evidence to make medical necessity determinations. The criteria are objective and evidence-based and take the individual circumstances and local delivery system into account when determining the medical appropriateness of home health care services.

Prerequisites:

- The SWH Nurse Case Manager determines coverage and authorizes services based on if the case meets established criteria and/or protocols for home health care
- Services are provided in accordance with a plan of care authorized and established by the SWH Nurse Case Manager
- SWH must be notified prior to any changes made to the care plan, including but not limited to services provided or hours of services
- Services shall only be reimbursed by SWH to the extent that the Provider complies with applicable authorization and referral policies and procedures.

Billing Requirements:

Medically necessary and authorized home health care services must be billed on a UB-04 using the appropriate revenue codes and CPT codes as listed in the Home Health Care Reimbursement Rates and Terms of the Provider's contract.

A "visit" is defined as a personal encounter in a member's home or other residence for the purpose of providing a contracted service. The type of provider, services and visit length of a visit are determined and authorized by the SWH Nurse Case Manager based on the needs of a particular member.

- If the visit length is not specified in the Nurse Case Manager's authorization, the default maximum length is two (2) hours

- Nursing visit (RN) is up to two (2) hours and is billed per visit (1 unit = up to 2 hours)
    - Each additional hour above 2 hours requires additional authorization (1 unit = 1 hour)

- Nursing visit (LPN) is billed per hour up to a maximum of two (2) hours unless otherwise authorized (1 unit = 1 hour)

- Home Health Aide/Certified Nursing Aid (HHA/CNA) is billed per hour up to a maximum of four (4) hours (1 unit = 1 hour)

Services should be rounded up to the nearest hour. For example, a one and one-half hour (1.5) home health aide visit should be billed as two (2) units; a three-quarter (¾) hour visit should be billed as one 1 unit.

Payment Guidelines:

Reimbursement is limited to the services listed in the Reimbursement Rates and Terms exhibit of the Provider's contract.

Services shall only be reimbursed by SWH to the extent that the Provider complies with applicable authorization and referral policies and procedures.

Routine supplies are included in these rates; non-routine supplies should not be billed under the Provider's contract.

The information provided herein in no way represents a guarantee of payment.

Payment for Other Supplies and Equipment Related to Home Health

This policy specifies the reimbursement terms that will be used for home health services only. Reimbursement for other equipment or supplies not identified in this policy will be paid in accordance with the appropriate policy (e.g. DMEPOS Reimbursement Policy.)

6.9 HOME INFUSION REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to eligible Providers of Home Infusion Therapy to SWH members. SWH benefits coverage and billing guidelines are based on Medicare and/or Medicaid benefit coverage and billing guidelines.

Benefit Overview:

SWH covers medically necessary home infusion therapy, rendered in the home to a SWH Member. Home infusion therapy is provided to SWH Members who do not need hospitalization but who need infusion therapy that can be safely administered in the home environment. Home infusion services may include medications, enterals, nursing services, professional therapies, and specialized equipment and supplies.

Prerequisites:

Authorization by a SWH Nurse Case Manager is required prior to rendering any and all home infusion services. Additionally some drugs require specific authorization from the SWH Pharmacy Department.

Billing Requirements:

Medically necessary home infusion therapy must be billed in accordance with the coding provisions listed in the contract's Reimbursement Rates and Terms section.

Per Diem Definition:

As related to reimbursement, the term "per diem" represents each day that a given SWH Member is provided access to a prescribed therapy, beginning with the day the therapy is initiated and ending with the day the therapy is permanently discontinued. The expected course and duration of the treatment shall be determined by the plan of care as prescribed by the ordering physician and as authorized by the SWH Nurse Case Manager.

Products and Services not included in the administration rate:

- Enteral formula
- Nursing services (Home Health/Hospice)
- Covered DME unrelated to infusion (100% Medicare allowable)
- Drugs: Covered under the Medicare Part B benefit shall be reimbursed at 100% of the Medicare allowable; Drugs covered under the Medicare Part D benefit shall be billed to SWH's pharmacy benefit manager

Payment Guidelines:

The information provided herein does not represent a guarantee of payment.

Reimbursement is limited to the services listed in the contract's Home Infusion Therapy Reimbursement Rates and Terms.

6.10 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) REIMBURSEMENT POLICY

Purpose:

SWH Reimbursement Policy governs payments made to Federally Qualified Health Centers (FQHC) for services to SWH members.

Benefit Overview:

SWH covers medically necessary services rendered at a Federally Qualified Health Center (FQHC). Reimbursement rates of payment to an FQHC are based on the provider's contractual rate with SWH as listed in the contract's Reimbursement Rates and Terms.

SWH also provides coverage for after-hours office care. Providers are required to bill the appropriate CPT codes for these services (99050, 99051) in addition to the base clinic visit codes for the level of care rendered. After-hours office care add-on codes may only be used with the clinic visit code and will be subject to auditing to ensure that the care rendered was after hours.

Definitions:

Federally Qualified Health Center (FQHC): A free-standing health center that is receiving grant money under Section 330 of the PHS Act, which requires that the clinic not be owned, controlled or operated by any other entity. Qualifications for an FQHC are determined by, and approved by the Centers for Medicare and Medicaid.

Clinic Visit: A face-to-face meeting between a member a physician, physician assistant, nurse practitioner, or registered nurse within the FQHC setting for the purpose of examination, diagnosis, or treatment.

Prerequisites: None

Billing Requirements:

Medically necessary clinic visits must be billed with the appropriate CPT codes to reflect the Evaluation and Management and Preventive Care Codes.

All other Covered Services provided by FQHC that are not included in the FQHC Reimbursement Rates and Terms will be reimbursed in accordance with the lesser of billed charges or the SWH standard Fee Schedule, which is based on the Medicare RVUs.

Payment Guidelines:

The information provided herein in no way represents a guarantee of payment.

When any other service is listed as the only reason for the medical visit, (e.g., laboratory, radiology, vaccine, treatment/procedure), the provider must bill using the appropriate HCPCS/CPT coding for the specific service identified and should not report an E&M or preventive visit code.

Reimbursement is limited to the services listed in the contract's FQHC Reimbursement Rates and Terms.

6.11 PRIMARY CARE PROVIDER (PCP) REIMBURSEMENT POLICY

Purpose:

The SWH Reimbursement Policy for Primary Care governs payments made to PCPs for the medical care rendered and administrative services provided.

Medical Services:

SWH reimbursement for services provided by a practitioner credentialed as a primary care provider (“PCP”) is the lesser of a SWH proprietary fee schedule (“SWH Standard Fee Schedule”) which is based on Medicare RVUs, or billed charges for all covered services provided under the terms of the provider’s agreement. As an exception, professional services are subject to “enhanced” reimbursement in accordance with SWH’s Enhanced Fee Schedule (“EFS”) which is based on 110% of Medicare RVU’s. Professional services subject to the EFS are services billed with the E&M and Preventive Care codes, the most current listing of which can be found in Attachment A.

In addition, SWH reimburses 100% of Medicaid for the following services when provided by a PCP. These services are not reimbursed by Medicare:

Code	Description
99050	Services provided in the office at times other than regularly scheduled office hours
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

Fee Schedule Updates:

SWH will notify its contracted PCPs thirty (30) days in advance of its intent to modify the underlying Medicare basis of its fee schedules.

SWH updates its fee schedules to reflect industry coding additions, deletions and description changes.

Administrative Services:

- Participation on the Primary Care Team and in Clinical Case Conferences
    - What is the Primary Care Team?

      SWH forms a Primary Care Team (PCT) to assist providers with management of Members with complex care needs. SWH Nurse Care Managers will coordinate non-medical resources such as transportation, personal care, homemaking, and medications management.

      PCT meets either in brief telephonic discussions or in face-to-face meetings. The purpose of these meetings is to review complex care members and identify those members who need SWH nurse care manager assessment.

    - Who is in the PCT?

      The PCT is comprised of the Member's PCP or clinical designee, and the SWH Nurse Care Manager. The PCP or his/her designee provides clinical direction and oversight. If needed, other professionals and support disciplines may be invited to participate in evaluation and planning services.

    - PCP Reimbursement for participating in clinical case conferences

      Please contact your Provider Relations Representative for further information

- Medical Home Fee

  PCP’s are compensated for providing clinical leadership in care coordination activities including management of Members’ complex care needs, as well as participation on the Primary Care Team. Please contact your Provider Relations Representative for further information.

- Member Initial and Ongoing Assessments
  - What is an Initial Assessment?

    Initial Assessments are performed by a PCP on new Members to determine his/her medical, behavioral health and pharmaceutical status and needs. These assessments allow the SWH Nurse Care Manager to identify and understand key issues facing the Member. SWH combines the information from the PCP’s Initial Assessment with information gathered from a Nurse Care Manager’s home-based assessment to determine the Member’s health and functional status, as well as any social support services that may be needed. The PCP must complete an Initial Assessment within thirty (30) days of a new Member’s effective date.

  - What is a Reassessment?

    Significant health status changes may require an updated assessment. For example, a reassessment may be required upon a Member entering a nursing facility, a new diagnosis, or a change in a Member’s ability to complete an Activities of Daily Living assessment. The PCP must complete a reassessment within thirty (30) days of request by an authorized SWH representative.

    If no significant health status changes occur in the course of a year which would necessitate a reassessment, SWH requires an updated assessment be completed on the anniversary of the Member’s effective date.

- How do I find/complete the form?

  An assessment form is mailed to the PCP with the monthly panel reports. The form may also be downloaded from www.seniorwholehealth.com.

  Providers also have the alternative of downloading the required information from an electronic medical record ("EMR") and sending to SWH. Chart summaries from the EMR and an electronic signature are acceptable. Please note that completed assessments must include the PCP's clinical and non-clinical assessment of the member, current diagnoses, medications, allergies, Advanced Directives, Health Care Proxy, and any other pertinent information. Visit notes pertaining to a specific visit are not considered adequate, nor are submitting notes limited to prescription change.

- Where do I send the completed form(s)?

  Clinical Services
  Attn: PCP Assessments
  Senior Whole Health
  58 Charles Street
  Cambridge, MA 02141
  Or fax to Clinical Fax at 617-494-5554

- How do I get paid?

  Compensation is paid in accordance with the provider's contract by the 20th of the month for completed forms received by the end of the prior month.

- Special Considerations

  PCPs are not required to complete assessments for SWH members who are residents of long term care facilities.

Attachment A

Code	Description
99201-99205	Office or other outpatient visit, new patient;
99211-99215	Office or other outpatient visit, established patient;
99304-99306	Initial nursing facility care, E&M, per day;
99307-99310	Subsequent nursing facility care, E&M, per day;
99315-99316	Nursing facility discharge day management;
99318	E&M, annual nursing facility assessment;
99324-99328	Domiciliary or rest home visit, E&M, new patient;
99339-99340	Individual physician supervision of a patient, home/domiciliary; development and/or revision of care plans; assessment; within a calendar month;
99341-99345	Home visit, E&M, new patient;
99347-99350	Home visit, E&M, established patient;
99363	Anticoagulant management; initial 90 days
99364	Anticoagulant management; each subsequent 90 days
99374-99375	Physician supervision, patient under care of home health agency, home/domiciliary; development and/or revision of care plans; assessment; within a calendar month;
99377-99378	Physician supervision, hospice patient; development and/or revision of care plans; assessment; within a calendar month;
99379-99380	Physician supervision, nursing facility patient; development and/or revision of care plans; assessment; within a calendar month;
99387	Initial comprehensive preventive medicine, E&M, new patient
99397	Periodic comprehensive preventive medicine, E&M, established patient
G0438	Annual wellness visit; includes a personalized prevention plan of service, initial visit
G0439	Annual wellness visit; includes a personalized prevention plan of service, subsequent visit
99401-99404	Preventive medicine, individual counseling;
99411-99412	Preventive medicine, group counseling;

SWH reserves the right to update the codes included on the Enhanced Fee Schedule from time to time.

Section 7 | # Membership & Eligibility

7.1 ELIGIBILITY INQUIRY

SWH strongly recommends that providers confirm member eligibility prior to every scheduled service. For emergency services, providers should verify eligibility as soon as possible following provision of the service.

SWH provides a number of tools for checking eligibility. We prefer that providers use online tools to check eligibility (see Appendix for instructions in job aid format).

NEHEN - New England Healthcare EDI Network

- Log in and select Medicaid as payer. Scroll to the Additional/Alternate Payer section, SWH is listed in the Managed Care Coordinator section.
- Available at no cost to NEHEN members.
- For NEHEN membership and other information: www.NEHEN.org or call 781-290-1290

New MMIS

- Log into Provider Online Service Center, click Manage Members/Eligibility, and look up patient by SSN or name and DOB.
- Scroll to the section titled: List of Managed Care Data (for MCO):
- Scroll to the section titled: MCO Name. SWH will be listed in that section.
- Free registration for MassHealth Providers.
- For registration and other information: www.Mass.gov/masshealth or call 800-841-2900
- New MMIS also has an Interactive Voice Response (IVR) option for up to three patient inquiries per call: 800-841-2900

FAX

- FAX eligibility requests using the Eligibility Confirmation FAX form (see Appendix for form). Fax number: **617-494-5599**

Provider Relations Call Center

- Provider Line is staffed M-F, 8am – 5pm. **617-494-5353** (ask for Provider Relations).

7.2 FILE AN APPEAL OR GRIEVANCE ON BEHALF OF A MEMBER

A physician may, when acting on behalf of a Member and with the Member's written consent, file an appeal or a grievance on his/her behalf.

To be appointed as a Member's representative, both the Member making the appointment and the representative accepting the appointment must sign, date and complete an Appointment of Representation Form. A non-clinical representative may also complete and sign the form with the member's consent. To obtain a form, call Senior Whole Health at 617-494-5353 and ask for the Quality Department.

A signed Appointment of Representation form is valid for one year from the date of signature.

To file an appeal or grievance on behalf of a member: Call or write the SWH Quality Department:

617-494-5353
Senior Whole Health
Attn: Quality Department
58 Charles Street
Cambridge, MA 02141

- **Appeal**
  Any SWH Member has the right to appeal a service decision made by SWH that: terminates, suspends or reduces a previously authorized service, denies a requested service or delays providing or arranging for a service.

- **Appeal Procedure**
  Appeals will be answered by SWH in writing within 30 days of the date of receipt. If a delay is in the interest of the member, a fourteen (14) calendar day extension may be requested. If information from the physician or other sources indicates that waiting the 30 days could jeopardize the Member's life, health or ability to regain maximum function, the appeal will be expedited.

  There are two processes for appeals: once for services administered under Medicare benefits and one for services administered under MassHealth benefits. For more information, please call Provider Relations at 617-494-5353.

- **Grievance**
  A grievance is any Member complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of a plan sponsor regardless of whether remedial action is requested. Grievances also include complaints regarding the timeliness, appropriateness of, access to and/or setting of a provided service, procedure, or item.

  A provider, assigned by a Member, may file a grievance on behalf of the member within 60 days of the event which precipitated the grievance. Grievances regarding quality of care may be filed beyond the 60 day time frame, but no longer than 180 days.

- **Grievance Procedure**
  Typically SWH Member Services will handle routine matters and attempt to resolve problems immediately.

  The provider may be asked to submit additional information, and must do so within fourteen (14) days of the request if the grievance cannot be immediately resolved or is more complicated.

If the grievance was in regards to quality of care, it will be investigated by the quality department. SWH will notify the Member or his/her designated representative in writing of the findings.

The Member and his/her designated representative will be notified of the outcome within 30 days of the filing of the grievance, or 44 days if an extension was granted. A Notice of Plan's Decision Regarding a Grievance is sent for all quality of care grievances, and/or if a written response is specifically requested.

7.3 REFER A PROSPECTIVE MEMBER (PATIENT)

Senior Whole health offers many options to providers to help them inform their patients of the opportunity to join the plan. Providers wishing to refer prospective members need to be aware that SWH will not reach out to a prospective Member without a direct request from that Member or Member's representative.

To speak with the Marketing Department, call 617-494-5353.

- **Dedicated Telephone Intake Line: 888-566-3526**
  SWH operates a telephone line dedicated to taking prospective Member inquiries. The line is staffed by trained and licensed representatives.

- **Business Reply Cards**
  Informational brochures and office displays are available in several languages. By completing the requested information on the brochure, a patient may request a call from an SWH Outreach Representative to receive more information about SWH and to schedule an appointment.

- **Marketing Relations**
  A Marketing Relations Specialist can work with your practice to help develop a mailing to potential interested patients. Providers may send a CMS approved letter to patients to inform them of the opportunity to join. Please call 888-566-3526 for information.

- **On-Site Outreach**
  Large practices may arrange to have a SWH Outreach Representative to provide on-site informational sessions at scheduled times.

7.4 WHO IS ELIGIBLE TO PARTICIPATE IN SWH?

Senior Whole Health Members must meet the following eligibility requirements:

- Be eligible for MassHealth Standard (Medicare is not required to join).
- Be 65 years of age or over.
- Reside in the SWH service area for at least six months each calendar year. The service area includes the following counties: **Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.**
- Exclusions:
  - People diagnosed with end stage renal disease (ESRD) are not eligible to join.
  - Not be subject to a six-month deductible period.
  - Not be a resident of an intermediate care facility for the mentally retarded.
  - Not be an inpatient of a chronic or rehabilitation hospital.

A SWH Outreach Representative will further assess eligibility and assist the applicant with enrollment.

7.5 MEMBERS THAT WANT TO CHANGE PCPs

SWH Members may change their Primary Care Physician at any time for any reason. Providers who become aware of a Member's desire to change may advise him or her to call Member Services at 888-794-7268.

7.6 MEMBER BENEFITS

SWH Members are eligible to receive all the benefits of Medicare, MassHealth, and the Medicare Part D Prescription Drug Program. SWH can also offer other benefits, as medically necessary, not typically available through Medicare and/or MassHealth but identified by the Member's Personal Care Team as important to maintaining their independence at home.

A full description of SWH benefits is available in the annual Summary of Benefits and the annual Evidence of Coverage.

To Obtain a Copy of the **Summary of Benefits** click on the following link:
http://www.seniorwholehealth.com/mass/members/summary_of_benefits.htm

To Obtain a Copy of the **Evidence of Coverage** click on the following link:
http://www.seniorwholehealth.com/mass/members/evidence_of_coverage.htm

To request paper copies call: **617-494-5353 and ask for Provider Services.**

7.7 COPAYMENTS, COINSURANCE, DEDUCTIBLES

The SWH benefit offers members payment if full for all covered services.

- No copayments (including no copayments for drugs unless required by regulation)
- No deductibles
- No coinsurance

7.8 COVERAGE DETERMINATION

Providers who are uncertain whether a service is covered, or who recommend a course of treatment that is not covered, may call the SWH Clinical Department for a coverage determination at 888-794-7268. Providers will be asked to provide pertinent information via FAX or telephone call. If SWH makes an adverse determination, the Member and the provider making the request will be so informed in writing.

Coverage determinations are also required for reductions, terminations or suspensions of services. Providers will be asked to provide pertinent information via FAX or telephone call. If SWH makes an adverse determination, the Member will be so informed in writing.

Medicare guidelines are followed in regard to responses to coverage determination requests.

Non-Covered Services:
Prior to delivering any non-covered service, a provider must advise the Member and the Member must agree, in writing, that the service is not covered by SWH and that the member is liable for payment in full.

7.9 ADDITIONAL BENEFITS

Senior Whole Health includes additional health and wellness benefits not covered by traditional Medicare and/or MassHealth. Providers may wish to encourage their patients to take advantage of these.

7.9.1 OVER-THE-COUNTER DRUG COVERAGE

SWH covers over-the-counter medications on the over-the-counter formulary when prescribed by a physician. See Section 8: Pharmacy for more information on the drug benefit.

7.9.2 HEALTH CLUB/FITNESS CLASSES

SWH allows fitness club membership, up to an allotted dollar amount, for health club or fitness class membership. Members may call SWH for additional information.

7.9.3 PREVENTATIVE HEALTH AND DISEASE MANAGEMENT

SWH offers several disease management programs to optimize patient care. To refer a patient, contact your nurse care manager. Programs include:

- Congestive Heart Failure
- Diabetes Management
- Chronic Obstructive Pulmonary Disease

7.9.4 TRANSITIONS OF CARE

SWH promotes continuity of care between care settings to assist Member's transitions of care and to reduce the potential for hospital/facility readmission during a period of high vulnerability. The SWH Nurse Care Manager actively engages in transition planning and follow-up including facilitation of physician communication and follow-up visits as well as medication management. Services are provided for all Members; no request need be made. For more information on the transitions of care model, see Section 12: SWH Care Model, Transitions of Care.

7.9.5 NON-EMERGENCY TRANSPORTATION

The SWH Medical Transportation benefit is handled directly between SWH and the Member, with no paperwork required from the provider (e.g. no PT-1 forms). Members may call SWH at 888-794-7268 to request transportation to/from medical appointments. Providers who believe that a Member may be in need of transportation services to keep medical appointments may call SWH.

7.10 MEMBER NON LIABILITY

SWH Members, as MassHealth Members, cannot be held liable for payments. Providers may not bill or collect payment for a covered service from Members for any reason. Please contact Provider Services at 617-494-5353 if you have questions.

7.11 ENROLLMENT - DISENROLLMENT

- **Enrollment:**

New Senior Whole Health Members are enrolled effective the first day of a month.

Upon enrollment, new Members are screened by a geriatric social worker from the local elder services agency (ASAP) to identify needs for community long-term care and social support services. Those who are deemed to be at risk or to be nursing home certifiable are further screened in their homes by a nurse care manager. For more information on these procedures, see the Care Management section.

All new Members receive a welcome call, in their own language, from SWH Member Services.

- **Disenrollment – Voluntary:**

SWH Members may voluntarily disenroll at any time for any reason. All disenrollments are effective on the last day of the month in which SWH was notified of the intent to disenroll.

A provider who becomes aware of a Member's wish to disenroll should advise the Member or the Member's representative to contact SWH at 888-794-7268. Members with Medicare Part D Prescription coverage will need assistance with the transition.

SWH will ensure that the Member understands when coverage will be discontinued. SWH advises the Member about making the transition back to Medicare, MassHealth, and Medicare part D or another health care plan.

➢ **Disenrollment – Involuntary:**

SWH may disenroll a Member involuntarily for a number of reasons.

The most common reason for involuntary disenrollment is loss of MassHealth eligibility. SWH regularly monitors a Member's MassHealth eligibility. If a Member needs to complete a redetermination application for MassHealth, SWH will attempt to assist the Member in order to meet the deadline and avoid disruption of service.

Disenrollments are effective on the last day of the month in which the member loses eligibility.

Examples of Voluntary Disenrollment	Examples of Involuntary Disenrollment
• Wishes to change plans • Wishes to return to fee-for-service MassHealth and Medicare coverage • Wishes to see a PCP not participating with SWH.	• Loss of MassHealth eligibility • Remained out of SWH service area for more than six consecutive months • Permanent relocation out of SWH service area • Fraud or Abuse

➢ **Disenrollment – Retroactive:**

A small percentage of SWH Members are retroactively disenrolled. The typical reason for retroactive disenrollment is a determination by MassHealth that the Member lost eligibility. MassHealth makes these determinations.

Please refer to the claims section of this manual for information on the financial implications of retroactive disenrollment.

7.12 SWH ID CARD

SWH Member ID cards list Member name and date of birth, plan ID number, effective date of plan membership, PCP name and contact information, co-pay information, and SWH contact information. (See Appendix for sample ID card.)

7.13 MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights:

Senior Whole Health is dedicated to providing quality health care services for its Members and to treating each participant with dignity and respect. Member's rights include:

- The right to be treated with fairness and respect.
- The right to the privacy of medical records and personal health information.
- The right to access his or her personal health information.
- The right to see plan providers; obtain covered services; and get his or her prescriptions filled within a reasonable period of time.
- The right to know about treatment choices and to participate in health care decisions.
- The right to use advance directives.
- The right to file complaints and appeals.
- The right to information about Senior Whole Health, covered services, and providers.
- The right to obtain information about his or her health care coverage and costs.

Member Responsibilities:

SWH defines basic Member responsibilities to include the following:

- To be familiar with his or her coverage and the rules governing care as a Member of Senior Whole Health.
- To give his or her physicians and other providers the information they need to provide care.
- To follow the treatment plans and instructions agreed upon with his or her PCP/Primary Care Team.
- To act in a way that supports the care given to other patients and does not interfere with the care provided in the doctor's office, hospitals, and other facilities.
- To use the hospitals, doctors and other services in the SWH network and approved by SWH.
- To talk with your doctor before seeking services except in an emergency.
- To provide written or verbal notice as soon as possible if the Member wishes to disenroll from SWH.
- To let Senior Whole Health know of questions, concerns, problems and suggestions.
- To notify SWH if he/she has other health insurance coverage or prescription drug coverage besides SWH.
- To notify SWH when he/she moves.

7.14 MEMBER COMPLAINTS ABOUT OFFICE SETTINGS

SWH will conduct a site visit if we receive three (3) or more Member complaints in a twelve (12) month period about an office site (cleanliness or access for example); or if a practice-specific survey detects a deficiency; or if an unfavorable report is received as a result of a provider relations site visit.

- SWH Provider Relations will schedule an on-site office review within 60 days of receipt of a Member complaint or detection of a deficiency.
- SWH will provide a confidentiality statement to the practice prior to reviewing sample patient records as part of the standard on-site review (if patient record reviews are necessary). If requested by the practice, the SWH representative will sign an appropriate confidentiality agreement provided by the practice.
- Site reviews shall be conducted during normal business hours at a time acceptable to the practice and in a manner so as not to unreasonably interfere with practice operations.
- A trained SWH Provider Relations staff person will conduct the site review using the SWH Office Site Visit Checklist - Office Evaluation Survey Tool. A member of the office practice staff may accompany the SWH reviewer during the entire site-review.
- Results of the office visit evaluation will be provided to the practitioner with any corrective action plan required.
- If deficiencies are noted, the site must develop and submit a corrective action plan for improvement within thirty (30) days of notification of the office visit results.
- Once an action plan has been submitted and approved by SWH, a SWH site representative shall evaluate the site at least every six (6) months and shall reassess each area where a deficiency is noted until the performance standard for that area has been met.

Section 8 Pharmacy

SWH staff pharmacists are available via phone or in person to review complex medication regimens. Please use the contact information below to make any request.

8.1 CONTACT INFORMATION

- **Monday – Friday 9:00 a.m. – 5:00 p.m.**
  617-252-6366 or toll free at 888-794-7268
- **After Hours, Weekends, and Holidays**
  A pharmacist is on-call 24 hours a day, 7 days a week. Call 617-494-5353 or toll free at 888-794-7268
  An SWH Nurse Care Manager will answer, so please indicate that you have a pharmacy emergency and the SWH Nurse Care Manager will page the on-call pharmacist.
- **Pharmacy Fax**: 888-251-7823
- **Email**: pharmacy@seniorwholehealth.com

8.2 RESOURCES

The following resource materials are located on our website:
http://www.seniorwholehealth.com/mass/drug_benefits/formulary.htm

- Abridged Formulary
- Comprehensive Formulary
- MassHealth Formulary
- Prior Authorization Criteria
- Prior Authorization Form
- Quantity Level Limits
- Step Therapy Algorithms

The SWH Formulary is also available at: http://www.epocrates.com

8.3 SWH PHARMACY AND THERAPEUTICS COMMITTEE (P & T)

The SWH P&T Committee is charged with reviewing and deciding on coverage for all SWH covered medications. In addition, they suggest and review other clinical initiatives involving medications, for example the development of the Warfarin management program. This committee is a group of both external and internal clinicians including the SWH medical director and pharmacy director, physicians including geriatricians, nurse practitioners and pharmacists.

8.4 SWH PHARMACY BENEFIT

SWH covers medications in four categories: Medicare Part D Formulary, Over-the-Counter (OTC) Formulary, Medicare Part B drugs and MassHealth covered drugs.

SWH Members have no out-of-pocket expense for drugs on the formulary or approved by SWH.

- **Medicare Part D Drugs** – An extensive formulary is reviewed and updated on an ongoing basis.

- **Over- the- Counter Drugs:** The SWH formulary includes many over-the-counter drugs. A prescription is required for these drugs to be covered by SWH.

- **Medicare Part B Drugs :**
  Medications administered in a provider's office should be billed to SWH using appropriate codes. If using a miscellaneous code, J3490 for example, include the NDC number, quantity and drug name.
  Some Medicare Part B drugs require prior authorizations; detailed information and authorization forms are available in the pharmacy resource materials.
  Physicians may obtain Part B drugs directly from **SWH's specialty pharmacy vendor, *Curascripts* : 866-848-9870. B**ill SWH for just the administration of the drug.

- **MassHealth Covered Drugs:**
  Many drugs not covered by Medicare may be covered by SWH because Member coverage includes both Medicare and MassHealth benefits. For example, benzodiazepines and barbiturates, not covered by Medicare, are covered. These drugs are included on the SWH Formulary.

- **Drugs Excluded from the Benefit:**
  Drugs not covered by Medicare or MassHealth are not covered by SWH. For example, erectile dysfunction drugs are not covered. There may be technical or regulatory reasons why a drug is not covered.

8.5 DRUGS WITH SPECIAL REQUIREMENTS OR RESTRICTIONS

- **Drugs Requiring an Exception:**

  For certain drugs and/or in certain situations, review by a SWH pharmacist is required for coverage.
  All drugs requiring review are so noted in the formulary as having a restriction (e.g. prior authorization). Providers may contact the SWH Pharmacy Department at 617-252-6366 to receive further information.
  Call the SWH Pharmacy Department if clarification is needed in regards to any special requirements or restrictions. This call will mitigate delays for Members at the pharmacy and phone calls from the pharmacy to the physician's office.

- **Process:**

- Forms are specific to the drug, diagnosis and/or the situation and can be requested by calling the pharmacy line.
- Telephone (physician to SWH pharmacist) for an immediate resolution
- SWH sends all approvals and denials to the requesting provider's office via fax. All decisions are made within 72 hours of receipt of needed clinical information. A prescriber can request an expedited decision, which will be made within 24 hours of receipt of the needed clinical information. Most decisions, both standard and expedited, are made much sooner than the required turn-around time frames.

- **Processes Include:**

  - **Prior Authorization (PA)**: These drugs most often require clinical information from your office. Use the Prior Authorization Form available on the SWH web site and in the Appendix.
  - **Step Therapy (ST)**: For certain drugs, SWH may request that the Member try one drug or group of drugs before going to the next drug or group of drugs. If the Member has had the pre-required drugs within the specified time frame, the next step will be processed without office intervention.
    If step therapy is not appropriate for the patient, call the SWH Pharmacy Department at 617-252-6366. SWH will FAX the appropriate form for documentation. Algorithms are available on the SWH web site and in the Appendix.
  - **Non-Formulary Drugs**: If a drug is not on the SWH formulary, it is not covered. If specific circumstances warrant it, an exception may be granted. Most often this requires documentation that one or more of the formulary alternatives has been tried and failed.
  - **Quantity Limits (QLL)**: For certain drugs, SWH limits the quantity that may be prescribed per time period. Quantity limits are specified for clinical and/or cost reasons. SWH does not require tablet splitting, however dosage consolidation is required. A pharmacy or the SWH Pharmacy Department may call to suggest alternative quantities of that same drug. Exceptions are granted when titrating a drug dosage up or down. A list is available on the SWH web site and in the Appendix.
  - **Medicare Part B vs. Medicare Part D**: Certain medications may be covered by a different part of Medicare depending on the diagnosis. For example, anti-emetics, used in conjunction with chemotherapy are covered under Part B, whereas, they are typically covered under Medicare Part D. Both Part B and Part D drugs are covered by SWH; a diagnosis is needed to categorize medications for specific members. Include the diagnosis when writing prescriptions.

8.6 DAYS SUPPLY PER PRESCRIPTION

- **30 or 90 day supplies**: Pharmacies are contracted to provide either a 30-day or 90-day supply of medications per prescription. Prescribers are encouraged to write 90 day prescriptions as appropriate as many SWH Network Pharmacies will provide a 90 day supply of medications. Members may also order 90 day supplies from Express Scripts mail order pharmacy. Physicians may advise members to call SWH Member Services to find the most convenient 90-day pharmacy.
- **Vacation Supplies**: 90-day supplies mitigate the need for special vacation prescriptions. SWH grants vacation overrides as needed (refills ahead of schedule and/or larger-than-usual quantity). Supplies of greater than 90 days require special authorization by SWH.
- **Lost Medications**: There is no need for authorization from your office unless a pattern is detected. A Member, a physician or a pharmacist may call SWH for an override if a medication was lost or left behind.

8.7 SPECIAL COMPLIANCE PACKAGING

If a SWH Member needs assistance in managing their medications specialized packaging may be appropriate and helpful. Please contact the pharmacy department if you would like to set this up for a patient.

8.8 MEDICATION THERAPY MANAGEMENT (MTM)

Managing medications appropriately keeps our Members out of hospitals and nursing homes. MTM is available to all SWH Members. SWH contracts with a vendor that uses both retail and consultant pharmacists to meet with and counsel patients about their medication use. Providers can make special requests for these services. Call the SWH Pharmacy Department at 617-252-6366 if you would like to refer a specific patient.

Section 9 Primary Care Physicians

9.1 PRIMARY CARE TEAM (PCT) and RESPONSIBILITIES

What is the PCT?

SWH forms a Primary Care Team (PCT) for certain Members. The PCT is designed to assist providers with management of Members with complex care needs by offering SWH resources to coordinate non-medical resources, such as transportation, personal care, homemaking, and medications management. SWH reimburses the PCP for participation in the PCT.

PCT meetings may range from a brief telephonic discussion to a face-to-face meeting. The purpose is to review complex care members and identify those members who need SWH nurse care manager assessment.

Who is in the PCT?

The PCT is comprised of the Member's PCP, or clinical designee at the practice, the SWH Nurse Care Manager, and, if a Member is a community resident, a Geriatric Support Services Coordinator. The PCP or his/her designee provides clinical direction and oversight. If needed, other professionals and support disciplines may be invited to participate in evaluation and planning services.

9.2 MONTHLY PCP REPORTS

Panel Report:

PCP practices receive a monthly panel report via mail identifying the SWH Members in their panel each month and activity in the current month. Member disenrollments on these reports are retroactive and reflect disenrollments in prior months. Member effective dates are noted on the report, and a header at the top contains a brief message, usually clinical in nature.

If a provider sees a Member on their panel that they believe is not their patient and they do not have contact information for the Member, the provider should contact the SWH Member Services Department at 888-794-7268.

Panel reports are typically sent to the practice. SWH may be able to make arrangements to send reports to a designated administrator at a group level upon request. Practices with a professional email address may receive their panel report via secure email, The email address may not be an internet-based email account (e.g., Yahoo, Gmail, Hotmail, Mail.com, Comcast.net, etc) or an internet-based email account belonging to an individual employee of the practice.

The billing group/entity for the PCP practice also receives a monthly roster showing current active Members.

9.3 MEMBER INITIAL ASSESSMENT

What is an Initial Assessment?

Initial Assessments are critical in that they allow the SWH Nurse Care Manager responsible for that Member to understand the key issues facing that Member. SWH combines the information from the PCP completing the Initial Assessment with the information gathered from the home-based assessment to more easily and quickly identify a new Member's health and functional status.

SWH feels that this tool is so critical to improving outcomes that it pays PCPs upon receipt of completed forms.

How Does the Initial Assessment work?

- Locating the Form:

  SWH mails a copy of the form to be completed along with the monthly panel reports, and providers may also download the form from our website.

- To Use an Electronic Medical Record (EMR):

  Providers with an EMR may pull the required data from the EMR and send to SWH in lieu of our form. Chart summaries from the EMR and an e-signature are acceptable. Please note that an Initial Assessment or a subsequent one must include: the PCP's clinical and non-clinical assessment of the member, current diagnoses, medications, allergies, Advanced Directives, Health Care Proxy, and any other pertinent information. Submitting visit notes pertaining to a specific visit or notes limited to an Rx change is not considered adequate.

  Assessments must be signed by the PCP, but may be signed electronically.

- Timeframe:

  SWH requires that the PCP complete an Initial Assessment when a new Member joins SWH. An Initial Assessment must be completed within 30 days of the Member's effective date and is critical to implementing timely treatment or other interventions.

  Additionally, significant health status changes trigger the need to complete an updated assessment. These include: Member entering a nursing facility, new diagnosis, and change in Member ability to complete an ADL. Providers should complete these within 30 days of request by SWH.

  If no significant health status changes occur over the year, SWH requires that an annual assessment is completed on the anniversary of the Member's effective date.

- Where do I send the completed form(s)?

  Clinical Services
  Attn: PCP Assessments
  Senior Whole Health
  58 Charles Street
  Cambridge, MA 02141

  They may also be faxed to the Clinical Fax at 617-494-5554

- Special Considerations:

  PCPs of long term care residents who become SWH Members do not need to complete an Initial Assessment nor subsequent assessments. Instead, the Nursing Home must complete an MDS 2.0 and return to SWH within a requested number of days.

9.4 OPENING AND CLOSING A MEMBER PANEL

- Definitions: SWH defines panel status as the following.

  - *New*: PCP will accept new patients who have SWH into their practice.
  - *Existing*: PCP will only accept those patients currently in their practice who may choose to join SWH.
  - *Nursing Home only*: PCP will only accept new SWH members who reside in long term care facilities.
  - *Home Visiting only*: PCP will only see SWH members who receive care in their homes.

- Changes:

All changes to panel status require written notice to SWH:

Senior Whole Health
Attention: Provider Relations
58 Charles Street
Cambridge, MA 02141
providerrelations@seniorwholehealth.com

Or fax to: Provider Relations at 617-494-5599.

PCPs may change their panel status from Existing to New upon five (5) days written notice to SWH, Provider Relations.

If a PCP closes his or her panel to all new patients, PCP may exclude Members who are not currently PCP's patients. However, existing PCP patients shall be included as PCP's patient at the time that they become Members. PCP shall notify

SWH in writing at least sixty (60) days prior to closing his or her panel to new Members. This would change the panel status to Existing.

9.5 REMOVING MEMBERS FROM PROVIDER PRACTICES

SWH views decisions to terminate a physician-patient relationship very seriously.

SWH is available to assist providers with difficult patient situations. Providers may seek assistance from Member Services by contacting 888-794-7268.

The Provider must send the Member a written notification by certified mail, return receipt, clearly stating the effective date of the termination, the reason(s) for the termination, and reference his/her own internal policy. The Provider must also forward the same correspondence to SWH.

Notification should be sent to:

Senior Whole Health, LLC
Attn: Client Services Director
58 Charles Street
Cambridge, MA 02141

The Provider must continue to provide care to the Member for at least 30 days beyond the termination date. SWH will assist the Member in selecting another PCP and will notify the Provider if this transition occurs in less than 30 days.

9.6 VISIT AND ACCESS REQUIREMENTS

All Urgent Care and symptomatic office visits must be available to Members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to Members within 30 calendar days of Member's request. Examples of non-symptomatic office visits include, but are not limited to, well and preventive-care visits for Covered Services, such as annual physical examinations or immunizations.

PCP shall ensure 24-hour-a-day, 7-days-a-week access to physician consultation, at least by telephone. PCP shall have arrangements with covering health care providers to provide or arrange for the provision of Medically Necessary Provider Services when PCP is not available.

9.7 NURSE PRACTITIONERS (NPs) AS PCPs

SWH allows NPs to practice as PCPs and hold their own panels. In order to qualify for this status the following conditions must be met:

- The NP must be delivering care in a practice contracted with SWH for primary care services.
- The NP must be delivering care under a supervising MD, who must be credentialed with SWH.
- The NP must have arrangements for admitting at an SWH contracted hospital.
- NPs not yet credentialed with SWH must follow guidelines for becoming a credentialed provider (see Section 13 on Provider Credentialing and Changes).
- NPs must notify SWH of their desire to act as a PCP by contacting SWH Provider Relations at 617-494-5353.
- An NP can begin building a Member panel following receipt of a "Change in Status" letter for currently credentialed NPs or a "Welcome Letter" for newly credentialed NPs.
- When the status is changed to PCP-NP, the NP's name will appear in our provider directory as a PCP-NP; and,
- The practice can inform current patients of the opportunity to select the NP as a PCP.

(NB: Providers on older contracts may require a simple contract amendment. Please feel free to contact Provider Relations with questions.)

Billing for NPs as PCPs:

All nurse practitioners, both PCP and non PCP, are asked to bill using their own NPI number (do not bill "incident to").

Specialty Care Physicians

10.1 REFERRALS

Specialists who are participating providers with SWH do not need to obtain an authorization for professional services rendered in an office or outpatient setting. Elective hospital admissions do require authorization.

Referrals to non-participating Specialists must come from the member's PCP and be authorized by SWH. See Appendix for copy of the Authorization Request Form.

If a specialist feels that additional treatment is required and he or she cannot provide these services, the specialist is responsible for contacting the Member's PCP, and suggesting that the PCP provide the Member with an additional referral.

10.2 REMOVING MEMBERS FROM PROVIDER PRACTICES

SWH considers decisions to terminate a physician-patient relationship as a serious matter requiring input from the practice and SWH.

SWH is available to assist providers with difficult patient situations such that Members are able to remain with their provider. Providers may seek assistance from Client Services by contacting 888-794-7268.

The Provider must send the Member a written notification by certified mail, return receipt, clearly stating the effective date of the termination, the reason(s) for the termination, and reference his/her own internal policy. The Provider must also forward the same correspondence to SWH.

Notification should be sent to:

Senior Whole Health
58 Charles Street
Cambridge, MA 02141

The Provider must continue to provide care to the Member for at least 30 days beyond the termination date. SWH will assist the Member in selecting another Provider and will notify the Provider if this transition occurs in less than 30 days.

10.3 VISIT AND ACCESS REQUIREMENTS

All Urgent Care and symptomatic office visits must be available to Members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to Members within 30 calendar days of Member's request. Examples of non-symptomatic office visits include, but are not limited to, well and preventive-care visits for Covered Services, such as annual physical examinations or immunizations.

Section 11 Quality Improvement Program

The SWH Quality Improvement Program (QIP) is an ongoing, systematic, interdisciplinary program designed to measure, assess and improve the care and services provided by SWH to this specific Member population and to support the mission of SWH to "maximize the quality of life, health and independence of members." The QI Program includes medical and behavioral health aspects of care as well as issues related to patient safety. The program description includes the scope of the program and the processes and information resources used to assist in identifying opportunities for improvement in care and services.

Annually, Senior Whole Health selects specific quality improvement initiatives. The QIP Summary Description is available in the Appendix. Providers may obtain the complete description by contacting Provider Relations at 617-494-5353.

11.1 PARTICIPATING PROVIDERS

As part of their commitment to the Quality Improvement Program, SWH's contracted providers:

- Pledge to abide by the policies and procedures set forth by SWH.
- Actively take part in SWH's care management process, serving as vital participants of the member's Primary Care Team, working to ensure optimal delivery of care and services.
- Participate in relevant quality improvement initiatives.
- Cooperate with medical chart review activities and audits.
- Provide member information in support of State and Federal regulations and accreditation standards.

11.2 QUALITY MODEL

The purpose of the QIP is to assess the quality and appropriateness of the process and outcomes of Member care and services. The program assists the SWH Board of Directors in developing strategies to maintain and improve quality within the organization as a whole. The QIP reflects the goals, principles of quality and policies adopted by SWH.

The Board has ultimate authority and responsibility for quality of care and service provided to SWH Members. It delegates its quality improvement responsibilities to the Medical Advisory Committee and Medical Director. The Medical Advisory Committee chaired by the Medical Director provides advice and consultation in quality of care issues.

Quality improvement activities focus on: Member satisfaction; complaints and appeals; contract services and credentialing; clinical services, utilization management and clinical program initiatives; outreach activities; education and reporting compliance.

The QIP's major function is assessment of the quality of care provided to Members as well as the overall efficacy of SWH health care initiatives. The management of Members' care is facilitated through a variety of program enhancements, all of which are monitored for improvement in Member health outcomes:

Trigger identification (risk factors)

- Chronic care improvement programs and preventive care initiatives
- Utilization management
- Care Transition management
- Health Outcomes Survey

Section 12 SWH Care Model

12.1 THE SWH PROGRAM AND PHILOSOPHY

Senior Whole Health's Care Model reflects its mission: to maximize Members' quality of life, health, security and independence. With its unique capacity to integrate all Medicare Part A and B, Medicare Part D, and MassHealth benefits, the care model mitigates fragmented care, promotes extended community care tailored to individual needs and supports Members and providers through care coordination to avoid acute care episodes and unnecessary long term placement.

The SWH Care Model is grounded in the philosophy that:

- Care should remain local and aligned with the providers and community with whom the elder is familiar;
- Member choice in care setting, care planning and services is fundamental;
- Coordination and advocacy across time, change in health and functional status, and care settings is the optimal way to provide care;
- Care is "holistic" including psychosocial, behavioral, and spiritual needs as well as physical;
- Cultural and linguistic competency is critical to access and quality care.

The core elements of a patient-centered medical home are fundamental to the SWH Care Model. The member is at the nucleus of a care system and the PCP is the "medical home" providing medical oversight in care planning and delivery. SWH supports the PCP through the use of nurse care managers who focus on care coordination. Assessment and screening for both medical and psychosocial needs, risk identification, care planning, and ongoing monitoring and reassessment are supported by the SWH Nurse Care Managers and other care team participants.

SWH offers preventive services and other benefits to promote the health and well-being of the Member and caregivers, all of which are incorporated into the care planning process. The wide array of community support services available to SWH Members promotes independence and options for elders to remain in the community while also recognizing and supporting the need for institutional care as the right choice for some Members.

12.2 PRIMARY CARE TEAM (PCT) AND RESPONSIBILITIES

The SWH Care Model is supported by SWH staff that actively assists with care planning, advocacy, and care coordination with the PCP. Care plans tailored to individual needs and services are evidenced-based and quality driven. To ensure a comprehensive, holistic approach to meeting Members' needs, a Primary Care Team of professionals and paraprofessionals is used for assessment, coordination and monitoring. The interactions may be telephonic, written or in-person. The PCP may invite other professionals and persons critical to meeting the care needs of the member to participate in evaluating and planning services. The Member, and his/her designated representative, are active participants in care plan decisions.

➢ **Primary Care Team (PCT) participants include:**

- Member and caregiver(s)
- Primary Care Provider (PCP)
- SWH Nurse Care Manager (NCM)
- Aging Services Access Point (ASAP) Geriatric Support Services Coordinator (GSSC)
- SWH Pharmacy Consultant
- SWH Community Resource Coordinators (CRC)
- Behavioral health consultants
- Others as needed

12.3 PRIMARY CARE PHYSICIAN (PCP)

Each Senior Whole Health Member is required to select a network Primary Care Provider (PCP) at the time of enrollment. Generally, this is the PCP with whom the Member has an established relationship. The PCP is the team leader and provides overall clinical direction to the PCT and serves as the "medical home" for the member. The PCP:

- Provides medical oversight;
- Provides primary care services;
- Assesses the Member initially and ongoing as needed;
- Collaborates in Individual Care Plan development and reinforces care plan compliance;
- Works with SWH to identify a change in Member status;
- Works with SWH to identify service needs/problems.

12.4 ROLE OF THE NURSE CARE MANAGER (NCM)

SWH Nurse Care Managers are RNs; they do not provide direct care. SWH has three (3) types of nurse care managers with expertise in specific care settings:

NCM TYPE	RESPONSIBILITIES
Community Nurse Care Managers	Manages Members with complex care needs residing in the community who require intensive care management of multiple services
Skilled Nursing Facility (SNF) Nurse Care Managers	Manages long term custodial Members and coordinates discharge planning with Community NCMs for Members with short term SNF stays
UM Nurse Care Managers	Authorizes hospital, SNF and other facility stays, assists with discharge planning and care transitions and coordinates with the NCM assigned to the Member

12.4.1 COMMUNITY NURSE CARE MANAGERS

Each PCP is assigned a SWH Nurse Care Manager (NCM). The NCM's primary responsibilities are to conduct care planning and to coordinate services for community-based Members with complex care needs. The SWH NCM is the single point of contact for providers whose role is to foster clear and consistent communication among the PCP, the Member, and other providers.

Ongoing communication and collaboration between the PCP and NCM is essential for care plan development and implementation. Interaction with the PCP may be telephonic, written, or in person. A SWH NCM is available telephonically 24 hours-a-day, 7-days-a-week. The Community NCM:

- Assesses Members in their homes and meets directly with family/caregivers;
- Develops Individual Care Plans and communicates with the member, PCP and other providers to implement and manage the care plan ;
- Arranges and coordinates services identified in the care plan and coordinates care across care settings;
- Reviews and monitors care plan with the PCP PCT and Member.

12.4.2 SNF NURSE CARE MANAGERS

A SNF NCM is assigned to each contracted nursing facility and is on-site at least weekly. Like their community counterparts, SNF NCMs coordinate among providers and facilitate care plan development and implementation. In addition to managing custodial members, the SNF NCMs oversee Members receiving short term care and collaborate with the Community NCMs for transitions of care upon admission and discharge.

12.5 AGING SERVICES ACCESS POINTS (ASAPs) AND GERIATRIC SUPPORT SERVICES COORDINATOR (GSSCs)

ASAPs are local elder agencies responsible for State home and community-based services such as homemaker, personal care, meals, etc. These agencies are essential in helping to keep Members at home and preventing hospitalization or nursing home placement. SWH contracts with ASAPs for care management services by a Geriatric Support Services Coordinator (GSSC) as well as for the home-based services. Every community-residing SWH Member, regardless of health status, is assessed upon enrollment and at scheduled intervals by a GSSC for functional status and psychosocial needs. The GSSC collaborates with the SWH NCM in care planning and service implementation as well as performing reassessments.

12.6 SWH PHARMACIST

SWH's Pharmacy Department works closely with SWH NCMs and providers to assist in the management of care of SWH Members. Goals of Pharmacy Care Management are safety, access, compliance, education and optimization of therapy. As a provider, you can request a medication review for your Members. In addition, the Pharmacy Department is actively engaged in programs related to medication management and medication reconciliation.

12.7 ROLE OF THE SWH COMMUNITY RESOURCE COORDINATOR (CRC) / CLIENT SERVICES

SWH serves a linguistically and culturally diverse elder population making health care delivery more challenging. To address this, SWH has incorporated Member Services into the clinical arena with multi-lingual staff representing major language groups. The Community Resource Coordinators have a role that goes beyond traditional Member Services in providing personal, high touch telephonic communication. CRCs are available to respond quickly to questions and concerns. They educate the member upon enrollment and have a roster of Members to contact on a regular basis to verify that all is well or to identify changing care needs. CRCs coordinate community-based services with local agencies and providers and the SWH NCM to ensure clinical and community resources are effectively linked.

12.8 CARE MANAGEMENT PROCESS

SWH is committed to empowering its Members and their families in the participation of short and long term planning to support community living as long and safely as possible. The health status and care needs of individuals are fluid. SWH incorporates systems to ensure ongoing reevaluation and restructuring of care services to respond to changing needs.

12.8.1 ASSESSMENT AND RISK CATEGORIES

SWH conducts multidimensional assessments of its Members in order to: have baseline information about the Member's current health status, services, and unmet needs; stratify for risk in order to ensure adequate care management oversight; ensure continuity of existing services upon enrollment in SWH; develop appropriate individual care plans; enable ongoing monitoring and rapid identification of status changes. Assessments are conducted at the time of enrollment as well as at regular intervals throughout membership, and at any time changes in status are suspected.

- Assessments include appraisals of:
  - Diagnostic conditions
  - Functional status (Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
  - Psychosocial status
  - Informal and formal support systems

- Risk Categories
  Based on assessment, Members are stratified into risk categories which are aligned with the intensity of care management needs. **These categories are identified with the Members' names on monthly PCP Panel Reports.**

CATEGORY	RISK	DEFINITION	CARE MANAGER
Community Other	Low risk	No ADL or IADL deficits; high functioning; limited or no chronic diseases.	CRC and GSSC
	High risk	No or limited ADL or IADL deficits; multiple chronic conditions; psychosocial needs. Does not meet NHC or AD/CMI criteria.	SWH NCM with PCP and GSSC
Complex Care Needs		Members with conditions or situations requiring expert coordination of multiple services.	
	Nursing Home Certifiable (NHC)	A Member residing in the community meeting MassHealth eligibility criteria for nursing facility care based on a state assessment tool conducted by SWH NCM. ADL and IADL deficits.	SWH NCM with PCP and GSSC
	Alzheimer's/Dementia Chronic Mental Illness (AD/CMI)	A Member residing in the community meeting MassHealth eligibility criteria for medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care. Based on State assessment tool conducted by SWH NCM.	SWH NCM with PCP and GSSC
Nursing Home	Long Term Custodial Care (NH)	Long term resident of a nursing facility.	SWH NCM with PCP

12.9 FEATURES OF THE SWH CARE MODEL

To promote health and prevent unnecessary illness, all facets of an individual's life must be addressed. Preventing acute episodes of illness and supporting elders in the home when necessary, leads to a healthier, independent individual. This holistic approach incorporates the following steps:

- Intake and initial assessment
- Individualized care plans (ICP)
- Coordinated, integrated care delivery
- Monitoring and continuous reassessment

12.9.1 INTAKE AND INITIAL ASSESSMENT

Information gathering about the new Member's health status and existing services begins as soon as possible after CMS acceptance of an enrollment application in order to ensure:

- Existing services continue without disruption upon enrollment.
- Continuity of care with existing providers and appointments.
- Transition of existing medications.
- Early identification of risk factors to ensure rapid implementation of needed services and stabilization of the Member.

An Initial Assessment is a comprehensive assessment that serves as the basis for the Individual Care Plan and includes: an evaluation of clinical status, functional status, nutritional status, and physical well-being; the medical history, including relevant family members and illnesses; screenings for mental-health status and tobacco, alcohol and drug use; and an assessment of need for long term care services, including the availability of informal support.

Initial assessments for SWH Members include:

Phone triage	SWH uses a phone triaging process to identify high risk triggers indicating whether or not an in-home assessment should be conducted by a SWH NCM as close to the first day of enrollment as possible.
In-home assessment for at-risk populations	If the Triage NCM determines a new Member is at risk, a SWH NCM is assigned to meet with the Member at home. A standardized State assessment tool is used that identifies: diagnoses, medications, ADL status, IADL status, support systems, mental health status, and nutritional status.
Welcome calls	CRCs conduct welcome calls to all new members within the first month of enrollment. During that call, CRCs may obtain information about needs of the Member. The CRC will forward this information to the SWH NCM for follow up.
GSSC In-home Assessment	GSSCs have extensive experience in assessing elders for home-based services. The GSSC completes an assessment in the Member's home to assess environmental, supportive and social needs. Every new Member, regardless of health status, receives this assessment to ensure the availability of baseline information. This facilitates early identification of status changes, ensures that needed services are in place and, identifies psychosocial issues that need to be addressed immediately.
PCP Assessment	PCPs are requested to submit an annual assessment either on a SWH PCP Assessment Form or using the Summary of the providers EMR to help SWH NCMs identify diagnoses, medications, preventive services, special needs, and the PCP's priorities for the Member.

12.9.2 INDIVIDUAL CARE PLAN (ICP)

Each Member has an ICP constructed based on:

- The PCP's, NCM and GSSC assessments and service recommendations;
- Member's functional, physical, behavioral, and psychosocial needs;
- The Member's wishes, as far as possible;
- What is feasible given the availability of a support network and caregivers;
- Health promotion and preventive services.

Members with Complex Care Needs (at-risk community based members including NHC and AD/CMI) receive in-depth care plans drafted by the SWH NCM based on the assessments and meetings with the Member and family. Recommendations of the PCP and GSSC are incorporated. The SWH NCM confers with the PCP to determine if further evaluation and care planning is needed as appropriate and to arrange referrals as needed and the NCM authorizes the services. Member concurrence with the ICP is a necessary component of care planning. CRCs work with the GSSCs to arrange and implement home-based services.

Nursing home residents have ICPs based on recommendations of the PCP, facility staff and Member.

12.9.3 COORDINATED, INTEGRATED CARE DELIVERY

The SWH NCM oversees implementation of ICP services and ongoing care needs through communication with the PCP, utilization management, communication with the Member and his/her caregivers, the GSSC who monitors home-based services, and with other involved providers. Contractual relationships with providers across care settings including home, hospital, outpatient, rehabilitation, DME, behavioral health providers, SNFs—both long term and short term—allow SWH NCMs to coordinate care in a meaningful way that fosters a "medical home" for the Member. This ensures timely and effective delivery of services without fragmentation and disruption. If a Member has unique needs, SWH NCMs will consult with the PCP to determine if a new approach or exception to benefit is needed. PCPs should contact the SWH NCM at 888-794-7268.

12.9.4 MONITORING AND ONGOING ASSESSMENT

The SWH NCM, GSSC, and CRC all have a role in monitoring the Member and his/her services to assure services are delivered, that they are delivered according to quality standards, and that the Member is satisfied. SWH NCMs and GSSCs conduct in-home reassessments at scheduled intervals based on risk category as well as any time there is a suspected change in status or an issue identified. CRCs maintain close telephonic contact with Members to determine needs and issues. PCPs are involved when changes and potential problems surface.

Scheduled reassessments are as follows:

	Community Other	**Complex Care (NHC and AD/CMI)**	**Nursing Home**
PCP Assessment	Annual/Change in status	Annual/Change in status	Annual/Change in status
SWH NCM Assessment	Only if status change	6 months and with status change; ongoing monitoring	6 months and with status change
GSSC Assessment	Annual	6 months and with status change; alternate with NCM assessments	None

12.10 CENTRALIZED ENROLLEE RECORD (CER)

SWH uses an electronic Member record to communicate information about the Member among internal staff (CRCs, SWH NCMs) and with GSSCs. This is **not** an Electronic Health Record (EHR), but rather a repository of information collected through assessments, claims—medical as well as pharmacy—case management notes, telephonic communication with providers and Members, ICPs, referrals and authorizations, demographic information, etc. The information is real time and web-based allowing SWH NCMs access to up-to-date information 24 hours-a-day, 7-days-a-week. This is a tool to facilitate care planning and communication.

12.11 TRANSITIONS OF CARE

SWH promotes continuity of care between care settings to assist Member's transitions of care and to reduce the potential for hospital/facility readmission during a period of high vulnerability. Care setting transitions may include home, hospital, SNF, rehab, etc. Responsibility for assuring a smooth transition from one setting to another resides with the Primary Care Team (PCT) and the SWH Nurse Care Manager (NCM).

The SWH NCM actively engages in transition planning and follow-up including facilitation of physician communication and follow-up visits as well as medication management. The SWH NCM:

- Discusses, plans reviews and obtains agreement on the care plan and transfer arrangements with the PCT, Member, and/or his/her caregiver.

- Collaborates with the GSSC to arrange services prescribed in the care plan, e.g., transportation, home care nursing, physical therapy, personal care, etc., and assures services are in place and staff notified as appropriate.

- Phones staff in the new care setting to determine status of member and services.

- The SWH UM Nurse contacts the hospital/nursing home specialist to arrange for an on-site visit or telephonic contact when appropriate.

- Schedules reassessments for PCT review of member care plan following the transfer for up to 3 weeks and then quarterly thereafter unless there is a change in status.

The table on the following pages describes the transitions of care responsibilities for different care settings.

Transition of Care	Tasks/Responsibilities
Hospital to SNF/LTAC/Rehab	SWH NCM-UM: • Identifies participating nursing home providers, directs the hospital discharge planner to participating facility • Notifies the SWH NCM-SNF of the impending transition • Notifies SWH NCM-Community and GSSC of transition • Establishes admission level of care and services with facility • Enters authorization into the authorization application
SNF/LTAC/Rehab to Hospital	SNF staff: • Contacts PCP when member's condition changes • Transfers the member in an emergency situation to the nearest facility as appropriate • Contacts SWH NCM-SNF to report transfer SWH NCM-SNF: • Monitors inpatient admission • Arranges for SNF bed hold • Coordinates discharge planning with hospital and nursing facility staff • Enters authorization into authorization application
Hospital to Home	SWH NCM-UM: • Ascertains the member's condition and status • Coordinates post discharge care plan with hospital discharge planner • Authorizes needed services • Enters authorization into authorization application • Communicates with appropriate SWH NCM-Community to alert NCM of need for post-hospital follow-up • Communicate with Client Services to notify GSSC to resume home and community-based services SWH NCM-Community: • Conducts post discharge phone call or home visit to member to manage transition • Schedules assessments, drafts care plan and coordinates an ICT review when change in status has occurred • Provides PCP with update on hospital stay

Transition of Care	Tasks/Responsibilities
Home to Hospital (non-elective)	SWH NCM-UM: • Reviews pre-admission status and care plan with NCM-Community and shares with hospital care manager. Review may include factors which affect hospital course and optimal discharge. • Contacts admitting facility to perform medical necessity review of admission • Enters authorization into the authorization application • Monitors progress of inpatient stay • Coordinates discharge plan with hospital staff with a focus on alignment of post-acute needs (i.e. advocacy for SNF placement, proximity to member's community, CLAS) • Communicates transition with SWH NCM-Community, GSSC

Home to Hospital (elective)	Facility or member/caregiver/home care nurse or PCP contacts SWH NCM-UM/Community.
	
	SWH NCM-UM/Community:
	• Discusses admission with the PCP
	• Contacts admitting physician to perform medical necessity review of admission and procedure
	• Arranges, as appropriate:
	    ○ pre-procedure conditioning programs
	    ○ Nursing facility site visits
	    ○ Home evaluation for DME
	    ○ Skilled service needs in the home
	    ○ Availability of family/care support post discharge.
	    ○ Community-based services in place prior to admission.
	• Enters authorization into the authorization application
	• Monitors progress of inpatient stay
	• Coordinates discharge plan with hospital staff

Home to SNF	SWH NCM : • Coordinates nursing facility admission with PCP, facility, member and ICT • Obtains orders from PCP and makes sure these are sent to receiving facility • Establishes level of care and services required with nursing home staff • Reviews care needs and health status, and arranges transportation and admission • Enters authorization into the authorization application • Notifies NCM-SNF of the admission and the care plan

Transition of Care	Tasks/Responsibilities
SNF to Home	SWH NCM-SNF: • Ascertains the member's condition and status • Arranges for discharge planning meeting at facility, including participants of the ICT (member and/or caregiver, NCM-Community and the GSSC) • Develops care and service plans • Arranges for both skilled and non-skilled services, including home and community-based services • Verifies that authorized services are in place • Requests medication reconciliation from Pharmacy Team and review at discharge • Confirms member/caregiver has filled prescriptions understands medication changes, • Confirms member has made a follow-up appointment with the appropriate physician • Completes a nursing home checklist to be used for post-discharge calls.
Home to ADH	SWH NCM-Community: • Ensures that PCP has assessed member • Drafts care plan and coordinates ICT • ICT finalizes care plan • Reviews the care plan and obtains signature from Member/designated representative • Contacts Adult Day Health (ADH) staff, reviews care needs and health status • Alerts Client Services and GSSC that member authorized for ADH • Enters authorization into the authorization application
ADH to Home	SWH NCM-Community: • Contacts day care staff, reviews care needs and health status • Reviews status with GSSC and PCP • Drafts care plan and coordinates ICT • Assures that PCT finalizes care plan • Reviews the care plan and obtains signature from member/designated representative • Arranges home services replacing ADH, if needed • Enters authorization into the authorization application

Section 13 Provider Credentialing & Provider Changes

13.1 CREDENTIALING A NEW PHYSICIAN PROVIDER

Credentialing a new provider is a simple process. Providers may only become credentialed if they are directly contracted with, or part of a larger entity contracted with, SWH.

SWH requires that new providers submit:

- A completed SWH Provider Data Form
- W-9
- Sample claim (with PHI removed)
- Joinder (If your contract requires a joinder, you will be notified by SWH.)

For providers enrolled in CAQH, SWH requests that the provider enable SWH to access his/her record through CAQH.

For providers not enrolled in CAQH, SWH requires additional fields completed on the Provider Data Form, including but not limited to, UPIN, Social Security and license. The Provider Data Form is available on our website at www.seniorwholehealth.com or may be requested by contacting Provider Relations at 617-494-5353 or providerrelations@seniorwholehealth.com

SWH may follow-up with providers to gather more complete or up-to-date information than what is available from CAQH. This includes office hours, languages spoken, or other fields required for Medicare.

Providers undergoing full credentialing will be effective the first of the month following the month in which they are approved at SWH's Credentialing Committee. SWH will notify providers in writing once they have been approved by the Committee. For large group providers, SWH also offers a convenient group submittal form upon request.

13.2 CREDENTIALING A NEW NON-MD PROVIDER

In addition to physicians, SWH also credentials licensed health professionals such as NPs, physical, occupational and speech therapists, dieticians, podiatrists, and chiropractors.

NPs must meet standard credentialing criteria. For NPs interested in participating as PCPs, additional criteria must be met, including:

- NPs must be delivering care in a practice contracted with SWH for primary care services
- NPs must be delivering care under a supervising MD, who must either be credentialed or meet credentialing criteria by SWH
- The NP must have arrangements for admitting to an SWH contracted hospital
- NPs must notify SWH of their desire to act as a PCP by completing a special enrollment form. This form is available from the SWH Provider Relations Department.

Feel free to contact Provider Relations at 617-494-5353 with any questions about credentialing.

13.3 RE-CREDENTIALING PROVIDERS

SWH re-credentials providers in accordance with Massachusetts regulations. SWH makes best efforts to begin the process two (2) months in advance of the re-credentialing due date and notifies providers at least two (2) times in writing if information is missing or requires updating. Timely provider assistance with this process is appreciated and avoids potential patient care disruptions.

13.4 PROVIDER DEMOGRAPHIC CHANGES

CHANGE	ACTION	NOTICE PERIOD
New Providers to a Practice	Submit Provider Data Form	60 days prior to joining group
Providers Leaving a Practice	Written Notice	30 days in advance of last day.
Change of address, phone, panel status, etc.	Written Notice	30 days prior to effective date
New Tax ID Number	New W-9	30 days prior to effective date

Questions may be directed to Provider Relations at 617-494-5353.

Written notification should be mailed to:

Senior Whole Health, LLC
Attn: Provider Relations
58 Charles Street
Cambridge, MA 02141

Via email send to: providerrelations@seniorwholehealth.com

Via fax send to: Provider Relations at 617-494-5599

13.5 NOTICE REQUIREMENT FOR PRACTITIONERS TERMINATING FROM GROUPS

Provider groups shall provide SWH written notice of an SWH credentialed PCP's or SCP's termination of his or her group affiliation at least sixty (60) days prior to such termination. In the event that the PCP's or SCP's termination is effective in a time period less than sixty (60) days, the group shall provide SWH written notice immediately.

Section 14 Provider Directory

14.1 SWH PROVIDER DIRECTORY

SWH publishes a printed provider directory for Members and Providers and will provide copies of these directories to any Participating Provider upon request. SWH includes contracted Providers in such directories on the same basis as other similar SWH Participating Providers.

14.2 DIRECTORY ON DEMAND

SWH maintains an on-line provider directory that can be accessed via the web at http://www.seniorwholehealth.com/mass/members/provider_directory.htm

14.3 DIRECTORY CORRECTIONS / UPDATE

If any information regarding a provider listing is incorrect or needs to be modified, please contact the Provider Relations department at Senior Whole Health. Refer to the Notice Provisions in the Provider Credentialing and Provider Changes Section of this manual.

Section 15	Appendix

15.1 QUICK REFERENCES

- **Quick Reference Guide**
- **Referral and Authorization Grid**
- **Authorization/Out of Network Referral Form**
- **Universal Health Plan/Home Health Authorization Form**

15.2 CLAIMS

- **Provider Payment Dispute & Adjustment Request**
- **R.A. Sample**

15.3 MEMBERSHIP & ELIGIBILITY

- **FAX Form for Eligibility Confirmation**
- **Sample Member ID Card**
- **Eligibility Verification**

15.4 PHARMACY

- Abridged Formulary
- Comprehensive Formulary
- MassHealth Formulary
- Prior Authorization Criteria
- Prior Authorization Form
- Quantity Level Limits
- Step Therapy Algorithms

15.5 PRIMARY CARE PHYSICIANS

- **SWH PCP Assessment Form**
- **PCP/NP Enrollment Form**

15.6 SPECIALTY CARE PHYSICIANS

- **Authorization/Out of Network Referral Form**

15.6 QUALITY IMPROVEMENT PROGRAM

- **Annual Quality Improvement Program Summary Description**

15.7 PROVIDER CREDENTIALING & CHANGES

- **Provider Data Form**